MAILBOX

Age related macular disease

EDITOR,—I am a retired doctor who suffers from the wet form of age related macular disease (ARMD) in both eyes. In the triangle of doctor, patient, and ARMD what are the implications for one of the key role holders, the ophthalmologists? Is there any longer a place for the phrase oft used by them “I am sorry I can do nothing further for you’’. There is in fact a lot doctors can do both in practical terms and in more subtle shifts of attitudes and behaviour. For example, general practitioners often admit they know little of the disease and may refer a case which requires an early opinion through the usual channels, which may take weeks. Opticians may not refer at all when necessary. Who better to educate and remedy these deficiencies but the experts, the ophthalmologists. Likewise, much needed low vision clinics are more likely to be achieved if promoted by a consultant rather than by a pressure group of patients. Or a rethink on how to make the loss of eyesight more easily interpreted to patients for whom the term “Sm.then” has little meaning—present criteria are primarily geared to use by professionals. Or an explanation that being registered blind has a different connotation from being totally blind and so on.

No general surgeon or physician nowadays would use such chilling words to a patient with a terminal or degenerative condition. It has been said that everyone in the health service including patients is a manager. Do all doctors realise the word manager also applies to them? Is there still a feeling among ophthalmologists that they continue to live in the halcyon days when being a doctor meant solely practising clinical medicine, while leaving the mundane business of getting the service to the patients to others. Doctors see themselves rightly as leaders of the clinical team which in turn exists for the purpose of serving the patient. Delay in the processing of forms for registration may mean little to the profession—but it may mean a lot for the patients. Registering as registered blind has a different connotation from being totally blind and so on.

Margaret Ewart
Kirkcudbrightshire, Scotland

Randomised controlled trial of corticosteroid regimens in endothelial corneal allograft rejection

EDITOR,—In the abstract of their paper Hudde et al conclude that “In treatment of graft rejection, additional systemic steroid treatment with 500 mg of methylprednisolone yields no significant benefit over intensive local corticosteroids alone.” The authors based their statement on the findings that the group of patients with ARMD graft rejection could not be reversed in three of 19 patients (16%) treated with local steroids alone, while none of 17 failed to reverse when given additional systemic steroid.

Even though the benefit of the additional steroid therapy may not have been statistically significant because of the small numbers, there is no indication that with larger numbers it might not very well become significant. The authors did not, however, limit their dismissal to a lack of statistical significance of the outcome, but broadened it to the wider summary statement of “no significant benefit”. Their data do not present such a sweeping condemnation. Reversal of the first graft rejection episode without a single failure in 17 patients would certainly constitute a strong clinical argument in favour of additional treatment with systemic steroids.

The authors do themselves admit that the statistical power of the study was such that it would only have been able to detect a difference in outcome of the order of 40%. Do they then reason that a difference in outcome of less than 40% is to be regarded as clinically irrelevant? Why was such an arbitrary statistical straightjacket chosen for this study? Considering the worldwide effects of the systemic steroid treatment were observed, I regard the outcome of the study of clinical relevance, particularly since an increased cure rate of the first (and possibly successive) rejection episode could also affect the long term outcome of these grafts. In my opinion, this study does not disprove the efficacy of additional systemic steroid treatment for initial episodes of graft rejection.

Klaus D Teichmann
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Reply

EDITOR,—Dr Teichmann is correct in stating that a larger sample size might possibly have demonstrated that graft recipients treated with systemic, in addition to topical, steroids have statistically significant improvement in outcome. However, as stated in the conclusion of the paper, we do not believe that our data are evidence of a major beneficial effect. If there is a small benefit, it is for readers to judge whether it justifies systemic steroid in addition to topical steroid. Weighing up possible benefits with risks, inconvenience, and cost is a decision so often encountered throughout therapeutic medicine.

We would make two further points in response. Firstly, in our study the rejection episode was reversed in a much higher proportion of patients than in previously reported studies; the power calculation used in planning the trial was based on these reports. Secondly, our analysis of combined graft survival and rejection-free survival in the two treatment groups (Fig 4 in the paper) took into account the reversal of rejection in all systemic steroid treated patients, yet indicated very similar outcomes (indeed, marginally superior survival in the topirical treatment group, not statistically significant) at 24 months from recruitment, when follow up was terminated.

