

sutures in this technique are in closer contact with the ocular surface because of the absence of scleral flaps and are more likely to erode through the conjunctiva. Even a microscopic break in the overlying conjunctiva could result in bacterial contamination. It would be worthwhile to compare the incidence of endophthalmitis and suture exposure over the long term with the authors' technique and the scleral flap method.

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REPLY: In response to the first point of Singh and Stewart, it is true that 2 penetrations in the eye in the region of the ciliary body would predispose it to further hemorrhagic complications. However, we do not make 2 entries into the eye in the region of the ciliary sulcus; instead, we create a scleral route 1.5 mm from the posterior limit of the limbus. From there, we pass the blunt end of the double-armed 10-0 polypropylene (Prolene) suture.

As for the risk for endophthalmitis with our technique, the Prolene knot that serves as an anchor does not remain in the subconjunctiva but is buried deeply in the scleral incision. In addition, the loose ends of the suture are carefully cut next to the knot. Consequently, the suture will not be close to the conjunctiva or superficial.

When the scleral flap technique is used, the borders of the scleral incision are usually closed with a polyglycolic acid (Dexon) 6-0 suture. This suture often unties during the procedure, which is responsible for a great loss of time. Additionally, in up to 30% of cases, there is some degree of scleral flap atrophy after 10 years, with erosion and extrusion of the knot through the conjunctiva, which are more likely to cause bacterial contamination and endophthalmitis.

In more than 10 years of patient follow-up, we have not experienced any erosion of the sutures or case of endophthalmitis; thus, we believe our technique is safer than the scleral flap technique.—*Manuel Monteiro, MD*

Reliability of peripheral corneal pachymetry with the Oculus Pentacam

In their recent paper, Khoramnia et al.¹ overlooked mentioning their stated reference point

when measuring peripheral corneal thickness. Did they use the default setting of pupil center as the reference point or the more reliable corneal vertex? We emphasize this point because in our study,² peripheral corneal thickness measurements showed poor repeatability (mean coefficient of repeatability [COR] $\pm 95\%$ limits of agreement³) $\pm 26.28 \mu\text{m}$ [range 22.37 to 30.04 μm] using the default pupil center, whereas a marked improvement in reliability (mean COR $\pm 16.00 \mu\text{m}$ [range 13.71 to 19.85 μm] was evident when corneal vertex was used as the reference point. We found that repeatability of peripheral corneal thickness measurements were comparable to repeatability of central thickness measurements using the corneal vertex as the reference but peripheral repeatability worsened twofold using the pupil center as the reference point. The poor reliability findings of Khoramnia et al. suggest that they used the default pupil center in acquiring their peripheral measurements.

The problem is inherent because the pupil center is an unreliable measure.² Because of the dynamic nature of pupil size and shape and the image acquisition time of 2 seconds, we propose that the pupil center is constantly moving so the results are variable. If the reference point keeps changing, it follows that the corneal sampling for peripheral thickness also changes between measurements. The end result is poor reliability.

The default standard of pupil center as the reference point when measuring corneal thickness, in the tradition of ultrasonic probe pachymetry,⁴ is an anachronism when using an automated scanner such as the Oculus Pentacam. We recommend that the default be altered to use corneal vertex as the more stable reference point.

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