

## Conflict of Interest

No potential conflict of interest relevant to this article was reported.

## References

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## Is This Really Sutureless Intrasceral Pocket Technique of Transscleral Fixation?

Dear Editor,

Cho et al. [1] described the “Sutureless intrasceral pocket technique of transscleral fixation of intraocular lens in previous vitrectomized eyes” in April issue. The authors prepare two scleral pockets with a crescent knife 2 mm from the limbus and opposed 180 degree each other without any conjunctival dissection. Following, they enter into the posterior chamber with a 26-gauge needle including 10/0 nylon suture transsclerally and transconjunctivally at a point of 1.5 mm posterior from the limbus. Following clear corneal incision (CCI), prolene sutures were exteriorized through the CCI pocket and a three-piece foldable acrylic intraocular lens was injected via CCI and the ends of the haptics were exteriorized through the CCI. The prolene sutures for each haptic in the intrasceral pocket bed were then tied and knots were buried under scleral flaps, in their technique.

To us, this description and title were not completely true. This technique is not a sutureless one. In fact, it is a modified sutured and intrasceral pocket technique of transscleral fixation of intraocular lens. In sutureless techniques defined until now, a permanent suture was not used inherently [2-5]. In the trocar-assisted technique of sutureless intrasceral posterior chamber foldable intra-ocular lens fixation which we described, we put a non-absorbable 10/0 nylon suture transconjunctivally after the placement of the haptics into the scleral groove and take it out 1 week after [2,3]. We aimed to stabilize the haptics at early postoperative period. The authors defined their technique as the first scleral fixation method without conjunctival dissection and

emphasized that it has the advantage of lack conjunctival dissection and lesser risk of conjunctival bleeding [1]. We disagree with authors about that. In the trocar assisted sutureless technique we developed, we have been entering into the eye with 25-gauge vitrectomy trocars without any opening of conjunctiva performing two 3 mm long scleral tunnels parallel to the limbus apart from 180 degree each other and angulating 10 degree with scleral surface. We performed vitrectomy entering by through these two canulas. One haptic of the intraocular lens which implanted through a CCI is held with a forceps that inserted through CCI and grasped in the eye with a forceps that inserting into and removed from the eye via trocar cannula and placed into the tunnels. We put a 10/0 nylon suture encircling the haptic for security and take it out 1 week after. By repeating same processes for other haptic, both haptics became implanted into the scleral tunnels. The advantages of our technique are lack of conjunctival dissection and scleral flaps in addition to minimal possible damage to circumferential tissues. We do not encountered with any complication such as decentralization or tilt of intraocular lens, endophthalmitis, glaucoma and retinal detachment [2,3]. In terms of simplicity, we think that our method is simpler and needs shorter surgical time as it does not need to prepare conjunctival dissection and scleral flaps.

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## Author reply

Dear Editor,

We appreciate the concerns Dr. Karadag and the Editor have about our report. In particular, Dr. Karadag indicated two important issues within the report. His concerns are summarized as follows: First, our technique of haptic suturing in the intrascleral pocket [1] was not the real meaning of “sutureless transscleral fixation”; thus our title was not appropriate. Second, Dr. Karadag indicated that his method—He used 25-gauge vitrectomy trocars to create two 3-mm-long scleral tunnels without conjunctival dissection, and then inserted an intraocular lens through a clear corneal incision; using a forceps to insert (and remove) haptics from the eye via trocar cannulas and with 10/0 nylon suture encircling each haptic [2]—has more advantages in transscleral fixation of posterior chamber fold-

able intra-ocular lens fixation than our method.

Actually, I agree with Dr. Karadag’s opinion of our report. In fact, our technique was introduced to minimize conjunctival damages and suture-related complications, such as, suture erosion and infection in previously vitrectomized eyes. Minimizing conjunctival dissection or division would decrease the needs for a postoperative conjunctival suture. For these reasons, the procedure we called “sutureless transscleral fixation” would be more appropriately called “transscleral fixation with intrascleral pocket technique”.

As Dr. Karadag also mentioned, sutureless transscleral fixation is simpler and requires less surgical time. However, transscleral fixation using trocars is unfamiliar, and thus burdensome, to anterior segment surgeons. Furthermore, there is a possibility that the trocars will pass through and injure the ciliary body of the pars plicata, causing bleeding. Therefore, we would like to mention that our transscleral fixation technique is safe and more familiar to anterior segment surgeons.

We thank Dr. Karadag again for his kind advice, and suggest that readers of our report recognize our method as “transscleral fixation with intrascleral pocket technique”.

Sincerely,

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