

BRITISH JOURNAL OF OPHTHALMOLOGY

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Editorials

The *BJO* in the 1990s

The *BJO* first came into existence in 1917 by the amalgamation of the *Royal London Ophthalmic Hospital Reports*, which had first seen the light of day in 1857, the *Ophthalmic Review*, origin 1881, and the *Ophthalmoscope*, a relative newcomer from 1903.

Observant readers will have noticed minor changes in style and format from time to time. For example, the copies on my own shelves, dating back only to 1958, illustrate one obvious change, the alteration from across the page printing to double columns. This change was made in the 1975 volume and surprisingly arrived without any editorial comment. The external appearance was changed in 1978 when a plain orange cover was introduced and the contents were moved from the front to the back, in my view not a logical position – all right for an index but surely not for contents.

Now for the first issue of 1990 some more changes and we hope improvements are introduced. Readers of this issue will not need to be told that it is larger. It is in fact A4, a size which is certainly fashionable though not everyone will agree superior to the previous quarto (especially those like me who have lovingly built their own bookcases to fit quarto volumes). Another change which it is hoped will be universally approved is the reinstatement of the contents on the front, where they should be. There are changes also in content. As well as the usual original articles there will now be a separate section for case reports. Case reports have always been a slight thorn in the editorial side – not that I dislike them. As a clinician I appreciate case reports as in some ways the life blood of a true clinical journal. What else does anyone expect from a journal with the pedigree of the *BJO*? What do the

original *Royal London Ophthalmic Hospital Reports* consist of? Not all case reports, naturally, but a pretty good ration of them. The reason why I have found case reports a slight problem is because there are quite a number of readers who regard them as inferior in some way to investigative articles. I believe this is not an entirely justified attitude but nevertheless I think I have some idea how it comes about. If a given issue of the journal contains, say, 16 or 17 articles, some readers feel that they have been almost defrauded if too many turn out to be case reports and not original articles. I am not sure that this is justified, but I think I can see the point. Henceforth, therefore, case reports will have a separate section to themselves and as before will be restricted in length, except in exceptional circumstances, to 600 words.

In addition mini reviews are being introduced. Usually written by the members of the editorial committee, they will cover a selection of topics during the year. Mini reviews will be about 1200 to 1500 words long and will be published in addition to the now regular shorter editorials, which will continue to focus mainly on one or more articles of that particular issue. The first of these reviews will be found in this issue.

Finally there are hails and farewells to be made to some members of the editorial committee. To those who are leaving, each after many years of meritorious service, we say farewell and we cannot thank you enough. To those who are joining the committee we extend a warm welcome and look forward to your forthcoming contributions to the editorial input of our journal.

REDMOND SMITH

Glaucoma: is there light at the end of the tunnel?

In this issue a paper reports the results of a long study of the natural history of primary open angle glaucoma at King's College Hospital in London. For many years the team in this unit, under the leadership of R Crick, has been patiently building up a bank of data in which two important components have been the visual field scores, derived chiefly from studies with the Friedman analyser, and the intraocular pressures of a large number of patients. The object of the study was to see how close a relationship there was between the pressures and the

field loss in these patients. The authors found a fairly strong correlation between pressure and degree of field loss at presentation, as would indeed be expected. Patients with the higher pressures tended to have more field loss than those with lower, but the correlation coefficient was not high, only – 0.26, though statistically significant. In practical terms one could say that more high-pressure cases of glaucoma were seen than low-pressure cases of glaucoma, which would of course be in keeping with usual clinical experience.

One should perhaps insert a word of caution here. The patients had presumably all to be referred to the clinic at King's College Hospital in the first place. One therefore has to ask, How were they detected in the beginning, before they were referred? Was the emphasis on pressure or on visual field loss? If routine measurements of pressure were done in the predetection stage, were routine measurements of visual field also? Such questions may sound somewhat academic, but they are nevertheless highly relevant where the correlation coefficient is fairly low, as in this study. However, common sense and a practically unanimous opinion among ophthalmologists would persuade one to accept this correlation in spite of such slightly uncomfortable doubts.

But when we come to the correlation between field and pressure during the follow-up period the doubts increase and the situation begins to look distinctly uneasy. For what the study finds is that the correlation coefficient between field loss and pressure while patients are under treatment is very weak indeed, only -0.06 , and it is difficult to see how much nearer one can get to zero than that.

What does this mean to us as clinicians, as advisers, counsellors, and comforters to our patients? Are we going to have to admit to them that our ability to control their rate of

visual deterioration is actually less than we have led them to expect of us in the past? Or are we going to continue with our optimistic attitude that all will be well provided they are strict about following the prescribed regimen of treatment? And, worse still, where do the surgical 'hawks' stand in the face of results like this? Are these results an argument for more surgery or for less? How do the histories of this group of patients compare if they are divided into those who had surgery and those who did not? This particular aspect was not dealt with in the present study, but it would be of interest to see such an analysis in future if it were possible to extract the figures from the data.

Like many papers on glaucoma which set out to answer a particular question the answer usually raises further questions. One fascinating proposition raised in the discussion is the possibility of subgroups existing within chronic simple glaucoma. This I have to say will be the subject of a future paper from a different group to be published in the *BJO* shortly. I wish I were able to say that all will be revealed, but I am afraid that would be putting it a little too strongly. However, some interesting data will be presented which may well help towards answering some of the difficult questions raised in the current paper.

REDMOND SMITH



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