Fig. 2 – Doppler showing multiple tortuous dilated vascular channels.

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Hypermetropic shift following CTR implant

Dear Editor,

We have read the article titled “A Study To Evaluate whether CTR increases unpredictability between predicted and actual IOL position” by Baranwal et al published in MJAFI 2014; 70:36–38. The findings of a hypermetropic shift following CTR implant and phacoemulsification and IOL implant in eyes with partial zonular dehiscence are very unique. While most surgeons would be content to get a good visual outcome with minor corrections in these surgically challenging cases the authors have gone ahead and looked into the finer aspects of refractive shift in predicted IOL power, which is quite laudable.

However it is not quite clear whether the posterior shift can be attributable to the CTR implant. Eyes with zonular dehiscence are often associated with a deeper anterior chamber and posterior shift in the Iris lens diaphragm. Vitreous loss and syneresis in such eyes also leads to poor vitreous support and may itself be responsible for the posterior shift documented by the authors. The authors have used the SRK II regression formula for predicting the IOL power, which may not be the most

accurate in these circumstances.¹ Modern theoretical formulas like the Haigis L and Holladay 2 reported to have greater accuracy in such cases, could have been used to improve the accuracy of the predicted IOL power.² Ideally a preoperative and post-operative ultrasound biomicroscopy of the same case at least in those cases, which present with zonular dehiscence should have been done in order to document an actual shift. In fact the CTR was designed not only to stabilize the capsular bag and permit safe phacoemulsification but also to help in centration of the IOL and achieve more predictable refractive outcomes. Though the CTR has definitely improved the safety of phacoemulsification in these cases but perfect centration and improved refractive outcome has not always been achieved.^{3,4} An alternative to the CTR in these cases is the Cionni ring, the advantage being that, it can be fixated by sutures to the scleral sulcus thereby ensuring better centration and placement of the IOL in the proper plane.⁵

The recommendation of the authors regarding hypermetropic shift and correction in calculated IOL power in

cases with CTR implant is interesting and worth noting but we feel that more conclusive evidence is needed before the correction factor recommended by the authors can be generalized.

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Reply

Dear Editor,

On behalf of the authors, I thank the readers for deep interest and scholarly analysis of the article. In response to authors concern my reply is as below:

1. The CTR actually makes the anteriorly sagging capsular bag more taut and thus the effective lens position is shifted slightly posteriorly, thus contributing to a hypermetropic shift.
2. The SRK-II formula holds well in such cases as the refractive change in such cases is $\pm 2D$ which does away for the application of advanced formulae like Haigis and Holladay 2.
3. UBM pre and post-op is difficult in these situations as the use of silicon cup for the procedure may cause compression and undue stress on the zonules.
4. It is absolutely correct that Cionni ring is an alternative to the CTR.

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