Correspondence

Monocular infantile cataract, intraocular lenses, and amblyopia

SIR, We welcome your invitation to reply to the editorial comment on our article,[1] as we consider Mr David Taylor overstates the case against intraocular lens implantation.[2]

We do not differ on the management of the majority of children presenting with cataract, and are equally aware that amblyopia is the dominant factor in their management and prognosis. We agree that on present knowledge patients with dense unilateral cataract known to be present from birth must be treated very early indeed to have any hope of a good visual outcome; in such patients presenting later we do not advise surgery. There is, however, a significant minority of cases where the duration of visually significant cataract is uncertain, who may have had a period of early binocular experience. This is especially recognised in patients with posterior lenticonus, and such patients contribute to the high mean age at surgery of our non-traumatic cases.

We endorse Mr Taylor's anxieties about excessive amblyopia treatment. Prolonged periods of occlusion and associated poor vision, allied with the stress of contact lens therapy, may be a strongly negative factor at a critical stage in the child's general development. Such treatment can be justified only if there is reasonable hope of significant benefit. In our series a number of the poor visual results occurred in patients with poor compliance or poor response to occlusion during contact lens wear. In such situations we did not consider it appropriate to continue to subject patients to contact lens wear, considering it a better option to implant an intraocular lens and revert to minimal occlusion in the hope of preserving peripheral visual function. We would stress that in patients untreated or left without correction after surgery, for example by failure to wear contact lenses, the final corrected acuity may be light perception only.[3]

Ophthalmologists are familiar with the amblyope who acquires a blinding disease in the good eye. Tommila and Tarkkanen[4] estimated the incidence of loss of vision in the healthy eye of amblyopes to be 1·75 (SD 0·30)/1000 in Finland. For the same period the overall blindness rate in children was 0·11/1000 and in adults 0·66/1000 of the general population. They infer that the risk of becoming blind is considerably higher for the amblyope than for the general population and the value of retaining vision in patients with unilateral cataract should at minimum be considered in this context. It is also in this context that we comment, 'even an acuity of 1/60 represents a significant improvement (above light projection) for a reserve eye'. We do not imply that this is an acceptable target acuity, and indeed only two patients in our series had final acuities as poor as this.

We re-emphasise that the patients in our report are a group selected for intraocular lens implantation because they were considered unsuitable for, or failed with, conventional treatment. We share Mr Taylor's anxiety over the long-term stability of intraocular implants. However, our own and others' experience, and experience with adults, indicates that in the medium term these implants are stable. The techniques available to deal with complications continue to improve, but at present there is no treatment available for late severe amblyopia. We therefore consider that amblyopia management should take precedence, and in that respect do not consider the possibility of late implant complications to be an 'all important risk'.

Even in centres specialising in the contact lens treatment of paediatric aphakia up to 15% of children are considered primary contact lens failures,[5] and complications are not infrequent.[6] Alternative means of optical correction are required for this by no means insignificant minority. We consider our findings support the view that intraocular lenses are one of the options to be considered. Mr Taylor argues untreated unilateral cataract to be of minor significance to a child's life, only an acuity compatible with a normal education to be of any value for a 'reserve eye', and intraocular lenses 'never likely' to be an ethical option in children. We must continue to disagree on all these points.

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Book review

Retinal Detachment: Diagnosis and Management. 2nd edn. By WILLIAM EDMUNDS BENSON. Pp. 238. £36·00. Lippincott: Philadelphia, 1988.

In the second edition of this book Dr Benson has continued the concise style and presentation that characterised the first edition. The book is intended, as the author states in his preface, to provide residents, fellows, and practitioners of ophthalmology with a guide to the diagnosis and management of retinal detachment. In the presentation of the

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