glaucoma secondary to proliferative diabetic retinopathy, and one had normal tension glaucoma. Three of these eight patients had documented gonioscopy. In cases in which gonioscopy was not performed, bilaterality, clinical suspicion, and clinical course indicated a non-pigmentary cause, although we agree that gonioscopy would be prudent to do in all cases in the future.

We agree with Drs Sandhu and Clarke about the importance of counseling patients regarding the risk of pigmentary glaucoma found in other studies.[2] Specifically, our study had a median follow-up of 12.5 months, whereas Chang *et al*[2] reported an average onset of glaucoma after 21.9 ± 17.1 months.

We are grateful to Dr Sandhu and Dr Clarke for their comments and emphasis on the importance of optic capture and its apparent benefit in reducing morbidity following sulcus placement of the MA50 intraocular lens.

Conflict of interest

The authors declare no conflict of interest.

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Sir,
Comment on 'Evaluation of choroidal thickness in patients with scleroderma'

We have read and reviewed the article entitled 'Evaluation of choroidal thickness in patients with scleroderma' by Coskun *et al*[1] with interest. The authors demonstrated that the patients with scleroderma had significantly thinner nasal, temporal, and subfoveal choroids compared with the healthy controls. The authors did not find any significant differences between the patients with limited-type and diffuse-type scleroderma in terms of subfoveal choroidal thickness (CT).

As it has been known and has been mentioned in the study, glaucoma may be seen in patients with scleroderma. Yamamoto *et al*[2] found a significantly higher prevalence of normal-tension glaucoma (NTG) and primary open-angle glaucoma (POAG) in patients with scleroderma when compared with the normal controls. Allanore *et al*[3] showed increased prevalence of ocular glaucomatous abnormalities in scleroderma. Therefore, we would like to ask the authors whether the patients included in the study had the data regarding cup/disc ratio and visual field, and whether the patients were analyzed for possible NTG and/or POAG.

Although the effect of IOP on CT is controversial, a number of studies in the literature indicated that it could have a significant effect on CT.[4,5] Saeedi *et al*[4] demonstrated a negative correlation between mean CT and IOP.[4] We also noted that IOP measurements and comparisons of the participants were not presented in the study.

A number of local and systemic physiological/pathological conditions may affect CT.[6] We wonder presence of any systemic diseases other than diabetes, history of the medications used for scleroderma or other diseases, use of alcohol or caffeinated or non-caffeinated beverages or smoking before OCT, and the systemic blood pressure measurements. It has been known that all those factors have significant effects on CT.[6]

Conflict of interest

The author declares no conflict of interest.

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