Book reviews

Symposium on Retinal Diseases. Transactions of the New Orleans Academy of Ophthalmology. Edited by MATTHEW D. DAVIS *et al.* 1977. Pp. 354, figs, tables, refs. C. V. Mosby, St. Louis (£30.50)

This book is the latest in the series of *Transactions of the New Orleans Academy of Ophthalmology*. It certainly lives up to the high standards set by its predecessors.

The book is divided into four parts and consists of 26 formal lectures presented by 9 participants, all well known experts in their field. The first part is devoted to vitreous surgery. The topics include preoperative evaluation, indications, instrumentation, techniques, and results of vitrectomy. The section dealing with the testing of visual acuity in patients with very poor vision is particularly informative. The second part deals with the various aspects of diabetic retinopathy. The third part covers many aspects of macular disorders, including the management of choroidal neovascularisation, central serous chorioidopathy, macular oedema, and macular holes. The last part of the book consists of round table discussions based on questions from the audience. This part of the book was both entertaining and informative. It was most reassuring to see that even the experts may have entirely conflicting views on many fundamental topics.

Although most of the material presented in this book has already been published elsewhere, it is highly recommended to those wishing to have a full account on 3 very important aspects of retinal disease.

J. J. KANSKI

Clinical Low Vision. E. E. FAYE. 1976. Pp. 396, figs. Little Brown, Boston (£15.00)

In this book, her third on the subject, Dr Faye states her target clearly and unequivocally in the preface. Low vision care is generally accepted as a field where interdisciplinary co-operation is essential, and wisely Dr Faye as editor and main contributor has included chapters from a social worker, an educationalist, a mobility expert, an audiologist, and an optometrist. There is a section on 'Medical and Surgical Management of Low Vision Problems' and another on 'Genetics for the Physicians'. Contributors to these sections include Irwin Siegal on albinism and genetics, Norman Medow on corneal disease, Charles Regan on retinal detachment, Jackson Coleman on vitrectomy, Arnold Patz and Stuart Fine on diabetes, Francis L'Esperance on photo-coagulation in macular disease, Brian Curtin on myopia, and Elliot Berson on night blindness: all, of course, with special reference to low vision.

The book has been carefully planned and cross-indexed so that the stated aim of allowing the reader to pursue a special interest and read the sections in any order is well met, proving a great advantage to anyone familiar with the subject. Each section is complete in

itself but indicates supplementary and complementary sections.

Of particular interest to this reader were the definitions, particularly the functional ones. Any worker with the visually disabled can bring to mind cases where a very similar clinical picture can produce a complete cessation of sighted activities in one patient and only relatively minor modifications of normal behaviour in another. Dr Augustus Colenbrander, who wrote this chapter, attempts only definitions. Explanations probably lie outside the eye and visual pathways and are more likely to be explained by the behavioural scientists. In her previous book (*Low Vision*, published by Charles C Thomas, Springfield, Illinois, 1975) there were contributions on both psychology and psychiatry, which makes their omission from the present volume a little surprising.

It is always easier to criticise than produce a book, but a good deal of confusion can be caused by Dr Faye's attempts to simplify the prescribing of hand magnifiers. The optics of loupe magnification are very difficult to understand, particularly since the distances between eye and lens and material are flexible. Dr Faye calculates magnification using a standard viewing distance of 40 cm from the image, an arbitrary decision that may not coincide with the inclinations or the needs of many patients. The power of magnifiers certainly does need sorting out, some manufacturers giving magnification, others dioptres, some focal length, and others diameters. But the simplest approach, that is, power in dioptres, would enable any practitioner with a basic knowledge of optics to calculate the actual magnification of an aid as used by a specific patient—surely, the truly significant information.

The British reader will find elsewhere too in this book that its virtues are also its faults. Some of the terminology is unfamiliar, for example, the Sloan M ratings, and, as there is no glossary of terms the advantages of being able to 'dip' are reduced. There is also, throughout, the assumption that low vision patients ideally should be managed at 'agencies for the visually handicapped or university teaching centres', whereas in the UK the prescribing of aids is normally seen as an integral, though often delegated, part of the overall ophthalmological care.

It is some measure that so few criticisms can be made. The book must not only convince any ophthalmologist or optometrist who reads it that 'something can be done' but may well cause a good few more to get on and do it.