D F P Larkin
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Indocyanine green guided laser photoacoagulation in patients with occult choroidal neovascularisation

EDITOR,—I read with interest the paper by Weinberger et al.1 In this pilot study about ICGA guided photoacoagulation of occult choroidal neovascularisation (CNV) in AMD, the authors provide evidence for a beneficial effect on visual prognosis by treating this CNV pattern. However, some concerns may be raised about both inclusion criteria and patients’ selection and then about results. On ICGA, all eyes included in the study show a choroidal neovascular network, with CNV size smaller than for AMD sample (the authors do not specify how many hot spots, plaques, or mixed lesions were in their sample). Indications for treatment, visual prognosis, and recurrence rate in these three CNV morphological types are quite different.1

Furthermore, a marked disproportion between eyes with pigment epithelial detachment (PED) (two cases) and those without PED (the remaining 19) raise doubts about the authors’ conclusion. The authors present the final anatomical and visual outcomes by considering all eyes as a single group; this method is questionable, since vascularised PED and RPE are definitely two distinct entities. Occult CNV with PED has a higher frequency of recurrence, probably due to the greater exudative activity of primary PED.1,2 And, even if anatomical outcome of laser photocoagulation is satisfactory, the functional result is usually poor.3 Then the encouraging final visual acuity reported in the paper is probably biased by anatomical sample composition and by improper grouping.

In order to draw definite conclusions and provide guidelines about ICGA guided laser treatment of occult CNV, there is a clear need for a randomised prospective, controlled clinical trial, with a larger population and a more realistic proportion between occult CNV with and without PED, and presenting separate final results for the two paras with regard to both anatomical and visual variables.

Stefano Da Pozzo
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www.bjophthalmol.com
Phacoemulsification combined with silicone oil removal through posterior capsulephlebitis

EDITOR,—We read with interest the report by Fraeyman et al and noted that our recent article in Ophthalmology was not cited as a reference. In a paper published in 1997 we demonstrated that ocular specific antigens (S-antigen; arresterin) and interphotoreceptor retinoid binding protein (IRBP), which are targets for pathogenic autoimmune processes, are expressed in the thymus of certain animals. Furthermore, we found that animals which express S-antigen or IRBP in their thymus are resistant to experimental autoimmune uveitis induced by the corresponding molecule, whereas the absence of thymic expression correlates with susceptibility.

CHARLES E EGWUAGU
PUWAT CHARUKAMNOETKANOK
IGAL GERY
National Eye Institute, NIH, Bethesda, MD, USA

NOTICES

Community participation in eye health and trachoma and the SAFE strategy

The latest issue of Community Eye Health (33) discusses provision of services for individuals with refractive errors with an editorial by Hugh R Taylor. 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) 0 20-7608 6909/6910/6923; fax: (+44) 0 7250 3207; email: eyeresource@ucl.ac.uk. Annual membership £25. Free to workers in developing countries.


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Mailbox, Notices, Correction


Reply

EDITOR,—We thank Dr Da Pozzo for his inter- est in our paper. He raised a number of inter- esting points.

Patient selection for ICGr guided laser photoacoagulation is extremely crucial. Functional results from different pilot studies on ICGr guided laser photoacoagulation show various outcomes. This may be explained either by the patient selection or by the indications for ICGr guided treatment. Especially, the definition of the choroidal neovascular network in ICGr angiograms is crucial since the interpretation of ICGr angiograms is still under discus- sion.

Our interpretation of ICGr angiograms for the detection of a CNV is based on the choroidal transit and recirculation phase of ICG dye recorded with a scanning laser ophthal- moscope. We consider this to be more accurate in determining the size, location, and geometry of CNV than the late phase. We have demonstrated that occult CNV defined by the MPS standards could be converted into visible neovascular membranes in up to 50% of cases independent of the presence of PED. Using other imaging techniques, hot spots and plaque hyperfluorescence were used to convert occult CNV into visible CNV. Previous studies on ICGr guided laser photoacoagulation rely almost exclusively on this interpretation of ICGr angiograms. However, it has recently been demonstrated that many eyes with hot spots in late ICG angiograms have polypoidal choroidal vascu- lopathy (PCV). Since previous studies did not differentiate between eyes with PCV and AMD, a quite encouraging final visual results we feel very comfortable with ICGr guided laser pho-
tocoagulation following our interpretation of ICG angiograms in occult CNV secondary to AMD.

