

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.² Most reported cases have occurred 2 to 3 years postoperatively. A retained corneal suture can be problematic.³ 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.⁴ 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.^{1,5} Endophthalmitis calls for vitrectomy, yet accompanying ocular morbidities need to be addressed simultaneously.

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

Reply: We appreciate the case report of late-developing, suture-related endophthalmitis several years after original cataract surgery. This case is unfortunately not unique, and many cases of suture-related infectious keratitis are witnessed when timely suture removal is not completed.¹ A small fraction of these suture-related infectious keratitis cases will lead to an

inner extension of the microorganism and result in endophthalmitis. In this case, the lack of a posterior capsule or posterior chamber lens led to a more rapid extension into the posterior chamber. Much of the aggressive nature of these cases will depend on the type of microorganism and the time to diagnosis and management. If time of suture breakage or loosening to diagnosis and removal and initiation of antimicrobial therapy is rapid, then more severe sequelae can be avoided. In environments where access to medical care might be delayed, a more severe sequelae such as the one seen here can occur. Your case underscores the need for timely removal of corneal sutures in the early postoperative period because this severe infection could have been avoided. Our article regarding postcataract surgery endophthalmitis related to cases of endophthalmitis in the acute to subacute postoperative period and not to suture complications and questioning the necessity of intracameral antibiotics in routine cataract surgery in a developed country.² The incidence of endophthalmitis without routine intracameral antibiotics at our tertiary-care hospital was low in routine cases. —*Marjan Farid, MD*

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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.¹ 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.^{2,3}

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.⁴ 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 enclaved to the capsulorhexis margin in both pig and rabbit eyes using



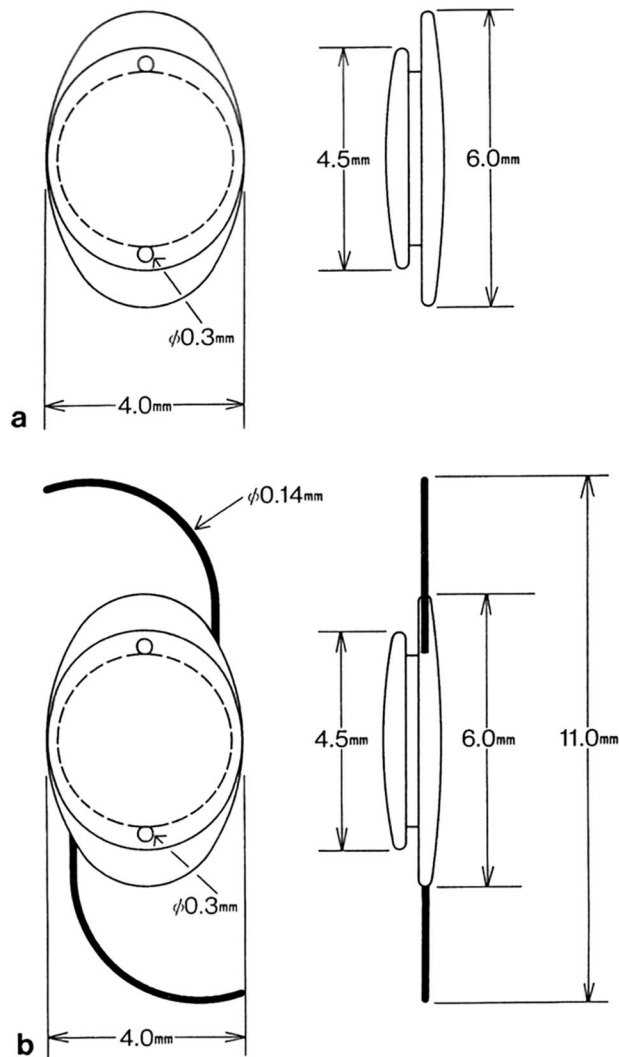


Figure 1. Capsulorhexis-supported intraocular lens made of poly (methyl methacrylate).

a similar technique to that of Darian-Smith and Versace. The needle of a syringe containing a silicone mix was injected (Figure 2). The needle was withdrawn on complete refilling of the capsular bag with the silicone mix.

