treated eye (score = 2) for publication. While the range of scores is not presented anywhere in the paper, the standard deviations are expressed as bars in Figure 1 in the article. Note that neither a 16 nor a 2 are represented in the standard deviation bars. Furthermore, the bars demonstrate the large variability in these scores, again calling into question the statistical analysis provided and the selection of these 2 representative photographs.

The authors performed statistical analysis using the chi-square test with P values obtained via the Fischer exact test. This test is appropriate for comparison of 2 groups. However, this study uses a 4-treatment, 2-vehicle design. In the Wilcoxon rank sum test used for post-comparison analysis, the authors appropriately adjusted for the multiple comparisons using the Bonferroni correction, obtaining a critical value of \( P \leq 0.0083 \) for significance. This correction should also have been applied in Table 2 in the article, where none of the \( P \) values were less than 0.0083 and, therefore, the differences between the treatment groups were not statistically significant. The authors were incorrect in stating that the difference in clinical scores between the collagen shield treatments was statistically significant. Their own post-comparison analysis demonstrates this lack of a meaningful difference between the gatifloxacin and moxifloxacin groups.

In light of the above concerns, the conclusion that “gatifloxacin... was statistically superior to placebo in treating or preventing endophthalmitis and that moxifloxacin was not superior” is misleading due to lack of laboratory data and statistical evidence.

Richard O’Callaghan, PhD
Jackson, Mississippi, USA

Christina Ohnsman, MD
Philadelphia, Pennsylvania, USA

Jenny Song, MD, MS
Plano, Texas, USA

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4. Solomon R, Donnenfeld ED, Perry HD, Snyder RW, Nedrud C, Stein J, Bloom A. Penetration of topically applied gatifloxacin 0.3%, moxifloxacin 0.5%, and ciprofloxacin 0.3% into the aqueous humor. Ophthalmology 2005; 112:466–469

REPLY: We appreciate this careful review of our study. We agree that it would be useful to have additional values on the CFUs following treatment, and sampling the bacterial load after treatment is an important follow-up of this pilot study. The parameters used to evaluate the animals following injection of the bacteria and treatment are the standard signs used to evaluate endophthalmitis in an animal model. Only after follow-up studies could we surmise that our clinical scores were due to an antiinflammatory effect, which we highly doubt, and not an antibiotic effect. The signs assessed indeed reflect the inflammatory response of the eyes to the bacteria.

Regarding the statistical analysis, it is always difficult to disagree with a biostatistician. We concede that the standard deviation bars demonstrate large variability, which makes statistical analysis of the multiple groups studied difficult. However, all statistical analysis was performed by an experienced statistician and we stand by the study and its conclusions.—Randall J. Olson, MD, Nick Mamalis, MD, Liliana Werner, MD, PhD, Brian Haugen, MD

Correlation between preoperative refraction and other variables

In their recent article about evaluating the biometry of cataract eyes, Jivrajka et al. noted several correlations. I would like to know whether the authors examined the relationship of any of the variables to the preoperative refraction. In Holladay’s second formula, the preoperative refraction is a significant variable in determining the postoperative refraction for an intraocular lens. Olsen also found the preoperative refraction to be an important preoperative variable. I would very much like to know whether the preoperative refraction correlated with any measurement for axial length, anterior chamber depth, or lens thickness.

David L. Cooke, MD
St. Joseph, Michigan, USA
REFERENCES

REPLY: Based on a scale of 1 to 4, a large number of our patients had grade 2 or grade 3 nuclear sclerosis, with a definite myopic shift in the preoperative refraction. Any correlation between the preoperative refraction and the reviewed parameters would have yielded erroneous and skewed results, and we elected not to include this in the study.—H. John Shammas, MD

ERRATUM
In the August issue, the mean patient age in the article “Two-Year Interval Changes in Orbscan II Topography in Eyes with Keratoconus” (J Cataract Refract Surg 2008; 34:1295–1299) was incorrect. The correct mean patient age was 31.6 years ± 14.9 (SD).