obtained with a Scheimpflug system was entered as the Kpost, we do not understand how the described method had better performance than the other mentioned methods. If that was the situation, the calculations of prediction errors must be rechecked.

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REFERENCES


OTHER CITED MATERIAL


Reply: Dr. Galvis et al. wrote that the coefficient of determination ($R^2$) of 0.73 for the regression equation between the preoperative mean anterior K values in the 3.0 mm zone (Km) and the postoperative mean posterior corneal power in the 6.0 mm zone (Kmm) in 72 post-LASIK eyes does not guarantee that the model fits the data sufficiently well, because a high $R^2$ can occur in the presence of a misspecified functional form of a relationship or in the presence of outliers that distort the true relationship. However, as shown in Figure 1 in our article, the relationship between the 2 variables in our study was linear and included no outliers, meeting the major assumptions for simple linear regression analysis. Therefore, we believe the simple linear regression model is an appropriate functional form for the data and the parameter estimates are unbiased.

Second, we want to confirm that the constants a0, a1, and a2 for the Haigis-L method and the constant SF constant for the Holladay formula recommended by the ULIB web page were entered into the American Society of Cataract and Refractive Surgery IOL power calculator.

Regarding the postoperative Km, I agree with the comment that the Km is no longer valid theoretically once corneal refractive surgery disrupts the physiologic ratio between the anterior and posterior corneal curvatures, and the total corneal refractive power and true net power of the Scheimpflug system should be more valid to use as the postoperative Km in the double-K method.

Actually, we initially tried to establish our method using the total corneal refractive power or the true net power of the Scheimpflug system to avoid erroneous corneal powers, and we explored appropriate diameters and patterns (zone or ring) of the analysis area. However, the results with the total corneal refractive power or the true net power did not exceed the results with the Km. We ultimately adopted the Km as the postoperative K in our method. Why the Km achieved the best results needs to be clarified in future studies. Considering the corneal topography, we assumed that our study patients who had LASIK included cases with various depths of ablations ranging from shallow to deep. Therefore, we believe that the best results achieved using the Km did not result from bias in the ablation depths among the patients. Further investigation of a larger sample size is necessary to confirm which parameter is best, and we continue to explore an appropriate keratometric value using our method.—Megumi Saiki, PhD, Kazuno Negishi, MD, Naoko Kato, MD, Rika Ogino, CO, Hiroyuki Arai, MD, Ikuko Toda, MD, Murat Dogru, MD, Kazuo Tsubota, MD

Refractive outcomes in pseudoexfoliation syndrome

In their study of patients with pseudoexfoliation (PXF) syndrome having phacoemulsification cataract surgery and implantation of a single-piece foldable intraocular lens (IOL) in the capsular bag, Ishikawa et al. considered the hypothesis that the study eyes might obtain different refractive outcomes than the control eyes.

This hypothesis is interesting, as a weaker zonular apparatus might determine a different effective lens position, hence a different behavior in terms of predicted postoperative refractive error. Although the axial length distribution was similar in the 2 groups, the optical biometry was performed for all the eyes, and the same IOL was implanted, we believe that the authors should also provide further clarification to enable acceptance of their results.

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