Intraocular lens implants and risk of endophthalmitis

EDITOR,—We would like to comment on the paper by Bainbridge and colleagues.1

The aim of their study was to investigate the possible association between the use of three piece foldable silicone polypropylene intraocular lenses and increased risk of endophthalmitis, and indeed the investigators have met this goal and proved this association in an elegant study.

In addition, the authors have supplied the reader in their article with very important information (Table 1) that was not discussed. All of the seven cases had a medical history of one or more systemic diseases that may affect the immunological conditions of the patients and contribute to the development of postoperative endophthalmitis.2 In fact, one patient with plastic anaemia was excluded from the statistical analysis.

Comparing the patients with endophthalmitis with control subjects in a random fashion, even in small series, may reveal additional risk factors such as medical history. The addition of a controlled group of patients undergoing the same surgery who did not develop endophthalmitis could add a lot to the strength of the study.

We believe that endophthalmitis develops when several risk factors are present. We are obliged to take all these factors into consideration before, during, and after surgical procedure, especially in debilitated and immunosuppressed patients. In this kind of patient prophylactic considerations must be borne in mind, including adequate preparation of the patient and surgical field, antibiotics, experienced surgeon, safer instruments, and IOLs.

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ALON HARRIS, MD
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“Cycloidote”

EDITOR,—I read with considerable interest the paper by Spencer and Vernon on the results of a standard protocol for transeccular diode laser cyclophotocoagulation (“cyclodiode”). The particular importance of this work to those of us with regard to more widespread use of this therapy lies in the high percentage (64%) of treated eyes with pretreatment Snellen acuity, and while a third of these eyes lost 2 or more lines of Snellen acuity, it appears that in these cases, not directly attributable to the cyclophotocoagulation, with particular note being made of the low rate of cystoid macular oedema.3

The authors report success rates in achieving IOP control with a standard protocol, but, as in most other published series, record findings after “repeat as necessary” retreatments (in this study up to five in number). While this is of obvious interest to clinicians, it may be of almost equal utility to know the effect of a single treatment. In an earlier paper, also using a standardised treatment protocol for cyclophotocoagulation,4 an attempt was made to elucidate any dose-effect relation from single cyclophotocoagulation treatment session. With a single treatment totalling 90 J through 360°, a mean lowering of IOP of 48% was achieved, but the predictability of outcomes in this series was hampered by the high number of neovascular glaucoma (NVG) cases, which are recognised as having highly variable responses.5 It would seem that Spencer and Vernon are uniquely placed—with their standard protocol and low numbers of NVG cases—to provide data pertaining to any dose-effect relation from a single treatment, information which may be used to enhance the predictability of the procedure for individual patients.

The authors also note that their cohort was largely free of cases having had previous cyclodestructive procedures: that is by definition not true, however, of all the retreatment cases, and the authors appear not only to have been reasonably forthcoming in their pursuit of an IOP <22 mm Hg, but also to have applied the same laser dose irrespective of the number of retreatments, with their retreatment plan leaving no untreated quadrant. In the series noted above, using a half standardised single treatment (45 J over 180°) for cases judged clinically to be at risk of hypotony (which included cases having had previous cyclodestructive procedures) a mean IOP reduction of 36% was still achieved.6 It would therefore be of great interest to know whether any cases in Spencer and Vernon’s paper were excluded from retreatment, despite inadequate postoperative IOP control, because of a concern about possible hypotony; similarly, it would be useful to know whether “all comers” were treated in the study to have whether there were specific exclusions from standardised cyclophotocoagulation treatment because of this perceived risk.

MARK J WALLAND
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Reply

EDITOR,—We thank Dr Walland for his interest in our paper and for summarising the results of his study which was published following our paper’s submission. It is difficult to quantify the dose-effect from a single treatment in cyclodiode because (a) it would depend on the follow up period as the effect may diminish with time, and (b) one would have to continue all the prelaser antiglaucoma medications (not always desirable) to see the true effect.

