CORRESPONDENCE

Diagnosis of activated protein C resistance in retinal vein occlusion

EDITOR,—I read with interest the article published in the BJO by Hunt.1 In this paper the author reports that the prevalence of APC resistance is more common than any other known thrombophilic state in over one third of patients younger than 45 years with central retinal vein occlusion (CRVO). Therefore, many would argue that a full thrombophilia screening should be performed in a young patient (<50 years old) after CRVO. This screening should be made using an easy to perform technique and providing good discrimination between normal and APC resistant subjects. In this regard, Hunt comments that the biological technique proposed by Dhälback et al5 yields sensitivity and specificity ranging from 85% to 90%, but that it is not reliable if the patient has abnormal clotting such as a lupus anticoagulant or is receiving anticoagulants. For these reasons this technique is not suitable for the screening of patients with venous thrombotic disorders, including CRVO. With regard to this point, it is worth taking into account that our group has proposed a technique, which modifies the initial technique proposed by Dhälback et al5, diluting the sample of the patient’s plasma with plasma lacking factor V. With this modification, both the specificity and sensitivity of the technique is 100% and, moreover, it may be used in patients receiving anticoagulant therapy and in those who have lupus anticoagulant.

Thus, in opinion of Dhälback, this technique may be suitable for the screening of patients with venous thrombotic disorders since it is very sensitive and specific as well as inexpensive and easy to perform.

JUSTO AZNAR
Department of Clinical Pathology, “La Fe” Hospital, Avenida 21 Valencia, Spain


Reply

EDITOR,—We thank Dr Gauntt for comments on our article.1 He raises some questions about the depth of the CZH within the sclera, about visualisation of this vessel by fundus fluorescein angiography (FFA), and about the diameter of the vessel appearing on FFA. Though we have not investigated the mean depth of the CZH within the sclera, it is questionable that the CZH lies at a relatively constant depth within the sclera. If the vascular circle lies in such a constant position within the sclera, why have previous studies using serous transverse or longitudinal histological sections to evaluate circulation of the anterior optic nerve failed to identify this intriguing vessel? This is partly because the CZH does not run in the same plane within the sclera, and we think that the present histological section may give a little information about the CZH. As our previous study suggests,1 the CZH has tremendous morphometric and morphological variations, both arteriolar and venous, and in the same subject through its course around the optic nerve. These interindividual variations have also been reported by Olver et al.3 Additionally, the branching pattern of the vascular circle is not uniform, so that in simple histological section the main body of the circle may not be distinguished from its branches to peripapillary choroid or to the optic nerve.

Gauntt expresses doubt as to the visualisation of the CZH by FFA, because he suggested that it runs within sclera at such a depth (345 µm from the retinal side of the scleral surface) as to be invisible. However, we would like to point out against this argument that the CZH has variable morphology in its course and does not run in the same plane anteroposteriorly and mediolaterally. Furthermore, chorioretinal atrophy and scleral thinning in the temporal crescent area, especially at the disc margin of simple myopia, may offer a better chance to appreciate the temporal part of the CZH by imaging methods such as FFA or indocyanine green angiography (ICG). A recent study demonstrates the visualisation of the CZH by ICG in severely myopic eyes which supports our idea. However, the CZH could not be visualised even in severe myopic conditions when it is deeply seated within the sclera.

Regarding the diameter of the CZH, our previous study using the flat section method1 showed marked variation. It ranged from 20 µm to 270 µm with a mean of 123 (SD 75) µm. Even in the same circle it showed fluctuation during its course. In some cases the diameter of the main body of the CZH was less than that of its branch. Moreover, the abrupt decrease of the vessel calibre, the normally uniform diameter of the CZH, was noted in many of our cases. Sometimes the peripapillary choroidal arterial arcade might be confused with the CZH in FFA. However we believe that it is distinguished from the CZH by several points. It is located along, the outer margin of the temporal crescent while the CZH appeared as concentric vascular filling within the temporal crescent or in the vicinity of the optic disc margin. It is obscured in the late phase of FFA by dye leakage from the intact choioreticapillaris along the temporal crescent margin. Also, some branches from the arterial circle directed to the optic disc or to the peripapillary choroid can be observed on FFA.

