To the Editor:

I would like to mention a few points in relation to the article by Romkens et al1 on “Early Phacoemulsification After Acute Angle Closure in Patients With Coexisting Cataract.”

The patients in this study underwent phacoemulsification within 3 months (range, 1 to 84 days) after an attack of acute primary angle closure (APAC). What I have observed is that, depending on the time of patient presentation after APAC, for a majority of patients, it generally takes around 2 to 3 days for epithelial oedema to subside and a weeks’ time for the corneal stroma to clear reasonably and inflammation to resolve, with medical management. Hence, it is unclear as to, how the surgery was performed on the first day after an acute attack of APAC, as corneal oedema precludes sufficient visibility to perform cataract surgery.

The preoperative and postoperative gonioscopy findings and duration of follow-up after the cataract surgery are not mentioned. The importance of performing gonioscopy, since the cornea clears, is to know the extent of peripheral anterior synechiae, which can cause trabecular dysfunction and an increase in intraocular pressure during the follow-up period.

As the preoperative and postoperative optic disc and visual field information is not known from the study, how did the authors divide the subgroups into PAC and PAC glaucoma. The optic disc, visual field,2 and retinal nerve fiber layer thickness3 show changes after APAC and if the patient has progressed to PAC glaucoma, combining phacoemulsification with trabeculectomy would have been more beneficial for the patient in terms of the intraocular pressure reduction and reducing the number of glaucoma medications.

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REFERENCES

In Reply:

We thank Mansoori for his comments on our manuscript titled “Early phacoemulsification after acute angle closure in patients with coexisting cataract,”1 and we feel pleased to have the opportunity to respond.

Cataract surgery was solely performed after the acute angle-closure (AAC) attack was treated according to our standard protocol with topical and systemic medical therapy to lower intraocular pressure (IOP) and clear corneal edema, after which laser peripheral iridotomy was performed as soon as the cornea permitted good visualization. In the 1 case in which cataract surgery was performed after 1 day, the AAC attack resolved quickly, and the cataract surgery could be performed because of sufficient visualization of the cornea.

The gonioscopy performed during the AAC attack reported that the trabecular meshwork was not visible and that the anterior chamber angle was closed. As a retrospective study, we acknowledged that it had some potential limitations and that further studies should confirm our findings. As mentioned, this resulted in missing data on the gonioscopy findings after cataract surgery. However, this study was solely performed to evaluate the effect on IOP number of glaucoma medications, visual acuity, and complications of cataract extraction after an AAC attack, and the extended study on gonioscopy findings fell outside the scope of this study. Nevertheless, one could hypothesize that the IOP decrease after surgery could only have taken place if the anterior chamber angle was opened, and there were little to no synechiae.

Primary angle closure (PAC) (glaucoma) was defined according to the definition of the consensus reading.2 PAC was defined as angle closure in three or more quadrants with either raised IOP and/or peripheral anterior synechiae, without glaucomatous visual field defects and without glaucomatous optic neuropathy. Primary angle closure glaucoma was defined as PAC but with reproducible visual field defects, glaucomatous optic neuropathy, or both.

The primary goal of this study was to report data on cataract extraction alone within 3 months after the AAC attack. There was no further follow-up concerning progression from PAC to primary angle closure glaucoma. Visual fields are performed several months postoperatively after which is determined whether further additional surgery is necessary. This study showed that early phacoemulsification with intraocular lens implantation results in a reduction in IOP and number of glaucoma medications after an AAC glaucoma crisis in patients with coexisting cataract. It was not designed to evaluate the effect of a combined

Disclosure: The authors declare no conflict of interest.

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phacotrabeculectomy, rather it could be stated that early phacoemulsification is meaningful, and a trabeculectomy could be performed in a second surgery.

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