valuable operating room resources. We agree that predicting operative time in cataract surgery is complex and that simply identifying high-risk preoperative clinical characteristics will not be adequate for developing a predictive model. We do, however, believe that these clinical characteristics in addition to knowledge of surgeon-specific factors will be essential elements of any future predictive model.—K. Matthew McKay, MD, Durga S. Borkar, MD, Giannis A. Moustafa, MD, Miriam J. Haviland, MSPH, Carolyn E. Kloek, MD, the PCIOL Study Group.

REFERENCES


Disclosures: None of the authors has a financial or proprietary interest in any material or method mentioned.

Delayed-onset postoperative endophthalmitis

In the recent article by Lu et al.,1 apart from highlighting the incidence and risk factors contributing to the development of endophthalmitis, the authors briefly discussed management strategy in 4 cases presented to them. In clinical practice, it is observed that patients do not develop endophthalmitis in the immediate postoperative period after a complicated cataract surgery, and the management of endophthalmitis is not met without a challenge. In this letter, we highlight the management challenges in 1 such case of delayed-onset postoperative endophthalmitis and address the relevant article by Lee et al.2

A 65-year-old woman presented with complaints of pain, redness, and marked diminution of vision in her left eye for 6 days. At presentation, she could only perceive light with inaccurate projection of rays in all quadrants. Intraocular pressure was low. This eye was operated for cataract 20 years ago, and an anterior chamber IOL was implanted. The surgical course was presumed to be complicated because a posterior capsular rupture was visible. The right eye had a corrected distance visual acuity of 6/12. A deep stromal corneal infiltrate at 12 o’clock (Figure 1, A) with underlying corneal perforation at the site of 2 loose sutures was visible after removing the infiltrate at that location. Vitreous cavity had exudates (Figure 1, A). Ultrasound B-scan demonstrated choroidal detachment.

Presuming suture-related endophthalmitis, infected sutures were removed, the perforation site was sealed with cyanoacrylate glue, and a bandage contact lens was applied. In addition, anterior chamber tap along with vitreous biopsy sample was retrieved, which was reported sterile on culture. Intravitreal vancomycin and tazobactam were administered. After 10 days of treatment with oral steroids and hourly instillation of ceftazidime 5% and tobramycin 1.3% eyedrops, choroidal detachment settled, and pars plana vitrectomy was performed. Intraoperatively, glue dislodged from its site, and therefore, the corneal fistula site was sutured with 10-0 nylon sutures,

Figure 1. Sequential slitlamp pictures. A: Deep stromal corneal infiltrate seen at 12 o’clock. Retrolental exudate was present. B: At 3 months after vitrectomy, corneal perforation site had sealed with 10-0 nylon sutures and glue in situ; however, corneal edema persisted.
replacing glue and bandage contact lens (Figure 1, B). Intravitreal injection of vancomycin, tazobactam, and dexamethasone was administered at the conclusion of vitrectomy. The patient responded well to treatment. Her visual acuity improved to 6/60 with accurate projection of rays, and intraocular pressure was 12 mm Hg; however, corneal edema persisted (Figure 1, B) for which she has been waitlisted for Descemet-stripping automated endothelial keratoplasty.

A rare category of surgical complications associated with cataract surgery is postoperative endophthalmitis complicated by the presence of sutures. Most reported cases have occurred 2 to 3 years postoperatively. Retained corneal suture can be problematic. Cataract surgeons should not be hesitant to place sutures to secure the wound when required nor should they forget the need for timely suture removal. Lifelong follow-up is indispensable for such cases, which can present after many years. The low yield of an organism from vitreous biopsy might be attributed to intensive topical antibiotic administration before sample retrieval. Endophthalmitis calls for vitrectomy, yet accompanying ocular morbidities need to be addressed simultaneously.

Siddharth Madan, MS, DNB, FICO
Monika Kapoor, MS
Himani Pal, MBBS
Preeti Singh, MBBS, MS
New Delhi, India

REFERENCES

Disclosures: None of the authors has a financial or proprietary interest in any material or method mentioned.

Another use for capsulorhexis-fixated intraocular lenses

I read with interest the report of the results and outcomes of capsulorhexis-fixated extended depth-of-focus intraocular lenses (IOLs) by Darian-Smith and Versace. Their findings gave support to the concept that IOL capsulorhexis fixation eliminated negative dysphotopsia. They further suggested that capsulorhexis-fixated IOLs might improve postoperative refractive predictability because the effective lens position and the alignment of the optic with the visual axis would be improved and that posterior capsule opacification, described by Tassingon et al., and negative dysphotopsia, described by Masket et al., might be prevented.

Capsulorhexis fixation of an IOL has yet an additional indication when performed together with small-incision cataract surgery and refilling of the lens capsule to restore accommodation, described some 30 years ago. In that report, 2 IOL designs were used, 1 with and 1 without a haptic (Figure 1). The groove at the IOL optic edge was enslaved to the capsulorhexis margin in both pig and rabbit eyes using...