LETTERS TO THE EDITOR

Laser card

SIR,—The management of diabetic patients in a large teaching hospital presents the medical and clerical staff with considerable logistical difficulties.

Many diabetic patients have to attend different specialist clinics: physicians, ophthalmic, renal, diabetic, foot, etc. The frequency of their visits to other departments such as the antenatal clinic may also be influenced by diabetes related problems. It can be a challenge to ensure that the medical records will be available at each and every visit. This might involve chasing sets of notes in various offices, clinics, and wards, sometimes located on more than one site. Furthermore, some departments like the renal unit may be understandably reluctant to release the records of patients due to have dialysis or awaiting transplants. The diabetic department at our hospital has found it useful to have its own records. However, this entails having a separate filing system. It would clearly be impracticable for each department to do the same; moreover this would cause a major breakdown of communication between the various specialists looking after a patient.

It is not surprising therefore that the phenomenon of 'missing notes' is commoner in teaching hospitals.[1] This leads to significant clinical difficulties and can affect patients' confidence in the system or the treatment. It also has a detrimental effect on auditing.[2]

The proper management and follow-up of diabetic retinopathy depends to a large extent on the availability of well documented medical records. In view of the limited time and number of ophthalmologists, and because the laser unit is located on the ward rather than in the outpatient department, it is not possible to perform laser treatment during clinic time. This is done in parallel with theatre sessions. The inevitable increase in number of patient attendances is associated with a higher incidence of missing records. This is further complicated by the possibility of entering clinical and treatment details in general, diabetic, or temporary sets of notes. No full and complete sequence will be available in any such record. This lack of continuity may have serious clinical and medicolegal implications.

The suggestion that each patient could hold his own record is attractive but can be achieved only if and when all records are computerised; otherwise it would involve a considerable amount of duplication. However, a simple compromise between such a system and the present one can be reached. We have designed a laser card (Figs 1 and 2) which is issued to every patient who requires laser treatment. It serves the purpose of an appointment card and provides the patient and the attending nurse with some useful information. More importantly, space is available in order to enter the treatment indicated (eg, focal above fovea, panretinal photo-coagulation (PRP), as well as details of the treatment performed. Diabetic patients are quite used to holding treatment cards and should have no problem handling the laser card.

In our experience the laser card has proved to be particularly useful when medical records are missing but it is also a convenient way to find out, at a glance, the total amount of treatment each eye has received. This can be helpful in prospective or retrospective studies which would otherwise be undermined by missing notes. The application of a similar system to various clinical practices could contribute to making data easily available for auditing.

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1 Gulliford MC, Petruckevitch A, Burney PGJ. Hospital case notes and medical audit: evaluation of non-response. *Br Med J* 1991; **302**: 1128–9.
2 Williams JG, Kingham MJ, Morgan JM, Davies AB. Retrospective review of hospital patient records. *Br Med J* 1990; **300**: 991–3.

ABOUT YOUR TREATMENT

IT WILL BE NECESSARY TO ADMINISTER EYE DROPS BEFORE YOUR LASER TREATMENT WHICH ARE LIKELY TO TEMPORARILY BLUR YOUR VISION.

IT WOULD BE ADVISABLE TO AVOID DRIVING ON THE DAY OF TREATMENT.

PLEASE NOTIFY US IF YOU ARE UNABLE TO ATTEND. OUR TELEPHONE NUMBER IS ON THE FRONT OF THIS CARD.

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CAMBERWELL HEALTH AUTHORITY
KING'S COLLEGE HOSPITAL
DENMARK HILL
LONDON SE5 9RS
TEL: 071 274 6222 Ext. 4819

LASER TREATMENT RECORD

NAME:
ADDRESS:

HOSPITAL NO:

PLEASE GO TO WILLIAM BOWMAN WARD ON THE 1ST FLOOR OF THE NEW WARD BLOCK.

PLEASE LET A MEMBER OF THE NURSING STAFF KNOW YOU HAVE ARRIVED.

NURSING STAFF
PLEASE DILATE EYE(S) AS INDICATED INSIDE THIS CARD WITH:

G TROPICAMIDE 1%
G PHENYL EPHRINE 10%

Figure 1 Laser treatment card.

RIGHT					LEFT				
DATE	TIME	Rx Indicated	Rx	INITIAL	DATE	TIME	Rx Indicated	Rx	INITIAL
6.9.91	9.00 am	FOCAL ABOVE FOVEA	15 x 100 µm x0.4w x0.1sec	W.A.	11.11.91	9 00 am	PRP	800 x 500 µm x 0.4 w x 0.1sec	W.A.
					25.11.91	9.00 am	PRP		

Figure 2 Reverse of card indicating treatment given.

