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.1 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 for the two groups. None of the patients was affected by cataract due to congenital, inflammatory, intraocular surgery, or trauma. All other causes were excluded. Thirty-five of the 40 cataractous subjects had bilateral cataract, 23 of whom had nuclear, seven had cortical posterior, and two had 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 2-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 χ² test revealed a significant difference (p<0·01) in the frequencies of the two groups. One fact that must 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 hight 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 trabeculectomy has replaced goniotomy as the preferred surgical treatment for congenital glaucoma’.1 To support this statement he cites Burke and Bowell’s report of an 87% success rate for performing trabeculectomy based on 13 eyes with primary infantile glaucoma and a mean follow up of 3–9 years.2 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.3 We reported a large long term follow up study of Rice and Lister’s patients with trabeculodygenesis (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.4 The risk of relapse in eyes having undergone trabeculectomy in childhood is significant especially if antifibroplastic agents are not used.5 The advantage of a primary goniotomy is that the conjunctiva is preserved for any further drainage to or for individual children, if they have to have a drainage operation, it will be when they are older and young age is a significant negative factor in bleb survival. Also there will hopefully have been advances in both surgical techniques and in agents used to improve bleb survival.

O’Connor also cites Miller and Rice6 as advocating primary trabeculectomy. This appears to be a misquote as their paper reports trabeculectomy being performed in eyes with relapse or failure of control of congenital glaucoma after goniotomy or trabeculectomy.

My remarks refer entirely to eyes with typical primary congenital glaucoma (tra- beculodygenesis (using the Hoyt classification)6, 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 because the initial surgery was not goniotomy. In most of these cases a primary trabeculectomy was performed as an adequate view of the angle could not be achieved because of corneal clouding. Trabeculectomy can be performed at a temporal, or even a superior, conjunctival excision. The congenital glaucoma which occurs in Middle Eastern countries is more often familial than it is in the West and may respond less well to goniotomy. O’Connor cites a more extensive angle anomaly (personal observation). I note that Elder’s paper in the same issue of the BJ OJO relates to his experience in Jerusalem.8 It may be that in this population and in eyes with iridotrabeculodygenesis with infantile onset glaucoma, combined trabeculectomy–trabeculotomy may be a useful operation. I, therefore, read his paper with interest and look forward to him reporting a longer follow up.

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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 stated 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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Reply

EDITOR,—In 1982, Small used a posterior approach technique to excise Muller’s muscle and recess the aponeurosis with two monofilament polypropylene mattress sutures passed through the levator aponeurosis. If the suture “relapse” he modified the technique to an anterior approach, cut the levator muscle above Whitnall’s ligament and held it recessed with a 6/0 monofilament polypropylene mattress suture brought through the skin. The suture is adjusted if necessary immediately after recovery from anaesthesia but by bringing the suture through a rubber cylinder cut from the edge of a surgical glove, the adjustment can be modified during the first postoperative week before finally tying the suture.

His paper shows some very impressive results and our recent paper confirms that adjustable sutures are very effective in treating lid retraction. We recess Muller’s muscle with the aponeurosis and thelevator muscle via an anterior approach and maintain the