

Characterization and Management of Late Postoperative Capsular Block Syndrome Following Phacoemulsification or Phacovitrectomy



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- **PURPOSE:** To compare the clinical characteristics of eyes affected by late postoperative capsular block syndrome (CBS) after routine phacoemulsification or phacovitrectomy, and to demonstrate the outcomes of neodymium-doped yttrium-aluminum-garnet (Nd:YAG) capsulotomy and posterior continuous curvilinear capsulorrhexis (PCCC) in the treatment of CBS.
- **DESIGN:** Retrospective interventional case series study.
- **METHODS:** Twenty-eight patients with late postoperative CBS, comprising 13 eyes after phacoemulsification (Group A) and 15 eyes after phacovitrectomy (Group B), were analyzed. Seventeen patients with minimal (degree I), mild (II), and moderate (III) posterior capsular opacification (PCO) underwent Nd:YAG capsulotomy (Group A, 10 eyes and Group B, 7 eyes), while 11 patients with severe (degree IV) PCO underwent PCCC (Group A, 3 eyes and Group B, 8 eyes).
- **RESULTS:** A statistically significant postoperative improvement in best-corrected visual acuity (Group A, $P = .0002$ and Group B, $P = .0070$) and a significant postoperative decrease in aqueous flare value (Group A, $P = .0077$ and Group B, $P = .0127$) were observed. No significant differences were observed in intraocular pressure, aqueous depth, and diopters ($P > .05$). No surgical complications were experienced by either group.
- **CONCLUSIONS:** Late postoperative CBS had similar characteristics whether it developed after phacoemulsification or after phacovitrectomy. Nd:YAG capsulotomy and the PCCC technique are efficient approaches to mild and moderate PCO and severe PCO with CBS, respectively. PCCC may be a viable alternative for treating dense PCO with CBS in pseudophakic eyes. (Am J Ophthalmol 2019;204:19–25. © 2019 Elsevier Inc. All rights reserved.)

CAPSULAR BLOCK SYNDROME (CBS) IS A RARE POST-operative complication of phacoemulsification and intraocular lens (IOL) implantation, characterized by the accumulation of transparent or opaque liquid in the capsular bag. According to the time of onset, Miyake and associates¹ classified 3 types of CBS: intraoperative, early postoperative, and late postoperative. Among them, late postoperative CBS is the most common manifestation, with an incidence of 0.73%,² occurring months or years after surgery. Besides the accumulation of liquid, fibrosis along the entire capsule opening and posterior capsule opacification (PCO) can occur.²

Current research has focused mainly on case reports of late postoperative CBS after phacoemulsification and IOL surgery.^{3–9} These studies inferred that collagen and lens epithelial cells migrate to and proliferate in the capsular bag, leading to PCO and causing the occlusion of the capsular opening by narrowing the space between the anterior capsule and the posterior chamber IOL (PC-IOL).¹ CBS may occur in any intraocular surgery associated with phacoemulsification and IOL implantation. Goodwin and associates¹⁰ reported a case of early postoperative CBS following phacovitrectomy, which may have been associated with sodium hyaluronate left behind the PC-IOL. With the wide application of phacovitrectomy and IOL implantation for cataracts with coexisting vitreoretinopathy, our clinical observations show that late postoperative CBS is not uncommon after both phacovitrectomy and phacoemulsification. Whether tamponade of the retina in the combined surgery facilitates the formation of CBS is unclear.

PCO and accumulated fluid in the posterior capsular bag are the main causes of decreased visual acuity in CBS patients,^{2,11} and a rational approach to PCO is therefore crucial in the treatment of CBS. In the literature and clinical applications, neodymium-doped yttrium-aluminum-garnet (Nd:YAG) capsulotomy is the most efficient and widely used treatment for established PCO,^{4,6–8} although other surgical procedures have been reported, such as anterior continuous curvilinear capsulorrhexis and vitrectorhexis with capsulotomy.^{12–14} In most cases, PCO can be treated effectively with Nd:YAG capsulotomy, but excessive laser energy for dense PCO can result in significant morbidity from postoperative

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complications, including IOL damage, intraocular pressure (IOP) elevation, vitreous prolapse, vitreous floaters, cystoid macular edema, and rhegmatogenous retinal detachment (RRD).^{15–20} These complications can be more common in CBS cases with dense PCO and capsular effusions. In cases of dense PCO with CBS, surgical management by posterior continuous curvilinear capsulorhexis (PCCC) through the pars plana with 23 gauge vitrectomy may be effective.²¹ It is therefore important to choose between laser and surgical treatment for CBS patients according to PCO density.

