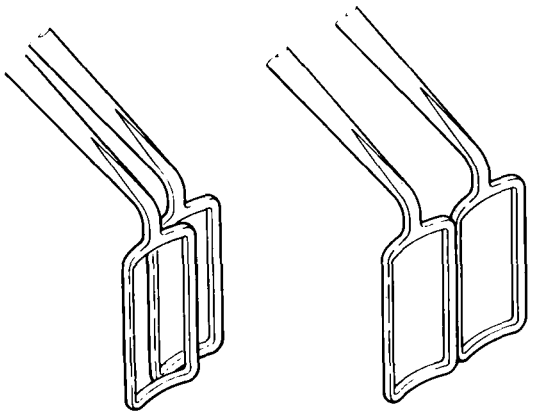

Fig. 2 (Mizuno). One retractor can overlap another (at left) or two can be used in parallel (at right).

method has been troublesome. I have now designed a steel-wire, rectangular, window retractor available in three different sizes, 5 × 10, 5 × 15, and 5 × 20 mm. Each retractor can be attached to either end of a holder (Fig. 1). The free end of the retractor is either straight or curved about 130 degrees against the axis of the retractor for about 4 mm, so that at least four pairs of retractors can be prepared (Fig. 1).

With the window retractor it is possible to perform retinal detachment surgery on more posteriorly located areas of the sclera. Soft deep orbital tissues are retracted from the sclera with the curved retractor. The instrument allows a needle for mattress sutures to pass through without hitting the retractor, as happens with conventional instruments. If orbital soft tissues protrude massively through the window of the retractor, the rectangles can be overlapped (Fig. 2). If a wider operating field is needed, two retractors can be used parallel to each other (Fig. 2).

Thus, the new rectangular window retractor produces a large and deep operating field and facilitates fine maneuvers, particularly for needlework in the deep sclera.

REFERENCES

1. Arruga, H.: Ocular Surgery, Hogan, M. J., and Chapars, L. E. (trans.). New York, McGraw-Hill, 1962, p. 612.
2. Schepens, C. L.: Retinal Detachment and Allied Diseases. Philadelphia, W. B. Saunders Co., 1983, pp. 398–399.

CORRESPONDENCE

Correspondence concerning recent articles or other material published in THE JOURNAL should be submitted within six weeks of publication. This correspondence must be typed and prepared in the same way as Letters to THE JOURNAL.

Every effort will be made to resolve controversies between the correspondents and the authors of the article before formal publication.

The Effect of Sodium Hyaluronate, Chondroitin Sulfate, and Methylcellulose on the Corneal Endothelium and Intraocular Pressure

EDITOR:

I was most interested in the article, "The effect of sodium hyaluronate, chondroitin sulfate, and methylcellulose on the corneal endothelium and intraocular pressure" (Am. J. Ophthalmol. 95:332, March 1983), by S. M. Mac Rae, H. F. Edelhauser, R. A. Hyndiuk, E. M. Burd, and R. O. Schultz, because I have used methylcellulose as a cushioning substance in more than 700 cataract operations with intraocular lens implantation since 1976.

Unfortunately, the authors missed the chance to clarify the role of methylcellulose experimentally. Methylcellulose appears to be clinically valuable and is widely used in many countries (for example, England, France, West Germa-

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.

P. U. FECHNER, M.D.
Hannover, West Germany

REFERENCES

1. Fechner, P. U.: Methylcellulose in lens implantation. J. Am. Intraocul. Implant. Soc. 3:180, 1977.
2. ———: Methylcellulose als Gleitsubstanz für die Implantation künstlicher Augenlinsen. Klin. Monatsbl. Augenheilkd. 174:136, 1979.
3. ———: Intraocular Lenses. Stuttgart, Enke, 1980, p. 66.
4. ———: Use of methylcellulose during lens implantation. J. Am. Intraocul. Implant Soc. 6:368, 1980.
5. Fechner, P. U., and Fechner, M. U.: Methylcellulose and lens implantation. Br. J. Ophthalmol. 67:259, 1983.

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.

SCOTT MAC RAE, M.D.
HENRY F. EDELHAUSER, PH.D.
Milwaukee, Wisconsin

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-