CORRESPONDENCE

Endonasal laser dacryocystorhinostomy

Editor,—I read the article by Sadiq and others with great interest. The figures presented, though in accordance with the literature, may be misleading at first sight. Of the 21 patients with endonasal laser dacryocystorhinostomy without intubation postoperatively, only 10 can be reported to be successful after 12 months. These are only 47.62% of the total number of patients who underwent surgery without stenting instead of the 91% reported. In the group of 65 patients with intubation postoperatively 41 (63.08%) were successful after 12 months instead of the 70% reported. Of the total number operated (86 patients) only 63 (59.3%) were successful after 12 months instead of the 81% reported. The figures presented by Sadiq and others disagree substantially in accordance with the literature, because success rates and reported figures are heterogeneous. The only common feature of all studies is that failure of laser assisted dacryocystorhinostomy as a result of fibromembranous scarring of the lacrimal system occurs in a rather early postoperative phase.

The main problem of all reviewed studies is the enormous heterogeneity in patient selection criteria, inclusion in the laser assisted dacryocystorhinostomy, equipment, approach, method, use of statistics, and follow up criteria. Obviously the results will be different in an identical patient group postoperatively resp. in a child compared with a chronic inflammatory process due to degenerative changes of the lids and the lacrimal apparatus with superinfection in an old patient with rosacea and an extended period of time after the laser intervention.

Thus, randomised and controlled prospec- tive trials with a well-defined standardised protocol are needed. We must define patient inclusion and exclusion criteria. Indications to specific patient and surgical methods must be determined. It is not helpful to compare the treatment of different patients with different diseases treated with different surgical methods. We must define what particular method and surgical methodology is to be used in what particular disease. There is no doubt, that the external dacryocystorhinostomy (Toti)13 as well as the endonasal approach (West)14 are the most frequently used with the highest success rates.15 The indications when to use a Toti or a West procedure find its place in lacrimal system surgery under nasolacrimal duct obstruction because of nasolacrimal duct membranous stenosis.

Editor,—We are interested in read Kirwan et al. on acute closed glaucoma (AAGC) associated with the antidepressant paroxetine (Seroxat),1 as we have reported a similar case.2 In Kirwan’s report, AAGC occurred within 24 hours of the first dose, suggesting an acute reaction to the paroxetine withdrawal. Our case occurred symptomatically some 2 weeks after daily dosage was commenced, leading us to postulate that the effect could have been mediated by serotonergic pathways. This raises the possibility of the effect on IOP occurring via the mirror-sided effects of other antidepressants and their withdrawal.

Paroxetine is an antidepressant of the selective serotonin reuptake inhibitor (SSRI) class. SSRIs act by inducing a gradual rise in the extracellular levels of serotonin (5-hydroxytryptamine, 5-HT) via desensitisation of the feedback systems which control the rate limiting enzyme in 5-HT synthesis.3 The 5-HT receptors involved have not yet been fully elucidated, and their role in oculomotor physiology is a subject of ongoing research. In animal studies, serotonergic stimulation may cause mydriasis, and can have an independent effect on IOP in the mirror-sided effect on IOP in the mirror-sided effect on IOP in the mirror-sided effect on IOP.

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experienced an elevation: in one patient the elevation was considered a normal diurnal variation [74 year old male, dosage 80 mg/day, examined at 2 months], in a second patient the elevation was felt to be related to angle closure [59 year old male, dosage 80 mg/day, examined at 4 months], the third patient acknowledged cocaine use prior to the examination and this was considered the probable explanation [37 year old male, dosage 80 mg/day, examined at 12 months], and the fourth patient had a 1 mm Hg rise with no probable extenuating circumstances [26 year old female, dosage 80mg/day, examined at 2 months]” (Dista Products Limited, personal communication).

Voluntary reporting of suspected adverse events with fluoxetine has identified a total of 63 cases of “glaucoma” in an estimated patient population of 21 million (Dista Products Limited, personal communication). The manufacturers of paroxetine are aware of four cases of AAGC, six of “glaucoma” (unspecified), and one of raised IOP, in a UK patient population of over one million (Smith-Kline Beecham Pharmaceuticals, personal communication).

These data indicate that our understanding of the effect of SSRIs on IOP is still uncertain.

