Correspondence

POSTERIOR CHAMBER LENS PLACEMENT
There has been a recent wave of interest in placing posterior chamber lenses in patients without available capsular support by means of sutures passed through the ciliary sulcus. It appears that this procedure offers advantages over inserting anterior chamber lens in spite of the fact that the operation is technically more demanding.

A small but significant aggravation in this procedure involves tying the sutures to the haptics of the posterior chamber lens. Prolene is relatively stiff and intraocular lenses tend to move at the slightest touch. A simple maneuver to expedite this step is to place a small bubble of viscoelastic substance on a lint-free surface under the microscope prior to beginning the operation. When the free end of the suture and the lens haptic are submerged together in this bubble it is quite simple to control each and to effect the ties quickly and easily.

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MISUSE OF "NONINVASIVE"
I certainly enjoyed your editorial entitled, "Why Physicians Must Stop Misusing the Word 'Noninvasive'" (Ophthalmic Surg. 1989; 20:764-765). Quite a number of years ago, an ophthalmologist in my area tried to do away with preoperative histories and physicals documenting the necessity for laser therapy on his patients, arguing that it was a "noninvasive" procedure. I explained to the hospital that laser procedures indeed are invasive and do have certain risks and complications. It is amazing to me that people in our own specialty try to ignore these risks while "marketing their practice."

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EYEDROPS OR SURGERY?
In the November Editorial critiquing the often misleading use of the term "noninvasive," you raised the issue of complications of topical eyedrops used on a chronic basis to treat glaucoma. I continue to be amazed how many patients do not realize or have not been informed of the numerous side effects of these medications or of the availability of alternative methods of treatment. I recall seeing an elderly gentleman who had had bilateral through-and-through filtration surgery for glaucoma in both eyes 30 years ago. When I saw him his vision was 20/20 in each eye with full fields and normal-appearing optic nerve heads. I asked him if he had had surgery because of difficulty with eyedrops. He answered that when the ophthalmologist who told him he had glaucoma informed him that he could either take eyedrops for the rest of his life or have surgery, his response was, "There is no way I will be bothered with eyedrops every day, so give me the surgery." It is impossible to know whether or not this patient truly had vision-threatening intraocular pressure or whether the surgery had really prevented visual loss. But at least he was given the opportunity to make a choice based on a clear understanding of the available alternatives. I wonder how many glaucoma patients today are as fortunate.

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LENS IMPLANTATION IN DEVELOPING COUNTRIES
I read with interest the article by Drs Brian and Hollows in the International Ophthalmology section (Ophthalmic Surg. 1989; 20:820-822). I had very similar thoughts and published an article titled "Rehabilitation of the Cataract Cripple in the Developing Country: An Axiological Approach" in Contact and Intraocular Lens Medical Journal. 1975;5 (2):52-60. My views were criticized by a professor from Pakistan who felt that it was irresponsible to recommend lens implantation in developing countries. Interestingly enough, less than 1 year later, he started doing lens implantations himself!

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