MYUNG-KYOO KO
DONG-SEOB KIM
YOOOK-KOO AHN
Department of Ophthalmology, School of Medicine, Hanyang University, Seoul, Korea

Effectiveness of occlusion therapy in ametropic amblyopia

EDITOR,—I congratulate the authors of this study for making the conceptual leap that control trials of intervention for amblyopia are necessary. 1 To my knowledge, this is the first study of its kind and while it has some limitations for which it will no doubt be criticised, it shows the way for future researchers in this field.

What the authors have shown is that occlusion for 1 hour a day had no long term additional benefits over spectacle correction alone. I am interested to know why they chose this occlusion regime. It would also have been helpful if the initial and final acuities attained for each patient had been documented. Are they also convinced that all their patients were truly ambylopic, and not just children with refractive errors who became more cooperative with repeated testing?

M P CLARKE
Department of Ophthalmology, University of Newcastle, School of Neurosciences and Psychiatry, Faculty of Medicine, Royal Victoria Infirmary, Newcastle upon Tyne NE1 4LP

Reply

EDITOR,—We would like to thank Mr Clarke for his support of our belief that occlusion therapy should be subject to controlled trials. As stated in our paper, we chose to adopt a minimal occlusion regime as this has previously been found to be beneficial while minimising the burden placed on parents and children. 1 We would stress, however, that our study was not primarily an attempt to evaluate this occlusion regime, rather to address some methodological issues which future studies will need to take into account. We could, therefore, have legitimately adopted any regime of our choosing.

Clarke’s concern that our subjects may not have been ambylopic but merely possessing refractive errors and a loss of visual acuity (in the absence of other pathological findings) could fall into one of three categories: those whose visual acuity loss is completely (and instantaneously) ameliorated by refractive correction; those whose acuity loss is restored over a period of weeks or months; and a third category, those in whom acuity, as in the preceding category improves over time, but never reaches 6/6. Conventionally, children in the first category would not be diagnosed as being amblyopic while those in the third category meet the standard diagnostic criteria of amblyopia. But what of those in the second category? Most authorities would also apply the label of amblyopia to these patients although we cannot differentiate the factors that contribute to the improvement associated with “long term” spectacle wear (for example, a putative anti-amblyopic effect, perceptual learning, familiarisation with test and testes) or define the nature of the underlying pathophysiology. In our study, none of the subjects who completed the trial attained 6/6 (category 3 above) though as alluded to in our paper and confirmed by subsequent experience, had the spectacle (“pre-treatment”) phase of the trial been extended, some subjects may have attained normal acuity (category 2 above). We acknowledged in our paper that increased cooperation with repeated testing could have contributed to the improvement seen in all of our subjects.

With the exception of one particular subject of interest, we did not refer to stating the changes in the mean and standard deviation of subjects’ recorded visual acuity at each phase of the trial, present data from individuals. We would be happy to make this available to anyone wishing to further analyse.

MERRICK J MOSELEY
ALISTAIR R FIELDER
Department of Sensorimotor Systems, Division of Neuroscience, University of Manchester College of Science, Technology and Medicine

MARY IRWIN
HELEN S JONES
Academic Unit of Ophthalmology, University of Birmingham

ROSEMARY J AULD
Department of Orthoptics, The Birmingham and Midland Eye Centre


High prevalence of recurrent symptoms following uncomplicated traumatic corneal abrasion

EDITOR,—We read with interest the comments by Sabri et al on the many treatments used to manage acute corneal abrasions and the lack of any evidence based protocol. An evidence based approach requires that the natural history of the condition is well understood: a review of the literature shows a surprising lack of documentation regarding the clinical course of corneal abrasion after the initial injury has healed. 2 Therefore, we present some of our observations of symptoms following uncomplicated traumatic corneal abrasion.

We prospectively followed 74 adults with traumatic corneal abrasion in previously healthy eyes. This was part of a study to assess whether the nightly use of lubricating ointment could reduce the incidence of recurrent corneal erosion. In 42 cases, the injury was caused by a fingernail. All patients were treated with a standard regimen of cyclopentolate 1% eye drops immediately and chloramphenicol four times daily for 5 days; eye pads were not used. 3, 4 “Fingernail” injuries were randomised to receive either the standard treatment alone, or to continue with a topical lubricating ointment nightly for 2 months. Symptoms were assessed 3 months after the injury by a telephone questionnaire, and case notes were reviewed after 2 years.