However, we can analyse the “single dose effect allowing for a reduction of medications” from our study by examining the results of only those eyes which had one treatment session. This subgroup contained seven primary open angle glaucoma, five aphakic, two pseudophakic, seven uveitic, three corneal/PK, four rubecic, one silicone oil, and three trauma cases, thus representing the whole spectrum of the cohort treated. Although this subgroup, by definition, selects out the “best case scenario”, this was achieved in over 50% of cases treated. With a mean follow-up of 19 months, the IOP of this subgroup decreased from a mean of 31.2 mm Hg to a mean of 16.2 mm Hg, with a 45% mean percentage reduction. This was associated with a reduction in numbers of patients taking acetazolamide from 88% to 6% and a mean medication usage from 2.2 to 1.2. None of these results differs significantly from those of the whole cohort.

In our study no eyes were denied treatment or retreatment because of a perceived risk of hypotony, and “all comers” were indeed treated by this modality if enhanced filtering was indicated. Thus, the results are relevant to our consultants throughout our region (population approximately six million). We cannot state that all eligible cases were treated by us, but we believe our cohort is likely to be representative of cases referred to other glaucoma specialists with a similar population to that found in the East Midlands of England.

We note that, in Walland’s study, the mean pulse energy delivered to IOP at a mean of 10.4 mW decreased from 25.8 mm Hg with only 55% <22 mm Hg even when a “full” treatment of 90 J was delivered. Although this may be as a result of the large numbers of patients with neovascular glaucoma in this group, it may also be due to the time and power output settings used (1.5 seconds and 1.5 W). With our settings of 2 seconds and 2 J per shot we were able to control IOP with a 65.7% reduction using a mean energy delivered. This could be due to tissue attenuation in certain eyes, operator technique variation, probe output differences, and ciliary process uptake/susceptibility factors.

STEPHEN A VERNON
ANNE FIONA SPENCER
Department of Ophthalmology, University Hospital, Nottingham

Is non-arteritic anterior ischaemic optic neuropathy related to homocysteine?

EDITOR,—We read with interest the paper recently published by Kawasaki et al. They suggested that hyperhomocysteinaemia may have a role in the occurrence of non-arteritic anterior ischaemic optic neuropathy (NAION) in non-diabetic patients younger than 50 years, and raised the question of the frequency of the methylene tetrahydrofolate reductase (MTHFR) C677T mutation in this population.

There have been anecdotal reports of thrombotic tendencies in patients with NAION. Although NAION is most probably related to factors compromising the posterior ciliary artery circulation at the optic nerve head (so called “disc at risk”), it is also possible that some systemic factors such as hyperhomocysteinaemia and the MTHFR C677T mutation may enhance local atherogenesis at the level of the posterior ciliary arteries, thereby precipitating the development of NAION in those at risk for the disease. Kawasaki et al could not demonstrate any change in plasma homocysteinaemia and NAION. However, the blood sample used to measure the homocysteine was obtained after the clinical event. Since homocysteinaemia fluctuates, it is possible that in this general population we underestimated the frequency of hyperhomocysteinaemia. We recently investigated prospectively the presence of hyperhomocysteinaemia and the MTHFR C677T mutation in patients with acute NAION.

Blood samples from 14 newly diagnosed patients with acute NAION presenting to our centre over a 1 year period (May 1998 to May 1999) were evaluated for serum creatinine, serum and red blood cell folate, B12, and total plasma homocysteine levels, as well as the C677T polymorphism in the MTHFR gene. There were 10 men and four women (13 white and one Asian), ranging in age from 28 to 68 years (mean aged 42.8 years). All patients had a disc at risk in the fellow eye. Five patients subsequently suffered NAION in their second eye. Four patients (28.5%) were heterozygous and one was homozygous for the C677T mutation in the MTHFR gene, which does not differ from the frequency reported in the general population. Only one of these five mutation positive patients had bilateral NAION. The homocysteine level was within the normal range in all 14 patients, as were the creatinine, folate, and B12 levels. Homocysteine levels were not higher in the mutation positive patients than in the mutation negative patients. Mutation positive and mutation negative patients did not differ with respect to clinical data concerning risk factors for NAION or coexisting vascular disease.

Although this is a small study, these results suggest that hyperhomocysteinaemia and the C677T MTHFR polymorphism do not have a role in the occurrence of NAION. Our results are similar to those of Kawasaki et al and the frequency of the MTHFR mutation is not higher than in the general population. As recently re-emphasised,1,2 laboratory testing for hypercoagulable states in a patient with NAION without past medical history or family history of a thrombotic event would be unwarranted. However, it is still possible that for a given individual already at risk for AI0N, a thrombogenic predilection may be a trigger for an acute ischaemic event of the optic nerve head. If there are clinical findings suggestive of a thrombogenic tendency, such as recurrent thrombotic events or a family history of thrombosis, or if there is no disc at risk in the fellow eye in a younger patient without vascular risk factors, an investigation for hereditary and acquired thrombophilic markers may be justifiable.

