

there were children with optic atrophy, macular degeneration, retinoblastoma, and bilateral retinoblastoma who would not be expected to derive much benefit from spectacles; there were also ESN(S) children and severely emotionally disturbed children, for whom there may have been valid non-optical reasons for withholding spectacles. A detailed analysis of reasons for lack of spectacle prescription among all children in this group had not been undertaken when the paper was published, and I felt therefore it would be inappropriate to make a comment about this group. Some of these data have now been analysed and will be submitted for publication in a further paper.

The second group of children whom Drs Charman and Jennings comment upon are those with isolated near vision defects; only a small proportion of all the children in this group had been prescribed spectacles. I was not surprised to find a low prescription rate in this group, since screening for defective near vision is not common in schools,¹ and such children would therefore rarely be identified. This group was, however, the only one among children with defective vision in which an associated educational disadvantage that might be attributable to their untreated hypermetropia was detectable.² It is therefore a group which is worthy of comment and, indeed, further investigation.

Hypermetropia is very common in primary school children. It may be that these children would all benefit from spectacles, but it is important, before embarking upon such treatment policy, that a controlled trial be undertaken to establish exactly how spectacles could be of benefit. Such a study is currently being planned in the Department of Child Health Bristol and the Department of Ophthalmic Optics UWIST Cardiff.

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- 2 Stewart-Brown S, Haslum M, Butler NR. Educational attainment of children with visual defects. *Dev Med Child Neurol* 1985; **27**: 498–503.

Screening for visual defects in preschool children

SIR, As part of the general ophthalmic service in Ayrshire and Arran Health Board primary orthoptic screening has been offered to all children at the age of 3½ since January 1978. A preliminary report of this has been published.¹ The methods used are often similar to those described by Ingram *et al.*,² but are always non-invasive and differ from those used by Ingram *et al.* in other ways. For example, the Sheridan Gardiner test (seven letters) is used for testing visual acuity, and the Frisby test is used for testing stereo acuity. Both those tests can give very accurate results and are eminently suitable for mass screening. Virtually no defects are missed and the false positive rate is approximately 1.5%. Unlike Ingram *et al.*, we consider an acceptable visual acuity to have to be at least 6/6.

We are now in the process of assessing the first five years of screening for both clinical effectiveness and cost effectiveness.

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- 1 Cameron JH, Cameron M. Visual screening of preschool children. *Br Med J* 1978; **ii**: 1693–4.
- 2 Ingram RM, Walker C, Wilson JM, Arnold PE, Dally S. Prediction of amblyopia and squint by means of refraction at age 1 year. *Br J Ophthalmol* 1986; **70**: 12–5.

SIR, I did know about the Camerons' paper in 1978, but overlooked reference to it, for which I apologise. I will await with interest publication of both their results of treating defective vision identified at 3½ and their methods of assessing 'cost effectiveness.' I still believe that a nationwide introduction of vision screening at 3½ should depend primarily on somebody being able to demonstrate that defective vision is more effectively treated if identified at 3½ than if it is left untreated until age 5+ (as at present).

I agree that the cost of any vision screening programme should also be considered, because we can no longer introduce a good idea just because it might be a 'good idea.'

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Atracurium and intraocular pressure

SIR, Murphy *et al's* paper on intraocular pressure (IOP) has just come to hand.¹ Their claim that the effect of atracurium had 'not hitherto been documented' is incorrect, as my coworkers and I studied and published² the effects of atracurium on IOP in 1984. It was nevertheless pleasing to see the results of our study independently corroborated.

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References

- 1 Murphy DF, Eustace P, Unwin A, Magner JB. Atracurium and intraocular pressure. *Br J Ophthalmol* 1985; **69**: 673–5.
- 2 Maharaj RJ, Humphrey D, Kaplan N, *et al.* Effects of atracurium on intraocular pressure. *Br J Anaesth* 1984; **56**: 459–63.

SIR, At the time of submission of our manuscript for publication there were no published reports on the effects of atracurium on intraocular pressure (IOP). Since that time two studies have been published apart from ours, that of Dr Maharaj *et al.*¹ and one by Tattersall, Manus, and Jackson.²