

recommended A-constant was used to calculate IOL power. The axial length adjustment with Wang–Koch modification was applied. The refractive value in the other eye determined the refractive aim in the operated eye.

In the Buckle group, 360 degrees encircling silicone band was inserted through four scleral tunnels at the beginning of surgery before phacoemulsification or inserting any trocars. The surgeries were done by two groups of surgeons according to their surgical preference, the first group adopted vitrectomy combined with scleral buckle and the second group adopted vitrectomy with retinectomy. Baseline characteristics of both groups were not statistically different which indicate that both groups were similar without any bias towards any of the two groups.

Heavy Silicon Oil Study which compares heavy and standard silicone oil (SO) in patients with inferior PVR failed to demonstrate superiority of a heavy tamponade [3]. Moreover, several complications have been associated with heavy SO surgery, such as prolonged intraocular inflammation and intraocular pressure increase, probably due to the early emulsification of heavy SO [4]. That is why we preferred to use SO (5000 cs) as a tamponading agent which has the least rate of emulsification [5].

The mean postoperative IOP was significantly higher in the Buckle group throughout the whole follow-up period. This may be due to impaired venous drainage from the vortex veins, leading to congestion of the ciliary body. The edematous ciliary body is displaced anteriorly, shifting the lens-iris diaphragm forward and resulting in narrowing of the angle [6]. Visual acuity was better at first month in the Buckle group, but this difference disappeared throughout the remaining follow-up period, achieving the same functional outcome.

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Smartphone adaptor use for nasal endoscopy

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The number of patients prevented subgroup analysis for the grades of PVR. Performing a prospective larger study for better statistical analysis will be a great idea. Once again, we would like to thank Awasthi et al. for sharing their comments.

Compliance with ethical standards

Conflict of interest The authors declare that they have no conflict of interest.

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Nasal endoscopic examination is an important part of the preoperative assessment in patients presenting with nasolacrimal duct obstruction, particularly when planning endoscopic dacryocystorhinostomy (DCR). Deviated nasal septum can impede the access to the middle meatus and identifying this preoperatively facilitates surgical planning for simultaneous septoplasty where indicated. Other pathologies such as synechia, nasal polyps and chronic

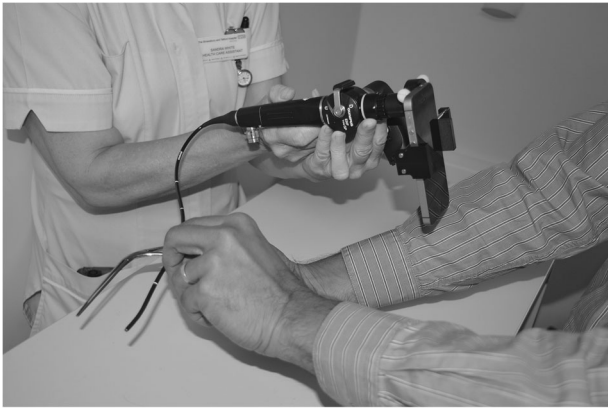


Fig. 1 Smartphone adaptor for nasal endoscopy set up

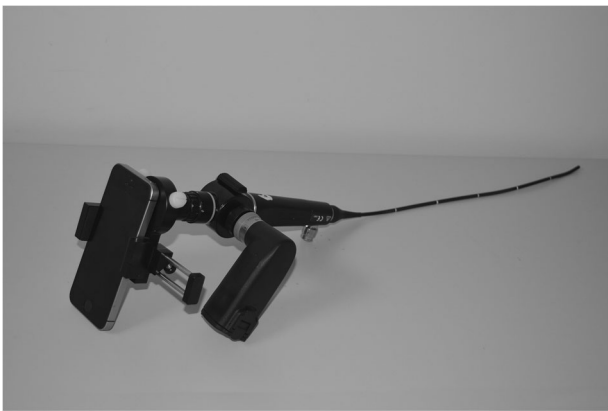


Fig. 2 Smartphone adaptor with the flexible nasal endoscope

rhino-sinusitis can also be identified during the nasal endoscopic examination preoperatively.

We routinely use a flexible endoscope for nasal examination in the clinic for preoperative assessment. A flexible endoscope is easier to use than a rigid endoscope [1] and is well tolerated without the need of topical nasal anaesthesia or decongestant. However, only one clinician can view through the eyepiece of the endoscope at any one time and it is not possible to demonstrate or teach simultaneously.

Using a smartphone adaptor enables live image display on the screen of the smartphone, which can be viewed by more than one clinician at a time [2].

It also allows the use of a flexible endoscope for removing silicone stents postoperatively, as the surgeon can use one hand to hold the forceps and the other to hold the tip of the flexible endoscope (Fig. 1). There is no need to hold the eyepiece of the endoscope, as this is attached to the smartphone and is held by an assistant (Fig. 1).

The smartphone adaptor (RVA Smart-Clamp) shown in figure 2 costs less than £115.00 and fits most of the modern smartphones (Fig. 2). This adaptor can be used with a flexible or rigid endoscope with a 31.75 mm eyepiece. There are several varieties of smartphone adaptors available in the market and we do not have any financial interest in any of the adaptors. Smartphone adaptor is significantly cheaper and a less cumbersome alternative than a camera with monitor attachment required for displaying the image.

We use a smartphone adaptor for preoperative and postoperative examination in patients undergoing DCR (see Supplementary video) and find it very useful in training junior doctors/fellows in the oculoplastic clinic. Attaching the smartphone adaptor to the flexible endoscope frees a hand of the clinician to allow removal of silicone stents postoperatively (see Supplementary video). We find this particularly useful, as flexible endoscope is more comfortable for patients compared to a rigid endoscope and can be used without the need of topical nasal anaesthesia or decongestant.

Compliance with ethical standards

Conflict of interest The authors declare that they have no conflict of interest.

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