As a consequence, an immediate firm enclavement of the optic edge groove to the capsulorhexis margin without silicone leakage was achieved. Within 2 hours, the silicone mix polymerized in the capsular bag, creating such a firm fixation that the IOL remained in its position despite extensive pressure exerted on the refilled capsular bag by the soft, malleable, silicone compound. Similar techniques using capsulorhexis-fixated IOLs might well have potential in the evolution of future cataract surgery methodology.

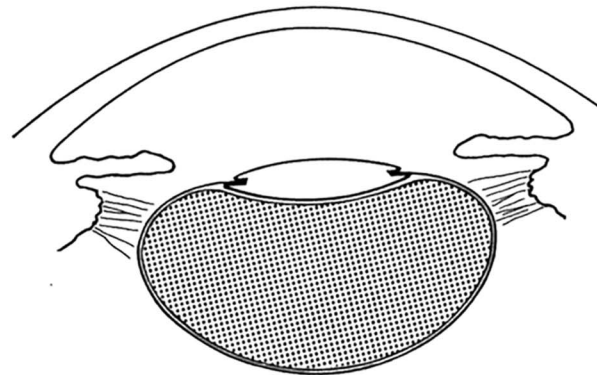
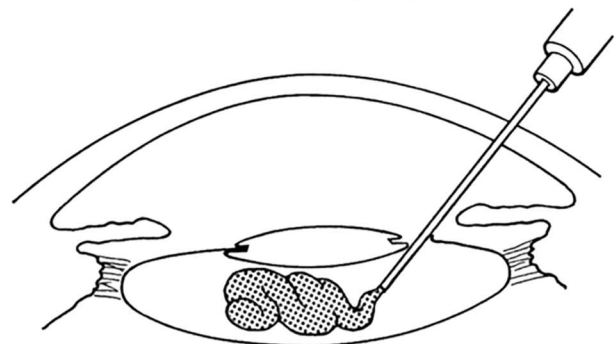
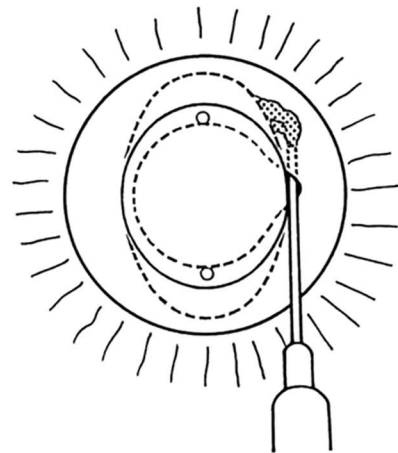


Figure 2. Schematic representation of the silicone refilling of the lens (From Ref. 4 with the permission of *Graefes Arch Clin Exp Ophthalmol*).

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Reply: We thank the correspondent for taking the time to remind us of capsular bag refilling as an aspirational technique for creation of an accommodating pseudophakic IOL. Capsular bag refilling with silicone polymers is an attractive option for restoring accommodation. An optical element could be used both to seal the capsular bag by closing the capsulorhexis opening and as a lens that moves in an anterior–posterior axis with the polymer lens shape change giving a power



shift for near focusing. Various techniques have been described for capsular bag refilling, but all have been limited by their inability to give a predictable refractive outcome and the loss of accommodative effect with capsular fibrosis.

The Femtis capsule-fixated extended depth-of-focus IOL (Oculentis) uses static optical principles to give the IOL extended range of focus. This avoids the vagaries of the changing anatomy of the eye postoperatively with the inevitable capsular fibrotic stiffening and allows predictable refractive outcomes. Attachment of the Femtis IOL to the anterior capsulorhexis is designed not to seal the capsular bag but to minimize the chance of capsular bag syndrome, and this principle of enclavation would not be appropriate for capsular bag refilling techniques. Lens development remains one of the most exciting areas of prosthesis research in medicine, and each design adds to our ability to optimize outcome and predictability of quality vision for our patients.—*Erica Darian-Smith MBBS MMed, Patrick Versace FRANZCO*

Ophthalmic Photographers' Society Exhibit, May 2019

Category: Slitlamp Photography—Honorable Mention



INTRALENTICULAR METALLIC BODY

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