This study was supported in part by a departmental grant (department of ophthalmology) from Research to Prevent Blindness, Inc., New York, New York, by core grant P30-EY06360 (department of ophthalmology) from the National Institute of Health, Bethesda, Maryland. We are recipient of Research to Prevent Blindness Lew R Wasserman Merit Awards.

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Reply

EDITOR.—We thank Bousses and colleagues for their comments on our article and their corroborative study. We agree that an extensive prothromlocagulable evaluation is not warranted in patients with NAION who have typical risk factors, including older age. The yield from such an evaluation in young patients with NAION, especially those without known risk factors or those who suffer recurrent events, still needs further elucidation.

AKI KAWASAKI
VALERIE PURVIN
RICHARD BURGESS

LASER pointers: not to be taken light

EDITOR,—We recently treated a 16 year old boy whose friends exposed both his eyes to a laser beam alternately for 20 seconds from a distance of around 1 metre in the course of horseplay with a key chain laser pointer (class 3a diode, 670 nm, maximum output 5 mW). Immediately thereafter, his vision was blurred bilaterally and he noted a red central scotoma in each eye. These symptoms resolved spontaneously within 2 days. An eye examination performed 3 days later disclosed that his vision and visual fields were normal, but there were retinal pigment epithelial disturbances which appeared in fluorescein angiography as...

The fourth edition of this standard text lives up to its enormous reputation. Jack Kanski sets out “to provide the trainee with a systematic and easily assimilated introduction to ophthalmology and a reference and update for the more experienced practitioner”. Undoubtedly these clear and circumscribed aims are well met in this beautifully and even more lavishly illustrated text. In addition to covering all those aspects of ophthalmology that trainees need to know, a new chapter on ocular trauma has been added in addition to descriptions of new surgical techniques and some pruning of outdated material.

This is and has been an extremely successful primer text for the trainee ophthalmologists and one might ask why this book rather than the many other texts available. Perhaps the answer lies in part in the approach taken with this text which is non threatening “patient oriented”: one can almost envisage the author examining the patient presenting to the ophthalmic clinic by starting systematically at the front of the eye and working his way posteriorly towards the orbit and/or cortex until he finds the source of the patient’s complaints. There is less emphasis on why the patient might have his complaints than finding out what exactly the problem is and what the practitioner should do about it. As such it works very well because it is concise but sufficiently detailed and above all immediately accessible. In fact there is a remarkable amount of detail (see, for instance, the section on corneal dystrophies) while one could debate occasional diagnoses attached to some of the fundus photographs (see, for instance, serpiginous choroiditis). There are also some very helpful line diagrams such as those included in the retina and orbit chapters. The section on neuro-ophthalmology contains several excellent illustrative radiological scans. Overall this is an excellent starting text. If there is any criticism that can be levied at this classic text, it is that it leaves this reader thirsting for further information. If a similar effect is induced in the trainee ophthalmologist it will have achieved its aim. I can therefore recommend this book as essential reading.


This is an important and thought provoking book which should interest not only within the medical profession but also by interested parties such as health economists and government officials whose responsibility it is to set budgets for healthcare programmes. I think it will also be of great interest to the lay public. The practice of medicine is as susceptible to the whims of fashion and pervasive ideology as any other human activity. It is therefore interesting to investigate how these fashions are set. James Le Fanu has a background in medical and scientific journalism, having spent time on the staff of the Daily Telegraph, one of the UK’s broadsheet newspapers. His thesis is that despite the significant advances in treating disease, which reached their peak in the post-war years, the promise of modern medicine as we are at the end of the century has failed to materialise. In fact, Le Fanu contends that much of the advances in the first half of the 20th century were accidental or at best serendipitous, citing as examples the discovery of antibiotics, which was never predicted, or the use of chloroquine for rheumatoid arthritis, which was based on clinical observations of patients treated for malaria. Even the success of aggressive chemotherapy for childhood cancer was the result of a determined but empirical approach of testing systematically multiple drugs in combination. The same approach has now been shown to be successful in the treatment of AIDS where the many drugs against a virus that was once thought “safe” carry the risk of potential damage to the eyes and that moreinincent toy. It damages the eye and should not be made freely available to youngsters whatever its strength, while the label of the innocent toy. It damages the eye and should not be made freely available to youngsters whatever its strength, while the label of the innocent toy. 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BOOK REVIEWS
NOTICES

