number of times surgical repositioning was recommended and was performed. Besides these 2 studies, to our knowledge, other studies reporting surgical repositioning rates had much smaller sample sizes. For example, Miyake reported 6 toric IOLs that underwent repositioning surgery in which the mean rotation was more than 40 degrees. Many other toric IOL studies did not specifically report the mean degree of misalignment in those eyes undergoing repositioning surgery. The strength of our comparison study is the determination of 2 primary end points (repositioning recommended and performed) in more than 5500 consecutive toric IOLs. Unfortunately, operative photographs were not practical in a study of this size.

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Comment on: Effect of anti-inflammatory regimen on early postoperative inflammation after cataract surgery

We discussed the study by Erichsen et al. during the ESCRS journal club on April 7, 2021. The investigators examined an important question regarding the efficacy of perioperative anti-inflammatory regimens in the control of postoperative inflammation after routine phacoemulsification cataract surgery in uneventful eyes. We would like to highlight some points of discussion which are of relevance to the interpretation of the study. Aqueous flare, measured on postoperative day 3, was presented as the primary outcome measure in the study. However, on trial registration (ClinicalTrials.gov, NCT03383328), macular thickness as measured on optical coherence tomography imaging at 3 months was presented as the primary outcome measure. If it can be shown that the risk for subclinical cystoid macular edema (CME) varied according to flare, which itself differed among the treatment groups, this would help to validate the significance of flare on postoperative day 3. Although anterior chamber cell counts were found to vary statistically between the dropless and other treatment groups, the mean cell counts in all groups would be classified similarly as grade 0.5+ by Standardization of Uveitis Nomenclature (ie, <6 cells); the difference may not, therefore, be clinically significant.

The dropless group did not receive an active postoperative treatment. This may have led to bias in the reporting of symptoms by patients or in the treatment of patients by clinicians, neither of whom was masked to treatment allocation. The rate of adverse events in the dropless group at 3 days postoperatively seemed high at 53% and may have occurred, at least partly, because of this bias. Sham sub-Tenon injections may have enabled masking of assessing clinicians and would also control for adverse effects related to the sub-Tenon injection itself.

The ESCRS PREMED studies shed light on the efficacy of prophylactic regimens in reducing the risk of CME—the most important sequel of postoperative inflammation. A combination of topical steroid and nonsteroidal anti-inflammatory drugs (NSAIDs) were shown to reduce the risk for CME compared with either agent alone in non-diabetic patients undergoing routine cataract surgery. Observations made by Erichsen et al. further support this conclusion. A useful finding of the study was that initiation of drops preoperatively did not influence aqueous flare measurements at 3 days postoperatively. However, preoperative NSAIDs have been shown to reduce the risk for CME. This further underlines the importance of examining the association between early postoperative flare and CME.

The findings of this study should not end the pursuit of dropless surgery. The ESCRS PREMED study 2 showed that subconjunctival triamcinolone (40 mg) at the conclusion of surgery was found to be beneficial in reducing the risk for subclinical and clinically significant CME in diabetic patients who also received a combination of topical agents. It is likely that other depot steroid preparations may show efficacy in the control of postoperative inflammation as a dropless strategy, albeit with a risk of raised intraocular pressure. In addition to clinical efficacy, cost-effectiveness and patient-reported outcome measures will be influential in determining the optimal perioperative anti-inflammatory regimen for patients undergoing routine cataract surgery.

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4. Wielders LHP; Schouten JSAG; Winkens B, van den Biggelaar FJHM, Donnenfeld ED, Perry HD, Wittpenn JR, Solomon R; Nattis A, Chou T. Effect of anti-inflammatory regimen on early postoperative inflammation. Treatment regimens were ketorolac monotherapy vs ketorolac and prednisolone vs dropless approach in a design where the eyedrops could be started 3 days preoperatively or on the day of surgery. The main outcome of this study was macular thickening at 3 months, but the specific aim of our article was early postoperative inflammation. Macular thickening and the association between macular thickening and early inflammation will be reported separately, and we are happy to learn that readers are awaiting these reports.

5. We welcome the suggestions on how to design future studies of dropless surgery vs eyedrops. We believe that dropless surgery should be a genuinely drop-free approach if it is to replace the use of eyedrops in standard cataract surgery. Thus, adding an active (eyedrop) treatment to participants in the dropless group to prevent report bias may cause inability to assess dropless surgery as a drop-free approach. In addition, sham injections may be associated with a risk for eyeball perforation, and we did not find that it was ethically justified.

6. We agree that the PREMED study is currently the best available study for evaluating combination of steroid and nonsteroidal anti-inflammatory drugs (NSAIDs) eyedrops vs steroid or NSAID monotherapy, and our article supports the findings of the PREMED study by providing results on the early inflammatory response, which was not assessed in that study. However, the PREMED study did not show that combination was superior to NSAID monotherapy; it reported that incidence of pseudophakic cystoid macular edema (PCME) was lowest in the combination group, but pairwise comparisons with NSAID monotherapy showed no statistically significant differences. Similarly, the observation by Donnenfeld et al. that preoperative initiation of NSAID prophylaxis reduced the incidence of PCME was not statistically significant. To accurately estimate relative risks for developing PCME, even larger prospective clinical trials than the PREMED study or meta-analyses of large studies are required, and an internationally accepted definition and classification of PCME is needed.

7. Yusuf et al. state that the pursuit of dropless surgery should not end with our study and we agree. But, we recommend investigating other approaches than sub-Tenon dexamethasone and that future studies compare dropless surgery with eyedrop regimens containing NSAID eyedrops and not steroid monotherapy.

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