There is no doubt that laser assisted dacryocystorhinostomy is a useful procedure. We must define what particular procedures are well established among ophthalmologists. The indications when to use a Toti or a West approach must be determined. It is not helpful to compare the treatment of different disease states as a result of fibro-obliterative scarring of the lacrimal system occurs in a rather early postoperative phase. The main problem of all reviewed studies is the 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 identical disease state with post-stenotic stenosis in a child compared 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 system. Thus, randomised and controlled prospective trials with a well defined standardised protocol are needed. We must define patient inclusion and exclusion criteria. Indications to sparing of bone 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 to use in what particular disease state. 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. The indications when to use a Toti or a West procedure are well established among ophthalmologists and ENT surgeons. 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?

CORRESPONDENCE

Endonasal laser dacryocystorhinostomy

Editor,—I read the article by Sadig and others with great interest. The figures presented, though in accordance with the literature, 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 47.62% 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 41 (63.08%) were successful after 12 months instead of the 70% of the 91% reported. Of the total number operated (86 patients) only 63 (59.3%) were successful after 12 months instead of the 81% reported. The figures presented by Sadig and others are plausible in accordance with the literature, because success rates and reported figures are heterogenous. The only common feature of all studies is that failure of laser assisted dacryocystorhinostomy is a result of fibroobliterative scarring of the lacrimal system occurring in a rather early postoperative phase. We are at present conducting long term observations of the technique and in the near future we hope to report the most suitable candidates for ELDCR.

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Acute glaucoma, chronic drugs, and serotonergic drugs

Editor,—We were interested to read Kirwan et al.’s report of acute angle closure glaucoma (AACG) associated with the antidepressant paroxetine (Seroxat),1 as we have reported a similar case.2 In Kirwan’s report, AACG occurred within 24 hours of the first dose, suggesting an anticholinergic effect. Our case became symptomatic some 2 weeks after daily dosage was commenced, leading us to postulate that the effect could have been mediated by serotonergic pathways. This raises the possibility of an acute ocular side effects with drugs of this class.

Paroxetine is an antidepressant of the selective serotonin reuptake inhibitor (SSRI) class. SSRIs act by inducing an increase 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.3 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, serotonergic stimulation may cause mydriasis, and can have an independent effect in raising the intraocular pressure (IOP).4 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 mm Hg, lasting 6–8 hours.6 We have found 5 hours of fluoxetine in one publication regarding the effect of IOP in the longer term, but we have recently become aware of previously unpublished data which partly address this issue.

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References


Reply

Editor,—We thank Dr von Arx for his appraisal of our report. Retrospective analyses are prone to a great number of problems, one of these being the dropout rate of patients attending for continued review. This may be for a variety of reasons including death, relocation, or a desire not to return to the hospital for appointments which may not be deemed useful by the patient usually due to a lack of symptoms rather than a return to the preoperative state—the latter of these usually results in earlier than arranged return). We (along with most clinicians) feel it better to use the terms dropout and the analysis. Moreover, although it can easily be seen that if these dropouts are regarded as a success or a failure, then this will either enhance or reduce the results respectively. Ignoring the dropouts, our results show 1 year success rates of 56% and 64% for patients without and with intubation respectively. We do believe these figures to be lower than the true rates owing to the reasons above. Furthermore, we have found that in several cases requiring revision conventional DCR, failure has occurred because of proximal pathology in the presence of a patent distal fistula created with the laser.

Our study involved consecutive patients undergoing endonasal laser DCR (ELDCR) and we have listed various risk factors which reduce the success rate of the procedure. Separating patients with and without these risk factors, we can achieve 1 year respective success rates of 56% versus 69% after intubation and 50% versus 66% without intubation (paper submitted). Case selection as suggested by Arx would therefore have increased our success rates, but we do not feel that selection of only low risk cases is a guarantee of the usefulness of a procedure and would give artificially better results. Randomised controlled trials are required to assess techniques which may be of equal efficacy, and as we have never offered ELDCR as having the same success rates as conventional surgery, we do not think that this type of study would be appropriate. Indeed, the technique was initially commenced to provide treatment alternatives for patients who were medically unfit to undergo the demands of a major operation such as conventional external approach DCR. We are at present conducting long term observation of the technique and in the near future we hope to report the most suitable candidates for ELDCR.

