CORRESPONDENCE

Endonasal laser dacryocystorhinostomony

EDITOR,—I read the article by Sadig and others with great interest.1 The figures presented, though in accordance with the literature,2 3 may be misleading at first sight. Of the 21 patients with endonasal laser dacryocystorhinostomy without intubation postoperatively, only 10 can be reported to be successful after 12 months. These are only 57.1% of the total number of patients who underwent surgery without stenting instead of the 91% reported. In the group of 65 patients with intubation postoperatively only 63 (59.3%) were successful after 12 months instead of the 81% reported. The figures presented by Sadig and others are doubtless in accordance with the literature, because success rates and reported figures are heterogeneous. The only common feature of all studies is that failure of laser assisted dacryocystorhinostomy in a result of fibromembranous scarring of the lacrimal system occurs in a rather early postoperative phase.

The main problem of all reviewed studies is the phenomenon of heterogeneity in patient selection criteria, indications for laser assisted dacryocystorhinostomy, approach, equipment, methods, statistics, and follow up criteria. Obviously the results will be different in an idiopathic, punctual postsaccal stenosis in an elderly patient with a chronic inflammatory process due to degenerative changes of the lids and the lacrimal apparatus with superinfection in an old patient with rosacea and an extended history of the lacrimal fistula postoperatively.

Thus, randomised and controlled prospective trials with a well defined standardised protocol are needed. We must define patient inclusion and exclusion criteria. Indications to specify further both for laser and surgical methods must be determined. It is not helpful to compare the treatment of different patients with different diseases treated with different surgical methods. We must define what particular method and operation can be called a result of fibromembranous scarring of the lacrimal system. There is no doubt, that the external dacryocystorhinostomy (Toti) as well as the endonasal approach (West) are the most frequently used with the highest success rates.1 11 12 The indications when to use a Toti or a West procedure are well established among ophthalmologists and ENT surgeons.11 12 There is no doubt that laser assisted dacryocystorhinostomy will find its place in lacrimal system occlusion surgery; the question is what method is best to use for what pathology in which patient at what price?

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Acute glaucoma, chronic medications, and serotoninergic drugs

EDITOR,—We were interested to read Kirwan et al1 2 in their report of acute angle closure glaucoma (AACG) associated with the antidepressant paroxetine (Seroxat),3 as we have reported a similar case.3 In Kirwan’s report, AACG occurred within 24 hours of the first dose, suggesting an an interaction with the drug. Our case became symptomatic some 2 weeks after daily dosage was commenced, leading us to postulate that the effect could have been mediated by serotoninergic pathways. This raised the possibility of the interaction occurring with certain ophthalmic side effects with drugs of this class.

Paroxetine is an antidepressant of the selective serotonin reuptake inhibitor (SSRI) class. SSRIs act by inducing a gradual rise in postsynaptic levels of serotonin (5-hydroxytryptamine, 5-HT) via desensitisation of the feedback systems which control the rate limiting enzyme in 5-HT synthesis.4 The 5-HT receptors involved have not yet been fully elucidated, and their role in ocular physiology is a subject of ongoing research. In animal studies, serotoninergic stimulation may cause mydriasis, and can have an independent effect in raising the intraocular pressure (IOP).5 Receptors for 5-HT have been demonstrated in the human eye.5 It is therefore possible that SSRIs could have an effect on IOP in humans. Consequently, we should look for raised IOP and open angle glaucoma as a side effect of SSRIs. A recent study has shown a significant short term rise in IOP after a single oral dose of the SSRI fluoxetine (Prozac). Twenty depressed patients were given either fluoxetine 20 mg or placebo in a randomised crossover blinded study, and fluoxetine was associated with a mean IOP elevation of over 4 mmHg, lasting 6–8 hours.6 We have been unable to find any publication regarding the effect of IOP on the longer term, but we have recently become aware of previously unpublished data which partly address this issue.