The demonstration of a short term IOP rise after a single fluoxetine dose implies that chronic administration lead to a sustained elevation of IOP. However, the manufacturer’s own data suggest that this is not the case, in that less than 1% of patients showed any IOP change after treatment. The low incidence of reported cases of AAGC with SSRIS does not exclude a real effect: many clinicians may not suspect a particular drug to be a contributory factor when diagnosing a particular condition, especially if a causal relation has not been suggested in the literature. This is particularly true of open angle glaucoma, which is common and usually idiopathic, and of AAGC, which is rarer but occurs in anatomically predisposed eyes.

We feel that this area merits further study and clarification, particularly regarding the effect of long term SSRIs administration on IOP. In the meantime, we would encourage colleagues to report cases of glaucoma or raised IOP to be associated with SSRIS to the Committee on Safety of Medicines.

**Authors’ reply**

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2 Kirwan JP, Subak-Sharpe I, Temimony M, Bilal acute angle closure glaucoma (AAGC), in a 35 year old man as a result of fluoxetine administration, during the fifth week of therapy. More recently, also Kline and Eke et al. have described two cases of AAGC associated with the administration of paroxetine, an antidepressant which acts as a selective inhibitor of the serotonin neuronal uptake (SSRI). In 1996 we described the effect of fluoxetine oral administration on intraocular pressure (IOP) in 20 consecutive depressed patients and demonstrated that after a single dose of 20 mg IOP was significantly increased.1 Serotonin (5-HT) is present in mammalian iris ciliary body and cornea at higher concentration than in non-mammalian species.1 While a transmitter role for serotonin in the retina has been established, conflicting data exist in the literature on whether or not activation of serotonin receptors can cause changes in IOP. Experimental evidences demonstrated that topical application of serotonin increased IOP in rabbit eyes1 and that 5-carboxamidotryptamine, a 5-HT receptor agonist, is even more effective than 5-HT itself in elevating IOP.1 These results confirm the involvement of serotonin receptors in the regulation of IOP and suggest that ketanserin, a compound with serotonergic blocking properties, reduces IOP in animals and humans emphasizing the role exerted by 5-HT on IOP.2 To date, no long term studies regarding the effect of SSRIs on IOP have been published. We know the prevalence of primary open angle glaucoma (POAG) (conservatively estimated to be approximately 1/200 of the general population) and of AACG (approximately 1/1000 of primary open angle glaucoma in the general population). It has a high mortality. It is estimated recently, also Kirwan et al. that severe depressive illness increases the risk of suicide by a factor of 30 such that 15% die. Furthermore, we know the prevalence of primary open angle glaucoma (POAG) (conservatively estimated to be approximately 1/200 of the general population) and of AACG (approximately 1/1000 of primary open angle glaucoma in the general population). It has a high mortality. It is estimated recently, also Kirwan et al. that severe depressive illness increases the risk of suicide by a factor of 30 such that 15% die.
by suicide. Alternative treatments with other antidepressants are generally less well tolerated, especially in the elderly. Despite the possibility of raised intracranial pressure the risk/benefit ratio will almost always favour treating depression with the optimum agent.

Until the real effect of SSRIs on IOP has been ascertained it is difficult to make suggestions on management and further evidence on this subject is required. However, it would seem prudent to closely monitor glaucoma patients who have recently commenced treatment with an SSRI. Given limited ophthalmic resources, until we know more about the long term effects of these drugs on IOP it does not seem reasonable to recommend ophthalmological screening of all patients commenced on SSRIs. Like Eke and Carr, we encourage colleagues to report cases of glaucoma or raised IOP that may be due to therapy with SSRIs. Additionally, we would stress the importance of communication between disciplines so that no doctor is unaware of prescribed medication.

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2 Scriptum Count 300 MAT to 26/8/94 [program]: Taylor Nelson Healthcare.

BOOK REVIEWS

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It is written against a background of 38 million people in the world who are blind, the majority living in hot developing countries. The introductory chapter is an excellent overview of the problem touching on the contributory causes, particularly poverty and lack of education and all that follows on from that. Approaches to prevention and treatment are discussed.

The remainder of the book deals with eye disease in a systematic way starting with chapters on basic anatomy, physiology, history taking, and eye examination. The common eye diseases in hot climates are mainly the same as in more temperate parts but the thrust of the book is the approach to these diseases in situations where there are limited resources in expertise, diagnostic equipment, and treatment. There are clear descriptions of how to perform basic examinations with limited cheap equipment and treatments recommended include the cheaper alternatives as well as the most modern medications. I particularly liked the advice on how to make up fortified antibiotic drops for corneal ulcers for example. As expected there are several good chapters on those diseases more specifically associated with tropical countries such as trachoma, xerophthalmia, onchocerciasis, and leprosy.

