

LETTERS TO THE EDITOR

Laser card

SIR,—The management of diabetic patients in a large teaching hospital presents the medical and clerical staff with considerable logistical difficulties.

Many diabetic patients have to attend different specialist clinics: physicians, ophthalmic, renal, diabetic, foot, etc. The frequency of their visits to other departments such as the antenatal clinic may also be influenced by diabetes related problems. It can be a challenge to ensure that the medical records will be available at each and every visit. This might

involve chasing sets of notes in various offices, clinics, and wards, sometimes located on more than one site. Furthermore, some departments like the renal unit may be understandably reluctant to release the records of patients due to have dialysis or awaiting transplants. The diabetic department at our hospital has found it useful to have its own records. However, this entails having a separate filing system. It would clearly be impracticable for each department to do the same; moreover this would cause a major breakdown of communication between the various specialists looking after a patient.

It is not surprising therefore that the phenomenon of 'missing notes' is commoner in teaching hospitals.¹ This leads to significant clinical difficulties and can affect patients' confidence in the system or the treatment. It also has a detrimental effect on auditing.²

The proper management and follow-up of diabetic retinopathy depends to a large extent on the availability of well documented medical records. In view of the limited time and number of ophthalmologists, and because the

laser unit is located on the ward rather than in the outpatient department, it is not possible to perform laser treatment during clinic time. This is done in parallel with theatre sessions. The inevitable increase in number of patient attendances is associated with a higher incidence of missing records. This is further complicated by the possibility of entering clinical and treatment details in general, diabetic, or temporary sets of notes. No full and complete sequence will be available in any such record. This lack of continuity may have serious clinical and medicolegal implications.

The suggestion that each patient could hold his own record is attractive but can be achieved only if and when all records are computerised; otherwise it would involve a considerable amount of duplication. However, a simple compromise between such a system and the present one can be reached. We have designed a laser card (Figs 1 and 2) which is issued to every patient who requires laser treatment. It serves the purpose of an appointment card and provides the patient and the attending nurse with some useful information. More importantly, space is available in order to enter the treatment indicated (eg, focal above fovea, pan-retinal photo-coagulation (PRP), as well as details of the treatment performed. Diabetic patients are quite used to holding treatment cards and should have no problem handling the laser card.

In our experience the laser card has proved to be particularly useful when medical records are missing but it is also a convenient way to find out, at a glance, the total amount of treatment each eye has received. This can be helpful in prospective or retrospective studies which would otherwise be undermined by missing notes. The application of a similar system to various clinical practices could contribute to making data easily available for auditing.

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- 1 Gulliford MC, Petrukevitch A, Burney PGJ. Hospital case notes and medical audit: evaluation of non-response. *Br Med J* 1991; 302: 1128-9.
- 2 Williams JG, Kingham MJ, Morgan JM, Davies AB. Retrospective review of hospital patient records. *Br Med J* 1990; 300: 991-3.

ABOUT YOUR TREATMENT		CAMBERWELL HEALTH AUTHORITY KING'S COLLEGE HOSPITAL DENMARK HILL LONDON SE5 9RS TEL: 071 274 6222 Ext. 4819	
IT WILL BE NECESSARY TO ADMINISTER EYE DROPS BEFORE YOUR LASER TREATMENT WHICH ARE LIKELY TO TEMPORARILY BLUR YOUR VISION.		LASER TREATMENT RECORD NAME: _____ ADDRESS: _____ HOSPITAL NO: _____ PLEASE GO TO WILLIAM BOWMAN WARD ON THE 1ST FLOOR OF THE NEW WARD BLOCK. PLEASE LET A MEMBER OF THE NURSING STAFF KNOW YOU HAVE ARRIVED.	
IT WOULD BE ADVISABLE TO AVOID DRIVING ON THE DAY OF TREATMENT.			
PLEASE NOTIFY US IF YOU ARE UNABLE TO ATTEND. OUR TELEPHONE NUMBER IS ON THE FRONT OF THIS CARD.			
SF 232		NURSING STAFF PLEASE DILATE EYE(S) AS INDICATED INSIDE THIS CARD WITH: G TROPICAMIDE 1% G PHENYL EPHRINE 10%	

Figure 1 Laser treatment card.

RIGHT					LEFT				
DATE	TIME	Rx Indicated	Rx	INITIAL	DATE	TIME	Rx Indicated	Rx	INITIAL
6.9.91	9.00 am	FOCAL ABOVE FOVEA	15 x 100 μm X0.4W X0.15sec	W.A.	11.11.91	9.00 am	PRP	800 x 500 μm X0.4W X0.15sec	W.A.
					25.11.91	9.00 am	PRP		

Figure 2 Reverse of card indicating treatment given.

Delayed ciliochoroidal detachment following intraocular lens implantation

SIR,—We read with interest the recent article by Dawidek *et al.*¹ The authors suggest that the ciliochoroidal detachment in their cases was due to ciliary sulcus fixation of the implant. We reported² hypotony and ciliochoroidal detachment following uneventful phacoemulsification due to traction on ciliary processes adherent to the posterior capsule and lens remnants. Surgical capsulotomy cured the ciliochoroidal detachment. Magruder *et al.*³ confirmed our observation. They reported a case of ciliochoroidal detachment that occurred after extracapsular cataract extraction with posterior chamber intraocular lens implantation which was cured by Nd:YAG laser capsulotomy. These two cases support the concept of ciliary body traction by the posterior capsule as a cause of ciliochoroidal detachment. Unfortunately the authors did not mention the status of the posterior capsule in their patients. We believe that capsulotomy should be considered in cases of ciliochoroidal detachment following extracapsular cataract extraction. Removal of



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