

tion (HESP) forms to permit a visit to an optician in order to obtain a low vision aid is not only notoriously expensive and wasteful, but is also not very helpful for the patients. The editorial suggested that reports of alternative models of low vision aid (LVA) services are 'essential' so that we can all learn from each other when setting up new clinics. The paper by Shuttleworth *et al*² in the same issue of the *BJO* is one such encouraging report. From Reading, a paper is in preparation reporting our experiences. Interestingly, our LVA clinic was set up as a result of a senior house officer's audit into our existing 'service' (HESP forms). The surgical business unit manager, who was genuinely motivated by a desire to establish a better service for the patients (as well as the obvious financial implications), worked closely with the SHO and the hospital audit department. The fact that the manager had been involved from the start, and had participated in the original audit meeting, undoubtedly helped in the process of the establishment of the LVA clinic. The presentation to the whole department at the audit meeting enabled interested colleagues, such as the orthoptists, to state what role they wanted to play in the training of the patients to use the LVAs. Subsequently, the orthoptists, in fact, liaised with the sensory needs department and the new clinic now also has input from the sensory needs service.

This was an example of a junior's audit project conducted in collaboration with a hospital manager which helped to change clinical practice in a district general hospital.

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Patient selection may be the key for the success of shared care for glaucoma

EDITOR,—We agree with Hitchings' views that shared care for glaucoma has, at least on the face of it, much to recommend it.¹ Despite the growing enthusiasm, it has not yet received critical evaluation for national adoption. Shared care is a way of integrating primary and secondary care services and is one of the targets set for the NHS in the 1990s.²

Shared care schemes have been in operation for patients with other chronic diseases such as diabetes,³ asthma,⁴ and hypertension for the past few years and such schemes claimed that shared care is clinically as effective as hospital outpatient department, cost effective, acceptable to the patients and general practitioners, and allows more new patients to receive specialist advice.⁵

Glaucoma patients constitute the bulk of the follow up patients in any general ophthalmic clinic. Our recent departmental audit revealed that 47% of all follow up patients are, in fact, the previously diagnosed chronic glaucoma sufferers. Any scheme that would reduce the work load of busy outpatient department without compromising the quality of care is welcomed by one and all.

We would like to highlight three important issues that need to be considered before embarking on any such ventures. Firstly, overcautious opticians running such schemes may result in more re-referrals to the hospitals defeating the basic objective. Secondly, the prerequisite to run a glaucoma shared care clinic is to have the same instrumentation and examination methods at the base hospital and the shared care centre. At present pneumatic 'applanation' tonometry, direct ophthalmoscopy, and a variety of visual field analysis techniques are popular with opticians in contrast with Goldmann tonometry and binocular non-contact funduscopy lens used by hospital doctors. Use of different methods might also mean unnecessary additional hospital referrals.

Finally, we think proper patient selection could be the single most important factor on which the success or failure of shared care schemes may depend. Understandably not all glaucoma sufferers are suitable for the shared care system. Ideally, only those patients with stable intraocular pressures and visual fields, and whose glaucoma is unlikely to need change of management should be recruited into such ventures in order to avoid inappropriate recycling of patients between hospitals and opticians. There is a need to identify the type of patients that are most suitable for shared care or otherwise. Currently, there are no established guidelines regarding patient selection for these new schemes and the outcome of pilot studies mentioned by Hitchings is eagerly awaited.

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Reply

EDITOR,—I thank Rao and O'Donnell for their kind comments on my commentary in the *BJO*.

They raise a number of useful points. It needs to be remembered that shared care has two aspects - diagnosis and follow up. For diagnosis the most cost effective method with the highest sensitivity and specificity possible is required. This will need to be nationally agreed and standardised. For follow up, there is greater latitude in the methods chosen although the same rigid protocol as that which constitutes change will be required.

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Use of glycopyrrolate as a prophylaxis for vaso-vagal syncope during retinal photocoagulation

EDITOR,—Application of a fundus contact lens for retinal photocoagulation may, though uncommonly, result in a vaso-vagal syncope

as a result of oculocardiac reflex bradycardia. Preoperative intramuscular anticholinergic agents were found to be partially protective against oculocardiac reflex bradycardia in adult squint surgery.¹ We report on three patients in whom we used intramuscular glycopyrrolate to diminish the oculocardiac reflex so that retinal photocoagulation could be carried out without resorting to retrobulbar or general anaesthesia.

PATIENT 1

A 26-year-old woman who previously suffered a vaso-vagal syncope after 23 burns of retinal photocoagulation was able to receive between 100 and 1250 burns per session when 0.2 mg of glycopyrrolate was given intramuscularly 30 minutes before each procedure.

PATIENT 2

A 31-year-old woman had had one vaso-vagal syncope and complained of feeling faint in subsequent treatment sessions when she received between 20 and 350 burns of retinal photocoagulation. She was able to receive up to 421 burns without any complaints with intramuscular glycopyrrolate before treatment.

PATIENT 3

A 47-year-old man, who previously had a vaso-vagal syncope after only four burns, was able to receive between 360 and 1002 burns of retinal photocoagulation with pretreatment intramuscular glycopyrrolate.

We did not encounter any of the anticholinergic side effects such as sinus tachycardia and dry mouth in our patients. Glycopyrrolate was used as the anticholinergic agent because it has been found to be associated with less tachycardia and dysrhythmias than atropine.¹⁻³ It also produces less central nervous systemic effect as it penetrates the blood-brain barrier poorly.⁴

In view of the above reports, we would suggest that intramuscular glycopyrrolate before retinal photocoagulation could be useful in preventing a vaso-vagal syncope in susceptible patients. Though a randomised, double blind, controlled study would be desirable, it is impractical owing to the rarity of the problem. Patients receiving intramuscular glycopyrrolate should be observed and monitored after treatment.

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