

# Response

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the treatment of Acute Angle Closure in patients with coexisting cataract. However, we have a few queries.

Firstly, the author mentioned that in 4 patients with very short axial length, phacoemulsification was combined with vitrectomy for the purpose of debulking. Our query is whether any of those cases were diagnosed with malignant glaucoma. Because to the best of our knowledge vitreous does not expand and does not contribute for narrowing of the angle and vitrectomy (debulking) only helps in the treatment of malignant glaucoma.<sup>2,3</sup>

Secondly, there were no data regarding preoperative and postoperative gonioscopy findings. So, the information regarding changes in angle morphology following early phacoemulsification is lacking, which we feel would have been useful information.

Thirdly, we would like to know whether there were any intraoperative difficulties or postoperative complications in the management of the patients with Acute Angle Closure Attack in comparison with phacoemulsification in other normal patients as previous studies have shown that patients with shallow anterior chamber depth are at an increased risk of developing complications during cataract surgery such as posterior capsule rupture/zonular dialysis, Iris prolapsed, corneal edema, descemet tears, etc.<sup>4</sup>

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## Response: Early Phacoemulsification After Acute Angle Closure in Patients With Coexisting Cataract

### In Reply:

First we would like to thank Dr Sengupta and colleagues for their keen interest in our study and we feel pleased to respond to their input.

The reason for performing vitrectomy before phacoemulsification was due to safety reasons and was not because of glaucoma treatment after acute angle closure. In these few cases, the anterior chamber was very shallow. Vitrectomy was performed to increase the anterior chamber depth and thus decrease the

chance of complications during phacoemulsification (anterior capsular tear, endothelial damage despite soft-shell technique, descemet tears, iris prolapse, or even rupture of the posterior capsule).

As a retrospective study, we acknowledged that it had some potential limitations. Because of the retrospective nature of the study, no standard postoperative gonioscopy was performed. We agree with Dr. Sengupta's suggestion that these gonioscopy findings would be of useful information and we reiterate the need for further research.

As mentioned in our Results and Discussion section in the manuscript,<sup>1</sup> in 6 eyes, a capsular tension ring was inserted because of zonular weakness. Posterior synechiolysis was performed in 9 patients. Rupture of the posterior capsule did not occur. There were no iris prolapses and no descemet tears. In our group, no corneal decompensation occurred after surgery; however, surgery was solely performed by highly experienced surgeons using a soft-shell technique with dispersive viscoelastics to protect the endothelium.

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1. Romkens HCS, Beckers HJM, Schouten JSAG, et al. Early phacoemulsification after acute angle closure in patients with coexisting cataract. *J Glaucoma*. 2018;27: 711–716.

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