MAILBOX

Advancing microsurgical instrumentation into the 21st century

EDITOR,—It seems a surprising omission from the Waldock’s recent commentary on the future of microsurgical instrumentation not to have mentioned contamination with specific reference to transmissible spongiform encephalopathies (TSE). Current thinking is that prion protein is not reliably destroyed by most disinfection or sterilisation procedures, including autoclaving at a temperature as high as 138°C for an hour. Although more effective methods, such as exposure to combinations of alkali and heat, are being developed they may require instruments to be particularly durable. Also fine, and particularly, toothed instruments require thorough cleaning before sterilisation by current procedures, to avoid retention of tissue.

Although there is no clear evidence of the transmission of TSE from one patient to another by ophthalmic surgery other than through central nervous transplantation,1,2 the only extant Department of Health guidelines state that any instruments used on patients with Creutzfeldt-Jakob (CJD) or suspected of this condition must be destroyed. Patients with chronic Creutzfeldt-Jakob are predominantly in their 60s and may come into contact with ophthalmologists because of cataract, glaucoma, and macular degeneration or because of visual symptoms caused by their condition.3

The number of individuals in the UK who are incubating variant CJD (vCJD), believed to be the human form of bovine spongiform encephalopathy (BSE), is unknown. Prion protein has been shown to be present in the tonsils and appendices of its victims; the possibility of it being present in the eye, and particularly in the retina and optic nerve of apparently healthy individuals, must unfortunately be entertained. The Department of Health has identified neurosurgery and ophthalmology as areas of particular risk, though arguably many forms of routine surgery could in theory pass on prions from one patient to another via contamination of instruments.

The only certain way to avoid the as yet unquantifiable risks of ophthalmic (or any set) surgical instruments as vectors of transmissible disease is for them to be disposable. Even then, the temptation to reuse disposable instruments for cost containment will be present. The Medical Devices Agency has already issued guidelines on devices that touch the eye, in particular contact lenses, though the full implementation of these recommendations is not possible without the eye services grinding to a halt. Nevertheless, there are situations when disposable instrumentation could be implemented—for example, eye banking, without compromising standards or indeed increasing costs, by saving on tracing and autoclaving.

We agree that surgeons, engineers, and manufacturers should engage in an active and productive debate on instrumentation for the 21st century, but this should include further initiatives to utilise new materials to facilitate disposable instruments. This dialogue may also bring about a rethink of the number of instruments on trays, the majority of which may be autoclaved time and again without being used.

A B TULLO
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EDITOR,—I thank Tullo and Taylor for their interest in our commentary and for highlighting the importance of discussing future microsurgical instrumentation. Instrument manufacturers are aware of the implications of contamination, in particular from transmissible spongiform encephalopathies. We agree that there is a need for everyone associated with high-risk transmission surgery, such as ophthalmology, to rethink the strategies towards avoiding the risks of contamination. This needs to include a review of cleaning and sterilisation procedures as well as surgical instrument design.

As far as engineers and manufacturers of ophthalmic surgical instruments are concerned, there needs to be a complete reconsideration of instrument design. This includes a review of the materials being utilised, taking into account the need for durability to rigorous sterilisation procedures as well as cost. The assembly of the instruments must enable easy and thorough cleaning, while an evaluation of the methods by which manufacturing costs can be kept to a minimum may enable the production of affordable disposable instruments. Despite such criteria, it is important to maintain the high standards of quality which are required from instruments used in this field of surgery. This poses an interesting challenge and one which we agree requires an active and productive discussion from surgeons, eye-bank technicians, engineers, and manufacturers,


Reply

EDITOR,—I thank Kwok et al for their observations. Kwok et al felt that the case presented by us was compatible with a diagnosis of idiopathic polypoidal choroidal vasculopathy (IPCV). We have recently described the indocyanine green angiographic (ICG) findings in a group of patients with IPCV, its different modalities of treatment and follow up over a period of 6 years. The polyps in IPCV persist following recurrent haemorrhages, and only disappear following laser ablation. Ophthalmic imaging, before onset of the submacular haemorrhage, in this patient showed classic features of central serous retinopathy. There were no polypoidal lesions (including the fellow eye) seen before or after the submacular haemorrhage in our patient. The hyperfluorescent spot, shown on the fluorescein angiogram and the ICG, shows no resemblance to polypoidal lesions in IPCV. In addition, a solitary lesion is not a characteristic of IPCV.