In premarketing and subsequent clinical tri-
The demonstration of a short term IOP rise of the eye (unspecified), and one of raised IOP, in a UK patient population of 21 million (Dista Products Limited, personal communication). The manufacturers of paroxetine are aware of four cases of AAGC, six of "glaucoma" (unspecified), and one of raised IOP, in a UK patient population of over one million (Smith-Kline Beecham Pharmaceuticals, personal communication).

These data indicate that the effect of SSRI s on IOP is still unclear. The demonstration of a short term IOP rise after a single fluoxetine dose implies that cholinergic mechanisms lead to a sustained elevation of IOP. However, the manufacturer's own data suggest that this is not the case, in that less than 1% of patients showed any IOP change after treatment. The low incidence of reported glaucoma with SSRIs does not exclude a real effect: many clinicians may not suspect a particular drug to be a contributory factor when diagnosing a particular condition, especially if a causal relation has not been suggested in the literature. We know the prevalence of primary open angle glaucoma (POAG) (conservatively estimated to be approximately 1/200 of the general population over the age of 40 years), and that of POAG in individuals over the age of 40 years, 1/1000 individuals over the age of 40 years, while the incidence of new cases within the population treated with SSRI s has not yet been evaluated, with the exception of the manufacturer's own data, which do not show a significant occurrence of IOP changes induced by SSRI treatment (Dista Products Limited, personal communication; Smith-Kline Beecham Pharmaceuticals, personal communication).

POAG is an asymptomatic disease, until a significant visual field loss occurs, and a single IOP reading does not necessarily exclude or confirm the diagnosis. The rise in IOP after a single dose of SSRI s was about 4 mm Hg 1/24 h in a non-glaucomatous population, equivalent to the diurnal fluctuations of IOP found in normal subjects, and probably is without long term effect on the ganglion cell integrity. On the contrary, this same variation, together with the small changes in pupil size reported by other investigators, in the so called "predisposed eyes" (that is, patients with positive family history of glaucoma and/or patients with physiological risk factors—relatively anterior location of the iris-lens diaphragm, shallow anterior chamber, and narrow entrance to the chamber angle) is able to modify the hydrodynamic homeostasis of the eye, leading to the acute angle closure.

The above data indicate the need to include an ophthalmological examination in the protocol of depressed patients before starting SSRI treatment. We know from recent publications that severe depressive illness increases the risk of suicide by a factor of 30 such that 15% die.

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Authors' reply

Editor,—In 1991 Ahmad' first reported the occurrence of glaucoma, probably an acute angle closure glaucoma (AACG), in a 35 year old man as a result of fluoxetine administration, during the fifth week of therapy. More recently, also Kerwan and Eke 2 described two cases of AACG associated with the administration of paroxetine, an antidepressant which acts as a selective inhibitor of the serotonin neuronal uptake (SSRI). In 1996 we described the effect of fluoxetine oral administration on intraocular pressure (IOP) in 20 consecutive depressed patients and demonstrated that after a single dose of 20 mg IOP was significantly increased. 3 Serotonin (5-HT) is present in mammalian iris ciliary body and cornea at higher concentration than in non-mammalian species. 4 While a transmitter role for serotonin in the retina has been established, conflicting data exist in the literature regarding the role of serotonin in IOP regulation. A compound with serotonergic blocking properties, reduces IOP in animals and humans and emphasises the role exerted by 5-HT on IOP. 5 To date, no long term studies regarding the effect of SSRI s on IOP have been published.

