Kim and Kang1 described the incidence and risk factors for pupillary optic capture after transscleral fixation of a posterior chamber intraocular lens (PC IOL) for dislocated IOLs. The authors concluded that a deeper anterior chamber was statistically correlated with an increased incidence of pupillary optic capture and recommend a more posterior placement of PC IOL haptics in that setting. We would like to comment on some aspects of their study that merit further consideration.

As described previously by Ma et al.,2 a larger anterior chamber depth (ACD) is correlated with a longer axial length, which is associated with reverse pupillary block, especially in vitrectomized eyes.3 Interestingly, Table 3 shows that 80% of the eyes were associated with a combined pars plana vitrectomy.1 However, reverse pupillary block as a causative factor for pupillary optic capture is not mentioned in the article. In fact, during a reverse pupillary block, the rise of intraocular pressure in the anterior chamber pushes the iris back against the PC IOL until it slips behind and creates the pupillary optic capture. At that point, the reverse pupillary block might not be evident and there is no countering force to put the iris back in its position. One of our cases2 also presented with pupillary optic capture in conjunction with reverse pupillary block, which can be challenging to diagnose. Higashide et al.1 described the use of anterior segment optical coherence tomography for identifying the concave iris configuration in reverse pupillary block in a small case series of pupillary optic capture of scleral-fixated PC IOLs.

The authors state that "the capture can reduce vision in some patients because of chronic uveitis with deposits on the IOL surface.” However, it is not mentioned whether the described 5 cases with pupillary optic capture had those findings. In fact, after PC IOL implantation, pigment dispersion might be associated with uveitis–glaucoma–hyphema (UGH) syndrome. In our study,3 we stated that reverse pupillary block might cause UGH syndrome after sulcus-placed PC IOLs in susceptible patients; that is, those with axial myopia and those who had a vitrectomy. It is important to look for those findings because this condition can be prevented with a laser peripheral iridotomy (LPI). In fact, in our case series,3 LPI was used to treat the reverse pupillary block with a resultant improvement in iris profile and resolution of UGH syndrome in all eyes, including the 1 with pupillary optic capture. To prevent reverse pupillary block and pupillary optic capture, the iridotomy is important and can also be performed during IOL placement surgery.

The authors concluded that to reduce the possibility of pupillary optic capture when the ACD is large, the haptics should be located more posteriorly from the limbus. Although optic and haptic position in relation to the iris plane is important in these eyes, we believe an iridotomy should be considered to address reverse pupil block and prevent pupillary optic capture. This might reduce the need for further surgical intervention.

Harmanjit Singh, MD, FRCSC
Montreal, Quebec, Canada
Steven G. Safran, MD, PA
Pennington, New Jersey, USA
Iqbal Ike K. Ahmed, MD, FRCSC
Toronto, Ontario, Canada

Disclosure: Dr. Ahmed is a consultant to Abbott Medical Optics, Inc., and Alcon Laboratories, Inc.

REFERENCES

Silicone intraocular lenses and negative dysphotopsia

An article by Henderson et al.1 compared the incidence of negative dysphotopsia associated with a silicone intraocular lens (IOL) (L61AO, Bausch & Lomb, Inc.) with that of an acrylic IOL (Acrysof SN60WF, Alcon Laboratories, Inc.). Oddly, and in distinction to previous reports, they found no negative dysphotopsia with the silicone IOL.2,3 They attributed this, in part, to the round edge of the silicone IOL, and, among other parameters, they impugn the square edge of the acrylic IOL. However, the authors are in error with respect to the edge of the silicone IOL because the L61AO has a continuous square-edged design.4 Therefore, the contention that negative dysphotopsia did not occur with the L61AO because of the round edge design is incorrect. Previously, we reported negative dysphotopsia in cases with the Crystalens (Bausch & Lomb, Inc.), a silicone IOL with a square edge; more noteworthy, we reported negative dysphotopsia with the AQ2010V (Staar Surgical Co.) and the SI-40NB (Abbott Medical Optics, Inc.), both silicone IOLs with round edges.5 Similarly, Trattler et al.6 reported...