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SIR, Thank you for allowing me the opportunity to reply to Dr Simons's letter. Perhaps I may answer, one by one, the points he raises.

Firstly, we cannot say that those in our sample who presented before 3½, almost inevitably with a cosmetically noticeable squint, would necessarily have done so in other socioeconomic conditions. The particular set-up we have in that part of our district could have predisposed us to the findings we reported.

Secondly, I accept that our 'false negative' rate was derived from the screening methods we used. 26% of those ultimately found to have abnormal vision had a 'false normal' visual acuity and/or cover test when screened at 3½. Likewise, 20% of those ultimately found to have abnormal vision, had a 'normal' refraction at 3½ and would have been 'missed' by this test.

The question of 'false positives' is equally important, because they cause increased and unnecessary parental concern, work and financial expense. In our series 56.7% of those who recorded abnormal or uncertain vision at 3½, and 51.2% of those who had an abnormal refraction (using our criteria) at 3½, actually had normal vision without any treatment. The majority of the 'false abnormal' refractions were hypermetropia without astigmatism or anisometropia. I have since realised that, if we had chosen only astigmatism and/or anisometropia as the criterion for abnormal refraction, the percentage of false positives using refraction would have been reduced to 29.5%. If we had combined this with a cover test, I calculate we would have identified 85% of those with abnormal vision (excluding myopia). It might be possible to simultaneously test for an abnormal refraction and squint using the more modern developments of photo refraction. Nevertheless, some false positives and false negatives are both inevitable whatever method is used.

Thirdly, Dr Simons justifiably questions our method for stereoacuity testing. Maybe guessing and inadequate co-operation should not have been a problem, but they were. We found interpretation of the response to be too unreliable for use as a one-off, non-repeated screening test in the population sample we screened. This does not mean to say that others would also find this so.

I will admit to being slightly 'partisan' against testing for stereoacuity, but no more than I am against any other 'subjective' screening test. This is because in most cases defective visual acuity is associated with an abnormal refraction and/or a squint, and therefore I think that an objective test *should* be more accurate than a subjective one, particularly in preschool children. Having said that, we have not recommended screening by refraction—we merely advised against screening at 3½ by any method.

Finally, our views on the results of occlusion in these children are questioned again. I do not think that improvement to 6/6 is necessary before one can conclude that occlusion has been valuable. However, I wonder whether

one or two lines improvement in the range 6/18 to 6/9 is worthwhile, and I do believe that the standard treatment of amblyopia should be questioned.¹

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Reference

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Adverse reactions to guanethidine eye drops

SIR, I write to express my regret that guanethidine 5% with adrenaline 1% eyedrops have been voluntarily withdrawn by the company responsible for their manufacture.

I have for some years been concerned about the rare effects of antiglaucoma medication and other topical eye therapy on the conjunctiva and cornea.^{1,2} There is no question that these adverse effects are rare, unpredictable, and not normally dose or time related.

All topical therapy, in common with other medicines, carries both benefit and risk, and it is the job of the prescriber to calculate this risk/benefit ratio for any patient receiving treatment. I understand that at least 1000 patients whose glaucoma was currently controlled with guanethidine 5% plus adrenaline 1% have now been deprived of useful therapy. I believe that it would have been more appropriate for the company to insert a warning in the package advising that the combination had been associated with conjunctival cicatrization and advising that prescribers should monitor the outer eyes of patients receiving drops. In addition to depriving a large number of patients of useful treatment the decision to withdraw the drops also creates an unreal impression of safety. Any topical therapy can produce an unaccepted adverse reaction, and all prescribers will need to continue to watch for signs of these adverse effects, which are not limited to guanethidine and may even be associated with common constituents such as preservatives.

Responsibility for monitoring adverse effects as well as benefits will always be the prime duties of a prescribing doctor.

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References

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Book reviews

Neuro-Ophthalmology: Clinical Signs and Symptoms. 2nd edn. By THOMAS J WALSH. Pp. 499. US\$52.25. Lea and Febiger: Philadelphia. 1985.

This book was first published in 1978 and the revised edition includes chapters by a number of authorities to augment the