

## Phacoemulsification and pars plana vitrectomy: A combined procedure

Dear Editor,

We read the article by Jain *et al.*<sup>1</sup> with interest. We congratulate the authors for their study and agree with them regarding the utility of the combined phacoemulsification and pars plana vitrectomy at the same sitting. Ours is a high volume retina unit and we are performing more than 50 similar combined procedures in a year. All our retina surgeons are proficient in phacoemulsification also. We would like to suggest few points to augment this fine study.

1. The authors have not discussed the remedies for difficult capsulorrhexis due to absent or faint red reflex (due to retinal detachment or vitreous hemorrhage). Capsular staining with Vision Blue® (D.O.R.C. International b.v. The Netherlands) is very useful in these cases. In some cases we switch to slit light in our operating microscope (OPMI VISU 210, Zeiss) which also helps.
2. It is true that phacoemulsification is difficult in previously vitrectomized eyes, especially in cases where gas was used because of absence of vitreous support. In silicon-filled eyes, there are two main problems. One is the appearance of emulsified oil through the zonules which interfere with visualization. At times, zonular dehiscence can even lead to unstable lens in which case capsular tension rings may have to be used. Second problem in silicone-filled eyes is the positive pressure of oil which pushes the posterior capsule up. This situation may be managed by keeping an anterior chamber maintainer in place. We agree that placing an intra ocular lens (IOL) prior to vitrectomy is a better option because after the globe is opened by way of sclerotomies and after fluid air exchange, gas or oil it would be difficult to place the IOL in the bag.
3. One interesting observation in the study by Jain *et al.*, was the use of hydrophobic acrylic IOLs in all the cases.

Hydrophobic acrylic IOLs are less biocompatible in comparison to hydrophilic IOLs. They have a tendency to bioadhesiveness, hence more difficult to perform Nd:YAG laser capsulotomy later, if there is posterior capsular opacification and there are more chances of IOL damage during laser.<sup>2</sup> Moreover, if silicon oil is to be used then hydrophobic acrylic IOLs are not a good choice because silicon oil adheres to it more readily than to the hydrophilic IOLs.<sup>2</sup> This will make visualization of fundus difficult in postoperative follow-up.

4. It would be interesting to know why sclerotomies were done 3.5 mm behind limbus in all the cases instead of standard 3.0 mm as is done in pseudophakic eyes.

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## References

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