cases (24%) of progressive endothelial cell loss requiring explantation. The mean interval between implantation and secondary intervention was 8.97 years ± 2.21 (SD) (range 2 to 14 years).

The patients presented by Coullet et al. were referred from another center and received contemporary management. Having said that, refractive surgery is usually elective in nature and patients present a diverse range of expectations and ocular examination findings. Lenticular solutions are well established, and we suggest they should be given greater consideration in the presbyopic (and prepresbyopic) age group.

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Oil-drop cataracts

In their article on progressive lenticular astigmatism in the clear lens,[1] Tatham and Prydral described a middle-aged myopic woman with rapid onset of increasing 5.0 diopters of myopic astigmatism that could not be corrected, even with a trial of contact lenses. However, after phacoemulsification and intraocular lens implantation, the problem was solved and the visual acuity restored. This history confirms that the pathologic etiology of the increasing myopic astigmatism was in the crystalline lens.

I have seen a considerable number of middle-aged myopic patients, especially women, who were referred for decreased vision caused by changes in the crystalline lens that were not apparent on slitlamp biomicroscopy. In these patients, the earliest signs of cataract are the change in the refractive index in the nucleus center. The lens is fairly clear on slitlamp biomicroscopy; however, the change in the refractive index from the nucleus periphery to the center, which causes the progressive drop in visual acuity and cannot be corrected with contact lenses or spectacles, can be detected only by retinoscopy and is seen as a scissoring reflex or an oil drop in the center of the nucleus.

In one report,[2] the oil-drop cataract was introduced as a common yet often overlooked cause of progressive vision loss. Although the nuclear change can be subtle on slitlamp biomicroscopic examination, retinoscopy reveals the classic oil droplet silhouetted against the red reflex. Some patients with oil-drop cataract had been referred for neuro-ophthalmologic evaluation because of the unexplained vision loss. All had been evaluated by multiple physicians and had extensive diagnostic testing. The patients' ages were between 40 and 60 years, and the visual acuities ranged from 20/20 to 20/400. In all patients, the neuro-ophthalmologic evaluation was normal except for lenticular nuclear changes, best appreciated with retinoscopy.

In another report of 5 patients with oil-drop cataracts, the underlying lenticular cause of myopic regression after laser in situ keratomileusis (LASIK) had been missed by the ophthalmologists. As a result, the patients were scheduled for or had LASIK enhancement. After oil-drop cataracts were diagnosed, phacoemulsification was performed successfully in at least 1 eye of all patients. These cases underscore the importance of considering lens-induced myopia in refractive surgery patients, especially those with an unstable preoperative refraction or postoperative myopic regression.[3]

In conclusion, in every patient with unexplained decreased vision, especially middle-aged myopic patients with or without a history of refractive surgery, retinoscopic examination by an ophthalmologist is mandatory to rule out oil-drop cataracts.

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Astigmatism terminology

I have the following comments about Hill's article[1] on the expected effects of surgically induced astigmatism on the results of implantation of the AcrySof (Alcon) toric intraocular lens (IOL):