We found a high prevalence of symptoms suggestive of recurrent corneal erosion at 3 months of follow up. Two of the patients (28%) reported frequent and significant pain, grittiness, photophobia, or watering of the injured eye only. 5 Symptoms were relatively minor (did not interfere with daily activities) in 9/42 (21%) of “fingernail” and 3/52 (9%) of “non-fingernail” injuries. Symptoms were severe enough to interfere with daily activities, or to cause the patient to seek advice from their general practitioner or pharmacist in four (10%) fingernail and four (12%) non-fingernail injuries. By 2 years, two patients with fingernail injuries had presented with recurrent corneal macroform erosions, 1 at 3 months and the other after 7 months.

Our results illustrate that our understanding of this common condition is still very limited as we face surprisingly high proportion of patients endure recurrent symptoms following traumatic corneal abrasion, but do not re-present to the ophthalmologist. This high prevalence of symptoms suggests that we should consider changing our initial treatment regimen. We suggest that any future evaluation of treatment for corneal abrasion should include long term follow up of patient symptoms.

DANNY MORRISON
TOM EIKE
DAVID J AUXTEN
Leicester Royal Infirmary NHS Trust

Correspondence to: Dr Danny Morrison, Department of Clinical Genetics, Molecular Medicine Centre, Western General Hospital, Edinburgh EH4 2XU.


Cluster of four cases of inadvertent injury to the globe secondary to peribulbar anaesthesia

EDITOR,—A cluster of four cases in 4 months of inadvertent injury of the globe after peribulbar anaesthesia (PBA) administered by both anaesthetists and ophthalmologists has led us to review their risk factors, management, and outcome with respect to the literature. 1 Despite varying symptoms the common sign of inadvertent injury was vitreous haemorrhage either preoperatively or immediately postoperatively. Time to referral for vitreoretinal opinion ranged from immediate to 48 hours by which time all eyes had extensive vitreous haemorrhage precluding...
visualisation of the fundus. All injuries required trans pars plana vitrectomy and internal tamponade with resulting visual acuity ranging from 6/9 to HM (Table 1).

PBA was first promoted as a safer alternative to retrobulbar anaesthesia (RBA) but a prospective comparative study has not been undertaken. The advantages of PBA include reduced incidence of inadvertent penetration of intraocular tissues which can result in brain stem anaesthesia while the disadvantages include inadequate akinesia in up to 50% of cases. Ocular factors such as increased axial length and technical factors such as inadequately trained personnel are associated with inadvertent injury which can result from administration of the anaesthesia by both ophthalmologists and anaesthetists. Inadvertent injury produces a variety of symptoms and signs and may even be silent. Although intraocular injections of anaesthetic agents are not retinotoxic, damage can result from mechanisms such as “jet stream effects” and elevation of the intraocular pressure.

Suspicion of an inadvertent injury by the administrator of the anaesthetic must be conveyed to the operating surgeon (if they differ), so that a full assessment can be performed before surgery. Differentiation between penetrating injuries (only an entry site) and perforating injuries (an entry and an exit site) and classification into one of three categories depending on the clarity of the media and the presence of retinal detachment has management implications. Category one patients with an adequate fundal view without retinal detachment may be watched as local haemorrhage may preclude the need for prophylactic laser therapy (cryotherapy in the presence of local haemorrhage has been implicated in the development of proliferative vitreoretinopathy). We agree with previous reports that trans pars plana vitrectomy in category two (an adequate fundal view with retinal detachment and category three patients (an inadequate fundal view) is the treatment of choice. Patient outcome depends on the amount of initial damage to the retina and despite successful retinal reattachment, factors including epiretinal gliosis, optic atrophy and proliferative vitreoretinopathy can result in poor visual acuity. Adequate training of personnel and a high awareness of potential risk factors may help to reduce the incidence of this serious complication of local anaesthesia. Early recognition of an injury and early vitreoretinal opinion to categorise the patients and formulate a management strategy may maximise a patient’s visual outcome.