The aim of this study was to compare the clinical characteristics of eyes affected by late postoperative CBS after routine phacoemulsification or phacovitrectomy, and to analyze the outcomes of Nd:YAG capsulotomy and PCCC in the treatment of CBS.

PATIENTS AND METHODS

• **PATIENTS:** This was a retrospective interventional study conducted at the Eye Center of the Second Affiliated Hospital, Zhejiang University School of Medicine in Hangzhou, China. All investigations were conducted in accordance with the tenets of the Declaration of Helsinki.

Twenty-eight eyes from 28 patients who underwent phacoemulsification or phacovitrectomy from December 2013 to May 2018 were included in the study. According to previously reported diagnostic criteria,^{1,7} late postoperative CBS was first identified as PCO by slit-lamp examination images when a transparent or opaque substance accumulated between the posterior capsule and the posterior surface of the PC-IOL more than 6 months after the initial surgery. Anterior segment optical coherence tomography (AS-OCT) (Visante OCT 1000; Carl Zeiss, Dublin, Germany) was used to scan raw images in high-resolution mode, and aqueous depth (AQD) was measured to confirm the diagnosis. AQD was defined as the distance from the central cornea endothelium to the anterior pole of the PC-IOL. The exclusion criteria were the following: (1) patients with traumatic cataracts; (2) patients with congenital cataracts; (3) patients with complicated cataracts (except from diabetes); (4) patients with pseudoexfoliation syndrome; and (5) patients whose AS-OCT indicated PCO with no liquid accumulation in the capsular bag, irrespective of the thickness of the proliferative cell mass.

Patient data included demographic (age and sex) and biometric parameters. All biometric parameters were measured 1 day before and again 1 day, 1 week, 1 month, and 3 months after surgery. These included best-corrected visual acuity (BCVA) expressed as the logarithm of the minimum angle of resolution (logMAR) scale, diopter measurements (KR-8900; Topcon Corporation, Tokyo, Japan), IOP (NT-510; NIDEK, Gamagori, Japan), laser flare photometry (FC-2000; Kowa Com-

pany, Ltd, Tokyo, Japan), anterior segment slit-lamp illumination images (SL-D8Z; Topcon Corporation, Tokyo, Japan), and fundus examination (TRC-NW8; Topcon Corporation, Tokyo, Japan), as well as the type of PC-IOL. The latter included 14 Akreos Adapt (Bausch & Lomb, Rochester, New York, USA); 7 SA60AT (Alcon, Fort Worth, Texas, USA); 4 Model 251 (HOYA; Tokyo, Japan); and 3 unknown. For each patient, diopters were measured first with autorefraction, and then manifest refraction was measured. The final refraction was determined by an optometrist. Late postoperative CBS was clinically diagnosed by 3 experienced ophthalmologists (J.J.L., Z.Q.C., and K.Y.).

• **GROUP ALLOCATION:** The 28 patients were divided into 2 groups according to the original surgical method used: 13 patients (13 eyes, Group A) had received phacoemulsification and PC-IOL implantation; 15 patients (15 eyes, Group B) had received phacovitrectomy and PC-IOL implantation. Preoperative and postoperative biometric features were assessed for 28 patients (28 eyes) with mean age (\pm standard deviation, SD) of 64.2 ± 9.3 years in Group A and 60.2 ± 10.8 years in Group B. All cases in Group A were age-related cataracts. In Group B, besides age- and diabetes-related cataracts, the primary eye diseases included RRD, macular holes (MHs), proliferative diabetic retinopathy (PDR), and vitreous hemorrhage (VH). In the following, we refer to the n-th patient in Group X (A or B) as patient Xn.

