

Sir,
Side-saddle cataract surgery for patients unable to lie flat: learning from the past

I was interested to see Nair and Rimmer's report of 'side-saddle' positioning for phacoemulsification in patients who are unable to lie flat.¹ I have been using a virtually identical technique for the last 2 to 3 years,² and I suggest some refinements. Topical-intracameral anaesthesia allows the patient to fixate the operating light and therefore keep the eye still, in the desired position, with a good red-reflex. Surgery may be further facilitated by a face turn, and/or chin-up head positioning, if the patient is able to do this. With these adjustments, it is usually easy to make an on-axis incision, which may be inferior, temporal, or nasal, as required. Sometimes it is more comfortable for the surgeon to stand rather than to sit, facing the patient. The more upright the patient, the more the operating microscope must be turned towards the horizontal, and consequently the surgeon's arms will be more outstretched. With more extreme positioning, the outstretched arms can make surgery feel less controlled than normal: in these cases, I prefer to use a 'divide and conquer' technique with a straight second instrument, rather than risk iris trauma with an angled chopper. My personal practice is to use the 'standing-temporal approach'³ for most patients who cannot lie flat, and to reserve 'side-saddle' positioning for those who cannot adopt the required 'face to ceiling' position, or who need an inferior incision for astigmatism.

To illustrate the usefulness of the technique, I presented two of my patients to the 'difficult cases' discussion' at the 2007 annual meeting of the British Ophthalmic Anaesthesia Society. Both patients had severe Meniere's disease. The first, aged 83, needed seven pillows to sleep, would vomit if laid flat, and had a previous cardiac procedure performed in the sitting position because of this. She also had angina, diabetes, and a hiatus hernia. The second patient, aged 82, would vomit and also have diarrhoea if laid flat (this is a recognised feature of Meniere's disease). She slept upright and also suffered from back pain and anxiety. The assembled audience of around 70 ophthalmic anaesthetists and ophthalmologists was unable to suggest any other safe approach to cataract surgery in these patients. Both of these patients had uneventful 'side-saddle' phacosurgery using topical-intracameral anaesthesia: the first had an on-axis infero-temporal incision with the patient seated almost upright (80° above the horizontal), and the second with an on-axis inferior incision, with the chair-back at 50° above horizontal. Both patients remained comfortable with no vomiting or other problems.

I agree that this technique can be very useful for those patients for whom the conventional positioning is not possible. It is not always as easy as phacoemulsification with the patient in the standard position, so it should only be attempted by the experienced surgeons.

References

- Nair J, Rimmer T. Side saddle cataract surgery for patients unable to lie flat: learning from the past. *Eye* 2007; **21**: 1122–1123.
- Ang GS, Ong JM, Eke T. Face to face seated positioning for phacoemulsification in patients unable to lie flat for cataract surgery. *Am J Ophthalmol* 2006; **141**: 1151–1152.
- Fine IH, Hoffman RS, Binstock S. Phacoemulsification performed in a modified waiting room chair. *J Cataract Refract Surg* 1996; **22**: 1408–1410.

T Eke

Norfolk and Norwich University Hospital, Colney Lane, Norwich, UK
E-mail: tom.eke@nnuh.nhs.uk

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Sir,
Reply to 'Side-saddle cataract surgery for patients unable to lie flat: learning from the past'

We thank Eke for his comments and suggestions of refinements for this posture used for cataract surgery for patients unable to lie flat. The method he reported in the *American Journal of Ophthalmology* certainly has striking similarities, even to the figure of 60° for the angle of declination of the axis of the operating microscope. It is indeed reassuring to know that none hearing his presentation to the British Ophthalmic Anaesthesia Society was able to suggest a better surgical approach.

We admire his ability to adjust his incision to the steep axis. We concede that in these challenging cases, we position the section to make it most accessible to the surgeon. We also admire his stamina in preferring the 'standing-temporal' option, which we find uncomfortable because of having to bear weight on one leg in order to operate the pedals.

We checked why our literature search did not pick up Eke's paper. We originally submitted our work to *Eye* in April 2006, two months before his paper was published. Nevertheless, we cordially salute his priority of authorship.

J Nair and T Rimmer

Peterborough District Hospital, Peterborough, Cambs, UK
E-mail: timothy.rimmer@pnh-tr.nhs.uk

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Sir,
OCT III imaging of whiplash maculopathy

We describe the fundus microscopy and the macular optical coherence tomography findings in a patient presenting with a unilateral paracentral scotoma following a whiplash injury.

Case report

A 24-year-old female suffered a car accident, inducing an extension–flexion movement of the neck. Within hours after the accident, she noted a paracentral scotoma in the left eye. Fundus examination of the affected eye