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Correspondence

Fundus changes in mesangiocapillary glomerulonephritis

SIR, I read the article by Josephine Duvall-Young, Mary MacDonald, and Nicol McKechnie on the fundus changes in (type II) mesangiocapillary glomerulonephritis.¹ They suggest from the title of the article and also in their discussion, that they have a clinicopathological correlation between the appearance of drusen in the eye and changes in Bruch's membrane and the choriocapillaris with ultrastructural similarities to the electron dense deposit seen in type II diseased glomeruli. On reading the article I was surprised to see that the histopathology was carried out on an eye which had had a central vein occlusion followed by a rubeotic glaucoma and then further by a bullous exudative retinal detachment. Clinically the other eye, which was not examined histopathologically, had drusen.

The article states that it has demonstrated involvement of the choriocapillaris and Bruch's membrane and is showing a clinical correlation with drusen-like spots in the fundus. This is definitely not the case. The drusen-like spots were in the left eye and they did histopathology in the right eye. The right eye had a central vein occlusion which had gone on to a rubeotic glaucoma and then further on to a bullous exudative retinal detachment. It could be that the fibrinoid-like material which they found in Bruch's membrane and the involvement they demonstrated in the choriocapillaris are a feature more of someone who has had a central vein occlusion, rubeotic glaucoma, and a subsequent exudative retinal detachment rather than a specific histopathological feature of type II glomerulonephritis. A study of a similarly affected eye in a patient without this specific renal condition will have to be undertaken as a control before such a conclusion is valid.

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Reference

- 1 Duvall-Young J, MacDonald M, McKechnie N. Fundus changes in (type II) mesangiocapillary glomerulonephritis simulating drusen: a histopathological report. *Br J Ophthalmol* 1989; **73**: 297–303.

SIR, The study of the eye of the patient with mesangiocapillary glomerulonephritis which was recently published showed deposits in the choriocapillaries and Bruch's membrane which was very dense on electromicroscopy. The deposit was very extensive and quite unlike any other which has been previously described in those areas. Clinically the other eye showed drusen-like deposits and our conclusion was that the finding in the enucleated eye correlated with the clinical finding in the fellow eye. Mr

Beaumont's suggestion that the study of the eyes of patients with vein occlusion and rubeotic glaucoma would have been valuable is valid. However, in our experience of examining large numbers of enucleated eyes at least one third of which would have had such conditions, we have never seen these deposits. The conclusion then would be either that the deposits are specific for MCGN (type II) or that this is an uncommon and possibly unique form of deposit in rubeotic glaucoma. We favour the first conclusion for two reasons. The first reason is described in the paper and is that the deposit is very like the deposit in the electromicroscopy of the kidney. The second reason is that following the published investigations we have studied a group of MCGN patients by clinical methods and have found a previously undiscovered deposit at the level of Bruch's membrane. These findings have been recently accepted for publication by your journal.

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Day case cataract surgery

SIR, We read with interest the article on day case cataract surgery by Watts and Pearce,¹ as we indeed support the concept of day stay surgery. However, we feel that some of the statements in this report deserve examination.

Firstly, we would like to endorse the statement that selection of patients is critical when considering this type of surgery. However, there is mention neither of the criteria for patient selection nor the status of the doctor asking the relevant questions. Far greater detail should have been provided on the degree of systems impairment in the 16 ill patients who were subject to this approach. Any significant degree of hypertension or diabetes, for instance, requires preoperative assessment and intraoperative management.

The statements regarding 'our techniques for anaesthesia' which 'obviate the need of an anaesthetist' suggest a purely local anaesthetic technique. We thought this approach disappeared a generation ago. A dose of temazepam 10 mg orally would have minimal beneficial effect for the patient, as this drug is not known for its antianxiety or amnesic properties. The presence of an anaesthetist means that low doses of an appropriate sedative/tranquilliser may be given, even to the elderly, to allow for a relaxed, calm state in which the patient is less likely to move, especially during the peribulbar injection of local anaesthetic. Furthermore, operative 'monitoring' should be considered. The surgeons were delivering a drug (oxygen) – without any monitoring – even to patients with emphysema. Appropriate monitoring with a pulse oximeter sets a baseline for cardiorespiratory performance and detects any untoward change, which can then be managed immediately by a practitioner qualified to do so. An electrocardiograph will detect any vagal effects resulting from the local anaesthetic injection and ocular or intraocular manipulation. Continuous non-invasive blood pressure readings are mandatory, especially when the patient's blood pressure is excessively high, as this may produce untoward systemic effects, and may even be a factor predisposing to expulsive choroidal haemorrhage.



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