A minor criticism is that the whole of ophthalmology is tackled and many rarer conditions just get a mention. Perhaps it would have been better to leave them out altogether and concentrate on the common conditions that are done so well. Nevertheless, this is a very valuable book for those working in developing countries where many workers find it indispensable. I will certainly continue to recommend it to students going overseas on electives for eye projects.

Thyroid eye disease. 3rd ed. By Devron H Char. Pp 293. £70. Oxford: Butterworth-Heinemann, 1997. ISBN 0-7506-9893-4. Thyroid associated ophthalmopathy continues to vex endocrinologists, ophthalmologists, and immunologists. At one of the earliest meetings of the Thyroid Club (now the British Thyroid Association) the debate on this subject was so intense that the secretary urged that it continue until no one was left, and the meeting closed with some difficulty at 10.00pm. Forty years later controversy still rages about the pathogenesis, the relation to the thyroid condition, and the best way to treat both the orbit and the thyroid in these patients.

This book, remarkably, is written by a single author and encompasses all of these areas. Devron Char is professor of ophthalmology and radiation oncology at the University of California at San Francisco. As the book is in its third edition already within 10 years, this demonstrates the changes that have been made in our understanding and provides a continuously revised text which gives a vast array of information. The shortcoming of this approach is that it is very difficult for anyone to be an expert these days in all areas that touch on ophthalmopathy. It is particularly in the areas of arcane immunology that the book is perhaps weakest and in future editions it might be worth commandeering the services of an immunologist to write specifically on this topic even if this leads to loss of uniform style. Another difficulty is that the text, although divided into sections, might benefit from further breakdown under subheadings. This is particularly apparent in chapter 6 which covers the pathogenesis and pathophysiology of thyroid ophthalmopathy. All of the immunological studies are grouped together under a single heading with no subdivision into genetics, antibodies, T cell involvement, and so on and this makes a difficult subject for the non-specialist even more taxing. There also appears to be some confusion over the role of free T4 testing in chapter 3 (Systemic diagnostic tests for thyroid ophthalmopathy and euthyroid ophthalmopathy). Free T4 assays are now simple, cheap, and cheap.

These, however, are relatively minor drawbacks compared with the overall worth of the book. The layout is very good and the pictures are excellent. The references are generally up to date as far as 1995 and there are one or two from 1996. Moreover, the references are extensive and give a detailed overview of even the earliest history of work on this disease. The second half of the book which details management is superb giving an overview of medical management (including radiation therapy) and surgical approaches. The author shows what can go wrong as well as what can go right and the personal account given makes compelling reading. Anyone who deals with thyroid associated ophthalmopathy will learn from this book. Perhaps by the next, or next but one, edition some of the questions which still remain will have been answered.

F D GREEN

NOTICES

Avoidable blindness

The latest issue of the Community Eye Health (no 25) discusses the elimination of avoidable blindness. With an editorial by Bjorn Thylefors, the editor of the WHO Programme for the Prevention of Blindness and Deafness, the issue covers treatment of cataract in regions of India and the role of patient counsellors in increasing the uptake of cataract surgery and IOLs. For further information please contact Community Eye Health, International Centre for Eye Health, Institute of Ophthalmology, 11–43 Bath Street, London EC1V 9EL. (Tel: (+44) 171 608 6910; fax: (+44) 171 250 3207; email: eyeresource@ucl.ac.uk) Annual subscription £25. Free to workers in developing countries.