We agree with Kwok et al that IPCV is a cause of massive submacular haemorrhage; the coexistence of two diseases in one patient...
is certainly possible. In this case, however, we feel there is no evidence that our patient had IPCV.

P L LIP
L MOWATT-DIXON
M W HOPE-ROSS
The Birmingham and Midland Eye Centre, City Hospital NHS Trust, Birmingham

Retinopathy and myopia of prematurity

EDITOR,—I have some comments on the recently published article by Choi et al. dealing with long term refractive outcome and oculometry variables in Korean children of very preterm delivery. As for the sample under study (n=65) there are certain points to state. 1. A manuscript is not composited from the usually analysed preterm cohorts. The material appears highly selective; over a 6 year period, from two university clinics, only 10–11 preterm infants have been included per year. Screening limits were 1500 g birth weight and 28 weeks' gestational age. Exclusion of a great number of preterms appears likely, but criteria are not specified or discussed.

Eighty three per cent acquired active ROP of at least stage 3. If unselected, this is the highest figure of advanced (and of any) ROP ever reported in developed countries. Apparently 54% of all the series had threshold or prethreshold ROP. To my knowledge, these figures have never been reported. Nevertheless, ROP is a disease which is certainly possible. In this case, however, we agree with cicatricial sequelae of the retina, the ability regarding ROP should markedly differ from what is known from nearby Asian metropolises. The authors further state that there are no previous longitudinal reports in the field. Depending on how “longitudinal” is defined, however, there are several studies of a rather similar sample, and with emphasis on subsequent refraction and oculometry results. It is from these studies that our present knowledge is compiled. This knowledge may be summarised as follows: In ordinary myopia the correlations between the “minor” refractive factors (corneal power, anterior chamber depth, lens thickness) all tend to reduce the myopia, otherwise independent of established main factors—the axial length elongation. Contrarily, as regards myopia of prematurity: the corneal curvature is steeper, anterior chambers are more shallow, and lenses thicker; axial lengths therefore appear relatively short for their myopia. Myopia is still mainly axial, but not so axial as usual. Though emphasising anterior segment features in high myopia the authors ignore or discard their own higher corneal powers compared with presumed norm values. Apparently the generally steeper corneas may have contributed 1–1.5 D to the myopia.

Finally, it was interesting to see the split up according to cryotherapy for the 29 eyes with cicatricial sequelae of the retina. With cryotherapy their first year myopia averaged −2.97 D. In contrast, those without cryotherapy had −6.18 D. This might be interpreted as some protection exerted by the cryotherapy against the relative developmental involvment which myopia of prematurity seems to represent. Otherwise, the cryotherapy itself has been blamed for generating myopia, but here it seemed to be subordinate to the severity of the eye disease for which the ablation therapy was applied.
deficiency was the cause of the epithelial healing problem and subsequent graft melting.

MARTIN FELPECE

Late onset lattice dystrophy

EDITOR,—I read with great interest the article by Stewart et al on late onset corneal dystrophy with systemic amyloidosis (familial amyloidosis of the Finnish type/Meretoja syndrome) and their claim that this was the first case described in the UK. I would like to point out our case report published in the *BJO* in November 1999.3 We described a classic case of Meretoja syndrome in an English woman which was confirmed by genetic testing of the patient and her daughter who both demonstrated the point mutation on the gelsolin located on chromosome 9.

The authors bring to our attention a second family with this disorder and rightly state that the concept of a geographically limited disorder—namely, familial amyloidosis of the Finnish type, must be treated with caution as inclusions in other tissues can occur elsewhere.

In our patient, immunocytochemistry of the corneal button removed at keratoplasty showed no labelling of the amyloid deposits with antibodies to pre-albumin, amyloid A, and C-reactive protein. This was in contrast with other studies where amyloid stained with antisera to serum amyloid P. Whether this represents a subtype of the condition is uncertain and it would be interesting to compare findings with Stewart et al although there is no mention of immunocytochemistry results in their paper.

