

Authors' reply

Sir,

We thank our colleagues for their keen interest in our article.^[1]

First, rate of posterior capsule opacification is higher irrespective of lens material used in vitrectomized eyes^[2] as elevated oxygen tension after vitrectomy induces a relatively higher concentration of oxygen distribution near the lens causing rapid proliferation of lens equatorial cells.^[2-4] In addition, neodymium-doped yttrium aluminum garnet capsulotomy in previously vitrectomized patients is not free from complications.^[5] In our experience, the view improves significantly by making an opening in the posterior capsule, especially during macular surgeries. Based on extensive prior experience, this has been our surgical preference when performing phacovitrectomy.

Another reference quoted claiming increased risk of neovascular glaucoma (NVG) after posterior capsular opening is related to eyes undergoing lensectomy with vitrectomy and dates back more than three decades (1983). These results cannot be extrapolated to combined femtosecond laser-assisted cataract surgery and 25 g vitrectomy for obvious reasons. To summarize, there is tremendous improvement in instrumentation, and techniques with wide-angle visualization systems allow better intraoperative visualization of peripheral retina for thorough endolaser photocoagulation, thus minimizing risk of neovascularization of the iris or NVG. We believe that making an opening in the posterior capsule is a matter of choice and not a debatable topic in the current context.

Second, we completely disagree on the assumption that capsulorhexis does not play an important role in phacovitrectomy. Hypotony secondary to retinal detachment and poor fundal glow in cases of vitreous hemorrhage pose significant challenges during capsulorhexis which can be appreciated while actually performing surgeries. The addition of femtosecond laser in our armory makes our job easier and eliminates an important concern.

Third, our colleagues question our choice of retinal reattachment surgery in two eyes. In our opinion, surgical decisions are made depending on the configuration of the retinal detachment, phakic status, extent of the posterior vitreous detachment, proliferative vitreoretinopathy, and previous surgical results among other factors.

We have preferred our surgical approach based on these variables as well as surgical comfort, which are not debatable issues and completely out of context of the current paper. Hence, we have refrained from bringing too many technicalities in our published paper, given that only 2 cases underwent phacovitrectomy for retinal detachment.

Fourth, our colleagues question intraoperative hypotony while performing vitreous base excision with sclera indentation. The 2.2 mm self-sealing tunnel made with keratome was stable with no wound leakage, negating the need for sutures while scleral depression was undertaken. As this question concerns the primary phaco incision that we have created manually and not using the femtosecond laser system, we fail to understand the need for this question in the current context.

Finally, our colleagues dogmatically state that "a femtosecond laser-assisted cataract surgery with vitrectomy has no advantages over a conventional phacovitrectomy." We find this statement unduly assertive and this mindset regressive, given the many advances that we are yet to witness with the femtosecond laser. We simply conclude that femtosecond laser-assisted cataract surgery combined with vitrectomy offers many practical advantages and a comparative study is required to show whether this offers better outcomes or not.

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Conflicts of interest

There are no conflicts of interest.

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