Residents’ Foreign Exchange Programme

Any resident interested in spending a period of up to one month in departments of ophthalmology in the Netherlands, Finland, Ireland, Germany, Denmark, France, Austria, or Portugal should apply to: Mr Robert Acheson, Secretary of the Foreign Exchange Committee, European Board of Ophthalmology, Institute of Ophthalmology, University College Dublin, 60 Eccles Street, Dublin 7, Ireland.
2nd International Conference on Ocular Infections

The 2nd International Conference on Ocular Infections will be held on 22–26 August 1998 in Munich, Germany. Further details: Professor J Frucht-Pery, 2nd International Conference on Ocular Infections, PO Box 50006, Tel Aviv, 61500, Israel. (Tel: 972 3 5140000; fax: 972 3 5175674 or 5140077; email: ocular@kenes.com)

Vth Tuebingen Angiography Course on AMD

The Vth Tuebingen Angiography Course on AMD with stereoscopic angiography wet-lab will be held on 26–27 August 1998 at the auditorium, University Dental Clinic and University Eye Clinic, Tuebingen, Germany. Further details: Dr W Inho, University Eye Clinic, Department of Ophthalmology III, Schleichstrasse 12, D-72076 Tuebingen, Germany. (Tel: +49-(0) 7071-292968; fax: +40-(0) 7071-293746; email: ingrid.kreissig@uni-tuebingen.de)

XVI Tuebingen Detachment Course

The XVI Tuebingen Detachment Course in retinal and vitreous surgery will be held 4–5 September 1998 in Odessa, Ukraine. Further details: Professor I M Logai, Director, The Filatow Institute, 49/51 Boulevard Francois, Odessa, 270061, Ukraine. (Tel: +38-0482-22 20 35; fax: +38-0482-68 48 51.)

International Agency for the Prevention of Blindness (IAPB)

The International Agency for the Prevention of Blindness (IAPB) will hold its next general assembly in Beijing, China on 5–10 September 1998. Further details: Gullapalli N Rao, Secretary General, IAPB Secretariat, LV Prasad Eye Institute, LV Prasad Marg, Banjara Hills, Hyderabad 500 034, India. (Tel: 091-40-215389; fax: 091-40-248267; email: IAPB@lvpeye.stph.net)

ICOP 98

The next International Conference in Ophthalmic Photography (ICOP) will be held on 19–21 September 1998. Further details: Mrs Gillian Bennerson, Senior Ophthalmic Photographer, Bristol Eye Hospital, Lower Mauldin Street, Bristol BS1 2LX. (Tel: 0117-928-4677.)

IV meeting of the European Society for Out-Patient Eye Surgery (ESOPES)

The IV meeting of the European Society for Out-Patient Eye Surgery (ESOPES) will be held in Vittel, France on 9–11 October 1998. Further details: Mrs Nicole Charron, Director, Palais des Congrès, Av Bouloumie, BP 57, 8802 Vittel, France. (Tel: +33 329 08 18 30; fax: +33 329 08 6601.)

Vth International Symposium on Graves’ Ophthalmology

The Vth International Symposium on Graves’ Ophthalmology will be held on 27–28 November 1998 in Amsterdam. Further details: Amsterdam Thyroid Club, Department of Endocrinology, F5-171, Academisch Medisch Centrum, Meibergdreef 9, 1105 AZ Amsterdam, Netherlands.

Singapore National Eye Centre

The 3rd SNEC international meeting and 11th international meeting on cataract, implant, microsurgery and refractive keratoplasty (ICIMRK) will be held at the Shangri-La Hotel, Singapore on 28–30 November 1998. Further details: Organising Secretariat, 3rd SNEC International Meeting and 11th ICIMRK, Singapore National Eye Centre Pte Ltd, 11 Third Hospital Avenue, Singapore 168751. (Tel: (65) 2277-255; fax: (65) 2277-2901)

Ophthalmic technologies

The 9th Ophthalmic Technology Conference will be held on 23–24 January 1999 during the International SPIE symposium on biomedical optics. Further information: The SPIE Organisation, PO Box, Bellingham, WA 98227-0010, USA. (Fax: (+1) 360-647-1445; email: www:spie.org/info/pw)

Laser eye injuries

A conference on the epidemiology, prevention, diagnosis, and therapy of laser eye injuries will be held in San Jose, California on 25–26 January 1999 during the International SPIE symposium on biomedical optics. Further information: The SPIE Organisation, PO Box, Bellingham, WA 98227-0010, USA. (Fax: (+1) 360-647-1445; email: www:spie.org/info/pw)

XII Congress European Society of Ophthalmology

The XII Congress European Society of Ophthalmology will be held in Stockholm, Sweden on 27 June–1 July 1999. Further details: Congress (Sweden) AB, PO Box 5819, S-114 86 Stockholm, Sweden. (Tel: +46 8 459 66 00; fax: +46 8 661 91 25; email: sore@congrex.se; http://www.congrex.com/sore/)


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