

The procedure has proved useful in all cases except one with secondary IOL implantation. This patient developed postoperative bacterial endophthalmitis that necessitated a vitrectomy and removal of the IOL, followed by intensive intraocular and extraocular antibiotic treatment. The eye fully regained its preoperative visual acuity (20/40). Thereafter, an intraocular antibiotic was administered at the end of the procedure in all cases. This seems advisable as the IOL is in contact with the conjunctiva much longer than in standard IOL surgery. All other eyes did not show signs of inflammation during the follow-up period. Intraocular bleeding occurred in one case and resorbed spontaneously.

Comment.—A variety of technical details must be considered when using this technique. It is important that the vitrectomy be performed meticulously, with no vitreous strands or lens remnants, which may cause retinal traction, left behind. The sutures must be placed exactly in opposite positions or decentration of the IOL will result. The sutures must be tied only after the eye has regained sufficient tension by the injection of balanced salt solution and after both haptics have been positioned accurately, or tilting of the lens may occur.

The feasibility of the procedure is demonstrated by the fact that all patients who underwent secondary posterior lens implantation regained preoperative visual acuity. The limited postoperative visual acuities in groups 1, 3, and 4 (Table) were caused by preexistent macular degeneration or by early corneal irregularity after keratoplasty.

We believe that this type of operation deserves broader trials by experienced anterior segment surgeons.

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The following letter was originally published in the May 1989 issue of the ARCHIVES (1989;107:636); however, due to errors in the original letter, it is being reprinted in full below. ED

Snellen Equivalent for the Bailey-Lovie Acuity Chart

To the Editor.—Many researchers have used the Bailey-Lovie acuity chart¹ in multicenter clinical investigations, such as the Early Treatment Retinopathy Study and the Prospective Evaluation of Radial Keratotomy, because testing with this chart eliminates many of the inherent problems associated with the standard Snellen acuity chart.² Thus far, to our knowledge, no one has reported a method for directly converting the number of letters read correctly from the Bailey-Lovie chart to the denominator of the Snellen fraction for 2 ft. Since the Bailey-Lovie chart is designed to have an equal logarithmic change between lines and there is an equal number of letters per line, a simple exponential equation can be derived to relate these two factors to Snellen acuity as follows:

$$\text{Snellen Acuity} = 20 \times 10^{(55 - X)/50},$$

where X is the number of letters read correctly from the Bailey-Lovie chart.

For example, if all Bailey-Lovie letters (X = 70) are

correctly identified, the score is equivalent to 20/10 Snellen acuity; 55, 20/20; and 58, 20/17. By using this formula, more precise Snellen equivalents are obtained that may allow the investigator to identify previously unidentified clinical subtleties in large study populations. It should be noted that when the number correct is not a multiple of five, resulting intermediate Snellen equivalents do not correspond to an optotype size on the chart. In the example above, where 58 letters were correctly identified, the result is 20/17, which is more commonly written as 20/15 —2. Although for the individual patient the "plus" and "minus" notations are more familiar to the clinician and may be more meaningful, the 20/17 value is the only acceptable data entry that maintains the logarithmic progression of the Bailey-Lovie chart. It is also the only appropriate value that can be used for database entry and statistical analysis.

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Partial Ablation of Neovascular Membranes Involving the Fovea

To the Editor.—We read with interest the article by the Macular Photocoagulation Study Group, "Persistent and Recurrent Neovascularization After Krypton Laser Photocoagulation for Neovascular Lesions of Ocular Histoplasmosis,"¹ in the March 1989 issue of the ARCHIVES. Neovascularization persisted or recurred more frequently if treatment did not entirely cover the neovascularization or did not meet the required level of intense burn on the foveal side. Persistent neovascularization developed in 17% (17 of 102 eyes) of neovascular membranes (NVMs) that were completely treated, and in 39% (14 of 36 eyes) of NVMs that were incompletely treated.

The authors emphasized that best results are obtained when the NVM is completely and intensely treated, implying that photocoagulation prevents recurrence of neovascular tissue by direct cauterization. However, Table 4 of their article notes that although 39% of incompletely treated NVMs persisted, 61% of incompletely treated NVMs regressed! This implies that a successful outcome may not require complete ablation and may involve other factors in addition to direct cauterization of the NVM. Perhaps an incompletely treated NVM involutes if vessels feeding the neovascular front are cauterized, or perhaps photocoagulation stimulates the production of an antineovascular factor.

Although this article made a good case for complete ablation of the NVM if it is located outside the foveal avascular zone, treatment inside the foveal avascular zone remains a dilemma. As the authors' data indicated, many NVMs that are not completely treated involute. For cases of NVMs extending beneath the foveal avascular zone, would it not be more prudent initially to split the NVM by applying treatment first to the NVM located outside of the foveal avascular zone, sparing further damage to the foveal receptors? If a follow-up angiogram at 1 or 2 weeks indicates persistence of foveal neovascular tissue, additional treatment could then be applied. This staged method might limit the number of foveal cones sacrificed. This difficult question can only be answered with a clinical trial.

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