

daytime supine IOP measurements can estimate peak nocturnal IOP. The correlation between office-hour supine and peak supine nocturnal IOP was higher than office-hour sitting and peak supine nocturnal IOP measurements ($r=0.713$ vs 0.601). Nakakura *et al*⁴ demonstrated that with only 33.8% of peak IOPs occurring during the day, it was difficult to estimate 24-hour IOP fluctuation and maximum 24-hour IOP on the basis of clinic-based measurements. What these studies show is that while office-based IOP measurements correlate reasonably well with mean circadian IOP, a significant amount of peak IOPs can go undetected if nocturnal measurements are not obtained. Twenty-four-hour monitoring, therefore, provides essential information for constituting the circadian pattern of IOP. Once this profile is established, its clinical relevance for glaucoma patients will emerge as an important area for research.

Other limitations of this study are those typically associated with any retrospective chart review. Nocturnal values were available for only 54% of patients, diminishing the sample size and introducing potential selection bias. In contrast to previous studies, this investigation included a mixed cohort of glaucoma subtypes. It is worth pointing out that 25% of overnight patients had congenital, aphakic or chronic narrow-angle glaucoma. It is possible that these patients have a different IOP profile from patients with primary open-angle glaucoma.

As long as reduction of IOP remains the most effective treatment of glaucoma, we believe that data on the 24-hour IOP profile will improve glaucoma management. With the advent of newer technologies, ambulatory 24-hour IOP monitoring in real-life conditions could soon be in the realm of the clinician.

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