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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.<sup>1</sup> 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,<sup>1</sup> 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.

There is no detail on 'patient satisfaction': did 33 of 40 patients actually refuse day case surgery for their second eye? Also the 5% incidence of posterior capsular rupture seems excessively high – could this be attributed to the technique? Finally, what would the surgeons have done in the recognition and management of any possible anaphylactic drug reaction?

We noted that the one patient who refused day only surgery was then offered only a general anaesthetic. We would argue for the presence of an anaesthetist at all cataract surgery, the use of appropriate low dose intravenous sedatives/hypnotics where indicated, and full monitoring techniques, which enable the selection criteria to widen to include almost every cataract patient. This assisted local anaesthetic (ALA) technique has been used successfully in our hands for many years now with minimal complications and great patient comfort.<sup>2</sup>

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- 1 Watts MJ, Pearce JL. Day case cataract surgery. *Br J Ophthalmol* 1988; **72**: 897–9.
- 2 Francis IC, Schumacher RS, Haylen MJ. Assisted local anaesthesia for cataract surgery (ALACS). *Aust NZ J Ophthalmol* 1987; **15**: 185–91.

SIR, We are grateful to Haylen, Schumacher, and Francis for their comments on our paper on day case cataract surgery and interested to hear of their different anaesthetic technique for day case patients.

We are certainly aware of the use of 'assisted local anaesthetic (ALA)' techniques, in which an anaesthetist gives intravenous sedatives and hypnotics in conjunction with local anaesthesia, and indeed use it regularly on patients staying overnight in hospital. However, for patients undergoing day case surgery we have preferred to use oral benzodiazepines and, although we would accept that these do not have amnesic properties, have found their sedative and anxiolytic properties to be good. These effects are indeed well recognised.<sup>1,2</sup>

Although details of perioperative monitoring were not given in our paper, it is in fact our standard practice to monitor patients with an electrocardiograph and automated sphygmomanometer for the reasons so correctly stated by Haylen *et al.* It is interesting to note that the incidence of expulsive haemorrhage may be lower under local than general anaesthesia.<sup>3</sup>

Patient satisfaction is, as we remarked, difficult to quantify particularly in those who have not previously undergone ocular surgery and therefore have nothing with which to compare. For this reason we did not attempt any formal analysis of it. Only the one patient cited declined surgery to the second eye under local anaesthesia as a day case.

With regard to the provision for management of any emergency, we would reiterate our comment that emergency anaesthetic cover should be available, and this remains a requirement of all our day case lists.

The choice between oral sedation and local anaesthesia and 'assisted local anaesthesia' remains controversial in the United Kingdom, both for ophthalmic and for other surgical procedures, and each unit must choose the appropriate technique to suit local requirements and facilities. We have found success using the technique described, but would not profess it to be the only one suited to day case cataract surgery.

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- 1 Nimmo WS. Hypnotics, sedatives and anti-depressants. In: Girdwood RM, ed. *Clinical pharmacology*. London: Baillière and Tindall, 1985: 152–3.
- 2 *British National Formulary* 1989; **17**: 429.
- 3 Taylor DM. Expulsive haemorrhage. *Am J Ophthalmol* 1974; **78**: 961–6.

## Book reviews

**Reap a Destiny: Divagations of a Taoist.** By T D V SWINSCOW. Pp. 334. £13.95. British Medical Journal: London, 1989.

*Reap a Destiny* is a success story but not in the conventional sense. In the dénouement there is no fortune gathered, no presidential appointments recorded, no civic honour flaunted. It is an account of personal adaptation from resentment and self-pity to peace of mind and inner harmony.

'I was about 7 when I realised that my parents often quarrelled over things I knew little or nothing about. . . . I would creep along a corridor, sit on the top stair of the staircase, and listen to their disputes with a lump in my throat and tears welling into my eyes.' At the age of 14 'I began to lose weight. . . and I recall staring into a mirror with a worried expression to see whether any of my hair had turned grey from sorrow.'

In these saddest of sad words lies the nub of the author's inherited problem and they declare the effect of parental strife, openly expressed on a child with an eye for beauty, an ear for music, a mind attuned to poetry, a numerate intellect, and a sensitivity to environmental disequilibrium as responsive as the G string to the bow of the violinist. Such is a prescription for what? A challenge to be faced or not to be faced?

The essential move made by the author to unravel this strangling knot was a process of liberation from the shackles of parental loyalty without irrevocably wounding himself or his parents. This was enacted over a period of lengthy incubation helped by delving into French literature and helped also by communing with Christine Nisbet, a cousin by marriage, a talented artist 10 years older than himself with whom he had fallen in love at a distance. He suddenly appreciated almost by a mystical experience that life on this planet formed a unit of which he was a sharing and significant member and in this concept he found consolation and confidence. At once it put his personal problems into perspective. It became apparent to him that what was denied him in his immediate family was on offer in abundance in the larger family of living organisms. His later researches



## Day case cataract surgery.

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