• **SURGICAL METHODS:** Subjective PCO grading was assessed as previously described.²² Three or more experienced ophthalmologists graded all slit-lamp images subjectively and independently, classifying them as minimal (degree I), mild (II), moderate (III), or severe (IV) according to the standard images proposed by Findl and associates.²² The amount and density of fluid in the capsular bag of the AS-OCT images were also evaluated. When different opinions arose, the final degree was determined by averaging the grades and performing further comprehensive assessment. In our clinical experience, a patient with severe PCO (degree IV) requires stronger laser intensity or multiple Nd:YAG posterior capsulotomies. Therefore, we set degree IV PCO as the criterion for treatment choice. As such, patients with PCO subjective degree I, II, and III were treated by Nd:YAG laser posterior capsulotomy, and degree IV patients received PCCC through vitrectomy trocars. Based on such criteria, 17 patients underwent Nd:YAG capsulotomy (Group A, 10 eyes and Group B, 7 eyes), and 11 patients underwent PCCC (Group A, 3 eyes and Group B, 8 eyes).

• **NEODYMIUM-DOPED YTTRIUM-ALUMINUM-GARNET CAPSULOTOMY:** All Nd:YAG capsulotomies were performed by the same surgeon (Z.Q.C.) using a Q-switched laser (VISULAS YAG III; Carl Zeiss Meditec AG, Jena, Germany). Pupillary dilation was obtained in all

patients with 1% compound tropicamide (Santen Oy, Osaka, Japan), and topical anesthesia was performed by instilling 0.5% proparacaine hydrochloride (Alcaine; Alcon, Ft. Worth, Texas, USA) 2 times at a 1-minute interval. A standard Abraham capsulotomy lens was applied. Capsulotomy was performed with the cross pattern method to form an opening at least 4 mm in diameter. Pulses of 1.5 to 2.0 mJ were applied, and the total energy used was 75 ± 28 mJ (mean \pm SD, range 40-175 mJ).

• **POSTERIOR CONTINUOUS CURVILINEAR CAPSULORHEXIS:** Prior to surgery, pupils were dilated with 1% compound tropicamide eye drops. All patients received retrobulbar anesthesia with injections of 2% lidocaine and 0.75% bupivacaine. The Stellaris PC System (Bausch & Lomb, Rochester, New York, USA) surgical system was used. A standard 3-port 23 gauge pars plana vitrectomy was used for eyes with PCO IV in both groups. For patients in Group A, core vitrectomy was performed first, followed by separation and removal of the posterior vitreous cortex. For patients in Group B, silicone oil was extracted first if it had not been previously removed. Supplementary vitrectomy was performed to peel the epiretinal membrane and inner limiting membrane, depending on the condition of the patient.

After routine vitrectomy was performed on all eyes, the cutter was brought to the vitreolenticular interface and the anterior vitreous was removed, followed by PCCC. Anterior vitreous detachment was induced by vacuum aspiration (200-250 mm Hg). The anterior vitreous membrane and cortex were pulled radially by suction toward the pars plana area, which was removed as much as possible by vitrectomy at the same time. With the removal of the anterior hyaloid vitreous, the posterior lens capsule (PLC) was exposed. The PLC was easily identified by a combination of coaxial illumination and retroillumination; improved microforceps were used to grasp the posterior capsule flap through a trocar cannula incision, about 3-5 mm in diameter, and conclude the PCCC. Meanwhile, all separated posterior capsules were removed, as was the residual hyperplastic lens cortex.

If the PLC was too thick for PCCC to be completed using microforceps alone, microscissors and a vitrectomy cutter were also used. If there was leakage in the sclerotomy site, it was closed with 8-0 absorbable sutures (VICRYL; Ethicon Inc, Cincinnati, Ohio, USA). All surgeries were performed by a single, experienced surgeon (J.J.L.).