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Topical analgesia during retinal laser photoacoagulation

EDITOR,—We read with interest the report by Weinberger et al, evaluating the analgesic effect of topical sodium diclofenac 0.1% during retinal laser photocoagulation. They found that topical sodium diclofenac 0.1% was associated with a statistically significant lower pain score compared with topical sodium chloride 0.9%, in patients receiving panretinal photocoagulation. We agree with the authors that topical sodium diclofenac 0.1% has a better analgesic effect than topical sodium chloride 0.9% in this group of patients. However, this finding may not be clinically relevant. Topical sodium chloride 0.9% does not have any significant analgesic effect. Moreover, it is a common practice that patients receive topical anaesthetic, like oxybuprocaine 4%, before the procedure and panretinal photocoagulation. It may be more meaningful to compare the analgesic effect of these two groups of agents. There is also concern about the side effects of topical diclofenac. Ocular stinging is one of them.1 This may cause patient discomfort, as well as affect the rating of pain score of the panretinal photocoagulation procedure. Exacerbation of asthma by topical diclofenac has been reported.2 It may not be the appropriate analgesic in laser treatment for asthematics and in patients with obstructive airway diseases. In summary, the role of topical diclofenac in patients receiving panretinal photocoagulation needs further evaluation.

Financial and proprietary interest: Nil.

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BOOK REVIEWS


The Art of LASIK is the second edition of the well known Excimer Refractive Surgery: Practice and Principles, by Jeffrey Machat, Stephen Slade, and Louis Probst. It is an outstanding reference, not only for the refractive surgeon but also for anyone managing or co-managing patients who have had or plan to have laser refractive surgery. With the successes of refractive surgery procedures, hyperop, and astigmas being on everyone’s lips, it is easy to become compliant as the number of successful cases and satisfied patients continues to mount. While the first edition placed great emphasis on procedures and techniques, there have been numerous advances in both instrumentation and in refinements of surgical technique in the intervening years to warrant a second edition. However, as one reads this volume, which has the contributions and clinical expertise of 45 clinicians worldwide, one cannot help but be impressed with its comprehensive scope, but more importantly, with the authors’ concerns for the importance of prevention of preventable conditions and their detailed management plans when postoperative complications do occur. The Art of LASIK also provides the reader with innovative chapters on the use of LASIK in patients with previous ocular surgery, as well as topography assisted laser ablation, and management of complex LASIK cases.

As one would expect, section one’s introductory chapter deals with refractive surgery options and with the historical evolution of today’s LASIK procedures from keratomileusis, PRK, keratophakia, epikeratoplasty, and automated lamellar keratoplasty, as well as newer peripheral mass addition techniques (such as intracorneal rings and gel injection adjustable keratoplasty). Dr Machat presents an excellent chapter on the fundamental principles of excimer lasers and excimer laser surgery, including discussion of the need for continual maintenance and the continual calibration of such lasers. He right- fully points out that despite the phenomenal precision of tissue ablation with excimer laser, PRK’s limitations revolve around the much less predictable effects of wound healing, thus paving the way for LASIK’s embrace by refractive surgeons worldwide. A useful section dealing with Munnerlyn’s formul a for ablation depth and mathematical considerations involved in microkeratome produced flap thickness, maintenance of adequate residual stromal thickness, and diameter of ablation zone is provided, along with specific highlighted “pearls” showing the maximal correction possible using various LASIK techniques. These highlighted clinical pearls are present throughout the book, which serve to nicely emphasize major points and clinical observations.

LASIK surgeons will find the chapter on predictive formulas for LASIK most valuable, with nomograms provided for various levels of refractive correction and for different lasers. The discussion of adjustment factors, based on altitude of the treatment centre, age of patient, and even dryness of the climate, is most interesting, as well as the discussion of LASIK, nomogram refinement from postoperative results.

Section two deals with the instrumentation involved in the LASIK procedure, including speculum, corneal markers, tonometry, forces and spatulas, as well as irrigation cannula and antisecodisation chambers (in the rare event of a free flap). A very useful chapter devoted to in-depth discussion of various traditional microkeratomers and their comparative data is presented, along with excellent photographs. A specific chapter on the operation of the Chiron Hansatome and the “down-up” LASIK technique for production of a superior based hinge was welcomed by both experienced and novice LASIK surgeons alike.

This section also has individual chapters devoted to disposable keratomers including the FLAPmaker (used on a monitored basis as numerous sites worldwide, including the Center for Sight at the Queen Victoria Hospital) and the Hydroblade waterjet microkeratome.

