In light of these considerations, if antibiotic prophylaxis in cataract surgery is to be avoided, it should be a joint decision by the ophthalmologist and patient, at least until an adequate trial or other evidence might demonstrate that antibiotic prophylaxis does not reduce the risk of pseudophakic endophthalmitis.

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In Reply The European Society of Cataract and Refractive Surgeons reported in 2007 that the use of intracameral cefturoxime at the conclusion of cataract surgery was associated with a significantly lower rate of acute-onset postoperative endophthalmitis when compared with a control group. However, there was a markedly increased rate of endophthalmitis in the control group, which was much higher than contemporary rates. A subsequent survey of European countries regarding the European Society of Cataract and Refractive Surgeons guidelines indicated that this treatment was not universally followed even in Europe. Reasons for not using intracameral cefturoxime include potential contamination, rare anaphylaxis, and increased resistance among Staphylococcus species. A recent study (2015) reevaluating intracameral cefturoxime for endophthalmitis prophylaxis after cataract surgery was not able to identify a difference between this treatment (n = 7366 eyes) given from 2010 to 2012 (incidence = 0.108%) and a group treated similarly from 2006 to 2010 (n = 7756 eyes) before intracameral cefturoxime sodium was given at the conclusion of cataract surgery (incidence = 0.155%). Moxifloxacin is ineffective in approximately 40% of coagulase-negative Staphylococcus isolates. Therefore, we disagree with Carifi and colleagues, who “strongly support the use of a bolus of antibiotic drugs administered intracameral at the end of the surgical procedure.”

In the United States, it is estimated that at least 2.2 million cataract operations are performed each year. The cost in terms of drug expense and personnel for mixing correct doses of antibiotics is high. Cost must be a consideration, especially in light of the questionable benefit of such prophylactic measures. In 1995, the Centers for Disease Control and Prevention made recommendations that vancomycin should not be used as a prophylactic agent. Complications from intravitreal vancomycin include toxic anterior segment syndrome, cystoid macular edema, and hemorrhagic occlusive retinal vasculitis, which can be associated with moderate to severe vision loss. Therefore, safety is not compromised when intracameral antibiotics are avoided.

We believe that modern cataract surgery is safer for the patient with a shorter duration than in past decades. However, the individual surgeon must evaluate the existing body of knowledge and determine the suitability of intracameral antibiotics in his or her own clinical practice.

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Conflict of Interest Disclosures: All authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest and none were reported.

Reported in Studies of Binocular Summation—Reply“ published online April 30, 2015, in JAMA Ophthalmology (doi:10.1001/jamaophthalmol.2015.0944), incorrect information appeared in the Table. For 2.5% low-contrast acuity in the better eye, the mean (SD) letter scores should have been 61 (13) preoperatively and 60 (12) postoperatively. For 1.25% low-contrast acuity in the better eye, the mean (SD) letter scores should have been 62 (12) preoperatively and 59 (12) postoperatively. This article was corrected online.