



Fig. 1 Fluorescein angiogram in the late venous phase showing leakage of dye and surrounding choroidal hypofluorescence at the sites of photocoagulation.

application the embolus was noted initially to pulsate and then it melted, disappeared, and reappeared at the next bifurcation where treatment was reapplied, and the embolic material was seen to disappear into the peripheral retinal vascular tree. Unfortunately in this case there was no recovery of visual function. Fig. 1 shows the appearance of a fluorescein angiogram taken 24 hours after treatment. A further angiogram taken one week later demonstrated no vascular leak.

To our knowledge treatment of retinal emboli by long-duration, low-intensity argon laser photocoagulation has not hitherto been reported. Although in this case no visual function was restored, consideration could perhaps be given to this treatment in cases in which 'traditional' treatment has been unsuccessful.

GORDON N DUTTON
GEORGE CRAIG

Tennent Institute of Ophthalmology
Western Infirmary
Glasgow G11 6NT

Needle holder with gap joints

SIR, Although very fine suturing usually requires suture tying forceps, there are many circumstances when time can be saved by the use of the needle holder, especially, for example, in tying sutures used for closure of conjunctival or skin wounds and in operations for squint and retinal detachments. Sometimes the suture material is entrapped in, or even cut by, the joints of the standard needle holder.

Fig. 1 shows the modification of the joints which avoids this entrapment. There is a generous gap between the shoulders, which are also rounded off to prevent snagging (which may occur even when entrapment has been avoided). Box joints have also been incorporated, partly to reduce the height of the shoulders on each side but mainly to improve

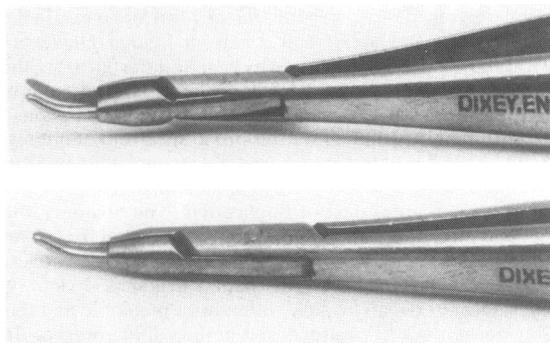


Fig. 1 Note the gap in the joints and round shoulders (upper) which prevent entrapment of sutures when the needle holder is used for suture tying. The box joints (lower) improve stability.

stability of the joints: box joints are not essential to the principle.

The basic needle holder we have chosen for this modification is the Barraquer pattern with curved jaws which has been such a fundamentally original contribution to ophthalmic and other surgery.¹⁻³ Other needle holders could be adapted in the same way. We have used this modified needle holder successfully in many operations, particularly for squint, eyelid surgery, and dacryocystorhinostomy.

The needle holder has been specially made by Dixey Instruments Ltd, 19 Wigmore Street, London W1A 4DU.

GRAEME I S MACKINTOSH
CALBERT I PHILLIPS

Ophthalmology Unit,
Department of Surgery (RIE),
University of Edinburgh,
and Princess Alexandra Eye Pavilion,
Royal Infirmary, Edinburgh.

Correspondence to Professor C I Phillips.

References

- 1 Roper-Hall M J, ed. *Stallard's eye surgery*. 6th ed. 1980: 23-5.
- 2 Arruga H. *Ocular surgery*. 1st ed. New York: McGraw-Hill, 1952: 20.
- 3 Harms H, Mackensen G. *Ocular surgery under the microscope*. 1st ed. Chicago: Year Book Medical Publishers, 1966: 40.

Book reviews

Eye Movement Disorders. Eds. E A C M SANDERS, R J W DE KEIZER, AND D S ZEE. Pp. 280. £79.95. Kluwer: Dordrecht, Netherlands. 1987.

This book constitutes the proceedings of a symposium held in the Netherlands in 1986. There are sections on anatomy and physiology, clinical and paraclinical (whatever that is) examination, ophthalmic causes of diplopia, myogenic disorders, neurology, and treatment. The various contributors are either ophthalmologists, neurologists, neurosurgeons, orthoptists, or basic scientists.