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REPLY: We are familiar with the elegant work of Sharma and his coworkers. If Descemet membrane is taken from a corneal button, a thin layer of posterior stroma could also be stripped off. In our clinic, we tentatively refer to such minimal stroma-supported grafts as "thin Descemet-stripping endothelial keratoplasty (DSEK) grafts" (±50 μm) to distinguish them from "Descemet membrane endothelial keratoplasty (DMEK) grafts" (±20 μm) that are stripped from an intact corneoscleral rim. This difference in thickness seems clinically relevant because the presence of even a thin stromal layer in thin DSEK cases may affect the final visual outcome (Melles, unpublished observations, 2007), whereas DMEK cases seem to achieve their maximum visual potential better.[1] In cases not appropriate for DMEK, we consider a thin DSEK a second-best alternative procedure.

However, Sharma et al.'s histological figures do not appear to show any remnant stromal layers. We therefore do not have a good explanation for the difference among studies in the tendency of an isolated Descemet membrane to form a roll (Melles GRJ, et al. IOVS 1998; 39(suppl):ARVO Abstract 343; Sharma A, et al. IOVS 2002; 43:ARVO E-Abstract 3179).[2]—*Jessica Lie, PhD, Renuka Birbal, Lisanne Ham, MSc, Isabel Dapena, MD, Jacqueline van der Wees, PhD, Gerrit R.J. Melles, MD*

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Risk for recurrent suprachoroidal hemorrhage during cataract surgery

I have some comments about the consultation section[1] concerning a 70-year-old woman with a history of vitreoretinal surgery and intraoperative suprachoroidal hemorrhage 8 years before progression of cataracts. After 11 pages presenting a wide spectrum of experts' opinions about the risk factors for recurrent suprachoroidal hemorrhage in this patient—from no risk (Neuhann) to mild risk (Hofbauer and Miller), moderate risk (Davison), and significant risk (Padilha)—the real outcome of cataract extraction remained unclear. Other significant controversies were in the choice of ocular anesthesia, including topical, retrobulbar, peribulbar, and general anesthesia.

There were also significant discrepancies in the duration of preoperative cessation of aspirin (from 7 days to 1 month). However, the reason aspirin had been prescribed by a general or cardiovascular physician and the probable side effects of discontinuing this anticoagulant on the patient's general heath were not mentioned. Before considering any change in medical prescriptions, I always look for the reason for the prescription of the medication and how it may be important and essential for the health status of the patient. If it is so critical that cessation for even 1 week may cause poor cardiovascular events, I continue the drug and proceed with clear corneal cataract surgery with topical anesthesia. I have never encountered problems with these patients; however, I have seen many cardiovascular problems in patients after discontinuing the anticoagulant.

Another issue was the need for wound suturing in this special case even if there was no leakage after stromal hydration, as there is the risk for hypotony after the lid speculum is removed, leading to postoperative choroidal hemorrhage. A single suture may decrease this probable risk with a negligible cost. A further issue is the type of cataract or "catarocks" as mentioned by Osher. It is mentioned in the literature that hard, black, and brunescent cataracts have a greater risk for suprachoroidal hemorrhage during cataract surgery.[2] Although most consultants noted the difficulties of cataract surgery in hard cataracts, none of them mentioned this as an independent risk factor for suprachoroidal hemorrhage.

The issue that prompted me to write this letter is that after reading all these controversies and discrepancies, which is sometimes the nature of consulting with different experts and the nature of medical science itself, the outcome of the surgery was not mentioned. As it is of utmost importance for clinicians to know the facts and not the fictions and because "the information is not the knowledge" and the points of views are not the realities and since most of the consultants

suggested cataract surgery for this patient, I suggest that the editor ask the primary physician to perform the surgery or refer the patient to an expert for cataract extraction and then report the outcomes in another issue of the journal to determine "who was right" and which precautions should have been performed to prevent the most probable complications. This may enhance the scientific value of this section and make it more attractive and educational for the readers as well as for the consultants.

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REPLY: I appreciate Mohammadpour's comments about the cataract consultation section question that concerns surgery in a patient with an advanced brunescent cataract, pseudoexfoliation, and a prior suprachoroidal hemorrhage during vitrectomy/retinal reattachment surgery. Curiously, earlier the patient's mother sustained an expulsive suprachoroidal hemorrhage at the time of cataract surgery.

Mohammadpour correctly asserts that there are many questions about management of this case that cannot be answered from searching the peer-reviewed literature. It is for that reason that cases of this nature stir controversy, create interest among the readership, and are selected for dissemination to obtain expert opinions. Would there be no "gray zones" for management, there would be no controversy and likely little interest. The varied responses for this particular case give testimony to its value for inclusion in the journal.

With respect to patient outcomes in the consultation section, for a variety of valid reasons, the editors have been loath to publish them routinely. However, with regard to your questions about this case, the patient was asked to discontinue aspirin for 14 days prior to surgery; it was considered to be medically unnecessary during the perioperative period as she used it for discomfort associated with osteoarthritis. Additionally, she was referred to a hematologist for evaluation to discern any form of coagulopathy; the work-up was negative. Surgery was performed under topical and intracameral anesthesia. An anesthesiologist provided limited sedation and monitored vital signs; the patient's blood pressure remained physiologic throughout the surgery. Torsional phacoemulsification using a stop-and-chop method was fortunately uneventful, and a toric single-piece acrylic intraocular lens was implanted in the capsule bag. At all times during the surgery, hypotony was avoided by adding either an ophthalmic viscosurgical device or balanced salt solution through the paracentesis simultaneous with removal of instruments or handpieces from the eye. Given that a 2.2 mm corneal tunnel incision was used, the incision was made square in its surface architecture and stromal hydration was used; no sutures were needed and the eye was never hypotonous after surgery. The patient was last examined 9 months postoperatively and had an uncorrected distance visual acuity of 20/20. Obviously, she is very pleased with the results of surgery.—*Samuel Masket, MD*