With regard to the observation window, 10 eyes with BRVO of 1 to 3 months' duration and 10 eyes with BRVO of 3 to 6 months' duration were enrolled. Of the first 10 eyes, 5 needed additional anti–vascular endothelial growth factor (VEGF) treatment, macular photocoagulation, or both in year 2. Of the remaining 5 eyes, 2 patients treated 2 months after symptom onset theoretically could have improved spontaneously within 3 months. Notably, other recent studies evaluating pharmacologic treatments for ME of BRVO have enrolled eyes with ME of fewer than 3 months' duration; these have included 37% of eyes in the SCORE Study[2] and more than 50% of eyes in the BRAVO Study (Campochiaro PA, et al. Safety and efficacy of intravitreous ranibizumab [Lucentis] in patients with macular edema secondary to branch retinal vein occlusion: the BRAVO Study. Paper presented at the Retina Congress. October 4, 2009; New York, New York).

Dr Wong and associates suggest that eyes receiving laser should have been excluded from the analysis to obviate their potential confounding effects. Only 1 eye received laser before enrollment, and 2 received laser during the study; neither had visual improvement at week 54. Therefore, in our 20-eye cohort, laser did not seem to influence the visual acuity findings. However, to address their request, we performed a post hoc analysis of eyes receiving pegaptanib monotherapy, excluding the 2 eyes that could have resolved spontaneously and the 3 eyes receiving photocoagulation. Taken together, the remaining 15 eyes at week 54 had an average visual acuity gain of 15.7 letters and center point thickness reduction of 235 μm, suggesting greater pegaptanib efficacy than reported for the original 20 patients.

Finally, our proposal that pegaptanib may have a theoretical advantage over nonselective anti-VEGF agents was in reference to the potential safety benefit of VEGF 165 selective inhibition. VEGF-A is a neuronal survival factor,[3] and based on experimental evidence, the overuse of nonselective anti-VEGF agents to treat wet age-related macular degeneration may lead to retinal ganglion cell, photoreceptor cell, and choriocapillaris toxicity in rodents.[4] Furthermore, patients who have retinal vein occlusion are at a 2-fold risk for stroke (Holecamp NM, et al. Myocardial infarction and cerebrovascular accidents in patients with retinal vein occlusion. Paper presented at the Retina Congress. October 4, 2009; New York, New York). Theoretically, chronic intraocular pan-VEGF inhibition could heighten that risk.

It is our belief that pegaptanib monotherapy leads to rapid foveal microarchitectural deturgescence often achieved within 24 to 36 hours after initial injection and sustained for at least 3 to 4 weeks. Although findings of post hoc analyses should be viewed with healthy skepticism because of the potential for bias, when assessing outcomes for the 15 eyes in our cohort that met Dr Wong and associates' criteria, visual acuity gains and center point thickness reductions were even greater than those reported for the full cohort. As such, we continue to be convinced that pegaptanib may provide a clinically important treatment option for patients with ME after BRVO. A larger randomized clinical trial to confirm this hypothesis is warranted.

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## Complications and Clinical Outcomes of Descemet Stripping Automated Endothelial Keratoplasty With Intraocular Lens Exchange

EDITOR:

WE READ WITH GREAT INTEREST THE RECENTLY PUBLISHED article "Complications and clinical outcomes of Descemet stripping automated endothelial keratoplasty with intraocular lens exchange" by Shah and associates.[1] We agree that Descemet stripping automated endothelial keratoplasty (DSAEK) and sutured intraocular lens (IOL) can be performed simultaneously even via a 7.0-mm wound. Under such a large incision, however, the anterior chamber is less stable than under a small incision. Hence, in patients with 3-piece acrylic lenses in the anterior chamber or aphakia, suturing an acrylic foldable IOL may be better than polymethyl methacrylate lens because the sclera tunnel or clear cornea wound doesn't have to be enlarged. In those cases, we used the Lewis method to suture the foldable acrylic IOL (AcrySof MA60AC; Alcon, Fort Worth, Texas, USA) in the sulcus.[2,3] Because there were

no eyelets in the haptics of the foldable IOL, the 2 fixation sites at the haptics should be as symmetrical as possible to keep the IOL not tilted in the posterior chamber. After the haptics are sutured, we pull the prolene in both sides together before implantation to test whether the IOL will be tilted or not.

The DSAEK was performed after suturing the IOL and the anterior chamber was then filled with air for 10 minutes. The transscleral fixation foldable IOL can stand the pressure of air tamponade and there is no suture slippage or IOL displacement in our cases. From our experience, transscleral fixation of a foldable IOL and DSAEK can be performed successfully in a small-incision procedure.

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## REPLY

WE FIRST WISH TO THANK DRS CHIANG AND TSAI FOR their interest in our article[1] and appreciate their comments on transscleral fixation of foldable acrylic intraocular lenses (IOL) in combination with Descemet stripping automated endothelial keratoplasty (DSAEK). We agree that insertion of a foldable acrylic IOL prevents the need for wound enlargement in combined surgery and has the potential to help in anterior chamber maintenance; however, we would like to address certain points in relation to our specific technique of DSAEK and combined IOL exchange surgery which may explain the benefits of a slightly larger scleral tunnel wound and insertion of a polymethyl methacrylate (PMMA) lens.

First and foremost, all anterior chamber IOLs (ACIOL) removed during the IOL exchange portion of the procedure in our study were 1-piece, made of PMMA material, and often had a 6.0-mm size optic, which makes these types of lenses difficult to remove through a smaller incision. Also, cutting thick PMMA optics inside the eye requires larger IOL-cutting scissors and/or other instruments that have the potential to traumatize the iris and other anterior segment structures during the process of removal. Since this surgery is already complex in nature, we feel that a larger incision offers the benefit of safe and easy removal of PMMA ACIOLs from the eye with minimal risks, especially since, using our simplified DSAEK technique with scleral, beveled, and self-sealing incisions,[2] the anterior chamber continues to remain stable throughout both portions of the procedure and specifically with insertion of the donor DSAEK tissue. We have also never experienced any significant induced astigmatism from the larger 7.0-mm scleral wound for any of our combined DSAEK procedures and therefore do not see the necessity of a smaller wound that would make IOL exchange more difficult.

Finally, the PMMA CZ70BD lens with its 7.0-mm optic (Alcon Laboratories, Fort Worth, Texas, USA) is specifically designed with eyelets on the haptics for suturing to the ciliary sulcus because prior to its design, late slippage of sutures tied to the polypropylene haptics of sulcus-placed 3-piece IOLs was reported.[3] We acknowledge and commend Drs Chiang and Tsai for their success with their technique of transscleral fixation of foldable IOLs, but it is also important to mention that further long-term follow-up of their patients for IOL dislocation secondary to late suture slippage is equally necessary.

In conclusion, and based on our experiences with our specific DSAEK and IOL exchange technique, we feel that a larger scleral wound with placement of a PMMA lens with eyelets on the haptics makes for a safer and easier surgery without significantly increasing the rates of postoperative complications.

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