Obituary

E. H. Cameron, MB, ChB, FRCSEd

Ernest Hugh Cameron, honorary consultant in ophthalmology to the Royal Infirmary, Edinburgh, died on 26 February at his home in Lasswade, Midlothian, at the age of 94.

Born in 1890, and educated at George Watson's College and at the University of Edinburgh, he graduated in medicine in 1910 and obtained the fellowship of the Royal College of Surgeons of Edinburgh in 1914. He was appointed house-surgeon in the eye wards of Dr George Mackay at the Royal Infirmary, and then spent a short time in general surgery. In January 1916 he joined the RAMC, serving mainly in Salonika and India. Returning to Edinburgh he became clinical tutor and later assistant ophthalmic surgeon in the Eye Department of the Royal Infirmary. In 1932 he was appointed surgeon in charge of wards.

Elected a member of the Ophthalmological Society of the United Kingdom in 1924, he served on the council of the society in 1931–5 and again ex officio in 1949–51, when he was President of the Scottish Ophthalmological Club. He also much enjoyed the meetings of the Oxford Ophthalmological Congress.

An excellent clinician, with no inclination towards research, he devoted his great talents to the care of patients and the teaching of undergraduates, an art in which he excelled. Ernest was also a very accomplished musician, particularly on the clarinet, and he played the organ at Roslyn Chapel and later at Lasswade.

He married relatively late in life, and his marriage was a supremely happy one. He is survived by his wife, two daughters, and two sons, one of the latter being a doctor.

G. I. S.

Correspondence

Effect of continuous subcutaneous insulin infusion on retinopathy

SIR, I read with interest the article by Lawson et al. on the failure of continuous subcutaneous insulin infusion (CSII) to prevent the progression of proliferative and preproliferative diabetic retinopathy.1 The hopes of many physicians and their diabetic patients with florid retinopathy could be dashed after reading it. I don’t think this is right. The metabolic control (HbA1) of the described patients were insufficient in 5 cases (cases 2, 6, 7, 8, 9) and borderline in 2 cases (cases 3 and 11) with mean blood-sugar values all in the high range of normal or elevated. Nevertheless this could be considered as a fair result in otherwise difficult cases of diabetes mellitus. The outcome appeared worst in cases 2, 8, 10, and 11; the level of HbA1 of case 10 is unknown, that of the 3 others was too high or borderline, indicating a moderate control, instead of the reported good control in 3 of them in Table 1.

But this is not the point. What would have been the outcome without CSII in these patients, including microangiopathy elsewhere in the body? The authors raise the possibility of a detrimental effect of CSII on the retinopathy and point mainly to 2 possible causes. The first, the so-called induced imbalance of somatomedin and growth hormone levels, is in fact a restoration of balance with very beneficial potential effect on growth, in spite of the fall in growth hormone concentration.2 The effect on new vessel growth is not known, but uncontrolled growth can have a deleterious effect on the retinopathy, as is known in adolescent diabetics without CSII treatment. In this series only case 3 could have had this problem, but his deterioration was probably related to temporary loss of metabolic control because of an abscess.

The second point which possibly could count, according to the authors, for the worsening of the retinopathy during CSII treatment is the ‘probable’ reduction in retinal blood flow by CSII. In fact it is not the flow which is important, but tissue hypoxia, and this causes secondarily increased blood flow. Normalisation of flow indicates normalisation of tissue oxygenation.

The primary cause of microangiopathy in diabetes is chronic hyperglycaemia. The mere fact that there is a progressive retinopathy points to insufficient metabolic control. It is probably too late when connective tissue strands appear on and in the retina, but before this stage is reached, every effort should be directed to normalise the blood sugar, including CSII, together with further photoagulations (diminishing retinal areas with presumed production of ‘angiogenic factors’ and leakage).

The introduction of CSII has brought new hopes for badly manageable diabetics with deteriorating retinopathy,3 and this is right. It cannot always totally prevent progression of retinopathy, so other measures remain important, including photoagulation. False hopes should not be raised by CSII, as the authors state, but surely it can be an excellent new tool in preventing or slowing down progression of diabetic microangiopathy.