JANET SILVER

Krill's Hereditary Retinal and Choroidal Diseases. Vol. 2. By ALEX E. KRILL. 1977. Pp. 1020, 951 figs., refs. Harper & Row, Maryland, USA (\$60)

Professor Alex Krill was tragically killed in December 1972. At that time the first volume of *Hereditary Retinal*

and *Choroidal Diseases* had been published, and he had completed 8 chapters and blocked the headings of the remainder of the second volume. Desmond Archer then took on the responsibility for completing the volume, and he and August Deutman (2 of his dedicated co-workers) wrote the bulk of the unfinished chapters.

The book is an admirable memorial to Alex Krill, who is missed by all who knew him. Each chapter is written with extreme thoroughness and is exceptionally

well referenced. One cannot help but admire the level of scholarship that has been devoted to the completion of this book. It is ideally suited as a reference book for any research worker interested in hereditary fundus diseases, the illustrations are extremely good, and yet the book is eminently readable. I would recommend this book to anyone who is working in this field or to any practitioner who wants a volume with up-to-date information on hereditary retinal and choroidal diseases.

A. C. BIRD

Correspondence

Long-term results of Choyce anterior chamber lens implants

TO THE EDITOR, *British Journal of Ophthalmology*
SIR, I am grateful to Mr J. L. Pearce for finding the time and taking the trouble to examine my patients in 1971 and to write the paper which you, Sir, were good enough to publish (Pearce, 1975). On p. 101, under the heading 'Less serious corneal changes', Mr Pearce lists 9 cases (13.2%) exhibiting areas of corneal oedema mainly in relation to the feet of the implant, illustrated by a figure on p. 102. Mr Pearce expressed the opinion that with the passage of time these changes could progress to frank corneal decompensation, thus increasing the incidence of bullous keratopathy, which he found to be 1.5%.

Nowadays I am often questioned about the subsequent fate of these 9 patients. The facts are that 2 died within a year of their examination by Mr Pearce with their corneal pathology and visual acuity unchanged. The other 7 have all been examined within the last 6 months, and their acuity and corneal status are also unchanged.

Their average age is now 76, and the average time since implantation is 12 years 8 months.

I have inserted approximately 1000 Mk VIII anterior chamber implants since the end of 1963, and my experience is that if corneal decompensation is going to occur it does so within 12 months of insertion and only rarely after longer periods of time.

Yours faithfully,

D. P. CHOYCE

9 Drake Road,
Westcliff-on-Sea,
Essex SS0 8LR

Reference

Pearce, J. L. (1975). Long-term results of the Choyce anterior chamber lens implants Marks V, VII, and VIII. *British Journal of Ophthalmology*, **59**, 99–106.

Treatment with urokinase

TO THE EDITOR, *British Journal of Ophthalmology*
SIR, I would like to clarify certain remarks concerning our intravitreal injection technique as mentioned in your excellent Editorial (1977). The statement that in earlier reports up to 1.5 ml of vitreous was aspirated before injection of urokinase in an equal amount of water has been referenced to our paper (Dugmore and Raichand, 1973) by mistake. We had, in fact, described aspiration of only 0.5 ml of vitreous. I hope that the following explanation will rectify certain statements in your Editorial.

As we were the first investigators to study the role of intravitreal urokinase in the treatment of vitreous haemorrhage (Raichand, 1970), we had to develop our own technique for the study. After evolving our technique in animal eyes, in February 1971, we performed the first intravitreal injection of urokinase in a human eye (Raichand, 1971a, b). Evaluation of intravitreal urokinase was done in 1970 (Raichand, 1970) when intravitreal techniques and vitreous surgery were in their infancy.

Since then the development of vitrectomy techniques has revolutionised the treatment of vitreous haemorrhage.

Contrary to the statement in your Editorial, it was a Glasgow report (Williamson and Forrester, 1972) that described intravitreal injection of 1.5 ml of urokinase without aspiration of vitreous or aqueous. We (Dugmore and Raichand, 1972) promptly questioned this report, for we were aware that technically this was impossible, and, if a large amount (1.5 ml) of vitreous was aspirated, improvement in visual acuity could also be attributed to this element of vitreous 'exchange'.

From our animal studies we had realised that it is practically impossible to inject even small quantities of urokinase in the eye without raising the intraocular pressure to a very high level and developing a severe reaction in the anterior chamber. Even anterior chamber paracentesis did not reduce the severe anterior chamber reaction; moreover, the amount of fluid that can be drained from the anterior chamber is about 0.25 ml. For