We know that less than 1% of patients showed any IOP change after treatment. The low incidence of reported glaucoma with SSRIs does not exclude a real effect: many clinicians may not suspect a particular drug to be a contributory factor when diagnosing a particular condition, especially if a causal relation has not been suggested in the literature. We know the prevalence of primary open angle glaucoma (POAG) (conservatively estimated to be approximately 1/200 of the general population over the age of 40 years) and that of POAG in individuals over the age of 40 years, 1/1000 individuals over the age of 40 years, while the incidence of new cases within the population treated with SSRI s has not yet been evaluated, with the exception of the manufacturer's own data, which do not show a significant occurrence of IOP changes induced by SSRI treatment (Dista Products Limited, personal communication; Smith-Kline Beecham Pharmaceuticals, personal communication). POAG is an asymptomatic disease, until a significant visual field loss occurs, and a single IOP reading does not necessarily exclude or confirm the diagnosis. The rise in IOP after a single dose of SSRI s was about 4 mm Hg 1/24 h in a non-glaucomatous population, equivalent to the diurnal fluctuations of IOP found in normal subjects, and probably is without long term effect on the ganglion cell integrity. On the contrary, this same variation, together with the small changes in pupil size reported by other investigators, in the so called "predisposed eyes" (that is, patients with positive family history of glaucoma and/or patients with physiological risk factors—relatively anterior location of the iris-lens diaphragm, shallow anterior chamber, and narrow entrance to the chamber angle) is able to modify the hydrodynamic homeostasis of the eye, leading to the acute angle closure.

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by suicide. Alternative treatments with other antidepressants are generally less well tolerated, especially in the elderly. Despite the possibility of raised intracranial pressure the risk/benefit ratio will almost always favour treating depression with the optimum agent.

Until the real effect of SSRIs on IOP has been ascertained it is difficult to make suggestions on management and further evidence on this subject is required. However, it would seem prudent to closely monitor glaucoma patients who have recently commenced treatment with an SSRI. Given limited ophthalmic resources, until we know more about the long term effects of these drugs on IOP it does not seem reasonable to recommend ophthalmological screening of all patients commenced on SSRIs. Like Eke and Carr, we encourage colleagues to report cases of glaucoma or raised IOP that may be due to therapy with SSRIs. Additionally, we would stress the importance of communication between disciplines so that no doctor is unaware of prescribed medication.

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2 Scriptcount 300 MAT to 26/8/94 [program]: Taylor Nelson Healthcare.

Thyroid eye disease. 3rd ed. By Devron H Char. Pp 293. £70. Oxford: Butterworth-Heinemann, 1997. ISBN 0-7506-9893-4. Thyroid associated ophthalmopathy continues to vex endocrinologists, ophthalmologists, and immunologists. At one of the earliest meetings of the Thyroid Club (now the British Thyroid Association) the debate on this subject was so intense that the secretary urged that it continue until no one was left, and the meeting closed with some difficulty at 10:00pm. Forty years later controversy still remains will have been answered. Nevertheless, this is a very valuable book for those working in developing countries where many workers find it indispensable. I will certainly continue to recommend it to students going overseas on elective projects.

F D GREEN

BOOK REVIEWS

If you wish to order, or require further information regarding the titles reviewed here, please write or telephone the BMJ Bookshop, PO Box 295, London W1X 9TE. Tel: 0171 383 6244. Fax: 0171 383 6662. Books are supplied post free in the UK and for British Forces Posted Overseas addresses. Overseas customers should add 15% for postage and packing. Payment may be made by cheque in sterling drawn on a UK bank, or by credit card (MasterCard, Visa, or American Express) stating card number, expiry data, and your full name. (The price and availability are occasionally subject to revision by the Publishers.)


It is written against a background of 38 million people in the world who are blind, the majority living in hot developing countries. The introductory chapter is an excellent overview of the problem touching on the contributory causes, particularly poverty and lack of education and all that follows on from that. Approaches to prevention and treatment are discussed.

The remainder of the book deals with eye disease in a systematic way starting with chapters on basic anatomy, physiology, history taking, and eye examination. The common eye diseases in hot climates are treated in a very similar way. As in more temperate parts but the thrust of the book is the approach to these diseases in situations where there are limited resources in expertise, diagnostic equipment, and treatment. There are clear descriptions of how to perform basic examinations with limited equipment and treatments recommended include the cheaper alternatives as well as the more modern medications. I particularly liked the advice on how to make up fortified antibiotic drops for corneal ulcers for example. As expected there are several good chapters on those diseases more specifically associated with tropical countries such as trachoma, xerophthalmia, onchoerciasis, and leprosy.

