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**Sir,**
**Stability and safety of MA50 intraocular lens placed in the sulcus**

We are grateful to the authors[1] for making this useful contribution to a limited literature, alluding to the fact that an ideal sulcus intraocular lens (IOL) option remains elusive, across a wide refractive range, for cases where posterior lens capsule support is lost.

Of particular interest is the data relating to the prevalence and description of glaucoma in this cohort, with none of the patients in whom optic capture was achieved developing glaucoma. The inference is that of the 38 eyes that did not have optic capture, 9 of these (24%) developed either ocular hypertension alone, glaucoma, or UGH type syndrome (non-neovascular glaucoma cases). It does seem reasonable here to suggest that the risk of further morbidity in these patients is enhanced by the absence of a captured optic, where support was available, exposing them to a greater risk of developing secondary glaucoma.

We do believe that the mechanism of ocular hypertension/glaucoma in this context is primarily an outflow obstruction, stemming from pigment deposition at the trabecular meshwork. This clinical scenario is well described in the literature for both sulcus-placed single-piece acrylic and 3-piece acrylic-PMMA intraocular lenses.[2–4] Indeed, from our own experience, the sequelae here can be significant, requiring aqueous shunt surgery.

In this patient cohort, most notably those without optic capture in whom the IOL would be prone to lateral instability, which included those cases in which ocular hypertension/glaucoma was observed, were no unilateral angle morphology changes observed at the trabecular meshwork consistent with pigment dispersion? One assumes that the clinical phenotyping of these patients was comprehensive, including gonioscopic evaluation? With a relatively short median long-term follow-up period in this study, more cases of pigment dispersion glaucoma may emerge after a longer follow-up period, as demonstrated in other case series.[3] It may be appropriate to counsel patients of this risk.

We believe that the importance of optic capture is understated and ought to attract greater emphasis in the management of phacoemulsification complications. Indeed, this practice was a recommendation of the 2009 ASCRS Cataract Clinical Committee, with Chang *et al*[2] eloquently describing the technique and the mechanisms of advantage.

### Conflict of interest

The authors declare no conflict of interest.

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**Sir,**
**Response to Dr Sandhu and Dr Clarke**

We thank Dr Sandhu and Dr Clarke for their correspondence in regard to our paper on the safety and stability of the MA50 intraocular lens when placed in the sulcus.[1]

In addressing the angle morphology of patients without optic capture of the intraocular lens in which ocular hypertension, glaucoma or iritis was observed, none were diagnosed with pigment dispersion syndrome based on clinical characteristics. Of the eight patients, three had iritis, one had iritis and open angle glaucoma, one had ocular hypertension alone, one had steroid-induced ocular hypertension, one had neovascular

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 $21.9 \pm 17.1$ 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.

### References

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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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