

Her main commitment throughout her working life was to the Royal Eye Hospital, where during the war of 1939–45 she was one of the few members of staff not on active service. In the initial postwar period the hospital was amalgamated with King's College Hospital. This link was severed in the mid 1950s, and as chairman of the Medical Committee she skilfully steered the hospital through an inevitably disruptive period. In succeeding years she was a long-standing member of the Group Management Committee.

She was a deft and gentle surgeon and in the early 1950s, together with a colleague, devised a technique of exenteration of the orbit and postoperative fitting of a prosthesis, enabling young patients with sarcoma of the orbit to have a more bearable period of life which was left to them. Her calm, reassuring approach endeared her to her patients, and her colleagues found her to be a strong member of their team, with a refreshing humour. Postgraduate and undergraduate students benefited from her teaching, which she enjoyed, latterly imparting great wisdom gained from her experience and often punctuated by poignant anecdotes. She gave stalwart support to nursing matters, and her interest in her patients extended beyond the hospital. She possessed and developed a unique association with medical social workers on their behalf.

Although not a physically energetic person, particularly in later years, she enjoyed walking on holidays, visiting places of archaeological or wild fauna interest. A reluctant housekeeper and gardener, her main leisure enjoyment was reading, so that, despite her natural shyness, she was an interesting and entertaining conversationalist. She retired from practice 17 years ago, and her death is a sad loss.

DOREEN A. BIRKS

## Book reviews

**Adler's Physiology of the Eye: Clinical Application.** 7th edn. Ed. ROBERT A. MOSES. Pp. 747. C. V. Mosby: London. 1981.

This book lives up to the high standard of production shown in the previous (1975) edition, and, as before, it is designed to emphasise the clinical aspects of its subject matter. As with any book having a multiplicity of authors there is both overlapping and omission, but in general the editor and his team are to be complimented on a most useful textbook.

Most of the sections have been updated and extended, but it is rather surprising to find that the discussion of retinal neurotransmitters in the section on retina and optic nerve is practically the same as in the 1975 edition and that there is no mention of the technique of specular microscopy in the section dealing with the cornea. The section previously headed 'Iris and Pupil' is now simply 'Pupil,' and, while some material has been deleted, the discussion of iris pharmacology has been updated. The section on visual acuity has been rewritten, and, by contrast with the 6th edition, very little is said about the use of gratings. One would also

have liked to see a little more about the role of timolol as an ocular hypotensive drug and some discussion of recent work on lens proteins.

These are, however, minor blemishes. On the positive side the new 'Adler' has a fresh lease of life in an edition only some 40 pages longer than its predecessor and containing as a new feature a 'Biological Index' which, apart from its intrinsic value to the reader, serves to indicate the importance of comparative studies in this field.

D. F. COLE

**Guidelines for Programmes for the Prevention of Blindness.** World Health Organization. Pp. 47. No price given. WHO: Geneva. 1979.

This is a work of reference which can be adapted as required for the planning of national or regional programmes for the prevention of blindness.

It was prepared at a meeting held in Asilomar, California, USA, in October 1978 and jointly sponsored by the WHO centre for reference and research on trachoma and other chlamydial infections, the FI Proctor Foundation, San Francisco, the International Eye Foundation, and the World Health Organisation.

There were 40 participants at the meeting representing the following countries—USA; Britain, Australia, Switzerland, China, Nigeria, Peru, Egypt, Guatemala, Upper Volta, Sri Lanka, Barbados, Kenya, and Indonesia.

It was agreed that most of the blindness that affects some 30 or 40 million people in the world mainly occurs in the less developed areas where malnutrition and infections are common, and it is potentially avoidable. The goal of the WHO programme for the prevention of blindness is to eliminate the burden of avoidable blindness, for which there are many simple and effective preventive measures that can be applied.

It was decided that the 4 principles for action in a national programme to eliminate avoidable blindness and visual impairment are: (1) the identification of communities with a high prevalence of avoidable blindness and determination of its cause; (2) the provision of early treatment to the worst affected communities by using preventive and therapeutic measures, and when there is an accumulation of patients in need of surgery (e.g., for cataract or distorted eyelids) surgical treatment should be carried out if a mobile surgical team is available; (3) the establishment of therapeutic and preventive measures for the promotion of eye health; (4) the improvement of ophthalmic services so as to provide an adequate referral system and a centre where supervision and training of personnel can be carried out.

It is emphasised that an effective blindness-prevention programme cannot be accomplished by the medical profession alone. Intervention must be based on the presence of cultural and social factors, general education, food production, nutrition, water supply, and transport, and it needs support from public and private sectors. An assessment of 'ocular status' (i.e., an investigation of the magnitude and causes of blindness within the region or country) is essential in order to plan an effective

programme. Committees should, if possible, be set up consisting of government representatives, ophthalmologists, and specialists in public health and leaders in industry and in the media.

Auxiliary workers who have been adequately trained should be employed for most routine procedures including vision screening, but full examination of the eyes should always be done by a person specially trained in ophthalmology. House-to-house examination by a survey team in conjunction with a central examination clinic is valuable, and members of the team should be prepared to treat all eye conditions which are amenable to topical therapy. An assessment of the economic resources of the country should be made and should include—statistics of births and of diseases, environment, and sanitation, facts in regard to general health and nutrition, education, and teaching, and transport and communication, and standard of general management and leadership. Local personnel who are a useful resource for help in giving instruction in eye health include teachers, social workers, local religious leaders and community workers, and of course ophthalmic nurses and assistants, optometrists, opticians, and orthoptists.

The 3 stages of eye care which should be available are described as follows. (1) *Primary eye care* which should be in accordance with the principles of primary health care and must include therapeutic and preventive activities and the promotion of eye health. It should provide treatment for conditions such as conjunctivitis, especially trachoma, superficial foreign bodies, minor trauma, and xerophthalmia. (2) *Secondary eye care*, which should be an integral part of general secondary medical care, should provide treatment for ocular trauma, cataract, corneal ulceration, intraocular infection, entropion, pterygium, and possibly glaucoma. (3) *Tertiary eye care units* are usually established in national or regional capitals and are preferably associated with a hospital which has a medical school. They should provide more sophisticated eye care such as surgery for the correction of detached retina, corneal grafting, and other more complex forms of treatment including treatment of eye conditions due to medical and neurological diseases. Close co-operation with peripheral units should be maintained so that the staff of tertiary centres should be available to participate in the work of primary and secondary units.

The methods recommended for control of trachoma, nutritional blindness, onchocerciasis, and cataract are summarised, and also the use of mobile services.

The training of primary health workers should include eye care as part of their duties. The training of ophthalmic assistants should be undertaken by ophthalmologists. They should be taught minor surgical procedures such as operation for chalazion and removal of corneal foreign bodies. Qualified nurses, because of their training, are particularly well suited for this job.

There are a number of intergovernmental and non-

governmental organisations to which national governments may turn for support in order to establish programmes for the prevention of blindness. The World Health Organisation has taken the lead in international action to assist national programmes. Its financial resources are limited but it provides liaison with a variety of governmental and non-governmental agencies and helps the mobilisation of efforts and funds both within and outside its own organisational structure.

International nongovernmental organisations which are active in this field and are in official relations with WHO are the International Agency for the Prevention of Blindness, the International Federation of Ophthalmological Societies, the International Organisation against Trachoma, and the World Council for the Welfare of the Blind. Other agencies with broad international programmes or interests include the Christoffel Blinden Mission, Helen Keller International Inc., the International Eye Foundation, and the Royal Commonwealth Society for the Blind and many others.

The publication has 4 Annexes. The first is a useful list of definitions and explanations of some of the terms used, and the second gives the coding of eye conditions in accordance with the 9th (1975) Revision of the International Classification of Eye Diseases. The third is a selected recent list of pertinent WHO publications, and the fourth gives a list of the names of participants at the Asilomar meeting.

T. KEITH LYLE

## Notes

### Vitreoretinal symposium

The Lake Tahoe Vitreoretinal Symposium, sponsored by the Retinal Faculty, University of California Davis School of Medicine, will be held at Granlibakken Ski Resort, Tahoe City, California 95730, USA, on 6-10 February 1983. Details from Donald May, MD, 2315 Stockton Boulevard, Sacramento, California 95817, USA.

### Microsurgical teaching workshop

A microsurgical teaching workshop will be held in Hong Kong on 18 and 19 March 1983 in conjunction with the 9th Congress of the Asia Pacific Academy of Ophthalmology. This meeting is jointly organised by the Royal Australian college of Ophthalmologists and the Asia Pacific Academy of Ophthalmology. Details from Dr Arthur S. M. Lim, Chairman of the Organising Committee, Unit 0609, Mount Elizabeth Medical Centre, Mount Elizabeth Road, Singapore 0922.



## Guidelines for Programmes for the Prevention of Blindness

T. Keith Lyle

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### Notes

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