Section three is devoted to the preoperative evaluation of the patient. This is an extremely important topic, which should be read by anyone involved in the care of the LASIK patient. To quote Dr Machat, “Managing patient expectations is the pivotal element to creating happy refractive patients”. Additionally, he writes “A surgeon who never has a complication is one who never performs surgery”. Candidate selection, careful screening for pre-existing conditions and anatomical limitations, as well as contraindications for LASIK are thoroughly explored, as is the topic of LASIK, as the procedure of choice of patients over the age of 40 is given, but the reality is that few refractive surgeons wish to retreat patients, and as such bilateral LASIK treatment is commonly recommended. This is unfortunate as most patients wish to shed their glasses or their presbyopic

As part of the Basic Bookshelf for Eyecare Professionals series Denise Cunningham’s contribution on clinical ocular photography describes exactly what it says and gives a clear, basic explanation of a range of photographic skills and techniques needed to provide an ophthalmic photography service. Aimed at professionals in all branches of eye care, subjects covered include basic and scientific photography, ophthalmic photography, external eye, fundus photography, slit lamp photography, and fluorescein angiography with sections on relevant darkroom techniques and photographic organisation.

There are 140 pages including a comprehensive bibliography and useful index. The photographs used to illustrate various viewpoints are excellent and ingeniously devised—for example, the use a photograph of the face with drawings of the pattern of blood vessels held in front of each eye to show orientation. The quality of reproduction in the publication is somewhat lacking, although this is not glossy hardback and the price reflects this. It is suggested that gaining knowledge of the interpretation of fluorescein angiography, including pattern recognition and association with disease or disorders, will make individuals’ work more stimulating and also make them more valuable to the employer.

This book does not include digital photography of any kind and neither anterior segment fluorescein angiography nor indocya

nine green angiography get a mention. However, although the digital age is with us all, a good background awareness of silver based photography as related to ophthalmic photography is still very important, and this publication provides it.

ALISON FARROW


This book is a diagnostic atlas of ophthalmic ultrasonography and the diagnostic scanning techniques and labelling formats are described with clarity in the opening chapter. The techniques described are based on those of Karl Ossioing, which have been further refined by Sandra Byrne.

B-scans are taken using a dedicated eye scanner with a mechanically rocked single transducer producing a sector format image. The probe is coupled to the open eye with methyl cellulose. The dedicated eye scanners are much less sensitive than their more modern whole body counterparts, and often operators work on the open eye to avoid a reduction in sensitivity caused by attenuation of sound as it is transmitted through the eyelid.

This atlas contains over 400 diagnostic images, three quarters of which are B-scans. This reflects a shift in stress away from the A mode technique. Each chapter concentrates on a different portion of the globe. The resolution and grey scale on images is in general poor but, despite this, the authors illustrate some retinal tears and the diagnoses given in the clearly printed and comprehensive figure legends are correct.

The book does not cover colour flow mapping or spectral Doppler techniques nowadays used routinely to image blood flow. The authors generally attempt to determine blood flow in tumours by flickering of echoes as seen using A mode techniques.

I found this atlas to be a clearly presented and, within the limitations mentioned above, well balanced book. I would recommend it to all those using dedicated eye scanners, and to those starting out in ophthalmic ultrasound.

MARIE RESTORI


This book will, no doubt, sell well. It has a well known editor and many prominent contributors. The book has a high quality feel to it but is let down by the very poor photographic reproduction of many of the photographs taken from preoperative videos. James Davidson (chapter 12) can produce reasonable quality stills. Why can’t the other contributors? Tables and figures, taken from lectures, may look great on screen, but look tacky when incorporated into text. There is clearly no “house style” since some of the chapters have attractive line drawing figures in the text. The lack of style is irritating in a subject where presentation so is obviously important. Equally irritating is the needless repetition of some figures.

I found the title a little misleading since several of the chapters, particularly those towards the end of the book, really have very little to do with clear corneal incisions. The information on a small portion of the book actually deals with the incision itself. For the most part what you have is a series of descriptions of “How I do phaco” by a series of well known cataract surgeons, which is fine. Of course, there are lots of other books along the same lines and another would probably not look so attractive. What would be a catchy title for another of the same? Clear Corneal Lens Surgery? Am I being cynical?

Clear corneal cataract incisions were not practised very widely in the USA before phacoemulsification but many British and quite a few European readers will have been entertained at home with excellent demonstration through a clear corneal incision and will have been familiar with its many advantages over a corneoscleral incision. Thus, moving from a scleral tunnel to the cornea as they settled into phaco techniques was a natural and welcome step. I thought the chapter on historical background was superficial and lacking the detail which subsequent chapters contained. Expansion could have made a much more fluent introduction to the topic and would have helped put it in better context.

