

editorial, contained no data on the general medical condition of the patients.

The study by Cole, Dodson, and Hendeles in this issue makes it clear that we have to review currently held convictions about the relationship between pre-existing glaucoma and CRVO. These authors have been able to show by a thorough examination of 43 patients with glaucoma and 24 with ocular hypertension presenting with a retinal vein occlusion, and a similar examination of a matched group without glaucoma or ocular hypertension, that the prevalence of the 'other' risk factors for retinal vein occlusions were remarkably similar in the two groups.

It should be emphasised at this point that Cole, Dodson, and Hendeles are not writing solely about unequivocal CRVO but are also including patients with shunt vessels on the disc as assumed CRVO. In addition, cases of branch and hemisphere occlusion (BVO and HVO) are included. They admit in their introduction that the association between CRVO and chronic simple glaucoma is more strongly supported in the literature than BVO, though they state that HVO has been reported as 'unquestionably related'.

I must admit that I have never held the view that BVO was significantly associated, so it comes as no surprise that the risk factors for these cases were the same whether they were in the primary glaucoma group or not. But the fact that the same applied to the CRVO cases certainly came as a surprise. One is perhaps just a little uneasy about the ready acceptance of old bypass vessels as proving prior CRVO, but, even if we were to assume that this was incorrect, nevertheless it does not seem likely that it would have materially altered the conclusions, especially as there

were only six such cases out of the total of 43 'CRVOs'.

After an exhaustive discussion in which consideration is given to every conceivable aspect of the relationship between IOP, blood flow, plasma lipids, blood pressure, treatment for blood pressure, glaucoma and treatment for glaucoma, and optic disc conformation and much more the authors come to the modest conclusion that glaucoma or ocular hypertension may have a less prominent aetiological role in venous occlusion than has been widely believed. I have to say that I believe they are possibly being too modest and their findings may well be confirmed by further studies of this nature to have more or less demolished the primary glaucoma—venous occlusion aetiological relationship which so many of us have accepted for so long, without ensuring that there was adequate evidence. If only I had used a sphygmomanometer as well as a tonometer back in 1955!

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#### References

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## Editorial: Postoperative eye padding

There was a time when an ophthalmic ward would be full of patients wearing not only one eye pad but two. At Moorfields they were fixed on by means of a brassiere-like contraption, but I have no doubt in other institutions there may have been other methods,

such as swathes of crepe bandage skilfully wrapped round the patient's head or even, in one surgeon's hands for certain patients, a plaster-of-Paris cast.<sup>1</sup> One of my earliest memories as a junior house-surgeon (the title of 'resident' was not in use in those

days) is of a senior surgeon who had just lost vitreous at the end of a classical Graefe knife—no sutures extraction, staring with some annoyance at the section, which was opening and shutting like the mouth of a fish, and then saying 'please put a pad on it.' It is difficult to accept nowadays that an eye could have been abandoned to its fate in such a manner, but one has to realise that sutures, cellulose sponge swabs, and even the idea of cutting vitreous with scissors, let alone with a high-tech machine, were outside the scope of normal ophthalmic surgical practice in those days; I am speaking of almost 40 years ago. But the eye pad had an important, almost mystical symbolic role as signalling the end of the operation and in continuity for the next fortnight or so guarding the patient against the evils of post-operative complications of various sorts. Whether it actually did any good is open to question, but it certainly helped the patient's and the surgeon's morale, and I have to admit that in the case just described the eye did not look too bad the next day. The gradual retreat from the double pad to the single, and in its turn to no pad, has been just a part of the gradual liberation of the patient from the 'doctor's orders' style of medicine in which lack of effective therapy was concealed behind a facade of impressive regulations, ceremonials, and treatments of dubious value.

The article on page 699 of this month's issue reminded me of the vitreous loss incident mentioned above and prompted me in turn to try to remember when I personally changed my attitude to eye padding. The first change would have been from double to single padding and the second to giving up the pad in favour of the cartella shield. I believe I may have given up double padding about 20 years ago but single-padding a considerable time later, probably

only a few years ago. I think that subconsciously I have always been a bit doubtful about padding, but nowhere have I felt this more strongly than in the case of postoperative hypotension with wound leakage or excessive subconjunctival drainage following anterior segment intraocular surgery. Squeezing out even more aqueous humour by the application of a firm pad and bandage has always seemed to me an inappropriate form of treatment or, to put it more bluntly, rather stupid.

However, one must not be too critical of padding. Many years ago I did an operation for strabismus on a charming ophthalmic nursing sister from my own hospital. As one would expect in such an important patient the first operation was not a complete success and a second had to be performed. The point of the story is that on one occasion we padded the eye and on the other we did not. I cannot remember if we padded the first or the second time, I rather think it was the second. Anyway she was quite definite in her opinion, the time she had the pad on postoperatively she was much more comfortable. This was clearly an inadequate scientific experiment, but nevertheless it convinced me that pads certainly have their uses, and one should not forget that, all other things being equal, the patient's comfort has to be remembered. It comes as no surprise, on reading the current article, to learn that the pad probably makes no difference to the bacteriology of the postoperative eye, and it seems that we are left with the final conclusion that to pad or not to pad is probably not a matter we should lose too much sleep over. Maybe we should leave it to the patient to decide.

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#### Reference

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