



## **Outcome of in-the-bag implanted square-edge polymethyl methacrylate intraocular lenses with and without posterior capsulotomy in pediatric traumatic cataract**

Dear Editor,

We read with interest the article "Outcome of in-the-bag implanted square-edge polymethyl methacrylate intraocular lenses with and without posterior capsulotomy in pediatric traumatic cataract"<sup>[1]</sup> by Verma *et al.*, in the September 2011 issue of IJO, but we have a few points and questions to make the article more pertinent.

The main purpose of the article is to study the outcome of square-edge Poly Methyl methacrylate lenses with or without primary posterior capsulotomy in traumatic cataract in children. Several studies have been done to compare various types of

lenses in children (which included traumatic cataracts) with and without primary posterior capsulotomy. Acrylic foldable lenses have shown better outcome as compared with PMMA lenses in these studies.<sup>[2]</sup> Therefore, we assume that the variable in this study would be the primary posterior capsulotomy. But, primary posterior capsulotomy in cataract surgery in children less than 6 years of age has become a standard of care<sup>[3,4]</sup> – why should there be any difference in surgery involving traumatic cataracts? The pathology of posterior capsular opacification is not going to change whether the cataract is developmental or traumatic? There should be some reason for not doing a primary posterior capsulotomy as visual axis opacification (VAO) is almost universal in children.<sup>[5]</sup>

Hence, the second part is also a foregone conclusion.

Was any upper limit of age considered for a primary posterior capsulotomy? There is no mention of this. Children older than 6 years of age can cooperate for a Yttrium Aluminium Garnate capsulotomy and hence a primary posterior capsulotomy may not be necessary.

The preoperative vision was recorded as ranging from perception of light with inaccurate projection to 20/80 in both groups. Was any thought given to why the patients had inaccurate projection and what was the final visual acuity in these patients?

The time interval between injury and trauma ranged from 0.7 to 7 months in group A and 0.2 to 25 months in group B. What was the reason for surgery as early as 0.2 months (as early surgery results in severe postop inflammation, posterior synechia, lens deposits and VAO and, possibly, cystoid macular edema, which is difficult to diagnose in children. Delaying the surgery by at least 6 weeks stabilizes the blood aqueous barrier and results in less inflammation and possibly decreases the possibility of CME. What was the reason for delaying surgery for as many as 25 months? (As late surgery will result in amblyopia.)

**Suresh Ramchandani, Sushama Ramchandani**

Shivam Eye Foundation, Nerul, Navi Mumbai, India

**Correspondence to:** Dr. Suresh Ramchandani,  
Shivam Eye Foundation, Plot no 14, Sector 25, Nerul (E), Navi  
Mumbai, Maharashtra, India.  
E-mail: [shivameyeclinic@hotmail.com](mailto:shivameyeclinic@hotmail.com)

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