Correspondence

To the Editor:

We read with great interest the article by Lee et al. In the article, the authors retrospectively compared the effects of two kinds of mydriatics on preventing postoperative posterior synechia. They claimed that the short-acting mydriatics were more effective in reducing the severity and incidence of posterior synechia. We would like to raise a few points to broaden the discussion.

First, this is a retrospective study, and certain biases may exist in a retrospective study. In this study, one important factor leading to bias is that the use of two kinds of mydriatics was not randomized. We do not know how the doctors decided to use which mydriatics. Is it related to the expected postoperative reaction? The authors may consider adjusting the reasons behind the use of different mydriatics to reduce this kind of bias.

Second, details about the anterior chamber reaction after surgery were not available in the article. Although "posterior synechia is the result of inflammation inside the anterior chamber," the severity of anterior chamber inflammation is judged not only from the postoperative anterior chamber fibrin deposit but also from the cells and flares present in the anterior chamber. It is necessary for the authors to list the details about the cells and flares in the anterior chamber of each postoperative visit and compare these details in the analysis. Moreover, details about the grading of postoperative anterior chamber fibrin deposit are also needed. Because the authors claimed that the fibrin deposit was one of the risk factors for developing posterior synechia, it is important for us to know whether the evaluation of the severity of postoperative fibrin deposit was appropriate.

Third, the authors may consider describing how well the patients stayed prone or in a face-down position after surgery. The posturing was originally advocated for patients who had long-acting gas tamponade. We found in our practice that the compliance of patients in the prone or face-down position was very important in the development of posterior synechia. If the patients cannot keep this kind of position or use the supine position too much, posterior synechia or even papillary block may occur more easily. Therefore, we routinely informed the patients to keep the prone or face-down position when they were discharged and in the first postoperative visit. Furthermore, the authors might consider the duration of the gas tamponade in the vitreous cavity, because the longer the gas is maintained in the eyes, the longer the growth factors may accumulate in the anterior segment in the prone or face-down position or the longer the gas may push the lens capsule against the iris in the supine position.

Fourth, the authors may consider giving the details of quantifying posterior synechia so that we can compare different studies on this topic. How to define the clock hour of posterior synechia? Is there a ring or something to be used or is it just evaluated on the slit lamp without any other tools? The distance from the center of the pupil to the site of posterior synechia is another point to consider if precise evaluation of the extent of posterior synechia is to be made, because the actual length of posterior synechia may be different if the very distances mentioned above are different, even if the clock hours are the same.

Finally, the authors may also consider cataract grading, especially nucleus grading and intraocular laser parameters, because these may also influence the severity of the postoperative reaction and hence affect the development of posterior synechia.

Yi Jun Hu, MD
Wei Qi Chen, MD
Joint Shantou International Eye Center
Shantou, Guangdong Province
China

References

Reply

To the Editor:

We thank Drs. Hu and Chen for their letter in response to our article “The effect of mydriatics on posterior synechia after combined pars plana vitrectomy, phacoemulsification, and intraocular lens implantation.” In general, we kindly ask Drs. Hu and Chen to bear in mind that this investigation was conducted with a retrospective chart review and might have that inherent weakness when looking for specific
information. Although we conducted a retrospective analysis, our study groups were sequential, and it was mentioned in our article. Therefore, our study could have some randomization effects in division of patient groups.

In our study, all patients had simple rhegmatogenous retinal detachment and most of them had mild cataract (61 patients with nucleosclerosis grade 1, 6 patients with grade 2, and 2 patients with grade 3). No statistically significant difference in nucleosclerosis grade was found between the two patient groups. In all patients, fluid–gas exchange was made with 14% C₃F₈, and the instruction was given to stay in the face-down position for 2 weeks after surgery. After surgery, posterior synechia was evaluated on the slit-lamp examination without any ancillary tool, and the details including the distance from the center of the pupil to the site of posterior synechia were not recorded. Regarding postoperative anterior chamber reaction, almost all patients showed mild anterior chamber cell reaction (grades 1 and 2) after surgery, and mild postoperative anterior chamber fibrin was only observed in eight patients. Furthermore, no postoperative synechia was detected in the patient groups that had postoperative anterior chamber fibrin. Therefore, we think that the anterior chamber reactions including fibrin deposit did not have an influence on our study results.

This study was retrospective and had some limitations. A larger prospective study including several detailed factors that could affect the development of posterior synechia, as Drs. Hu and Chen mentioned, will provide more information about the relation between other factors and posterior synechia.

Sung Bok Lee, MD
Deok Goo Lee, MD
Joo Young Kwag, MD
Jung Yeul Kim, MD
Department of Ophthalmology
Chungnam National University
Deajeon, Korea

To the Editor:
I read with interest the article by Ji et al.¹ The authors mention fastidious Gram-negative bacilli such as HACEK and Haemophilus as causes of bilateral endogenous endophthalmitis. This may be redundant because the letter “H” in HACEK stands for Haemophilus.²

Weekitt Kittisupamongkol, MD
Hua Chiew Hospital
Bangkok, Thailand

References

Reply
To the Editor:
We thank Dr. Weekitt Kittisupamongkol for his constructive criticisms and suggested revisions for the article. His point is well made and correct.

We reviewed Dr. Weekitt Kittisupamongkol’s statement that “the authors mention fastidious Gram-negative bacilli such as HACEK and Haemophilus as causes of bilateral endogenous endophthalmitis. This may be redundant since the letter ‘H’ in HACEK stands for ‘Haemophilus.’” Again, Dr. Kittisupamongkol is correct.

The acronym HACEK refers to a group of Gram-negative bacilli; Haemophilus species (Haemophilus parainfluenzae, Haemophilus aphrophilus, and Haemophilus paraphrophilus), Actinobacillus actinomycetemcomitans, Cardiobacterium hominis, Eikenella corrodens, and Kingella kingae. We thank you and Weekitt Kittisupamongkol, MD, for carefully reviewing our article.

Shuxing Ji, MD, PhD
Xiaolei Yin, MD, PhD
Rongdi Yuan, MS
Shaozhang Liu, BS
Jian Ye, MD, PhD
Department of Ophthalmology, Daping Hospital
Third Military Medical University
Changjiang Zhilu, Daping
Chongqing, People’s Republic of China