We totally agree that there is a clear need for a randomised prospective, controlled clinical trial to prove the efficacy of ICG guided laser photoacoagulation with occult CNV. Based on our promising results we would suggest following our approach for imaging and interpretation of ICGr angiograms for this study.

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AW A WEINBERGER
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Phacoemulsification combined with silicone oil removal through posterior capsulorhexis

EDITOR,—We read with interest the report by Fraeyman et al and noted that our recent article in Ophthalmology was not cited as a reference. In this article we reported our experience at Moorfields Eye Hospital with 34 eyes prospectively evaluated to look at the efficacy and potential complications of combined cataract extraction and silicone oil removal with poste- rior chamber lens implantation. We also reported the method of Rostock, ophthalmic ultrasound specialist at Moorfields Eye Hospi- tal, for calculating the IOL power in an oil group. We consider this to be more

Community Eye Health (33) discusses provision of services for individuals with refractive errors with an editorial by Hugh R Taylor. 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) 0 20-7608 6909/6910/6923; fax: (+44) 0 7250 3207; email: eyeresource@ucl.ac.uk. Annual membership £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.

DR-2000, International Forum on Diabetic Retinopathy

The International Forum on Diabetic Retinopathy will take place on 7–9 September 2000 at the Palazzo Reale, Naples, Italy. Further details: Francesco Bandello, Congress Secretariat, MGR Congressi, Via Servio Tullio, 4, 20123 Milano, Italy (tel: 39 02 430071; fax: 39 02 48008471; email: dr2000@mgr.it).

VIII Tuebingen Angiography course

The VIII Tuebingen Angiography course with wet lab will take place on 9 September 2000 in the auditorium, University Eye Clinic, Schleichstrasse 12, 72076 Tuebingen, Germany. Further details: WIT-Wissenstransfer, Universität Tubingen (tel: ++49 7071-29 76439; fax: ++49 7071 29 5051; email: wit@uni-tuebingen.de; wit).

30th Cambridge Ophthalmological Symposium

The 30th Cambridge Ophthalmological Symposium entitled “The Ageing Macula” will be held on 13–15 September 2000 at St John’s College Cambridge. Chairman: Professor Alan Bird. Further details: COS Secretariat, Church Street, Great Shelford, Cambridge CB2 5EL (tel: 01223 847464; fax: 01223 847465; email: b.ashworth@easynet.co.uk).

European Association for Vision and Eye Research (EVER)

The European Association for Vision and Eye Research (EVER) will be meeting on 4–7 October 2000 in Palma de Mallorca, Spain. Further details: Secretariat EVER, Postbus 74, B3000 Leuven, Belgium (fax: +32 16 33 67 85; email: EVER@jmed.kuleuven.ac.be).

Fifth Annual Meeting of the Association for Ocular Pharmacology and Therapeutics

The Fifth Annual Meeting of the Association for Ocular Pharmacology and Therapeutics will be held on 2–5 November 2000 in Birmingham, AL, USA. Further details: Jimmy D Bartlett, OD, Department of Optometry, University of Alabama at Birmingham, 1716 University Blvd, Birmingham, AL 35294-0010, USA (tel: 205-934-6764; fax: 205-975-7052; email: Jbartlett@icare.opt.uab.edu).

American Institute of Ultrasound in Medicine—Millennium Ultrasound Course Series

A course entitled “Ultrasound Diagnosis and Management of Fetal Growth Abnormalities” will be held in Las Vegas, Nevada, on 3–5 November 2000. Further details: Stacey Bessling, Public Relations Coordinator, AIUM, 14750 Switzer Lane, Suite 100, Laurel, MD 20707-5906, USA (tel: 301-498-4100; email: sbessling@aium.org).

