Correspondence

Quantitative trabeculectomy

SIR, I would like the opportunity to comment on the correspondence that appeared in the July edition of the *British Journal of Ophthalmology*, where Robert David[1] replied to a letter by Geoffrey Jay.[2] Geoffrey Jay had criticised David and Sachs's paper[3] on quantitative trabeculectomy, stating that for the authors to make the claims that they did they should have had a control series. Robert David disagreed, on ethical grounds, with this suggestion that 'control operations for comparison' should be performed.

In their paper David and Sachs started out with the premise that, if a superficial lamellar scleral flap of varying thickness was left behind at the time of trabeculectomy operation, then the pressure reduction achieved would be varied accordingly, and they suggested that there would almost be an inverse relationship between the thickness of the flap and the pressure reduction achieved. Starting out with the premise they applied it to a series of patients with varying intraocular pressure noted preoperatively. They found that all their patients had intraocular pressures controlled by their procedure and used this control as evidence that their initial premise was correct. Geoffrey Jay pointed out that in his and Murray's paper[4] they found that a pressure reduction which was proportional to the starting pressure was achieved, although they made no conscious effort to vary the thickness of the lamellar scleral flap. David and Sachs appeared to have ignored this point. For their premise to be correct they should have said we will take 2 series of patients with varying preoperative pressures. In one series we will apply the 'quantitative trabeculectomy' technique and see what the intraocular pressure control is likely to be, and for the other series perform a standard trabeculectomy and then see whether the degree of pressure control is any different. As this premise was unproved at the outset of study, I see no ethical reason why this approach should not have been taken.

I have a second criticism of David and Sachs's paper, which is that they gave no method by which they could demonstrate a constant thickness of the lamellar scleral flap they allowed to remain. In their paper they illustrated diagrams showing ½ thickness or ⅓ thickness or a ¼ thickness remaining, and they gave a table where they showed that up to $^{4}/_{5}$ths of the scleral tissue could be removed. Unfortunately without a reasonable method to demonstrate that they can be sure that they were removing the amounts of tissue that they say they removed one has to suggest that considerable overlap between the groups could occur.

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References

1 David R. Quantitative trabeculectomy. *Br J Ophthalmol* 1982; **66:** 474.
2 Jay JL. Quantitative trabeculectomy. *Br J Ophthalmol* 1982; **66:** 474.
3 David R, Sachs U. Quantitative trabeculectomy. *Br J Ophthalmol* 1981; **65:** 457–9.
4 Jay JL, Murray SB. Characteristics of reduction of intraocular pressure after trabeculectomy. *Br J Ophthalmol* 1980; **64:** 432–5.

Simultaneous trabeculectomy and cataract extraction

SIR, I read with great interest the paper by Miriam Romem *et al.*[1] I fully agree with the authors' point of view that a simultaneously performed trabeculectomy and cataract extraction in those patients in whom these procedures are indicated has significant advantages when compared to doing the procedures separately. This point was made by Dr Berlin and myself.[2] We also pointed out the advantages of using a fornix-based conjunctival flap for the procedure rather than a limbus-based flap as described by the authors. There are many advantages to a fornix-based flap, particularly the opportunity of safely fitting a contact lens a few weeks after the surgery. We thought it worthwhile bringing this point to the attention of your readers.

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1 Romen M, Isakow I, Zvi D. Simultaneous trabeculectomy and cataract extraction. *Br J Ophthalmol* 1982; **66:** 250–2.
2 Luntz MH, Berlin MS. Combined trabeculectomy and cataract extraction. Advantages of a modified technique and review of current literature. *Trans Ophthalmol Soc UK* 1980; **100:** 533–41.

Book reviews

Essential Ophthalmology. By H. B. CHAWLA. Pp. 179. £4·95. Churchill Livingstone: Edinburgh. 1981.

A racing driver if asked to nominate the exact position of his gear handle in the highest and lowest position will probably have to think it out, having long ago relieved his cerebral cortex of such monitoring by relegation to his cerebellum. So with the experienced ophthalmologist who feels he could probably perform a cataract extraction in his sleep but if asked how he did it would have to wake up.

This book is a product of just such an exercise. Written by an ophthalmologist of wide interests who has relived his processes of learning, it records in simple language what he found to be all important. Such an account cannot enable the reader to solve all problems in ophthalmology, but if the main message is hoisted in, the student is likely to sense his limitations when confronted by a problem and realise when advice is required. Illustrated by line diagrams, the book must be judged within its framework, and as a first introduction to the discipline of ophthalmology it is readily understandable and soundly based. It is, however, an introduction only; a stepping-stone to higher things if the reader is so inclined; excellent for the medical undergraduate or