<table>
<thead>
<tr>
<th>Patient 1</th>
<th>Patient 2</th>
<th>Patient 3</th>
<th>Patient 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>F</td>
<td>F</td>
<td>F</td>
</tr>
<tr>
<td>Age (years)</td>
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<td>71</td>
<td>69</td>
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<tr>
<td>Preoperative visual acuity</td>
<td>6/18</td>
<td>6/18</td>
<td>HM</td>
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<tr>
<td>Axial length (mm)</td>
<td>25.52</td>
<td>33.43</td>
<td>22.00</td>
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<td>Peribulbar anaesthetic details:</td>
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<td></td>
<td></td>
</tr>
<tr>
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<td>Anaesthetist</td>
<td>Ophthalmologist</td>
</tr>
<tr>
<td>Number of injections</td>
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<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Needle type</td>
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<td>Sharp</td>
</tr>
<tr>
<td>Interval to diagnosis (days)</td>
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<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Clinical indicator(s) of inadvertent injury:</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Pain</td>
<td>N</td>
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<tr>
<td>Decreased visual acuity</td>
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<td>Y</td>
<td>Y</td>
</tr>
<tr>
<td>Hypopyon</td>
<td>N</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Vitreous haemorrhage</td>
<td>Y</td>
<td>Y</td>
<td>Y</td>
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<tr>
<td>Subretinal haemorrhage</td>
<td>Y</td>
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<td>N</td>
</tr>
<tr>
<td>Decreased visual acuity</td>
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<td>Y</td>
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<tr>
<td>Hypopyon</td>
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<tr>
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<tr>
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<td>Y</td>
</tr>
<tr>
<td>Other</td>
<td>N</td>
<td>Retinal detachment</td>
<td>N</td>
</tr>
</tbody>
</table>

Table 1 Summary of individual patient data

TPPV = trans pars plana vitrectomy; SF6 = sulphur hexafluoride gas; Phaco and IOL = phacoemulsification cataract extraction with insertion of intraocular lens.

Telemedicine and computers in diabetic retinopathy screening

Editor,—Williamson and Keating in a recent commentary in the BJO highlight the need to provide full screening for diabetic patients for retinopathy throughout the community. They presuppose that the key to diabetic retinopathy screening is efficiently obtaining images of the retina for classification. While the idea of digital fundus images being remotely assessed by trained personnel or even analysed by a computer automatically is attractive and may be practicable in the not so distant future, retinal photography is not the only way to organise screening for diabetic retinopathy. The other main approach to screen for diabetic retinopathy is a dilated fundus examination done by trained personnel. Optometrists are ideally suited to fulfil this role, as they are spread throughout the community and as a large section of diabetics already visit their optician.

To be effective a screening programme has to achieve near total coverage of the target population. This can only be done if a database of all known diabetics is maintained in the form of a diabetes register, which will generate call and recall and monitor outcomes. This is a priority that has been recognised by the task force of the British Diabetic Association and the UK Department of Health. The setting up and maintenance of a diabetes register is largely computer dependent, involving assimilation of data from general practice and hospital computer systems. Several districts including our own have already implemented this or are well on their way.
Correspondence to: Dr Prasad.

EDITOR,—We suspect that in diabetic screen-
retinopathy screening to achieve this.

for computers in the organisation of diabetic
way to doing so. There is a fundamental role

of optometry screening services.

register based screening and indeed recent
optometrists could well provide computer

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could in the future be combined with digitised
patients. With advancing technology this
improve cost e

ciency. A national register
the identification of diabetic patients and

matters is currently the subject of a Department
wasteful of resources. The extent of popula-
patients may be being screened by several dif-

for the health purchaser?

This would

as a “scale for measuring the angle of hetero-
tropic squint” and the Maddox rod is used for
quantify the deviation. The author describes
methods of detection, one of which can also

and for the health purchaser?

The other issue is that not all diabetics
attend an optometrist regularly, especially
young, emmetropic, type 1 diabetics who are
at higher risk of aggressive retinopathy. Other
patients may be being screened by several dif-
ferent services which is unnecessary and
wasteful of resources. The extent of popula-
tion coverage by retinopathy screening serv-
ices is currently the subject of a Department
of Health supported national audit. A compu-
terised database would undoubtedly improve
the identification of diabetic patients and
improve cost efficiency. A national register
would be desirable allowing for allocation of
resources and the effective relocation of patients.
With advancing technology this could in the future be combined with digitised
imaging and storage systems.