• **STATISTICAL ANALYSIS:** Snellen visual acuity was converted to logMAR units for comparison. The following conversion to logMAR was used for low vision: counting fingers = 1.6; hand movements = 2.0; light perception = 2.5; and no light perception = 3.0.²³ Diopters were converted to spherical equivalent (SE) computed as the spherical power plus $\frac{1}{2}$ of the cylindrical power. Preoperative (1 day before surgery) and postoperative (3 months

after surgery) BCVA, SE, IOP, and AQD levels were compared using the Student *t* test. BCVA improvement (postoperative minus preoperative BCVA) of the patients treated with the different surgeries was also analyzed using Student *t* test. To avoid the effects of silicone oil, diopters were compared excluding patients without silicone oil removal (patients B2 and B15). PCO degrees I-IV were translated into the corresponding Arabic numerals: minimal (degree I) = 1, mild (II) = 2, moderate (III) = 3, and severe (IV) = 4. All tests were 2-sided, and *P* values < .05 were considered statistically significant. All analyses were performed using IBM SPSS Statistics for Windows, version 23 (IBM, Armonk, New York, USA).

RESULTS

• **DEMOGRAPHICS:** There were 13 patients (13 eyes; 4 male, 9 female) in Group A and 15 patients (15 eyes; 8 male, 7 female) in Group B. The mean time (\pm SD) of CBS onset was 28.54 ± 14.39 months (range 7-53 months) in Group A and 35.13 ± 26.80 months (range 6-92 months) in Group B (Table). All 13 eyes in Group A presented with age-related cataract as the primary disease and had undergone successful cataract surgery in the past. Eyes in Group B included 13 cases of age-related and 2 of diabetes-complicated cataract, with primary RRD in 9 eyes (60.0%), RRD associated with MH in 3 (20.0%), PDR in 2 (13.3%), and age-related macular degeneration associated with VH in 1 (6.7%). Of these 15 eyes, 6 (40.0%) had undergone surgery with an intraocular tamponade of octafluoropropane (C₃F₈) gas and 9 (60.0%) with an intraocular tamponade of silicone oil; 7 of these had undergone silicone oil removal. Fourteen (93.3%) eyes had previously undergone 1 surgery (not including silicone oil removal), while 1 eye (6.7%, Patient B13) had undergone multiple surgeries (Supplemental Tables 1 and 2; Supplemental Material available at AJO.com).

All other patients in both groups had 1-stage surgery in our eye center, except for Patients A4, B9, B12, and B13, who had their initial surgeries at other hospitals. Among these, only Patient B9 could provide documentation about the type of PC-IOL used.

• **COMPARISON OF CLINICAL INDEXES BEFORE AND AFTER TREATMENT, AND BETWEEN THE 2 GROUPS:** The mean values of BCVA, IOP, aqueous flare value, AQD, and diopter of the patients in each group, 1 day before and 3 months after treatment, are listed in the Table. A statistically significant improvement after treatment was noted in BCVA (Group A, *P* = .0002 and Group B, *P* = .0070) and in aqueous flare value (Group A, *P* = .0077 and Group B, *P* = .0127). In contrast, IOP, AQD, and diopters showed no statistically significant difference (IOP: Group A, *P* = .981, Group B, *P* = .1095; AQD: Group

TABLE. Demographics and Clinical Data of Patients in Group A and Group B

Parameter	Group A	Group B
Population (n)		
Eyes	13	15
Patients	13	15
Mean age (y) ± SD	64.2 ± 9.3	60.2 ± 10.8
Sex (M/F)	4/9	8/7
Operated eye (n) (right/left)	3/10	8/7
PCO degree ± SD	3.00 ± 0.71	3.27 ± 0.96 (<i>P</i> = .4171) ^a
Surgical procedure		
Silicone oil/C3F8 gas	/	9/6
Mean time of onset (months) ± SD	28.54 ± 14.39	35.13 ± 26.80 (<i>P</i> = .4353) ^b
Preoperation		
BCVA (logMAR)	0.84 ± 0.40	1.29 ± 0.65
IOP (mm Hg)	15.81 ± 4.99	19.67 ± 10.30
Aqueous flare value (pc/ms)	18.15 ± 10.84	34.42 ± 34.61
AQD (cm)	3.85 ± 0.36	3.93 ± 0.42
Diopter	-1.04 ± 3.25	0.36 ± 4.05 ^c
Postoperation		
BCVA (logMAR)	0.28 ± 0.22 (<i>P</i> = .0002)	0.67 ± 0.50 (<i>P</i> = .0070)
IOP (mm Hg)	15.77 ± 3.00 (<i>P</i> = .9812)	15.07 ± 3.18 (<i>P</i> = .1095)
Aqueous flare value (pc/ms)	8.56 ± 4.91 (<i>P</i> = .0077)	10.39 ± 4.92 (<i>P</i> = .0127)
AQD (cm)	3.86 ± 0.23 (<i>P</i> = .9643)	3.97 ± 0.41 (<i>P</i> = .8239)
Diopter	-0.75 ± 2.12 (<i>P</i> = .7910)	-1.62 ± 2.89 (<i>P</i> = .1652)