A minor criticism is that the whole of ophthalmology is touched and many rarer conditions just get a mention. Perhaps it would have been better to leave them out altogether and concentrate on the common conditions that are done so well. Nevertheless, this is a very valuable book for those working in developing countries where many workers find it indispensable. I will certainly continue to recommend it to students going overseas on elective projects.

NOTICES

Avoidable blindness

The latest issue of the Community Eye Health (no 25) discusses the elimination of avoidable blindness. With an editorial by Bjorn Thylefors, 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 counselors 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 5140000; fax: 972 3 5175674 or 5140077; email: ocular@kenes.com)

Vth Tuebingen Angiography Course on AMD

The Vth Tuebingen Angiography Course on AMD with stereoscopic angiography wet-lab will be held on 26–27 August 1998 at the auditorium, University Dental Clinic and University Eye Clinic, Tuebingen, Germany. Further details: Dr W Inho, University Eye Clinic, Department of Ophthalmology III, Schleichstrasse 12, D-72076 Tuebingen, Germany. (Tel: +49-(0) 7071-292968; fax: +49-(0) 7071-293746; email:ingrid.kreissig@uni-tuebingen.de)

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 Filatow 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@lvpeye.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.)

IV meeting of the European Society for Out-Patient Eye Surgery (ESOPES)

The IV meeting of the European Society for Out-Patient Eye Surgery (ESOPES) will be held in Vittel, France on 9–11 October 1998. Further details: Mrs Nicole Charron, Director, Palais des Congrès, Av Bouloumie, BP 57, 8802 Vittel, France. (Tel: +33 329 08 18 30; fax: +33 329 08 6601.)

Vth International Symposium on Graves’ Ophthalmology

The Vth International Symposium on Graves’ Ophthalmology will be held on 27–28 November 1998 in Amsterdam. Further details: Amsterdam Thyroid Club, Department of Endocrinology, F5-171, Academisch Medisch Centrum, Meibergdreef 9, 1105 AZ Amsterdam, Netherlands.

Singapore National Eye Centre

The 3rd SNEC international meeting and 11th international meeting on cataract, implant, microsurgery and refractive keratoplasty (ICIMRK) will be held at the Shangri-La Hotel, Singapore on 28–30 November 1998. Further details: Organising Secretariat, 3rd SNEC International Meeting and 11th ICIMRK, Singapore National Eye Centre Pte Ltd, 11 Third Hospital Avenue, Singapore 168751. (Tel: (65) 2277-255; fax: (65) 2277-2901)

Ophthalmic technologies

The 9th Ophthalmic Technology Conference will be held on 23–24 January 1999 during the SPIE symposium on biomedical optics. Further information: The SPIE Organisation, PO Box, Bellingham, WA 98227-0010, USA. (Fax: (+1) 360-647-1445; email: www:spie.org/info/pw)

Laser eye injuries

A conference on the epidemiology, prevention, diagnosis, and therapy of laser eye injuries will be held in San Jose, California on 25–26 January 1999 during the International SPIE symposium on biomedical optics. Further information: The SPIE Organisation, PO Box, Bellingham, WA 98227-0010, USA. (Fax: (+1) 360-647-1445; email: www:spie.org/info/pw)

XII Congress European Society of Ophthalmology

The XII Congress European Society of Ophthalmology will be held in Stockholm, Sweden on 27 June–1 July 1999. Further details: Congress (Sweden) AB, PO Box 5819, S-114 86 Stockholm, Sweden. (Tel: +46 8 459 66 00; fax: +46 8 661 91 25; email: soe@congrex.se; http://www.congrex.com/soe/)