Correspondence

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Optical Coherence Tomography to Evaluate Dengue

Dear Editor,

The recent report you published on the use of optical coherence tomography (OCT) to evaluate dengue was very interesting [1]. Rhee and Han [1] concluded that "Follow-up examination of individuals with dengue fever and associated visual impairment should involve the use of OCT to evaluate visual acuity and visual field change." In fact, the ocular complications of dengue are typically overlooked, as a proper examination is rarely performed. As Mendes et al. [2] noted, "Dengue fever can lead to visual impairment detectable by ophthalmological exams such as angiography, retinography, and OCT imaging, as well as retinal and cortical electrophysiology." Severe dengue, dengue shock, also tends to cause complications [3]. Close follow-up of these patients is required and ocular examination should be included in the clinical practice guidelines.

Beuy Joob

Sanitation Medical Academic Center, Bangkok, Thailand
E-mail: beuyjoob@hotmail.com

Viroj Wiwanitkit

Hainan Medical University, Haikou, China

Conflict of Interest

No potential conflict of interest relevant to this article was reported.

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2. Mendes TS, Sobrinho EF, Rosa AA, et al. Dengue maculopathy: visual electrophysiology and optical coherence tomography. *Doc Ophthalmol* 2009;119:145-55.
3. Wiwanitkit V. Dengue fever: diagnosis and treatment. *Expert Rev Anti Infect Ther* 2010;8:841-5.

Author reply

Dear colleagues,

We were encouraged to your comment and thank for your concern. As you know that South Korea is not endemic region of dengue fever, so we cannot meet dengue fever patient usually. Fortunately, I could find three patients in a short period. Recently, more and more Korean and people lived in non-endemic area visit other country, so we have more chance to meet dengue fever patients. Dengue fever and dengue with hemorrhagic manifestation are recognized as the world's second most prevalent infection in tropical and subtropical regions, after malaria, but the first in the American continent [1]. That and ophthalmic examination had been overlooked. Your suggestion that ocular examination should be included in the clinical practice guidelines must be very helpful for dengue fever patient.

Jung Il Han

Kim's Eye Hospital, Konyang University College of Medicine, Seoul, Korea
han66139@kimeye.com

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Is This Really Sutureless Intrasceral Pocket Technique of Transscleral Fixation?

Dear Editor,

Cho et al. [1] described the “Sutureless intrasceral pocket technique of transscleral fixation of intraocular lens in previous vitrectomized eyes” in April issue. The authors prepare two scleral pockets with a crescent knife 2 mm from the limbus and opposed 180 degree each other without any conjunctival dissection. Following, they enter into the posterior chamber with a 26-gauge needle including 10/0 nylon suture transsclerally and transconjunctivally at a point of 1.5 mm posterior from the limbus. Following clear corneal incision (CCI), prolene sutures were exteriorized through the CCI pocket and a three-piece foldable acrylic intraocular lens was injected via CCI and the ends of the haptics were exteriorized through the CCI. The prolene sutures for each haptic in the intrasceral pocket bed were then tied and knots were buried under scleral flaps, in their technique.

To us, this description and title were not completely true. This technique is not a sutureless one. In fact, it is a modified sutured and intrasceral pocket technique of transscleral fixation of intraocular lens. In sutureless techniques defined until now, a permanent suture was not used inherently [2-5]. In the trocar-assisted technique of sutureless intrasceral posterior chamber foldable intra-ocular lens fixation which we described, we put a non-absorbable 10/0 nylon suture transconjunctivally after the placement of the haptics into the scleral groove and take it out 1 week after [2,3]. We aimed to stabilize the haptics at early postoperative period. The authors defined their technique as the first scleral fixation method without conjunctival dissection and

References

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emphasized that it has the advantage of lack conjunctival dissection and lesser risk of conjunctival bleeding [1]. We disagree with authors about that. In the trocar assisted sutureless technique we developed, we have been entering into the eye with 25-gauge vitrectomy trocars without any opening of conjunctiva performing two 3 mm long scleral tunnels parallel to the limbus apart from 180 degree each other and angulating 10 degree with scleral surface. We performed vitrectomy entering by through these two canulas. One haptic of the intraocular lens which implanted through a CCI is held with a forceps that inserted through CCI and grasped in the eye with a forceps that inserting into and removed from the eye via trocar cannula and placed into the tunnels. We put a 10/0 nylon suture encircling the haptic for security and take it out 1 week after. By repeating same processes for other haptic, both haptics became implanted into the scleral tunnels. The advantages of our technique are lack of conjunctival dissection and scleral flaps in addition to minimal possible damage to circumferential tissues. We do not encountered with any complication such as decentralization or tilt of intraocular lens, endophthalmitis, glaucoma and retinal detachment [2,3]. In terms of simplicity, we think that our method is simpler and needs shorter surgical time as it does not need to prepare conjunctival dissection and scleral flaps.

Remzi Karadag, Huseyin Bayramlar
*Department of Ophthalmology, Istanbul Medeniyet University
School of Medicine, Istanbul, Turkey
E-mail: remzi.karadag@medeniyet.edu.tr*

Ozgur Cakici
*Department of Ophthalmology, Istanbul Medeniyet University
Goztepe Research and Training Hospital, Istanbul, Turkey*