High prevalence of lactose absorbers in patients with presenile cataract from northern Sardinia

EDITOR,—An elevated incidence of cataract has been observed by Simoons et al in high milk drinking populations. Other studies have found that the percentage of lactose absorbers among subjects with cataract was higher than in the normal population. We studied 40 adult male subjects with cataract (they were aged less than 56 years and more than 44 years), and 50 healthy similarly aged control males from northern Sardinia. Milk drinking habits were similar to the two groups. None of the patients was affected by cataract due to congenital, inflammatory, iatrogenic, diabetic, traumatic factors, or other causes. Thirty-five of the 40 cataractous subjects had bilateral cataract, 23 of whom had normal, seven cortical posterior, six corneal, two posterior polar, and two zonular cataract. All the subjects were given a 50 g oral load of lactose as a 15% water solution; the hydrogen breath concentration in the expired air was measured in each subject before the lactose oral load and at 15 minute intervals for the next 4 hours, using a Quintron 121 gas chromatograph. Lactose malabsorption was diagnosed if the maximum increase in hydrogen in the expired air was more than 20 parts per million. Only seven (14%) of the 50 normal subjects were lactose absorbers compared with 16 (40%) of the 40 cataractous subjects. The x² test revealed a significant difference (p<0.01) in the frequencies of the two groups. One fact that may be emphasised is that all the lactose absorber cataractous patients had bilateral nuclear cataract; the difference between the frequency of this subgroup and the control group is highly statistically significant. These results confirm that in our region (northern Sardinia), characterised by high milk drinking habits, adult lactose absorbers are more prone to develop presenile cataract than non-lactose absorbing individuals.

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In defence of goniotomy

EDITOR,—O'Connor's editorial states that 'primary trabeculotomy has replaced goniotomy as the preferred surgical treatment for congenital glaucoma'. To support this statement he cites Burke and Bowell’s report of an 87% success rate for primary trabeculotomy based on 13 eyes with primary infantile glaucoma and a mean follow up of 3-9 years. Rice has reported an 86% success rate (212/246 eyes) for goniotomy for eyes with primary infantile glaucoma which in the majority (73%) of cases only required a single procedure. We reported a large long term follow up study of Rice and Lister’s patients with trabeculodysgenesis (339 eyes) in which we showed that 92% of eyes controlled in infancy by goniotomy were still controlled after 5 years of follow up; however, Kaplan-Meier actuarial survival curves demonstrate that there is a risk of relapse throughout life. The risk of relapse in eyes having undergone trabeculotomy in childhood is significant especially if antifibroproliferative agents are not used. The advantage of a primary goniotomy is that the conjunctiva is preserved for any future drainage procedures and for individual children, if they are to have a drainage operation, it will be when they are older and young age is a significant negative factor in bleg survival. Also there hopefully will have been advances in both surgical skills and in agents used to improve bleg survival.

O'Connor also cites Miller and Rice advocating primary trabeculotomy. This appears to be a misquote as their paper reports trabeculotomy being performed in eyes with relapse or failure of control of congenital glaucoma after goniotomy or trabeculotomy.

My remarks refer entirely to eyes with typical primary congenital glaucoma (tra- veculodysgenesis or the Hoskins classification4), which is the commonest form of congenital glaucoma seen in the UK and to the results for a surgeon experienced in the technique of goniotomy. Examination of the angle is crucial when planning the surgical approach. Goniotomy should never be performed without a view of the angle. However, a view of the angle can be usually achieved by removal of the corneal epithelium. O'Connor states that goniotomy cannot be performed in approximately 50% of cases of congenital glaucoma because of corneal opacity. However, we found that in addition to the 211 patients reported in our study to have been treated by goniotomy, only a further 20 patients (<10%) with trabeculodygenesis were seen during the same time but were excluded from our paper as the initial surgery was not goniotomy. In most of these cases a primary trabeculotomy was performed as an adequate view of the angle could not be achieved because of corneal clouding. Trabeulocytotomy can be performed at a temporal, or even inferior, port-cuts to preserve the superior bulbar conjunctiva. The congenital glaucoma which occurs in Middle Eastern countries is more often familial than it is in the West5 and may respond less well to goniotomy. O'Connor makes an extensive reference to the angle anomaly (personal observation). I note that Elder's paper in the same issue of the BJ OJO relates to his experience in Jerusalem. It may be that in this population and in eyes with iridotrabeculodygenesis with infantile onset glaucoma, combined trabeculotomy—trabeculoplasty may be a useful operation.


Contemporary lenses

No reply to my letter of 29 October about the use of the term contemporary lenses is awaited. If such lenses are now available the concept of surgical adjustment to control the surgical outcome is now important.

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1 Simoons FJ. A geographic approach to senile cataracts: possible links with milk consumption, lactase deficiency and galactose metabolism. Die Diasc 1982; 37: 257-64.

Adjustable sutures in eyelid surgery

EDITOR,—I would like to comment on the article by J R O Collins and E A O'Donnell.1 In that article, they suggested that their technique of postoperative adjustment of lid height is new. Work I have done shows that the adjustable suture technique was introduced in 1982 and has been used with modifications for 12 years.2

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