SOMDUTT PRASAD
KAREN JONES
RUSSELL P PHILLIPS
Aerose Park Hospital, Upton, Wirral, L49 0PE

Reply

Editor,—We suspect that in diabetic screen-
ing, as with other practical areas, it is not who
screens or what method is used but how effect-
ively it is done. Trained, highly motivated
optometrists could well provide computer
register based screening and indeed recent
joint working party guidelines have been
issued for optometry screening services. 1 This
report recommends annual dilated fundus-
copy, ideally using slit lamp biomicroscopy.
However, it also stresses the need for contin-
uing annual audit and evaluation to ensure an
adequate sensitivity and specificity of detec-
tion of retinopathy as previously recom-
manded for any screening service. 2 This would
be time consuming for the optometrist and no
national arrangements for financing this serv-
vice have been made; therefore, would this be
cost effective for the optometrist’s business
and for the health purchaser?

The other issue is that not all diabetics
attend an optometrist regularly, especially
young, emmetropic, type 1 diabetics who are
at higher risk of aggressive retinopathy. Other
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imaging and storage systems.

HELEN L COOK
TOM H WILLIAMSON
Department of Ophthalmology, St Thomas’s Hospital,
London SE1 7EH

DAVID KEATING
Tennent Institute of Ophthalmology, Western Infirmary,
Glasgow G11 6NT

1 Optometry screening programme for diabetic eye
2 Greenwood RH. Population-based screening for
diabetic retinopathy: a promising start. Diabetic

BOOK REVIEWS

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Express) stating card number, expiry date,
and your full name. (The price and
availability are occasionally subject to revi-
sion by the Publishers.

Dictionary of Optometry and Visual Sci-
It would be churlish to be critical of this book.
To have reached its fourth edition in 11 years,
and have the previous edition reprinted three
times suggests that it is doing something right.
It is indeed a very useful reference book for
optometrists and others in involvement in
optical science. The appeal to the student is
its comprehensive nature: to have geometrical
optics formulas alongside ocular anatomy
makes it a daily companion. For the experi-
enced practitioner too, it provides a concise
reminder of dimly remembered definitions,
and proof that there is always something new
to learn. When I looked up the description
given by colleagues of their method of
measuring pupil size, I found that this was in
fact “Broca’s pupillometer”—although my
recollections of using an instrument called a
Wesley keratometer for this purpose were not
featured!
Space is obviously at a premium in the book
with over 3800 terms included, and the fourth
edition has been expanded to reflect the addi-
tion to the title of “Visual Science”. Terms
such as magnocellular which did not appear in
the previous edition are now amply covered,
with copious cross referencing to lateral
geniculate bodies, Y cells, parvocellular visual
system, and dyslexia! This cross referencing
is used very effectively to avoid repetition.
To take an example, a Maddox cross is described
as a “scale for measuring the angle of hetero-
phoria and heterotropia” but it is only by fol-
lowing the cross reference to Maddox rod that
you find out how this is done. Reading further
you find that the Maddox rod can be used to
measure cyclophoria, you again look else-
where to find out what that is, and then the
cross references to “test, double prism” and
“test, Maddox rod” provide you with two
methods of detection, one of which can also
quantify the deviation. The author describes
this as an effective method of self teaching—
its only danger is that you become sidetracked
by intriguing entries such as “test, Rubb-
tischek” along the way. (In case you have never
heard of it either, it is actually a test chart to
measure astigmatism.) There is plentiful use
of alternate listings to be sure you find what
you are looking for, even if you don’t go to it
immediately. ARM, AMD, and senile macular
Degeneration all lead to “maculopathy, age-
related.” It is a little frustrating at first, but
the reader soon realises that “cover test” is under
“test, cover”, and ciliary muscle is “muscle,
ciliary”, although “frequency, spatial” is much
less intuitive. A new feature in this edition is
the truly excellent use of tables. As well as the
more conventional data such as optical
constants of the eye, average size of the normal
visual field, and common photometric units,
there are also helpful lists of all the terms the
book contains within a particular subject area—for example, ophthalmic drugs, optical
dispersion, and contact lenses. Some figures
and photographs have also been added, but
their usefulness is more mixed. To illustrate
the “target of the direct comparison ekono-
meter” is of enormous help in understanding
the description, but “occluder in front of the
left eye” is less illuminating, and the photo-
graph of the “typoscope” is even slightly mis-
leading.
In summary, any reader with a few minutes
to browse cannot fail to find an intriguing trail
of cross references to follow. For those with
more definable purpose who seek enlightenment,
they will surely find it in this compre-
hensive volume which looks set to go from
strength to strength.

