The success rate of those cases with less than three lashes per lid was 75-6% while the overall success rate was 62-6%. This is in accord with other authors’ findings. Sharif explained this by the number of laser burns per lash. Our findings show the association between lower recurrence rate and higher number of burns per lash: with no recurrence there were 16-7 burns per lash and with recurrence there were 14-7 burns per lash. However, this association cannot be proved statistically. Another possible explanation is that in those lids with high number of aberrant hairs the disease leading to trichiasis is still active and the hairs regrow after treatment.

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Electroretinogram as indicator of prognosis of central retinal vein occlusion

EDITOR,—Matsui and colleagues reported on ERG b/a wave ratio changes in central vein obstruction and conclude that retinal ischaemia in ischaemic central retinal vein occlusion (CRVO) cannot be reversible. This result is surprising, as the natural history of ischaemic CRVO has been clearly documented correlating the degree of retinal ischaemia with the development of neovascularisation— a process that may only be reversed by panretinal photocoagulation (PRP). Their findings are based on investigations including fluorescein angiography (FA) and electroretinogram (ERG), both of which are now better understood.

Firstly, with respect to the FA results in the good prognostic groups which supposedly illustrate resolution of retinal ischaemia. In case 3, the initial FA at 1 month was masked by retinal haemorrhages and the degree of ischaemia cannot be determined owing to the absence of peripheral photographs. Therefore, the FA at 5-5 months, said to show significant improvement, merely shows the predictable changes expected in a well perfused CRVO. Despite inaccuracies in statements regarding the timing of treatment and photography in case 1 (Fig 4), we feel there is no evidence of improvement of ischaemia (in accordance with the caption) the recovery FA at 5-5 months; this clearly demonstrates marked capillary dropout and macular ischaemia. It also demonstrates PRP which was supposedly not performed until 11 months.

Secondly, different ERG techniques were used with only one set of normal values and no affirmation that each individual patient was always examined using identical techniques.

Thirdly, the ERGs in Figure 2 show a speculative b-wave identification on an ERG with no replication, and result in a markedly localised CRVO than when initially seen. The b-wave were taken at the first visible peak, a very different amplitude value would be obtained. What were the criteria for b-wave identification?

Finally, following PRP, if case 1 stabilised, how do the authors explain such marked trial to trial variations in a- and b-wave amplitude (Table 1)? What is the expected intercurrent variability for their laboratory (normally about 10%)?

We therefore suggest that Matsui et al re-evaluate the results of comparison with the study of the old values. Only two cases were recorded with the new system. ERG data used in those two cases were those recorded with bright single flash, strong enough to record oscillatory potential. The device was compared with that of the old system. Only ERG b/a ratio was used in those two cases.

Thirdly, Cordeiro & al of mentioned that b-wave identification in Figure 2 was speculative. This criticism would not have been taken if we had to measure the b wave from this recording only. We routinely record ERG on EEG recording paper simultaneously with the electro-oculogram. In the reading on the EEG paper, whose paper speed is much slower, identification of the b wave is easy. We recorded the amplitude from both the findings.

Finally, Cordeiro et al questioned if case 1 was stabilised, why was there a marked a- and b-wave amplitude variation after PRP. It would be wishful thinking that the retinal function would be stabilised after PRP. Obviously, it was not only the change in the fundus appearance after PRP besides the scar formation on the laser spots, such as haemorrhage or vascular anastomosis during a long observation period after PRP, as described in the text. Vision fluctuated too. Therefore, it is not surprising to see some fluctuation of the ERG findings. In spite of this fluctuation, there was a trend in which the a-wave declined and the b-wave improved. Therefore, the suggestion was made to repeat the study with greater scientific stringency. Such a study requires a long time if done by one institute. A nationwide study in CRVO has been recently completed in the United States in which multiple medical centres participated. This study included ERG and FA. The results of the study may disclose a similar case. Namely, ischaemia in CRVO may not be permanent and may be reversible in some.

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Effect of trabeculectomy on pulsatile ocular blood flow

EDITOR,—We read with interest the paper by James.

An increase of pulsatile ocular blood flow (POBF) was found in the standing position following trabeculectomy. This was attributed to an increase in perfusion pressure which is expected with reduction of intraocular pressure (IOP) assuming autoregulation was absent.

In the lying position, however, POBF was unchanged following trabeculectomy despite similar magnitudes of IOP lowering. It was suggested that in this group, because of the extremely high IOP in the lying position preoperatively, the POBF was somehow maintained at an elevated level by autoregulatory mechanisms which masked any improvements due to POBF after surgery. This was also felt to be responsible for the regaining of the usual postural changes following trabeculectomy.

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