the implant as suggested by the authors is probably unnecessary.

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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 oral capsule in all three cases detachment treatment were expected. Although the in processes possible, therefore, none had a significant.


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 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.

Optic foraminal radiography - a redundant investigation?

Sir,-The paper by Kincaid and Dutton1 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 foramens 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 un sound logic. Another example is Professor Eddy's 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 foramens views and on the consequent saving of resources and the reduction in radiation dose to future patients.

F STUBBS
Department of Biomedical Science, Sheffield University, Sheffield


FLUORESCEIN ANGIOGRAPHY
Please return to the Photographic department

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<th>Address</th>
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Referral Details

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Please would referring doctor fill out ALL FOUR parts of this section

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2 Fluorescein initial run on:
3 Next out-patient appointment
4 Signed

Right
Left
BP
Diabetic

Right Vision
Complications
Previous Fluorescein:
Yes
No
Photographic No

Report

Diagnosis

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

(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.1 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 requirement of simplifying data input and note retrieval, but would preclude a more detailed analysis on the basis of data contained in the