Delayed ciliochoroidal detachment following intraocular lens implantation

SIR,—We read with interest the recent article by Dawidek *et al.*[1] The authors suggest that the ciliochoroidal detachment in their cases was due to ciliary sulcus fixation of the implant. We reported[2] hypotony and ciliochoroidal detachment following uneventful phacoemulsification due to traction on ciliary processes adherent to the posterior capsule and lens remnants. Surgical capsulotomy cured the ciliochoroidal detachment. Magruder *et al*[3] confirmed our observation. They reported a case of ciliochoroidal detachment that occurred after extracapsular cataract extraction with posterior chamber intraocular lens implantation which was cured by Nd:YAG laser capsulotomy. These two cases support the concept of ciliary body traction by the posterior capsule as a cause of ciliochoroidal detachment. Unfortunately the authors did not mention the status of the posterior capsule in their patients. We believe that capsulotomy should be considered in cases of ciliochoroidal detachment following extracapsular cataract extraction. Removal of

the implant as suggested by the authors is probably unnecessary.

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1 Dawidek GMB, Kinsella FM, Pyott A, Hughes DS, Kyle PM, Lane CM. Delayed ciliochoroidal detachment following intraocular lens implantation. *Br J Ophthalmol* 1991; **75**: 572–4.
2 Geyer O, Godel V, Lazar M. Hypotony as a late complication of extracapsular cataract extraction. *Am J Ophthalmol* 1983; **96**: 112–3.
3 Magruder GB, Harbin TS. Ciliochoroidal detachment associated with stretched ciliary processes. *Am J Ophthalmol* 1989; **106**: 357–8.

Reply

SIR,—We wish to thank Geyer and Lazar for kindly pointing out a further possible cause of late ciliochoroidal detachment following extracapsular cataract extraction. In their case and that reported by Magruder and Harbin a peripheral iridectomy was performed which allowed subsequent visualisation of the ciliary processes in that area. With our three cases, although the posterior capsules were all intact, none had a peripheral iridectomy. It was not possible, therefore, to see if ciliary process traction were present. However, the posterior capsule was flaccid, and this suggests that traction was not significant. Furthermore, our three cases all responded briskly to high dose oral steroids. Neither oral nor topical steroids could be expected to relieve ciliary process traction. The resolution of the ciliochoroidal detachment in all three cases following drug treatment strongly suggests that persisting ocular inflammation and altered permeability of the blood aqueous barrier were present. These could be due to ciliary sulcus fixation of the implant. Although posterior capsulotomy cured the ciliochoroidal detachment in the two cases described in the above letter, it is worth considering that capsulotomy itself may be complicated by cystoid macular oedema and retinal detachment.

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Optic foraminal radiography – a redundant investigation?

SIR,—The paper by Kincaid and Dutton[1] illustrates an example of medical practices which are passed on, almost anecdotally, for many years without there being any hard evidence to support them.[2] Undoubtedly optic foramen views *can* show evidence of glioma, meningioma, etc where these exist but to conclude that they are therefore worth doing routinely is illogical.

A fair proportion of medical practice can be shown to be based on unsound logic. Another example is Professor Eddys' discovery that the established treatment of glaucoma had been passed down through the generations since 1906 without any controlled trials ever being done to support it.

The authors are to be congratulated on pointing out the inefficiency of routine optic foramen views and on the consequent saving of resources and the reduction in radiation dose to future patients.

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1 Kincaid, W, Dutton GN. Optic foraminal radiography — a redundant investigation? *Br J Ophthalmol* 1991; **75**: 665–6.
2 Smith R. Where is the wisdom. . . ? The poverty of medical evidence. *BMJ* 1991; **303**: 798–9.

Installing a database for the retrieval of fluorescein angiograms

SIR,—We have developed a computerised database filing system for the storage and retrieval of fluorescein angiogram records. This was achieved by harnessing a novel coding and classification system to a frequently used database program. The system was devised to replace the manual punch card filing system for fluorescein angiograms 7 years ago. It was originally written for an Apricot Personal Computer, using the dBase II software package and has now been modified to run on an IBM 386 compatible hard disc computer running dBase 3+, but it remains downwardly compatible with all MSDOS computers. The use of current classification systems[1-3] was entertained but rejected because of lack of detail. Fortunately this allowed us to structure the database according to our specific requirements, which included:

(1) A new four-section request and report form.