Reading most of the chapters in the main part of the book I found it difficult to believe I was not reading a formalised version of the authors’ talks on their favourite method of performing cataract surgery. There was a lot of description and opinion but not very much in the way of explanation or justification. This is not the sort of book that one could dip into, and it certainly is not the sort of “cookbook” that could take a beginner through a procedure. Someone trying to identify a technique that would suit his or her personal style would have to work quite hard to get what was wanted. The information is there but there is a great deal of repetition in the process.

JOEL A SILBERT

Director, Cornea and Specialty Contact Lens Service, The Eye Institute, Philadelphia, PA, USA
CD ROM REVIEW


This is one of a series of CD ROMs on international health produced by the Wellcome Trust. The series was originally planned as a replacement when the trust closed its museum of tropical medicine more than 10 years ago, and has been a long time in gestation. The available software has come a long way in the past 10 years, and we have to come to expect a degree of user friendliness that enables a computer illiterate such as myself to gain easy access to the material, but unfortunately this CD ROM did not come up to my expectations in this respect. It was only after some frustration and considerable help from my wife that I was able to get hold of the main menu. The menu revealed that the material was arranged in three main scenarios: a glossary, an image library, and a tutorial. The glossary is very broad and covers a wide variety of ophthalmological terms that bear no relation to trachoma. The image library is extensive, but includes a large number of pictures of Chlamydia trachomatis at various stages of its life cycle in tissue culture; it is hard to see that these will be relevant to most users with an interest in trachoma, who are unlikely to have access to tissue culture facilities. The other unfortunate, but undeniable fact is that all images are of very poor quality when viewed on standard PCs, whether desktop or laptop. I tried both, but the images were at best of advanced cartoon standard. The tutorial was well written and well planned, but also suffered seriously from the poor quality of the images; it would not be possible to learn how to diagnose or grade trachoma with images such as these.

In conclusion, given the choice, I would prefer a simple manual written on paper, which would be more easily accessible, and considerably more informative than this expensive produced CD ROM.

DAVID MABEY

NOTICES

Community participation in eye health and trachoma and the SAFE strategy

The latest issue of Community Eye Health (33) discusses provision of services for individuals with refractive errors with an editorial by Hugh R Taylor. For further information please contact Community Eye Health, International Centre for Eye Health, Institute of Ophthalmology, 11–13 Bath Street, London ECIV 9EL. (Tel: (+44) 0 20 7608 6909/ 6910/6923; fax: (+44) 0 7250 3207; email: ceph@ucl.ac.uk) Annual subscription £25. Free to workers in developing countries.

COLIN M KIRKNESS

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.

Guide Dogs for the Blind Association

The Guide Dogs for the Blind Association will host the 10th International Mobility Conference at Warwick University on 4–7 August 2000. Further details: Guide Dogs, c/o Michelle Grant, One Events (tel: 020 8682 2442; email: michelle@one-events.com).

Ophthalmology 2000

A conference “Eye care in the clinic and the community” will be held 9–12 August 2000 in Melbourne, Australia. Further details: John Keefe, Centre for Eye Research Australia at the Royal Victorian Eye and Ear Hospital, 32 Gisborne Street, East Melbourne 3002, Australia (tel: +61 3 9929 8360; fax: +61 3 9662 3859; email: 2000@cera.unimelb.edu.au).

American Institute of Ultrasound in Medicine—Millennium Ultrasound Course Series

A course entitled “Diagnostic Ultrasound in the 21st Century” will be held in New York City, NY, on 25–27 August 2000. Further details: Stacey Bessling, Public Relations Coordinator, AIUM, 14750 Sweitzer Lane, Suite 100, Laurel, MD 20707-5906, USA (tel: 301-498-4100; email: sbessling@aium.org).

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 Secretary, DR-2000, International Forum on Diabetic Retinopathy, MGR Congressi, Via Servio Tullio, 4, 20123 Milano, Italy (tel: 39 02 430071; fax: 39 02 48008471; 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, Schleischtrasse 12, 72076 Tuebingen, Germany. Further details: WTI- Wissenstransfer, Universitatis Tübingen, (tel: ++49 7071-29 76439; fax: ++49 7071 29 5051; email: wti@uni- tuebingen.de/wit).

30th Cambridge Ophthalmological Symposium

The 30th Cambridge Ophthalmological Symposium entitled “The Ageing Macula” will be held on 13–15 September 2000 at St John’s College Cambridge. Chairman: Professor Alan Bird. Further details: COS Secretariat, Cambridge Conferences, The Lawn, 33 Church Street, Great Shelford, Cambridge CB22 4EL (tel: 01223 847484; fax: 01223 847465; email: aashworth@easynet.co.uk).
Ophthalmic Anesthesia Society—14th Annual Meeting

European Association for Vision and Eye Research (EVER)
The European Association for Vision and Eye Research (EVER) will be meeting on 4–7 October 2000 in Palma de Mallorca, Spain. Further details: Secretariat EVER, Postbus 74, B3000 Leuven, Belgium (fax: +32 16 33 67 85; email: EVER@med.kuleuven.ac.be).

