anaesthesia. It could be argued that the low incidence of complications in the survey reflects inadequate monitoring but a serious complication would be hard to miss.

The survey suggested that most surgeons performing intracocular surgery under local anaesthesia in UK hospitals have an anaesthetist present. Fifty per cent of surgeons did not secure intravenous access. Of the surgeons who reported that they had encountered life-threatening situations only 56% routinely had intravenous access.

The opinion was divided on the need for an anaesthetist to be present. While 55% thought that an anaesthetist should be present, in practice about one third of those who did, had covered this available. Several surgeons pointed out that they were practising cataract surgery in a district general hospital where the eye theatre was part of a much larger theatre suite and anaesthetists and the crash team were always available. The situation may be different in a dedicated eye hospital.

I conclude that in the UK the incidence of life threatening complications of local anaesthesia in cataract surgery is probably lower than that reported by Hamilton et al.1 It would seem that a comprehensive long term prospective survey of experience in the UK might be helpful in providing guidance on this subject.

Life expectancy in keratoconus – correction to data used

EDITOR,—In 1992 we published a paper in the journal on life expectancy in keratoconus. Since publication it has become apparent that the most appropriate analysis of the data was not used. Additionally, information became available for some patients who were originally classified as untraceable. Thus, it has been appropriate to reanalyse the augmented data.

Patient records from the keratoconus clinic at Moorfields Eye Hospital were used to identify 313 patients (193 male and 120 female), born before 1951, who were known to be alive in 1982. These patients were followed up during 1991 to identify the number of deaths within the sample; in order to investigate the hypothesis that underlying connective tissue disease was common in patients with keratoconus. Actuarial techniques for constructing life tables were used to calculate the expected number of deaths within the sample (separated by sex) of the patients had experienced the mortality indicated in English Life Tables Number 14 (ELT14). These tables are based on the mortality experience in England and Wales during 1980–2. As in the previous analysis though, it was also possible to incorporate prior knowledge of the social class distribution of patients attending the clinic.

For males, the expected number of deaths based on ELT14 was 7·6 and incorporating prior knowledge about social class reduced the expected number of deaths to 6·2. There were seven actual deaths recorded. For females, the expected number of deaths was 5·7 and five deaths were recorded. In each case the predicted number of deaths is very close to the number of deaths observed. Thus, the data do not suggest that patients with keratoconus suffer higher mortality than the general population.

The results of our new analysis are entirely consistent with the conclusions drawn in the original paper.

L C M MOODALEY
E G WOODWARD
L J CLIU
R J BUCKLEY
D S F BLOOMFIELD
Contact Lens and Precorneal Department, Moorfields Eye Hospital, City Road, London EC1V 2PD


ECCE for advanced cataracts in Africa

EDITOR,—Cataract surgery in developing countries has received increasing attention over the past few years with controversy over appropriate methods. We conducted a prospective audit to determine the success of routine extracapsular cataract extraction (ECCE) for age-related cataract in Malawi. All patients presenting to a central hospital with age-related uncomplicated cataract underwent ECCE by one surgeon. A total of 295 eyes of 292 patients (mean age 66) were analysed. Preoperative visual acuity was light perception in 224 (77%) eyes; 85 (28.8%) of the lenses were hypermetra-

2 The overall vitreous loss rate was 8% (95% confidence interval 5.6–12%). There was a significant association (p=0.002) between vitreous loss and the maturity of the cataract. An improvement in preoperative visual acuity, from light perception to hand motion was associated with a decrease in vitreous loss from 11% to 1·5%. The risk of vitreous loss with hypermaturity was 10·2 times that of vitreous loss if preoperative vision was better than light perception. We believe this is related to changes in the capsule which do not occur until the cortex in opacified (usually the case in light perception cataracts). Attempts to tear or puncture a tough capsule with a cystotome frequently lead to tears in the zones.

Although not associated with vitreous loss, the posterior capsule neomembrane was in 15 (18%) eyes with hypermature cataracts because it was flapping in the visual axis or had unremovable central opacities.

These findings may have relevance to policy recommendations for appropriate surgical techniques in populations with very advanced cataracts. Although there are reports of success with routine ECCE with posterior chamber intraocular lenses in large populations in Asia,1 the patients had significantly fewer light perception and hypermetraic lenses than ours. Asian patients with cataract may also be younger than African, and age may contribute to zone fragility. In addition, there are important socioeconomic, manpower, and infrastructure differences between Asia and Africa; what is possible in one area may be inappropriate in another.

SUSAN LEWALLEN
PO Box 273
Blantyre, Malawi

BOOK REVIEW


This American textbook is well laid out. Each of its nine chapters starts by defining its 'objectives' and the skills required to attain...