Clinical Ophthalmology

RESPONSE TO LETTER

Immediate Sequential Bilateral Cataract Surgery: Are We Overstating the Case? [Response to Letter]

Samar Al-Swailem[1], Khabir Ahmad[2], Abdulaziz Jabr AlJbreen[3], Sara AlHilali[1]

[1]Anterior Segment Division, King Khaled Eye Specialist Hospital and Research Center, Riyadh, Saudi Arabia; [2]Research Department, King Khaled Eye Specialist Hospital and Research Center, Riyadh, Saudi Arabia; [3]Ophthalmology Department, Security Forces Hospital, Riyadh, Saudi Arabia

Correspondence: Sara AlHilali, Anterior Segment Division, King Khaled Eye Specialist Hospital and Research Center, P.O. Box 7191, Riyadh, 11462, Saudi Arabia, Tel +966544017155, Email SaraAlHilali@gmail.com

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Dear editor

We thank the authors for their thoughtful commentary on our article, "Immediate Versus Delayed Sequential Bilateral Cataract Surgery: A Systematic Review".[1] Their letter shows the need for care when evaluating evidence. This is especially true regarding rare bilateral eye complications, improvements in vision correction, and whether results can hold for all patients beyond the carefully chosen groups.

We concur with the authors that cataract surgery is, in most cases, an elective procedure and that the rationale for immediate sequential bilateral cataract surgery (ISBCS) is primarily based on efficiency and patient convenience rather than clinical necessity.[2] Our objective was not to propose ISBCS as a universal replacement for delayed sequential bilateral cataract surgery (DSBCS), but to assess whether current evidence supports its use as a safe and effective alternative in appropriately selected patients. We suggest using this method with strict protocols, clear patient consent, and individualized planning for each eye, especially for those considering premium intraocular lens (IOL) options or who may experience unexpected vision changes.

We also agree that choosing the right patients is critical. As per our review, the available evidence primarily comes from carefully selected groups undergoing simple cataract surgery under controlled conditions, which may limit the extent to which these findings can be applied.[1] Our findings support reserving ISBCS for suitable patients in hospitals that follow strict protocols. Furthermore, we explicitly called for additional high-quality trials with standardized outcomes and extended follow-up periods.

Regarding safety, we acknowledge the authors' important observation that rare but catastrophic bilateral sight-threatening complications may not be fully captured in existing datasets and remain central. Notably, the Swedish national registry study reported no cases of bilateral postoperative endophthalmitis after 92,238 ISBCS procedures and only very few cases of infection in one eye when proper cleaning methods were used.[3] Our review found no significant differences in rates of endophthalmitis or other serious complications, and no reported cases of bilateral endophthalmitis when appropriate aseptic measures were followed.[3,4] Nevertheless, we agree that the absence of evidence does not equate to the absence of risk. This highlights the need for continued vigilance and further high-quality data.

Regarding functional outcomes, we agree that many patient-level benefits, including improved quality of life and reduced fall risk, may be achieved after first-eye surgery.[5] However, several studies included in our review indicate that ISBCS may provide advantages such as faster binocular visual rehabilitation and higher patient satisfaction,[6,7] which are important considerations in clinical decision-making.

Concerns about refractive predictability are valid, especially in refractive cataract surgery. The inability to adjust intraocular lens power after the first eye is a limitation of ISBCS. Still, current evidence shows similar refractive accuracy between ISBCS and DSBCS in standard cases.[8,9] Extra caution is needed in complex cases or when premium intraocular lenses are used.

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We further acknowledge the authors' views on economic and system-level implications. SBCS reduces hospital visits and helps faster vision recovery, but its impact on healthcare resources itself is complex and needs further study based on different contexts.[2] As per common practice, cost-effectiveness models like quality-adjusted life year (QALY) analyses, do not fully show the complete picture regarding surgery complexity, patient care needs, and caregiver burden.[10]

In conclusion, we appreciate the opportunity to clarify these points and the focus on cautious interpretation. We agree that future studies should address external validity, perioperative burden, patient support needs, and the customization of vision correction in today's cataract treatment.

Disclosure

The authors report no conflicts of interest in this communication.

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