(2) A new coding structure to meet the future research and data retrieval requirements.

(3) Computerised storage of patient and consultant details.

(4) A user-friendly system allowing data access without prior computer knowledge, rapid and simple data entry.

(5) A multiple layer data security system.

The request and report form was drawn up to enable the medical photography department (Fig 1) to ascertain the indications and special features to be assessed with angiography. It has the additional benefit of allowing the doctor to write the report without the need to refer back to the patient's records. Specific photographic problems and details are recorded, and the report is summarised and coded for computer data entry. After the angiogram is entered into the database the form is then stored with the angiogram for security.

The success of a database is ultimately dependent on its ease of use. The tedious and time-consuming parts of database use are data input, and a system had to be developed which matched this task with the training and motivation of the staff available. The two fundamental questions to be answered were whether or not to code and how much information to record.[4,5] Coding is helpful in that it eliminates the problems caused by synonyms in medical terminology. This saves time, because a non-coded system requires to be extensively validated at the time of data entry. Coding has the further advantage of enabling data to be easily classified. Each digit is used in a hierarchical fashion in which the first digit describes the general entity, while each succeeding digit specifies greater detail. We decided to limit the codes to diagnosis only rather than break down the data into further detail. This uniaxial approach would satisfy the requirements of simplifying data input and note retrieval, but would preclude a more detailed analysis on the basis of data contained in the

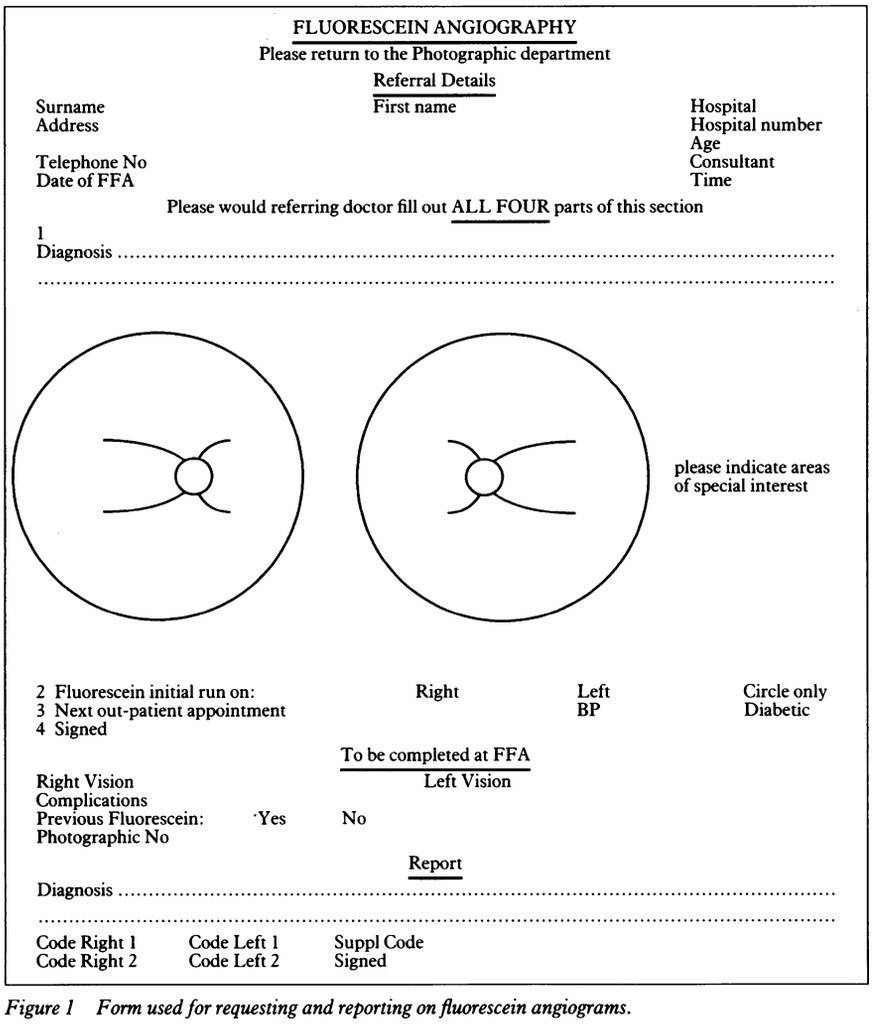

Figure 1 Form used for requesting and reporting on fluorescein angiograms.