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▼ Fig. 2 a Medial rectus tendon held with superior rectus holding forceps and pulled temporally to confirm lateral movement of the eyeball. b Cotton suture used to bridle the medial rectus and traction applied temporally by clamping along with the sterile drape. Note the centration of the eyeball and resultant ease to proceed the surgery

References

 Apt L. An anatomical reevaluation of rectus muscle insertions. Trans Am Ophthalmol Soc. 1980;78:365–75.

Eye (2018) 32:1153–1153 https://doi.org/10.1038/s41433-017-0012-0

- Sethi HS, Dada T, Rai HK, Sethi P. Closed chamber globe stabilization and needle capsulorhexis using irrigation hand piece of bimanual irrigation and aspiration system. BMC Ophthalmol. 2005;5:21.
- Loeffler M, Solomon LD, Renaud M. Postcataract extraction ptosis: effect of the bridle suture. J Cataract Refract Surg. 1990;16(4): 501–4
- 4. Gupta D. *Glaucoma Diagnosis and Management*. Lippincott Williams & Wilkins, USA; 2005. 378 p.

Comment on: 'How to defuse a demographic time bomb: the way forward?'

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I enjoyed reading the article by Buchan et al. [1], and agreed with the authors' proposals until I read that 'Bilateral cataract patients can be treated with just three hospital visits...' but surely the answer should be 2 not 3? If the patient has bilateral cataract and no specific contraindication, why can they not have a first hospital visit to confirm the diagnosis, obtain consent and biometry, followed by second hospital visit for ISBCS (Immediate Sequential Bilateral Cataract Surgery)? Follow-up and data on optical outcomes can be done in the community by accredited optometrists.

The risk of bilateral endophthalmitis, which has never been described with modern techniques correctly applied, is now calculated to be of the order of 1 in 12 million operations [2]. TASS should never occur and is probably rarer than endophthalmitis although hard data doesn't exist. Fears about biometry have largely been overcome with optical biometry and improved formulae such as the Hill RBF. Published data from a large American series shows no difference in outcome between ISBCS and 2 delayed sequential cataract surgery [3].

In seeking improvements, we should not cling to outdated fears which complicate cataract management pathways. The UK should follow other countries such as Finland where the cost advantage of 839€ per patient (at 2011 costs) is well recognised [4] and conversations with local ophthalmologists indicate that the majority of cataract surgery is now ISBCS.

There is nothing more powerful than an idea whose time has come.

Compliance with ethical standards

Conflict of interest The author declares that he has no competing interests.

References

- Buchan JC, Amoaku W, Barnes B, Cassels-Brown A, Chang BY, Harcourt J, et al. How to defuse a demographic time bomb: the way forward? Eye 2017;31:1519–22.
- Li O, Kapetanakis V, Claoué C. Simultaneous bilateral endophthalmitis after immediate sequential bilateral cataract surgery: what's the risk of functional blindness? Am J Ophthalmol. 2014;157(4):749–51.
- Herrinton LJ, Liu L, Alexeeff S, Carolan J, Shorstein NH. Immediate sequential vs. delayed sequential bilateral cataract surgery: retrospective comparison of postoperative visual outcomes. Ophthalmology. 2017;124(8):1126–35.
- Leivo T, Sarikkola AU, Uusitalo RJ, Hellstedt T, Ess SL, Kivelä T. Simultaneous bilateral cataract surgery: Economic analysis; Helsinki Simultaneous Bilateral Cataract Surgery Study Report 2. J Cataract Refract Surg. 2011;37:1003–8.

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