P values mentioned in the table refer to differences in BCVA (logMAR), IOP (mm Hg), aqueous flare value (pc/ms), AQD (cm), and diopters in the same group before and after treatment (Student *t* test).

AQD = aqueous depth; BCVA = best-corrected visual acuity; IOP = intraocular pressure; PCO = posterior capsular opacification.

^a*P* value of the difference in PCO degrees between Group A and Group B (Student *t* test).

^b*P* value of the difference in time of onset between Group A and Group B (Student *t* test).

^cExcluding Patients B2 and B15, who did not undergo silicone oil removal.

A, *P* = .9643, Group B, *P* = .8239; diopters: Group A, *P* = .7910, Group B, *P* = .1652).

No significant difference between the 2 groups was observed for PCO degree (Group A: 3.00 ± 0.71, Group B: 3.27 ± 0.96, *P* = .4171) or time of onset (Group A: 28.54 ± 14.39 months, Group B = 35.13 ± 26.80 months, *P* = .4353). Detailed information about the patients in Group A and Group B is shown in [Supplemental Tables 1 and 2](#), respectively.

• **RESULTS FOR PATIENTS WITH MINIMAL (DEGREE I), MILD (II), OR MODERATE (III) POSTERIOR CAPSULAR OPACIFICATION, TREATED WITH NEODYMIUM-DOPED YTTRIUM-ALUMINUM-GARNET POSTERIOR CAPSULOTOMY:** Three patients complained of floating debris in the visual field within 2-5 days of Nd:YAG capsulotomy, although the floaters soon disappeared. After this procedure, all patients had a stable PC-IOL position and a relatively round central margin of the posterior capsule, without PC-IOL rupture. No surgical complications were reported in either group. The mean BCVA (± SD) of these patients improved from 1.00 ± 0.57 to 0.39 ± 0.36, and this difference was statistically significant (*P* = .0007). For

example, Patient B4 was initially diagnosed with moderate (degree III) PCO; biomicroscopic slit-lamp examination and AS-OCT images of his right eye showed a medium amount of pearly turbidity along the entire capsule opening and translucent PCO floating between the posterior surface of the PC-IOL optic and the posterior capsule. An Nd:YAG posterior capsulotomy was performed to remove the PCO. Three months after capsulotomy, the central part of the posterior capsule was transparent, and the liquid cavity had disappeared ([Figure 1](#)), and the BCVA improved from 0.4 to 0.3 logMAR units ([Supplemental Table 2](#)).

• **RESULTS FOR PATIENTS WITH SEVERE (DEGREE IV) POSTERIOR CAPSULAR OPACIFICATION, TREATED WITH POSTERIOR CONTINUOUS CURVILINEAR CAPSULORRHESIS:** The PC-IOL position was stable and the posterior capsule margin remained round in all patients who received PCCC. The mean BCVA (± SD) of these patients improved from 1.20 ± 0.63 to 0.64 ± 0.52, and this difference was statistically significant (*P* = .0323). No significant difference was observed in BCVA improvement between patients treated with Nd:YAG posterior capsulotomy and PCCC surgery (mean improvement ±

