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Correspondence

Posterior chamber lens implantation

SIR, I wish to make two points following recent articles by Percival[1] and Jay[2] concerning posterior chamber intraocular lens implantation associated with filtration surgery. My first point concerns the risk of visual loss in the postoperative period. It would appear that glaucoma patients are at risk of the damaged optic nerve being further compromised from postoperative hypertension following cataract surgery even if the intraocular pressure was controlled with medicines preoperatively. For such eyes the provision of a 'blow off valve' should always be considered, and the presence of an intraocular lens is not a contraindication.

The second point concerns the worry that endothelial damage may follow the occurrence of flat chambers in eyes with a posterior chamber lens. If, as seems likely, these follow excessive drainage through the bleb or along non-conventional outflow pathways, it may be possible to avoid the former by correct suturing of the lamellar scleral flap and the latter by avoiding intraocular lens implantation in eyes severely damaged from glaucoma.

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ROGER A HITCHINGS

References

1 Percival SPB. Glaucoma triple procedure of extracapsular cataract extraction, posterior chamber lens implantation, and trabeculectomy. *Br J Ophthalmol* 1985; **69:** 99–102.
2 Jay JL. Extracapsular lens extraction and posterior chamber intraocular lens insertion combined with trabeculectomy. *Br J Ophthalmol* 1985; **69:** 487–90.

SIR, Postoperative ocular hypertension may indeed act adversely on an already compromised optic nerve. However, it is a recognised complication of any intraocular surgery including trabeculectomy and laser trabeculoplasty. It is transient and, if watched for, should not rise to dangerous or unmanageable levels. The use of Healonid during the glaucoma triple procedure may enhance this complication but tends to obviate the more serious risk of shallow or flat anterior chamber and possible macular oedema associated with hypotony.

Concerning the contraindication to lens implantation, experience has shown that, using the technique recommended,[1] flat chambers seldom arise. The capsule supported posterior chamber lens once in position is unlikely to compromise the corneal endothelium or optic nerve either directly or indirectly. Thus severe glaucoma is not necessarily a contraindication to its use.

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Reference

1 Glaucoma triple procedure of extracapsular cataract extraction, posterior chamber lens implantation, and trabeculectomy. *Br J Ophthalmol* 1985; **69:** 99–102.

SIR, In his letter Mr Hitchings mentions firstly the risk of a postoperative rise in intraocular pressure in glaucoma patients following cataract surgery. This problem seems less likely where trabeculectomy has been combined with the cataract extraction and is one of the reasons why many surgeons favour a combined operation.

His second point is more directly relevant to my own paper.[1] He seems concerned about the risk of a postoperative flat anterior chamber in the presence of a posterior chamber intraocular lens following combined surgery. I may best answer this point by quoting from the summary of my paper: 'In addition the anterior chamber cannot become shallow, as the rigid legs of this lens [Rayner Pearce tripod] extend behind the iris beyond the periphery of the cornea and prevent forward movement of the implant even if there is excessively free drainage of aqueous after the operation.' This fail-safe feature of the Pearce tripod lens is explained in the discussion section and illustrated in Fig. 3.

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Reference

1 Jay JL. Extracapsular lens extraction and posterior chamber intraocular lens insertion combined with trabeculectomy. *Br J Ophthalmol* 1985; **69:** 487–90.

Book review

Contemporary Issues in Ophthalmology. Vol 1. **Herpes Simplex Infections of the Eye.** Edited by Frederick C Blodi. Pp 171. £37·00. Churchill Livingstone: Edinburgh. 1984.

This short volume has chapters by several authors covering some important topics on herpes simplex infections of the eye. The first and last chapters are particularly useful, giving concise and contemporary analysis of the eye disease and management. My only criticism is that I would have expected more basic science as far as the virus itself was concerned and the antiviral agents used. Apart from this I found the book very readable, interesting, and informative. Priced at £37, it is within the grasp of most ophthalmologists

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