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Sir,
Response to: 'A different approach for manual foldable IOL injection for keeping wound size and integrity'

Many thanks to Özyol and Özyol[1] for their interest in our article.

Intraocular lens implantation is facilitated by the use of ophthalmic viscosurgical devices (OVDs) that possess moderate viscosity at medium shear rate.[2] We agree that the use of OVDs can be associated with complications if proper removal is not done; however, their use during implantation of intraocular lens (IOL) makes the process smooth and safe.

'Hydro-visco-implantation technique' may be a good approach to maintain the wound integrity and size after IOL implantation as suggested by the authors.[3] Presence of both OVD and balanced saline solution in anterior chamber produces a duality in the chamber that can result in poor visibility and shallowing of anterior chamber during IOL insertion. Irrigation can also lead to wash out of the OVDs as stated by Özyol and Özyol in their study, which can cause anterior chamber instability.[3]

It would have been really nice if Özyol and Özyol had done measurement of incision size and size of side port before and after IOL implantation. Anterior segment optical coherence tomography (ASOCT) study in such patients would really tell about the wound integrity and changes that occur both at the main incision site as well as the side ports where irrigation cannula is placed.

Hence we suggest the use of ASOCT to study the wound architecture after the technique described by Özyol and Özyol, which would further certify the safety of the technique.

Conflict of interest

The authors declare no conflict of interest.

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Sir,
Comment on 'The incidence of serious eye injury in Scotland: a prospective study'

We read with interest the paper by Morris *et al*[1] regarding 1-year incidence of serious eye injury in Scotland. The authors conclude that the incidence of serious ocular trauma requiring hospital admission for observation or treatment had decreased fourfold, from 8.14 per 100 000 in 1992 to 1.96 per 100 000 in 2009.[1] They postulate that under-reporting may account for a portion of this difference, noting a discrepancy between the Scottish Morbidity Records (SMR01) admission data and those reported through the British Ophthalmic Surveillance Unit.

We would like to report the annual incidence of serious eye injuries in our tertiary unit in Scotland at a similar time. Our stand-alone unit receives all serious ocular trauma in Edinburgh and the Lothians. Patients were identified from the ward admission logbook and cross-checked with theatre logbooks to ensure consistency. We identified 71 cases of ocular trauma requiring hospital admission in Edinburgh between January 2005 and December 2008 inclusive. This gives an annual incidence of 2.17 per 100 000 of population.[2]

Table 1 Visual outcomes 12 months after injury

OTS category	*NPL*	*PL to HMs*	*CFs to 6/60*	*>6/60 to 6/18*	*6/12 Or better*
1	4 (40%)	6 (60%)	0 (0%)	0 (0%)	0 (0%)
2	3 (23%)	6 (46%)	2 (15%)	1 (8%)	1 (8%)
3	0 (0%)	2 (14%)	0 (0%)	5 (36%)	7 (50%)
4	0 (0%)	0 (0%)	0 (0%)	2 (22%)	7 (78%)
5	0 (0%)	0 (0%)	0 (0%)	0 (0%)	3 (100%)

Abbreviations: CFs, counting fingers at 1 m; HMs, hand movements at 1 m; NPL, no perception of light; OTS, ocular trauma score; PL, perception of light.
This table shows the visual outcomes from our group of patients, broken down into numbers and percentages for each category.

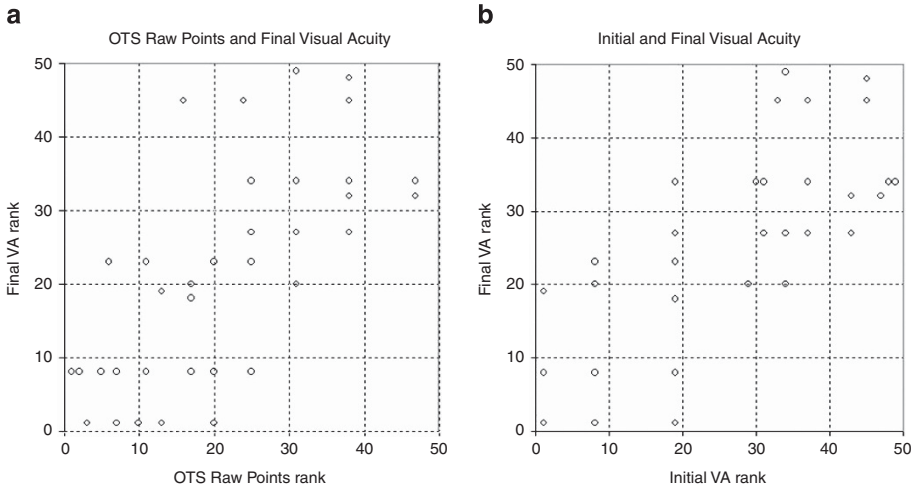

Figure 1 (**a**) Scattergraph plotting rank correlation of visual acuity at initial examination against final visual acuity. Correlation coefficient 0.785. (**b**) Scattergraph plotting rank correlation of OTS points allocated at initial examination against final visual acuity. Correlation coefficient 0.720.

Table 2 Results of regression analysis on the our data

Regression	*Coefficients (and P-values) of variables*						*Adj* R^2
	Constant	*Initrank*	*RAPD*	*Rupture*	*Endop*	*RD*	
I	5.9 (0.013)	0.732 (0.000)					0.608
II	17.0 (0.000)	0.437 (0.000)	− 12.6 (0.001)				0.683
III	6.3 (0.021)	0.725 (0.000)		− 1.02 (0.764)			0.607
IV	6.2 (0.009)	0.729 (0.000)			− 12.0 (0.190)		0.615
V	6.7 (0.016)	0.712 (0.000)				− 2.08 (0.552)	0.603
VI	16.8 (0.000)	0.439 (0.000)	− 12.9 (0.001)	1.16 (0.709)			0.677
VII	16.7 (0.000)	0.449 (0.000)	− 12.0 (0.003)		− 5.2 (0.547)		0.679
VIII	18.2 (0.000)	0.408 (0.001)	− 12.7 (0.001)			− 2.60 (0.407)	0.681

Abbreviations: endop, endophthalmitis; RAPD, relative afferent pupillary defect; RD, retinal detachment.
Initrank = ranking coefficient based on initial visual acuity; rupture = blunt trauma globe rupture.
The *P*-values (in brackets) on the coefficients are based on a two-way *t*-test.

Visual outcomes at 12 months were obtained for 49 patients undergoing surgical repair of open-globe injury (Table 1). These were grouped by severity of initial ocular trauma, as categorised by the Ocular Trauma Score (OTS).[3] Comparing our outcomes with those of the original OTS data, we found initial visual acuity (VA) to have a similar predictive value of final VA to the OTS-predicted outcomes (correlation coefficient 0.785 *vs* 0.720; Figure 1). Moreover, out of the OTS variables noted on initial examination, linear regression analysis showed the presence of a relative afferent pupillary defect (RAPD) to be the single greatest predictor of poor visual outcome (Table 2).

Our data, gathered over 4 years, also demonstrate a reduced hospital admission rate for serious ocular trauma, supporting that of Morris *et al*. Prevention strategies, along with improvements in ocular trauma management, are likely to account for the reduced incidence and improved visual outcomes. Clinicians are reminded that initial VA and the presence of an RAPD are important prognostic indicators in ocular trauma.

Conflict of interest

The authors declare no conflict of interest.

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