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References

SIR, After reading the letter from Dr L. Bastiaensen regarding our paper we would like to make the following comments. We sympathise with his sentiment that ‘the
introduction of CSII has brought new hope for badly manageable diabetics with deteriorating retinopathy', but unfortunately this has not yet been shown to be the case.

Our study confines itself to a specific type of diabetic retinopathy and, despite the fact that there were no control patients, shows clearly that preproliferative and proliferative retinopathies are not reversed or progression halted by CSII management. Criticisms of the degree of control obtained in our study are invalid, as the study was of CSII and not the degree of blood glucose control per se. In fact the control achieved in the majority of our patients is typical of CSII control, which does not of course normalise blood glucose but usually maintains an HbA1 just above or in the upper range of normal. In addition we also believe that an important feature was the improvement in control which clearly occurred in all but one patient.

The reason why we discussed the possibility of CSII worsening the retinopathies was that despite having no controls this was our clinical impression. Although we accept that this is anecdotal, the subject is of such importance that it should be discussed to alert clinicians to this possibility, in order that they proceed with caution when managing retinopathy patients with CSII, ensuring that they obtain regular fundal reviews.

We agree that the way to examine this problem is by a controlled study, and there are at least 2 of these currently under way investigating CSII in background retinopathy. Interestingly the most recent results of one of these studies suggest after one year that retinopathy deteriorated more in the patients treated with CSII.

We appreciate Dr Bastaensen's hopes that CSII may be a forward step in the management of diabetic patients with and without complications, and we personally believe that good blood glucose control must be better than bad. Rapidly improving blood glucose in patients who already have pathology is, however, a specific issue, and it is important to remember that any new therapy requires close observation in order to ensure that a comprehensive understanding of its benefits or possible shortcomings is obtained.

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PAUL LAWSON
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References
1 KROC Collaborative Study Group. New Haven, London
England, London Canada, Chicago and Rochester. Is a multi-
centre trial of diabetic control and complications feasible?
Diabetes 1982; 31 (suppl 2): 4A.
2 Lauritzen T, Frost-Larsen K, Larsen HW, Deckert T, and the
Steno Study Group. Effect of one year of near-normal blood
glucose levels on retinopathy in insulin-dependent diabetics.

Notes

International Association of Ocular Surgeons
The Biennial Meeting of the IAOS will be held at the
Sheraton Waikiki Hotel, Honolulu, Hawaii, USA, on 5–9
December 1983. Symposia and round-table discussions on:
glaucoma, cataract/Intraocular lens, oculoplastic surgery,
retina/choroid/vitreous, strabismus and keratorefractive
surgery. Fee: $300.00 (includes membership). Further
information from: John G. Bellows, MD, IAOS Director,
211 East Chicago Avenue, Suite 1044, Chicago, Illinois
60611, USA.

Cataract and Intraocular lens surgery
The First International Symposium on Cataract and
Intraocular Lens Surgery will be held by the Sociedade
Brazilieira de Implantes Intraoculares and the International
Intraocular Implant Club on 25–27 August 1983 at the Rio
Palace Hotel, Rio de Janeiro, Brazil. Panel discussions,
courses, and a free paper session will be included on all
aspects of cataract and IOL surgery and related subjects,
with international participation. Further details from
Sociedade Brasileira de Implantes Intraoculares, Rua
Visconde de Silva, 52—gr. 501, Botafogo—CEP 22281, Rio
de Janeiro, Brazil.

International Symposium on Uveitis
The International Symposium on Uveitis will be held on
16–19 May 1984 in Espoo, Finland. Further information
from Duodecim, Mrs Leena Antikainen, Runeberginkatu
47 A, SF-00260 Helsinki 26, Finland.

X International Ergophthalmological
Symposium
The X International Ergophthalmological Symposium will
be held in Tampere, Finland, on 25–28 May 1984. Further
information from Duodecim, Mrs Leena Antikainen,
Runeberginkatu 47 A, SF-00260 Helsinki 26, Finland.

Correction
The paper entitled 'Intraocular lens power calculation for
planned ametropia: a clinical study,' by Jeffrey S. Hillman
(BJO 1983; 67: 255–8) contained a misprint in Table 3. The
second row under 'Dioptres' should have read 1.0 to 1.99
instead of 1.0 to 0.99. We regret this error.