LETTERS TO THE EDITOR

Withdrawal of 0.6% Glauline (metipranolol)

Sir,—Following reports of a number of cases of anterior uveitis associated with the 0.6% strength of our ophthalmic β blocker, Glauline, we are now withdrawing this strength from the market. The 0.1% and 0.3% concentrations remain available for prescription as usual.

Our advice to ophthalmologists and general practitioners is that all patients managed with 0.6% Glauline should have their medication reviewed as soon as possible and changed to the 0.3% strength or to an alternative ocular hypotensive. If a patient presents a prescription for Glauline 0.6% following this notification, pharmacists are asked to contact the prescriber to confirm that it should be dispensed.

As we appreciate the difficulty in seeing all patients to make this change immediately, we will continue to make Glauline 0.6% available until 1 October 1990 to ensure that their prescriptions can be met in the interim. We will be recalling unused stock at a later stage.

We have written individually to ophthalmologists, general practitioners, and pharmacists concerning the withdrawal and would be grateful if you could include reference to it in your publication.

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Eye surgery in Eritrea

Sir,—We have just finished a ward round of 27 patients: 24 extracapsular cataract extractions with posterior chamber intraocular lenses, one anterior chamber intraocular lens, and two trabeculectomies. All the eyes look good; corneas were clear and only the anterior chamber lens a little hot.

All were done by an Eritrean in the air conditioned theatre of this rocket blasted hospital. We brought the equipment and lenses from Australia, and instructed and supervised. They did them.

The eye surgery is the first to be done here since the Eritreans recaptured Massawa Port some five months ago. It is certainly the first series of modern cataract operations to be done in this part of the world.

Many of the patients came from Danakel, said to be the hottest place on earth. One such man, an Afar of no more than 40 years, had the whitest of white cataracts. Like most of the others he was blind. But not now. In this place, ‘somewheres east of Suez, where... a man can raise a thirst,’ it is hard not to see a link between light, heat, and cataract. After all, Dahlak blindness (Lagarob keratopathy, climatic droplet keratopathy) is common here, as are corneal buring with clusters of spherical droplets.

We came via Sudan and the arid hills of Northern Eritrea. There, in a base hospital camouflaged and half underground, we did or instructed Eritreans (all but one not medically qualified), while they did another 25 or so cataracts with intraocular lenses. Locally produced Ringer’s lactate was used, with all corneas lustrous.

Travelling is tough by any standard—done at night in four-wheel drive vehicles over river beds. The equipment, previously tested in rural Nepal and outback Australia, is well packed and so travels without damage.

Africa, with about 500 million people, needs at least 3½ million eye operations each year just to keep up with cataract, glaucoma, and trachoma blindness. However, it has only about as many eye surgeons as Australia with its population of 17 million. The Eritrean medical assistants have good hands and need only microscope training and surgical tuition to become modern eye surgeons. As surgeons emerged from barbers, so must medical assistants in Africa become the ones to shoulder the enormous eye surgery load of this continent.

Eritrea’s battle to regain its identity has lasted almost 30 years. We have seen some of that conflict’s casualties. In a single camp 150 young people are blind from war-related injuries and intraocular foreign bodies. Most of the injuries would defy the skills of even the best vitrecomast, corneal graft, and anterior segment reconstructor combined. We have also seen many cases of sympathetic ophthalmitis. Perhaps earlier and more skilful microscopic trauma repair would prevent some of this.

The Eritreans, friendly, considerate, and hardworking, are well organised and keen to play a part in leading Africa into better times. This makes helping them an easy task. For good eye surgeons who can handle some ‘hard going’, we recommend an approach to the Eritrean Relief Association, 96 White Lion Road, London, N1 9PF, UK. Volunteers should expect to instruct rather than do, and bring and leave microscopes and other items as we have done.

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