CHIRS DICKINSON

Fungus fluorescein angiography. By
Amresh Chopdar. Pp 148. £72.50. Oxford:
0-7506-1885-X.
This relatively short book gives an introduc-
tion to fluorescein angiography. The first few
chapters outline the relevant basic sciences and
the reader will learn the history of fluores-
cein angiography, as well as discover that the
melting point of sodium fluorescein is 315°C!
A chapter entitled “Techniques and pitfalls”
provides useful information for those who are
planning to do the photography themselves.
The chapters concentrate on the appear-
ances of normal angiograms and how to inter-
pret abnormal features. The bulk of the book
gives a fairly standard step by step account of
different retinal and choroidal diseases. There
are separate chapters for age related macular
degeneration and diabetic retinopathy. Throughout, the author provides high quality
images to demonstrate different pathologies.
The author, however, frequently digresses
from describing retinal and choroidal pathol-
ogy to give details on their clinical manage-
ment. The last chapter very briefly, covers the
advancing field of digital retinal imaging
which, unfortunately, is already looking dated.
Every chapter ends with a helpful list of ref-
ences and there are appendices which list
the resuscitation equipment and drugs
required to perform fluorescein angiography.
However, the final appendix on the
classification of laser burns seems rather
superfluous.
Overall, this book gives a good introduction
of fluorescein angiography, it will be useful to
candidates who intend to sit postgraduate examinations as well as to those who wish to
refresh their knowledge on this subject. The
quality of the angiograms will both impress
the reader as well as incite some envy.

PARWEZ HOSSAIN

Downloaded from http://bjo.bmj.com/ on April 19, 2017 - Published by group.bmj.com
NOTICES

Avoidable blindness

The latest issue of the Community Eye Health (no 25) discusses the elimination of avoidable blindness. With an editorial by Bjorn Thy-efors, the director of the WHO Programme for the Prevention of Blindness and Deafness, the issue covers treatment of cataract in regions of India and the role of patient counsellors in increasing the uptake of cataract surgery and IOLs. For further information please contact Community Eye Health, International Centre for Eye Health, Institute of Ophthalmology, 11–43 Bath Street, London EC1V 9EL. (Tel: (+44) 171 608 6910; fax: (+44) 171 250 3207; email: eyeresource@ucl.ac.uk) Annual subscription £25. Free to workers in developing countries.

Residents’ Foreign Exchange Programme

Any resident interested in spending a period of up to one month in departments of ophthalmology in the Netherlands, Finland, Ireland, Germany, Denmark, France, Austria, or Portugal should apply to: Mr Robert Acheson, Secretary of the Foreign Exchange Committee, European Board of Ophthalmology, Institute of Ophthalmology, University College Dublin, 60 Eccles Street, Dublin 7, Ireland.

2nd International Conference on Ocular Infections

The 2nd International Conference on Ocular Infections will be held on 22–26 August 1998 in Munich, Germany. Further details: Professor J Frucht-Pery, 2nd International Conference on Ocular Infections, PO Box 50006, Tel Aviv; 61500, Israel. (Tel: 972 3 514000; fax: 972 3 5175674 or 5140077; email: ocular@kenes.com)

XVI Tuebingen Detachment Course

The XVI Tuebingen Detachment Course in retinal and vitreous surgery will be held 4–5 September 1998 in Odessa, Ukraine. Further details: Professor I M Logai, Director, The Filatov Institute, 49/51 Boulevard Francois, Odessa, 270061, Ukraine. (Tel: +38-0482-22 20 35; fax: +38-0482-68 48 51.)

International Agency for the Prevention of Blindness (IAPB)

The International Agency for the Prevention of Blindness (IAPB) will hold its next general assembly in Beijing, China on 5–10 September 1998. Further details: Gullapalli N Rao, Secretary General, IAPB Secretariat, LV Prasad Eye Institute, LV Prasad Marg, Banjara Hills, Hyderabad 500 034, India. (Tel: 091-40-215389; fax: 091-40-248267; email: IAPB@lvpradeye.stph.net)

ICOP 98

The next International Conference in Ophthalmic Photography (ICOP) will be held on 19–21 September 1998. Further details: Mrs Gillian Bennerson, Senior Ophthalmic Photographer, Bristol Eye Hospital, Lower Maudlin Street, Bristol BS1 2LX. (Tel: 0117-928-4677.)

Notices

The XII Congress European Society of Ophthalmology

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