

Self-repositioned IOL in a vitrectomized eye

I would like to address some important issues raised by Mansouri's report of a self-repositioned intraocular lens (IOL) in a vitrectomized eye.¹

First, it is not clear when the radial tear at the 9:30 o'clock position occurred. I question whether it occurred during placement of a foldable single-piece plate-haptic acrylic IOL such as the Acri.Smart 48 S (Acri.Tech). The tear might have occurred during capsulorhexis or phacoemulsification or there might have been a preexisting posterior capsule defect that occurred during the previous pars plana vitrectomy. Consulting the retinal surgeon and/or carefully studying the surgical notes might reveal posterior capsule injuries during vitreoretinal surgery. If there are capsular injuries before surgery, phacoemulsification, especially microincision cataract surgery, may cause the nucleus to drop. Using an inflow through the pars plana and traditional extracapsular cataract surgery seems safer in this situation.

Second, as shown in Figure 3 (*right*), the IOL is not stable and is supported by roughly one third of the shrunken posterior capsule. Any maneuver that caused the IOL to come from the vitreous cavity (on the retina) to the ciliary sulcus may cause the reverse movement and dislocate the IOL into the vitreous

cavity again. Therefore, I suggest exchanging the IOL for an iris-fixated anterior chamber IOL as soon as possible while it is in the ciliary sulcus and available through an anterior segment approach.

Third, the author did not mention whether there was an intact capsular bag before IOL implantation. Plate-haptic IOLs are designed for implantation only in an intact capsular bag and are not suitable for ciliary sulcus implantation.

Fourth, the author concluded that "[i]n a case such as this one, one can wait and see what may happen and not rush to surgically remove the IOL." He also stated that IOL removal is not urgent when the retina is not damaged, the patient should have frequent follow-up examinations, and one should explicitly discuss the pro's and con's of a second surgical intervention with the patient. A waiting policy to hope that self-repositioning of the dropped IOL will occur does not seem realistic.

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REFERENCE

1. Al Mansouri SM. Self-repositioned intraocular lens in a vitrectomized eye. *J Cataract Refract Surg* 2007; 33:1336–1338

QUERIES - JCRS5535

[Synopsis] Not needed for this article type.
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