ny, East Germany, and India). Its advantage, of course, is its low price.

Mac Rae and associates used 0.4% methylcellulose which has never been used clinically. Although I originally described the use of 1% methylcellulose,[1,2] I have since changed to 2% methylcellulose.[3-5] The authors stated that 0.4% methylcellulose did not adequately protect the corneal endothelium, whereas 1% sodium hyaluronate did. This statement means little because sodium hyaluronate was tested at its clinical concentrations (1%) whereas methylcellulose was reduced to one fifth of its clinical concentration (0.4% instead of 2%). The viscosity of 1% sodium hyaluronate is approximately 10,000 centipoise and that of 2% methylcellulose is 3,000 centipoise but that of 0.4% methylcellulose is only 40 centipoise.

Until the endothelium abrasion test is repeated with an adequate concentration of methylcellulose one should not conclude that methylcellulose is clinically inferior to sodium hyaluronate.

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Reply

EDITOR:

We concluded that 0.4% methylcellulose did not provide equivalent endothelial protection compared with 1% sodium hyaluronate and 20% chrondroitin sulfate. We did not wish to imply from our results that all concentrations of methylcellulose are inadequate to protect the corneal endothelium. As Dr. Fechner points out, methylcellulose with a higher viscosity would be appropriate for greater endothelium protection. Continued investigation on the potential benefits of methylcellulose as a viscous aqueous substitute is warranted.

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Uveal Findings in Patients with Ocular and Cutaneous Melanoma

EDITOR:

In their article, "Uveal findings in patients with cutaneous melanoma" (Am. J. Ophthalmol. 95:474, April 1983), D. M. Albert, S. S. Searl, B. Forget, P. T. Lavin, J. Kirkwood, and J. J. Nordlund rightly raised questions about the possible relationships of the ocular and cutaneous melanocytic systems.

In 1980, I[1] suggested that all patients wih cutaneous malignant melanomas, especially those related to the B-K mole syndrome (dysplastic nevus syndrome) phenotype, and patients with vitiligo should undergo ophthalmoscopic as well as dermatologic examinations and that patients with ocular malignant melanomas and dyschromias should undergo dermatologic examinations. I still strongly believe that this would lead to a better understanding of the potential of melanocytes at different sites to undergo malignant or other transformations. This thought grew out of reports[2-4] describing patients with simultaneous ocular and cutaneous malignant melanomas. These patients were characterized as having irregular, variable, multicolored cutaneous nevi that histopathologi-