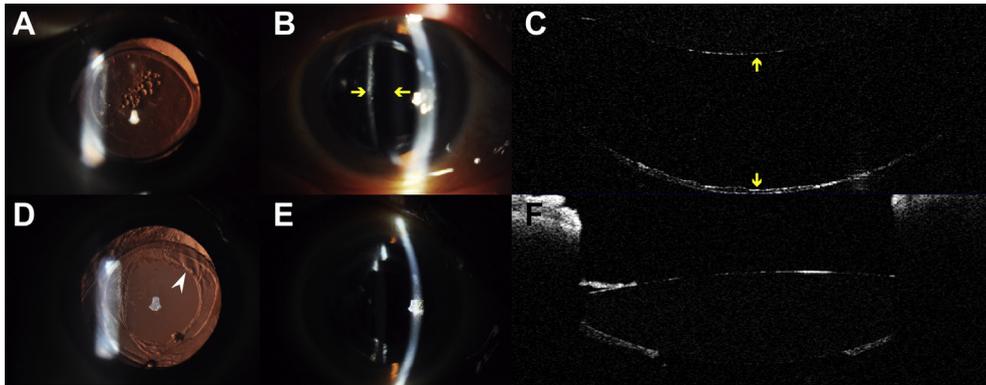


FIGURE 1. Patients with minimal (degree I), mild (II), and moderate (III) posterior capsule opacification, treated with neodymium-doped yttrium-aluminum-garnet (Nd:YAG) posterior capsulotomy. Slit-lamp photography (A, B) and anterior segment optical coherence tomography (AS-OCT) image (C) for Patient B4 1 day before Nd:YAG posterior capsulotomy. A turbid substance between the posterior surface of the posterior chamber intraocular lens optic and the posterior capsule is visible (yellow arrow). Slit-lamp photography (D, E) and AS-OCT image (F) for Patient B4 3 months after Nd:YAG posterior capsulotomy. Rigid fibrosis of the posterior capsule opening rim is visible (white arrowheads).

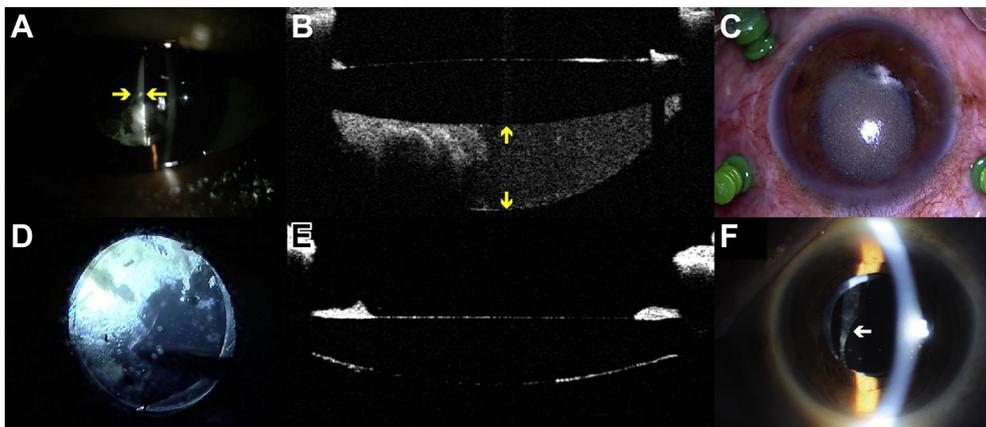


FIGURE 2. Patients with severe (degree IV) posterior capsule opacification, treated with posterior continuous curvilinear capsulorhexis (PCCC). Slit-lamp photography (A) and anterior segment optical coherence tomography (AS-OCT) image (B) for Patient B13 1 day before surgery. A turbid substance between the posterior surface of the posterior chamber intraocular lens optic and the posterior capsule is visible (yellow arrow). Intraoperative photographs (C) of the anterior segment show silicone oil emulsification. PCCC with microforceps (D). AS-OCT image (E) and slit-lamp photography (F) of the eye of Patient B13 3 months after surgery. A continuous and complete posterior capsule ring is shown (white arrow).