Fifth Annual Meeting of the Association for Ocular Pharmacology and Therapeutics
The Fifth Annual Meeting of the Association for Ocular Pharmacology and Therapeutics will be held on 2-5 November 2000 in Birmingham, AL, USA. Further details: Jimmy D Bartlett, OD, Department of Optometry, University of Alabama at Birmingham, 1716 University Blvd, Birmingham, AL 35294-0010, USA (tel: 205-934-6764; fax: 205-975-7052; email: jbartlett@icare.opt.uab.edu).

American Institute of Ultrasound in Medicine—Millennium Ultrasound Course Series
A course entitled “Ultrasound Diagnosis and Management of Fetal Growth Abnormalities” will be held in Marina del Rey, CA, on 12–14 January 2001. Further details: Stacey Bessling, Public Relations Coordinator, AIUM, 14750 Sweitzer Lane, Suite 100, Laurel, MD 20707-5906, USA (tel: 301-498-4100; email: sbessling@aium.org).

Mind’s Eye 2—Psyche and Sight Loss
The Society for Psychosomatic Ophthalmology and the British Psycho-Analytical Society present a conference “Mind’s Eye 2—Psyche and Sight Loss” on 4 November 2000 at the Institute of Psycho-Analyis, London. Further details: Mandy O’Keeffe, 67 Avenell Road, London N5 1BT (tel: 020 7288 2359; email: okeeffe@ukgateway.net).

12th Afro-Asian Congress of Ophthalmology
The 12th Afro-Asian Congress of Ophthalmology (Official Congress for the Afro-Asian Council of Ophthalmology) will be held on 11–15 November 2000 in Guangzhou (Canton), China. The theme is “Advances of ophthalmology and the 21st century.” Further details: Professor Lezheng Wu, Zhongshan Eye Center, SUMS, New Building, Room 919, 54 Xianle Nan Road, Guangzhou 510060, PR China (tel: +86-20-8760 2402; fax: +86-20-8777 3370; email: lwuicv@gzsums.edu.cn).

Singapore National Eye Centre 10th Anniversary International Congress
The Singapore National Eye Centre 10th Anniversary International Congress will be held in conjunction with 3rd World Eye Surgeons Society International Meeting on 2–4 December 2000 at the Shangri-La Hotel, Singapore. Further details: The Organising Secretariat, 11 Third Hospital Avenue, Singapore 168751 (tel: (65) 2277255; fax: (65) 2277290; internet: www.snecc.com.sg).

The Hong Kong Ophthalmological Symposium ’00
The Hong Kong Ophthalmological Symposium ’00 will be held 4–5 December 2000, in Hong Kong, China. Further information: Miss Vicki Wong, Room 802, 8/F Hong Kong Academy of Medicine, 99 Wong Chuk Hang Road, Aberdeen, Hong Kong (tel: (852) 2761 9128; fax: (852) 2715 0089; email: cohk@netvigator.com).

American Institute of Ultrasound in Medicine—Millennium Ultrasound Course Series
A course entitled “Obstetrical Ultrasound” will be held in New York City, NY, on 24–26 August 2001. Further details: Stacey Bessling, Public Relations Coordinator, AIUM, 14750 Sweitzer Lane, Suite 100, Laurel, MD 20707-5906, USA (tel: 301-498-4100; email: sbessling@aium.org).

Optometry Study Tour to Kenya, Tanzania, and Zanzibar
The tour offers a wonderful opportunity to optometrists and ophthalmologists to examine eye care in East Africa. It will take place from 28 January to 10 February. Further details: Master Travel, Croxted Mews, 288 Croxted Road, London SE24 9BY (tel: 0208 678 5320; fax: 0208 674 2712; email: tours@mastertravel.co.uk).

American Institute of Ultrasound in Medicine—Millennium Ultrasound Course Series
A course entitled “Obstetrical and Gynecological Ultrasound” will be held in New York City, NY, on 24–26 August 2001. Further details: Stacey Bessling, Public Relations Coordinator, AIUM, 14750 Sweitzer Lane, Suite 100, