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SIR, Professor Hayreh attempts to circumvent the confusion resulting from the use of the term venous stasis retinopathy to describe two different retinal vascular disorders by claiming that most published cases of 'VSR' are actually VSR—i.e., that Kearns, Hollenhorst, and others misdiagnosed cases of central retinal vein occlusion as being ischaemic in origin due to carotid artery disease. Paradoxically, Professor Hayreh is prepared to challenge, wholesale, diagnoses made by experienced ophthalmologists without, I presume, being able to examine personally the patients in question, yet he decries 'personal biases' and 'erroneous interpretations' with which 'the field of medicine is littered.'

Professor Hayreh implies that he was the first to distinguish between the ischaemic and non-ischaemic varieties of central retinal vein occlusion. However, his classification is based on an unsubstantiated belief that the ischaemic-type central retinal vein occlusion is precipitated by blockage of the central retinal artery with arterial circulation becoming re-established 'within a few hours or days.'^{1,2} It was Laatikainen and Kohner³ who pointed out that in some patients central retinal vein occlusion causes extensive retinal capillary closure associated with a high risk of developing thrombotic glaucoma. It is this consecutive retinal ischaemia, also seen after retinal branch vein occlusion, to which the term ischaemic-type central retinal vein occlusion refers and not a hypothetical, transient interruption of the arterial blood supply to the retina.

Use of the words 'stasis' and 'haemorrhagic' to distinguish the two main forms of central retinal vein occlusion, both of which are characterised by slow perfusion and varying degrees of haemorrhage, is illogical. More importantly, the use of the two categories venous stasis retinopathy and haemorrhagic retinopathy may mislead the unwary into thinking that central retinal vein occlusions can be neatly subdivided into two types, whereas of course the retinal capillary response following central vein occlusion covers a spectrum with many patients showing well preserved capillary perfusion, some showing patchy non-perfusion and a minority developing very extensive capillary closure.⁴ Some patients with initially good capillary perfusion or only small areas of non-perfusion following central retinal vein occlusion may later develop progressively larger areas of retinal ischaemia, leading to an increased risk of rubeosis. In such cases it is easier to think of progressive retinal ischaemia rather than having to change the diagnosis from venous stasis retinopathy to haemorrhagic retinopathy.

In conclusion, the terms venous stasis retinopathy and haemorrhagic retinopathy should be abandoned.

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Safety glasses only for boys?

SIR, Belated congratulations to V Tommila and A Tarkkanen on their paper on incidence of loss of vision in the healthy eye in amblyopia¹ Their findings are most important and significant. I would like to know what the sex incidence was for the 23 patients in their group as a whole and especially the sex incidence for those 12 patients who lost their eye as a result of trauma.

From Vereecken and Brabant's work² one may suspect that trauma is almost always in males. If so, one would not have to insist that the girls with permanent amblyopia wear safety glasses—only the boys. That is, the probability of a permanently amblyopic female losing her good eye due to an accident might drop to perhaps 1:10000, while the probability for a boy would approach 1:300 (i.e., 1.75/500).
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SIR, We are grateful indeed for the letter of Dr Romano. As a reply to his question about the sex incidence of our series we can state that there were 17 males and six females. Of the females two were children aged 9 and 12 years. We agree with Dr Romano about the importance of suggesting safety glasses for patients with permanent amblyopia.

Although the probability of a permanently amblyopic female losing her good eye is low, we insist that the girls should also wear safety glasses because their good eye may be a target of flying objects, such as stones thrown by the boys.

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