Mind’s Eye 2—Psychic and Sight Loss

The Society for Psychosomatic Ophthalmology and the British Psycho-Analytical Society present a conference “Mind’s Eye 2—Psychic and Sight Loss” on 4 November 2000 at the Institute of Psycho-Analysis, London. Further details: Mandy O’Keeffe, 67 Avenell Road, London N5 1BT (tel: 020 7288 2359; email: okeffe@ukgateway.net).

12th Afro-Asian Congress of Ophthalmology

The 12th Afro-Asian Congress of Ophthalmology (Official Congress for the Afro-Asian Council of Ophthalmology) will be held on 11–15 November 2000 in Guangzhou (Canton), China. The theme is “Advances of ophthalmology and the 21st century.” Further details: Professor Lezheng Wu, Zhongshan Eye Center, SUMS, New Building, Room 919, 54 Xianlie Nan Road, Guangzhou 510060, PR China (tel: +86-20-8760 2402; fax: +86-20-8777 3370; email: hivicz@gzsums.edu.cn).

Singapore National Eye Centre 10th Anniversary International Congress

The Singapore National Eye Centre 10th Anniversary International Congress will be held in conjunction with 3rd World Eye Surgeons Society International Meeting on 2–4 December 2000 at the Shangri-La Hotel, Singapore. Further details: The Organising Secretariat, 11 Third Hospital Avenue, Singapore 168751 (tel: (65) 2277255; fax: (65) 2277290; internet: www.snecc.com.sg).

The Hong Kong Ophthalmological Symposium ’00

The Hong Kong Ophthalmological Symposium ’00 will be held 4–5 December 2000 in Hong Kong, China. Further information: Miss Vicki Wong, Room 802, 8/F Hong Kong Academy of Medicine, 99 Wong Chuk Hang Road, Aberdeen, Hong Kong (tel: (852) 2761 9126; fax: (852) 2715 0089; email: coch@netnavigator.com).

American Institute of Ultrasound in Medicine—Millennium Ultrasound Course Series

A course entitled “Obstetrical Ultrasound” will be held in Marina del Rey, CA, on 12–14 January 2001. Further details: Stacey Bessling, Public Relations Coordinator, AIUM, 14750 Switzer Lane, Suite 100, Laurel, MD 20707-5906, USA (tel: 301-498-4100; email: sbessling@aium.org).

Optometry Study Tour to Kenya, Tanzania, and Zanzibar

The tour offers a wonderful opportunity to optometrists and optometrists to examine eye care in East Africa. It will take place from 28 January to 10 February 2001. Further details: Master Travel, Croxton, 288 Croxton Road, London SE24 9BY (tel: 0208 678 3520; fax: 0208 74 2712; email: tours@mastertravel.co.uk).

First International Congress on Non-Penetrating Glaucoma Surgery

The First International Congress on Non-Penetrating Glaucoma Surgery will take place in Lausanne, Switzerland on 1–2 February 2001. Further details: Dr Tarek Shaarawy, Organising Committee, University of Lausanne, Hospital Ophthalmique Jules Gonin, Avenue de France 15, 1004 Lausanne, Switzerland (tel: 41 21 626 81 11; fax: 41 21 626 88 88; website: www.glaucoma-lausanne.org).

Call for papers—6th European Forum on Quality Improvement in Health Care, 29–31 March 2001, Bologna, Italy

Further details: BMA/BMJ Conference Unit, BMA House, Tavistock Square, London WC1H 9JP, UK (tel: ++44 (0) 20 7383 6409; fax: ++44 (0) 20 7383 6869; email: quality@bma.org.uk; website: www.quality.bmjg.com).

American Institute of Ultrasound in Medicine—Millennium Ultrasound Course Series

A course entitled “Obstetrical and Gynecological Ultrasound” will be held in New York City, NY, on 24–26 August 2001. Further details: Stacey Bessling, Public Relations Coordinator, AIUM, 14750 Switzer Lane, Suite 100, Laurel, MD 20707-9096, USA (tel: 301-498-4100; email: sbessling@aium.org).

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Age related macular disease

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