Correspondence

Foveomacular retinitis

SIR, Kuming's description¹ from South Africa of 10 cases of foveomacular retinitis as an entity distinct from solar retinopathy rekindles old controversies.^{2,3} A knowledge of the racial origin of their patients would be helpful, as a predominance of low pigmentation has been noted in other series.^{4,5} In view of more recent reports,^{6,8} including one example from our own series,⁹ indicating that sunbathing without direct sungazing may provoke this retinal lesion, there would appear to be only one aetiology.

Regarding the nature of the phototoxic macular lesion, I feel that a good clinicopathological correlation is achieved with recourse to experimental work.^{10,11} The essential finding is that of pigment epithelial depigmentation associated with filamentary proliferation giving rise to a feature designated as a fibrillar 'tuft' in our own report.⁹

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The statement that recent reports indicate that sunbathing without direct sungazing may provoke this retinal lesion is not accurate. Ridgway's report documents a patient who gazed at the sun while sunbathing. MacFaul documents only those cases who sustained a macula injury following direct gaze at an eclipse in 1966, except for case 19 who while sunbathing gazed directly at the sun for up to six minutes, and Gladstone's cases all admitted looking at the sun while sunbathing.

Thus one must disagree with the statement that there appears to be only one aetiology, as all the references quoted show that the patients concerned looked directly at the sun. The evidence quoted only confirms that direct sungazing is dangerous and to be avoided at all costs. None of my patients admitted sungazing, in fact all strongly denied this. In none of my patients was there a specific time of onset that could be related to any form of sunbathing or sun exposure.

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SIR, All the patients described in my paper were Caucasian. While agreeing that the aetiology is controversial, the fact still remains that my patients (and many others) flatly deny any direct gazing at the sun. Nowhere in the paper by Jacobs *et al* do they state that their one patient who sunbathed did not have direct exposure to the sun. It is not unlikely that their patient inadvertently opened his eyes while sunbathing, as did these patients described by Gladstone and Tasman.

The levels of sunshine in South Africa are far higher than that in the UK. Many thousands of patients take to the beaches to sunbathe throughout the year, yet the reported incidence of solar retinopathy in SA after sunbathing is practically nil.

Lenses for fundus examination

SIR, Many ophthalmologists in training, especially in the junior grades, are faced with significant expense when acquiring all the necessary tools of the trade. It may be of interest to know that there are alternative sources for some of these items, in particular the lenses used for fundus examination by the indirect method, using either the indirect ophthalmoscope or the slit-lamp microscope.

The Coil aspheric stand magnifier uses a high quality aspheric plastic lens and is available in powers of 20 and 28 dioptres. Removal of the legs (Fig. 1) leaves a perfectly functional lens which compares favourably with 'indirect' lenses costing 15 times as much. These lenses do of course scratch very easily and may need to be replaced every year or two.

90-dioptre aspheric lenses are extremely useful for examining the optic disc and macula, without the need for a contact lens, while the patient is sitting at the slit-lamp. Small lenses of approximately the same power are available

Fig. 1 Stand with legs removed.