MISLEADING TERMINOLOGY

Your editorial "Laser Treatment is Invasive Surgery," which appeared in the July issue, is well taken. I agree that the term "non-invasive" should not be used to refer to laser sclerostomy or any laser procedure. There are other ways to express the advantages of laser sclerostomy without being misleading. Probably, ultrasound therapy (non-diagnostic) should similarly not be termed "non-invasive."

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TRANSIENT LENTICULAR WATER CLEFT

The article "Transient Lenticular Opacification Following Trabeculectomy" (Ophthalmic Surgery 19:508) reminded me of a patient (female, age 62) who developed a transient lenticular water cleft after a non-traumatic prophylactic peripheral iridectomy for angle-closure glaucoma in her left eye (1970). The extensive water cleft extended from the area of the peripheral iridectomy toward the pupil. The postoperative course of the left eye was uncomplicated. The patient had been treated for acute angle-closure glaucoma with a peripheral iridectomy in her right eye 3 weeks previously.

Visual acuity in the left eye was 20/20 with correction before the peripheral iridectomy. After surgery, visual acuity was blurring to 20/50 with correction due to an extensive water cleft extending over the central visual axis. Six weeks later the water cleft disappeared and visual acuity returned to 20/20. Follow-up visits for the next 15 years revealed only a minimal progressive amber nuclear sclerosis, with no recurrence of any lenticular cortical water clefts or opacification in the left eye. The visual acuity on her last office visit before her death was 20/25.

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IMPLANTATION OF A POSTERIOR CHAMBER LENS WITHOUT CAPSULAR SUPPORT DURING PENETRATING KERATOPLASTY OR AS A SECONDARY LENS

I have read the recent article entitled "Implantation of a Posterior Chamber Lens Without Capsular Support During Penetrating Keratoplasty or as a Secondary Lens" by Spigelman et al in the June issue of Ophthalmic Surgery (1988; 19:396-398) with a great deal of interest. My colleagues and I have reported our experiences on posterior chamber lens implantation in the absence of capsular and zonular support and are most pleased that Spigelman et al have also had encouraging experiences by using techniques similar to ours. I was especially pleased to see that the technique that they have employed for a secondary implantation of a posterior chamber intraocular lens uses the principle of threading the lumen of a needle with a prolene suture. I described this technique a few years ago for a repair of iris coloboma in a closed chamber,1 which we2 as well as others3 have used for suture fixation of the intraocular lens haptics, especially when a special needle such as Ethicon CIF-4 (catalog 788-Gr, Ethicon Inc.) is not available.

As my colleagues and I have already pointed out repeatedly,2,4 it is important to use posterior chamber intraocular lenses with their haptics having either a control tip or club-like deformation at each end to prevent accidental slippage of the fixation suture intraoperatively or postoperatively.

I also want to mention that in some eyes that have had complicated extracapsular cataract extraction or phacoemulsification, there may be enough capsular and zonular remnant proximally or distally that it can support one of the haptics without suture fixation, and only one haptic may need to be fixated with a suture to the sclera through the ciliary sulcus.

The growing body of experiences and evidence for successful implantation of posterior chamber intraocular lens with suture fixation of the haptics to the sclera through the ciliary sulcus in the absence of capsular and zonular support2-6 may encourage more anterior segment surgeons to prefer a posterior cham-