

bilateral LASIK depending on the length of time contact lenses or glasses were worn preoperatively. We believe the authors should provide information about the length of use of contact lenses or concave glasses before LASIK in their study population.

In western countries, most patients having LASIK correction have worn contact lenses longer than glasses and hence their AC/A ratios are near emmetropia preoperatively with the contact lenses.² Although this may not be true for the population in the Prakash et al. study, it would be more informative to include the type of correction (ie, contact lenses and/or glasses) with the preoperative AC/A ratio. Even the asthenopic symptoms described by the authors may vary in patients who had long contact lens use preoperatively compared with those who had longer use of concave glasses. Because these symptoms may vary in anisometric and isometric myopia patients, we believe the 95% confidence interval of the difference in spherical equivalent between right and left eyes would be more informative than the standard deviation. It is known that myopic patients tend to have higher AC/A ratios than emmetropic and hyperopic patients.³ We would appreciate it if the authors would comment on whether one would expect the same trend but with lower AC/A ratios in hyperopic patients having bilateral LASIK.

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Risk factors for ectasia after LASIK

There are some important issues in Binder's recent article¹ about risk factors for keratectasia after laser in situ keratomileusis (LASIK) that should be addressed.

Binder mentions that "all patients had similar preoperative screenings with new technology testing performed as the equipment became available," a vague method for screening and excluding patients for refractive surgery. He has performed LASIK in a significant number of

patients who had residual stromal beds thinner than 250 μm , central corneal pachymetry less than 500 μm , mean K reading greater than 47 diopters (D), and oblique cylinder greater than 2 D; LASIK surgeons usually avoid doing refractive surgery under these conditions. Keratectasia is a late-onset complication and has been reported even many years after surgery.^{2–4} What were the author's exclusion criteria for performing LASIK?

It is obvious that to evaluate the risk factors for a disease or pathologic condition, you have to examine the involved cases and not just the healthy ones. Even in historical cohort studies, the overall population should be considered; however, in this study, Binder included only the LASIK candidates who were eligible for refractive surgery according to the surgeon's own criteria, which were not mentioned in detail in the article.

All eyes that developed keratectasia had abnormal topography, and the author mentions that "if one used those days criteria for abnormal topography, these eyes would have been excluded from having LASIK." What were "today's criteria for abnormal topography" that the author did not exclude these eyes? Binder concluded, "Individual preoperative and operative factors did not in and of themselves increase the risk for ectasia," a concept that may encourage other surgeons to perform LASIK in high-risk patients and refer to this article.

In conclusion, I think the best way to analyze the risk factors for ectasia is an exact survey of the patients with post-refractive-surgery keratectasia. The abnormal topography seems to be an important risk factor; however, one should also pay attention to other risk factors since LASIK is an elective surgery in healthy eyes.

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ISO eye model not valid for assessing aspherical lenses

The study by Artigas et al.¹ analyzes the imaging quality of 2 aspherical and 2 spherical intraocular