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experienced an elevation: in one patient the elevation was considered a normal diurnal variation [74 year old male, dosage 80 mg/day, examined at 2 months], in a second patient the elevation was felt to be related to angle closure [59 year old male, dosage 80 mg/day, examined at 2 months], the third patient acknowledged cocaine use prior to the examination and this was considered the probable explanation [37 year old male, dosage 80 mg/day, examined at 12 months], and the fourth patient had a 1 mm Hg rise with no probable extenuating circumstances [26 year old female, dosage 80mg/day, examined at 2 months]" (Dista Products Limited, personal communication).

Voluntary reporting of suspected adverse events with fluoxetine has identified a total of 63 cases of “glaucoma” in an estimated patient population of 21 million (Dista Products Limited, personal communication). The manufacturers of paroxetine are aware of four cases of AACG, 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 our understanding of the effect of SSRIs on IOP is still unclear. The demonstration of a short term IOP rise after a single fluoxetine dose implies that this medication can 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. This is particularly true of open angle glaucoma, which is common and usually idiopathic, and of AACG, which is rarer but occurs in anatomically predisposed eyes.

We feel that this area merits further study and clarification, particularly regarding the effect of long term SSRIs administration on IOP. In the meantime, we would encourage colleagues to report cases of glaucoma or raised intraocular pressure which may be associated with SSRIs to the Committee on Safety of Medicines.
by suicide.7 Alternative treatments with other antidepressants are generally less well tolerated, especially in the elderly. Despite the possibility of raised intracocular pressure the risk/benefit ratio will almost always favor 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.8 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 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 rages about the pathogenesis, the relation to the thyroid condition, and the best way to treat both the orbit and the thyroid in these patients.

This book, remarkably, is written by a single author and encompasses all of these areas. Devron Char is professor of ophthalmology and radiation oncology at the University of California at San Francisco. As the book is in its third edition already within 10 years, this demonstrates the changes that have been made in our understanding and provides a continuously revised text which gives a vast array of information. The shortcoming of this approach is that it is very difficult for anyone to be an expert these days in all areas that touch on ophthalmopathy. It is particularly in the areas of arcane immunology that the book is perhaps weakest and in future editions it might be worth commandeering the services of an immunologist to write specifically on this topic even if this leads to loss of uniform style. Another difficulty is that the text, although divided into sections, might benefit from further breakdown under subheadings. This is particularly apparent in chapter 6 which covers the pathogenesis and pathophysiology of thyroid ophthalmopathy. All of the immunological studies are grouped together under a single heading with no subdivision into genetics, antibodies, T cell involvement, and so on and this makes a difficult subject for the non-specialist even more taxing. There also appears to be some confusion over the role of free T4 testing in chapter 3 (Systemic diagnostic tests for thyroid ophthalmopathy and euthyroid ophthalmopathy). Free T4 assays are now simple, cost effective, and available.

These, however, are relatively minor drawbacks compared with the overall worth of the book. The layout is very good and the pictures are excellent. The references are generally up to date as far as 1995 and there are one or two from 1996. Moreover, the references are extensive and give a detailed overview of even the earliest history of work on this disease. The second half of the book which details management is superb giving an overview of medical management (including radiation therapy) and surgical approaches. The author shows what can go wrong as well as what can go right and the personal account given makes compelling reading. Anyone who deals with thyroid associated ophthalmopathy will learn from this book. Perhaps by the next, or next but one, edition some of the questions which still remain will have been answered.

A P WEETMAN

NOTICES

Avoidable blindness

The latest issue of the Community Eye Health (no 25) discusses the elimination of avoidable blindness. With an editorial by Bjorn Thyl-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 Ache-son, Secretary of the Foreign Exchange Committee, European Board of Ophthalmol-
ology, 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 Inhoffen, University Eye Clinic, Department of Ophthalmology III, Schleichstrasse 12, D-72076 Tuebingen, Germany. (Tel: +49-(0) 7071-292968; fax: +40-(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: +33-0482-22 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 (ICMRK) will be held at the Shangri-La Hotel, Singapore on 28–30 November 1998. Further details: Organising Secretariat, 3rd SNEC International Meeting and 11th ICMRK, Singapore National Eye Centre Pte Ltd, 11 Third Hospital Avenue, Singapore 168751. (Tel: (65) 2277-255; fax: (65) 2277-290/1)

Ophthalmic technologies

The 9th Ophthalmic Technology Conference will be held on 23–24 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)

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 Symposium, 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/)
Endonasal laser dacryocystorhinostomy

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