

Comment on: To assess survival outcomes of combined femtosecond laser-assisted cataract surgery with 25-gauge vitrectomy surgery at a tertiary eye care center

Sir,

We have read with keen interest the article entitled, "To assess surgical outcomes of combined femtosecond laser-assisted cataract surgery with 25-gauge vitrectomy surgery at a tertiary eye care center" by Kelkar *et al.*^[1] Although the article has enlightened us, we have a few queries regarding the same.

1. Why was a posterior capsulotomy done in all cases? Was it because of intraoperative view issue? Was it to prevent postoperative opacification with necessity of a yttrium aluminum garnet capsulotomy?

If an aspheric hydrophobic lens was used in all cases, the incidence of posterior capsular opacification would be low in any case.^[2] Second, the incidence of neovascularization of iris increases with an open capsule and hence a posterior capsulotomy should have been avoided in the diabetic vitrectomy cases at least.^[3]

None of the patients had a Grade 4 cataract. A competent phacoemulsification surgeon would have had no difficulty in doing cataract surgery in any of these cases. In any case, the authors have mentioned that they did away with nucleus softening procedures in cataract less than Grade 4 nuclear sclerosis, which in effect includes all the patients [Table 2]. Hence, we gather that the only procedure, which was done consistently, was a femto rhexis. In our experience, the rhexis does not play such an important role in combined cataract surgery and vitrectomy to merit such a complex and expensive procedure.

There were two cases of rhegmatogenous retinal detachment with cataract. What was the indication of vitrectomy in these cases? Was it a primary vitrectomy? In which case why was silicon oil used as tamponade? Did the patients have proliferative vitreoretinopathy changes? Was there any need for a band? As the retina was attached postoperatively in both the cases, probably a belt was not needed but then could these patients have been managed with either pneumatic retinopexy or a buckle, and a cataract surgery could have been done at a later date. This would have solved the conundrum of intraocular lens power calculation in an eye with retinal detachment. Gómez-Resa *et al.* have used a scleral buckle in the single case that was found to have a retinal detachment intraoperatively in spite of doing 23-gauge vitrectomy with a femto cataract surgery.^[4]

2. Vitreous base shaving was done in the eyes with retinal detachment. Was scleral depression used during this maneuver? Was the tunnel stable during this procedure? In our experience, the main tunnel has to be sutured to prevent leakage and subsequent problems in a conventional phacovitrectomy for retinal detachments. This suture is removed at the end of surgery. Was it different here? The tunnel was anyways made with a

keratome and hence the femto wound architecture is taken out of the equation.

We feel that the jury is still out for femto cataract surgery and hence, in our country at least with economic constraints, a femto cataract surgery with vitrectomy has no advantages whatsoever over a conventional phacovitrectomy.

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Conflicts of interest

There are no conflicts of interest.

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