**Rebuttal: Case of a Failed Probing for Nasolacrimal Duct Obstruction**

To the Editors:

Although the comments regarding the panelists’ indications for using the LacriCATH® balloon catheter in the Eye to Eye panelist discussion that appeared in the November/December issue of the *Journal of Pediatric Ophthalmology* were generally positive, Quest Medical, Inc., manufacturer, would appreciate an opportunity to clarify some inaccurate statements on pages 327-328. The discussion surrounding packaging of the pump, or inflation device, is incorrect. Quest Medical has never advocated, packaged, or labeled the product in a way that requires or promotes a surgeon to use a different pump on both eyes. The kits are packaged in unilateral and bilateral configurations with one inflator per kit; therefore, one inflator is used for bilateral cases.

Quest moved to this format of packaging in 2004 in an effort to reduce the number of product complications that arose from reusing, or reprocessing, the inflator. In fact, when comparing data from 2003, before kits were implemented, to 2005, when kits were fully implemented, the data reveal an overall 90% reduction of inflation device-related product failures. This validates that the current packaging has helped ensure a quality product for the patient as well as the surgeon, ensuring the device is not reprocessed and used for subsequent procedures. It is important to note that the device may not perform to specifications with reuse. We continue to see excellent product performance from the conversion to procedure kits.

Additionally, the FDA labeling of this device clearly states, “For one time use only. Do not reuse. Do not re-sterilize.” Quest Medical is not packaging the device to promote overuse. The product is packaged and sold according to all applicable laws and regulations as a sterile, single-use product.

With regard to reusing a balloon catheter in the second eye, Dr. Wagner, moderator, is correct. You can never get the balloon deflated to the thin profile once it has been inflated. During manufacturing, the balloon is folded to a specific profile for easy insertion. Once inflated and used clinically, this thin profile cannot again be achieved. Although the balloon material is soft and designed to be easily removed without causing trauma, removal is done with a twisting motion so that the balloon can compress on itself and partially wrap on withdrawal. To minimize trauma to the puncta, and to ease insertion, we only recommend following the labeling guidelines for single use.

**Reference**


Sue Reynolds  
Quest Medical, Inc.  
Allen, Texas

To the Editors:

Adding the pediatric ophthalmology perspective to Ms. Reynolds’ comments on the Eye to Eye panelist discussion printed in the November/December issue, we are fortunate to have excellent procedures to treat and cure tear duct obstructions including standard probing, silicone intubation with bicanalicular or monocanalicular tubing, and balloon dilation with the LacriCATH®. Each of us should make our surgical decision based on our comfort level and the clinical picture presented during the case. It is my fervent belief that although we all look at price as an important factor, we are fortunate to have the technology at our disposal to choose what we feel is the best procedure for our patients. As far as the discussion presented in the Eye to Eye column, I used to attempt to use the same LacriCATH® on the second side in a bilateral case, and although it was successful almost universally, it is technically difficult to insert the LacriCATH® on the second side and the inflation on the second side is possibly inconsistent. With the advent of the simultaneous balloon dilation system, I have eliminated the guess work and decreased the anesthesia time for my patients.

I appreciate Drs. Jaafar and Coats’ comments in the interview and thank the *Journal of Pediatric Ophthalmology*.
Ophthalmology & Strabismus for having the forum for experts in pediatric ophthalmology to discuss issues important to our practices.

Reference

Disclosure: Dr. Gold is a consultant for Quest Medical, Inc.

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Gillespie Syndrome With Impaired Accommodation

To the Editors:

Gillespie syndrome is a rare form of congenital dysautonomia characterized by mental retardation, nonprogressive cerebellar ataxia, partial aniridia, and hypoplastic irides. It was first identified in 1965 and, to our knowledge, until now 21 cases had been reported. Genetically, it is an autosomal recessive condition with no mutation of the PAX6 gene.

Ocular findings described include iris and foveal hypoplasia, hypoplastic optic disc, ptosis, nystagmus, and pigmentary retinopathy. We report a typical case of Gillespie syndrome with impaired accommodation. To our knowledge, this is the first case reported of impaired accommodation in Gillespie syndrome.

A 5-year-old girl was referred to the clinic for further assessment and management of her ocular condition as her family moved to Scotland from London. She was diagnosed as having Gillespie syndrome with apparently dilated nonresponsive pupils and hypoplastic irides. She had generalized motor developmental delay. Clinical examination showed partial aniridia, jerky, smooth pursuit eye movements, and nystagmus on eccentric gaze. Her fundi showed retinal hypopigmentation and situs inversus of the optic discs. Her binocular visual acuity with Cardiff card was 6/12 with near acuities of N18. Dynamic retinoscopy showed no accommodation. Magnetic resonance imaging of the brain confirmed mild cerebellar atrophy with no other significant abnormality. Her parents had no relevant ocular problems, although her sister attends the clinic for oculo-cutaneous albinism. Impaired accommodation was confirmed by open field objective autorefraction, which measured a maximum accommodative response to near viewing of 0.81 ± 0.31 diopters (D) over the 0 to 5 D stimulus range (normal value for age is approximately 4.5 D).

She was given varifocal tinted glasses by adding +2.5 D to her distance prescription of +1.00 D both eyes. She was encouraged to wear her glasses regularly. She has been followed up routinely in the clinic since then and she is coping well with the glasses and using her full visual potential for both distance and near with distance and near visual acuities of 6/9 and N8.

Dilated pupils in Gillespie syndrome are thought to result from decreased cholinergic activity associated with aplasia of the iris sphincter muscles. The marked deficiency of accommodation seen in this case suggests it could be associated with hypoplasia of the ciliary muscles in addition to decreased cholinergic sensitivity. It is important to diagnose impaired accommodation in a case of Gillespie syndrome so that appropriate spectacles (varifocal or bifocal) can be prescribed to prevent long-term visual deprivation and to allow the child to make full use of the visual potential for both near and distance. Hypermetropia requires compensatory accommodation and hypermetropic eyes without accommodative function can develop amblyopia. Thus, young children with Gillespie syndrome require refraction with and without paralysis of accommodation to prevent amblyopia.

References

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