the surgical trauma during the normal course of postoperative care. However, other studies have defined postoperative endophthalmitis as severe inflammation involving both the anterior and posterior segments after intraocular surgery. Many times when the corneal clarity is poor or significant anterior chamber inflammation is present, B-scan ultrasonography is required to detect vitreous infiltrates. A distinction should have been made between clinical and proven cases of endophthalmitis as was done in the European Society of Cataract & Refractive Surgeons Endophthalmitis study, because exaggerated postoperative inflammation can also be toxic anterior segment shock syndrome or noninfectious uveitis.

Positive vitreous cultures were reported to be 36.6% in the current study, which is lower than that reported in previous reports (53%–75%). One of the reasons for this result could have been that the authors subjected the vitreous samples only to bacteriologic analysis. Fungus has been implicated as an etiologic agent for postoperative endophthalmitis in 7.1% to 12.7% of cases in Asian countries. Thus, it would be prudent to perform microbiological investigations to rule out fungal infection.

Also, study patients received either chloramphenicol 0.5% or ciprofloxacin 0.3% topically postoperatively. It would be interesting to know if any difference existed between the incidence of endophthalmitis between these 2 groups. Both drugs are broad-spectrum antibiotics, but ciprofloxacin has much greater activity against Gram-negative bacteria, especially *Pseudomonas aeruginosa*.

**References**


**Re: Chu et al.: Risk factors and incidence of macular edema after cataract surgery: a database study of 81 984 eyes**

(Ophthalmology 2016;123:316-323)

**TO THE EDITOR:** We read with interest the retrospective database study by Chu et al, but we have concerns regarding the study’s...