CORRESPONDENCE

Ophthalmic services for children

EDITOR,—It was with interest that I read the report of the joint working party produced by the Royal College of Ophthalmologists and the British Paediatric Association, December 1994. This is an excellent report, clearly presented and easily readable. The report makes many very worthy recommendations, but a degree of public debate will be required to bring these recommendations into being. I would like to highlight a few points:

(1) Do paediatric senior house officers (or obstetric senior house officers, if there are no resident paediatricians) actually receive at least one tutorial near the beginning of their 6 month post by an ophthalmologist in most hospitals? (Ch 1.5). If not, in the same way that many units provide teaching for casualty officers, should we not likewise for the paediatricians? This teaching could be provided by a registrar or senior registrar.

(2) With respect to screening for retinopathy of prematurity (Ch 4.1.1), the report states ‘a designated ophthalmologist, suitably trained, should provide this service’. In many hospitals no one provides this service, and in some it is delegated to the registrar. The question ‘Is this acceptable?’ should at least be asked.

(3) Chapter 7, paragraph 4, of the report advises that a multidisciplinary visual disability team should be established in each district to assess children, inform, counsel, and offer practical support to families. I have been completely amazed at how little parents know about available practical support for their chronically handicapped child. (Few have even heard of toy libraries or have got a copy of the BBC’s In touch handbook.) I would suggest it is our responsibility to inform them and to initiate the establishment of district visual disability teams.

I would be very interested to hear the views of colleagues.

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Proliferation of lens epithelial remnants after Nd:YAG laser capsulotomy

EDITOR,—Jones and colleagues recently described massive proliferation of lens epithelial remnants following Nd:YAG laser capsulotomy in patients with pre-existing retinal pathology.1 We would like to add to their contribution by describing a similar case but with no associated retinal pathology. Our patient, an 80-year-old woman, had bilateral open-angle glaucoma associated with anterior capsulotomy. Owing to uncontrolled intraocular pressures she had undergone bilateral drainage procedures by trabeculectomy. Three years later she had a left extracapsular cataract extraction. Visual acuity improved from 6/30 to 6/6 but 9 months later an Nd:YAG laser capsulotomy was necessary because of progressive posterior capsular opacification reducing visual acuity to 6/18. Visual acuity initially improved to 6/9 but deteriorated over the following 6 month period to perception of light only, as a result of the proliferation of vascularised lens/capsular remnants anterior and posterior to the intraocular lens. Anterior lens capsular remnants were noted on slit lamp examination in the right eye, which had not been previously noted. The capsular remnants in the left eye were excised by an anterior cortico-capsulotomy using a posterior vitreoretinal probe and anterior infusion.

Brooks and associates have postulated that anterior segment ischaemia may be found in association with pseudoxeolisation of the lens capsule.2 This would help explain the presence of bilateral vascularisation of the capsule in this patient. It may also explain the proliferation of capsular remnants anterior to the intraocular lens. Nd:YAG laser capsulotomy seems to promote proliferation of the lens epithelium;1 in the setting of anterior segment ischaemia it may lead to massive proliferation.

This would suggest that lens capsule neovascularisation can occur with pseudoxeolisation in eyes that have undergone anterior segment surgery and patients with both features are also at risk of lens cell proliferation following Nd:YAG laser capsulotomy which may result in a profound decrease in visual acuity.

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Replay

EDITOR,—The rationale for the choice of treatment described in our letter to the British Journal of Ophthalmology in 1989 was as follows:

(1) The melting point of cholesterol is such that the cholesterol of synthetic scintillators in the anterior chamber of an aphakic eye disappears when a hairdryer is played upon the closed eyelids.

(2) Cholesterol, like xanthophyll, is yellow and thus will absorb blue light with conversion to heat. (We did not anticipate that the green component or the argon laser light would heat the yellow embolus to the same degree and for that reason did not filter out the blue light.)

(3) Warming of the embolus requires a continuous application of energy until plaque particles of less than 105 μm reliably produced both retinal and intraocular lenses. Visual acuity initially improved to 6/9 but deteriorated over the following 6 month period to perception of light only, as a result of the proliferation of vascularised lens/capsular remnants anterior and posterior to the intraocular lens. Anterior lens capsular remnants were noted on slit lamp examination in the right eye, which had not been previously noted. The capsular remnants in the left eye were excised by an anterior cortico-capsulotomy using a posterior vitreoretinal probe and anterior infusion.

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