Community participation in eye health and trachoma and the SAFE strategy

The latest issues of Community Eye Health (nos 31 and 32) discuss community participation in eye health (issue 31) and trachoma and the SAFE strategy (issue 32). 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 6909/6910/6923; 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, Pediatric Ophthalmology Unit, Children’s Hospital Medical Centre, Pediatric Ophthalmology Unit, University Hospital and Medical School of Parma, Via Gramsci 14, 43100 Parma, Italy (tel: +39 0521 259106; fax: +39 0521 259099; email: nuzzi@ipruniv.cce.unipr.it).

The 5th International Vitreoretinal Meeting–IIV 2000 will be held in Parma, Italy, on 15–18 June 2000 at the Meistersingerhalle, Nuremberg, Germany. Further details: MCN Medizinische Congressorganisation Nuremberg AG, Zerzebabelhofstrasse 29, D-90478 Nuremberg, Germany (tel: +49-911-3931621; fax: +49-911-3931620; email: doerflinger@mcn-nuernberg.de).

XXXV Nordic Congress of Ophthalmology

The XXXV Nordic Congress of Ophthalmology will be held in Reykjavik, Iceland, 18–21 June 2000. This meeting celebrates the 100 year anniversary of the Nordic Ophthalmology Conference. Further details: Iceland Incentives Inc, Hamragáb 1–3, Is-Kópavogur, Iceland (tel: +354 554 1400; fax: +354 554 1472; email: incentiv@stn.is).

III Modern Cataract and Refractive Surgery International Symposium

The III Modern Cataract and Refractive Surgery International Symposium will be held on 19–22 June 2000 at Banská Bystrica, Slovakia. Further details: Clinic FD Roosevelt Hospital, Arm Gen L Svobodu Sq, 1, 975 17 Banská Bystrica, Slovakia (tel: 00421 88 413 4671; fax: 00421 88 413 2047).

6th Congress of the European Glaucoma Society

The 6th Congress of the European Glaucoma Society, millennium meeting 2000, will take place at the Atlantic Hotel, London, on 26–29 June 2000. Further details: Eurocongres Management BV, Jan van Goyenkade 11, 1075 HP Amsterdam, Netherlands (tel: +31 20 679 34 11; fax: +31 20 673 73 06; email: egs@eurocongres.com).

British Ophthalmic Photographic Association


Joachim Kuhlmann Fellowship for Ophthalmologists 2000

The Joachim Kuhlmann AIDS Foundation, Essen, Germany, is sponsoring two fellowships per year for ophthalmologists at a well known institute, who want to train in CMV retinitis and other HIV related ophthalmological diseases. The fellowships are valued at $US5000 each. Deadline for application is 31 July. Detailed applications, including CV and publication list, should be sent to Joachim Kuhlmann AIDS Foundation, Bismarckstrasse 55, 45128 Essen, Germany (tel: 0201 87910-87; fax: 0201 87910-99; email: jk-stiftung@t-online.de).

DR-2000, International Forum on Diabetic Retinopathy

The International Forum on Diabetic Retinopathy will take place on 7–9 September 2000 at the Palazzo Reale, Naples, Italy. Further details: Francesco Bandello, Congress Secretariat, MGR Congressi, Via Servo Tulio, 4, 20123 Milano, Italy (tel: 39 02 4308771; fax: 39 02 4308084; email: dr2000@mgr.it).

VIII Tuebingen Angiography course

The VIII Tuebingen Angiography course with wet lab will take place on 9 September 2000 in the auditorium, University Eye Clinic, Schleichenstrasse 12, 72076 Tuebingen, Germany. Further details: WT-Wissenstransfer, Universitäts-Augenklinik (tel: +49 7071 29 76439; fax: +49 7071 29 5051; email: wt@uni-tuebingen.de).