SD: -0.61 ± 0.42 and -0.56 ± 0.25 , respectively, $P = .7663$). For example, Patient B13 was initially diagnosed with severe (degree IV) PCO; his anterior capsular membrane was adhered to the PC-IOL surface with moderately sized white cotton wool-like fragments in the lower capsular bag. The capsular bag was filled with a milky white liquid and distended behind the PC-IOL, accompanied by silicone oil emulsification. The patient underwent vitrectomy surgery with silicone oil removal and PCCC procedure with both epiretinal membrane and inner limiting membrane peeling. Three months after surgery, AS-OCT and anterior segment imaging showed the central region of the posterior capsule to be clear (Figure 2), and the

BCVA improved from 0.8 to 0.1 logMAR units (Supplemental Table 2).

DISCUSSION

THIS STUDY IS A COMPREHENSIVE EVALUATION OF POSTOPERATIVE CBS following 2 types of treatment. By comparing the mean diopters before and after treatment (excluding Patients B2 and B15, who did not undergo silicone oil removal), we observed that patients in Group A had a slight hyperopic shift; that is, CBS had caused the original

refraction to shift toward myopia, while patients in Group B had a myopic shift, meaning that CBS had caused the original refraction to shift toward hyperopia. Although some cases showed high refractive deviation, such as Patients A13, B5, B11, and B14, there was no statistically significant difference in diopters before and after CBS treatment in either group. Our results show that neither surgical strategy changes the diopters of eyes with late postoperative CBS.

Moreover, there was no statistically significant difference in AQD or IOP before and after CBS treatment. These results are consistent with previous reports.^{4,21,24,25} We believe that because the movement of the PC-IOL was limited by the presence of phimosis in the anterior capsule,²⁶ the anterior chamber was relatively stable. Additionally, the absence of statistically significant differences in IOP appeared to be due to the structure of the anterior chamber angle being undamaged; perhaps, ocular self-regulation maintains the balance of normal IOP.

No significant differences were observed in the onset times and PCO degrees of Group A compared with Group B. This result indicates that the intraocular surgical processes on the posterior segment did not change the development or increase the severity of late postoperative CBS.

Timely and effective removal of PCO is important to relieve visual impairment in CBS patients. In this paper, we propose that the PCO degree of CBS patients could be used as a reference to select a specific treatment. Nd:YAG capsulotomy is becoming increasingly safe and effective, although it cannot be carried out in patients with complex CBS and still has some side effects.¹⁹ For patients with a minimal, mild, or moderate PCO, the pupillary area after treatment was transparent and no postoperative complications were observed. In contrast, PCCC is suit-

able for the treatment of dense PCO in patients with advanced CBS. Removal of dense PCO by PCCC can be achieved at the same time as vitreoretinal surgery for patients with severe CBS and vitreoretinal diseases. In this study, no complications were experienced in patients receiving PCCC through the pars plana combined with 23 gauge vitrectomy surgery.

Nd:YAG capsulotomy is accepted as the standard treatment for PCO. Improvement in visual acuity, glare, and contrast sensitivity are well documented.^{27–29} As compared with Nd:YAG capsulotomy, PCCC can prevent remnants of posterior capsule fragments in the eye, relieve the stimulation of capsule effusion and masses to eye tissues, and also avoid the potential risks of lasers. Additionally, vitrectomy can remove fluid from the capsular bag that has drained from the vitreous cavity and prevent ocular inflammation.

Standard vitrectorhexis, that is, capsulotomy using a vitrectomy probe, is used to remove the posterior capsule opacity. As compared with vitrectorhexis, PCCC makes a continuous and complete posterior capsule ring, thus making the capsule more resistant to tension, and thus the PC-IOL more stable. Besides, the separated tissue of the posterior capsule can be pathologically studied.

In summary, this is a systematic report of late postoperative CBS after routine phacoemulsification or phacovitrectomy. Late postoperative CBS had similar characteristics whether it developed after phacoemulsification or phacovitrectomy. Nd:YAG capsulotomy and the PCCC technique are efficient approaches for mild and moderate PCO and severe PCO with CBS, respectively. The PCCC technique may be a viable alternative for treating dense PCO with CBS in pseudophakic eyes.

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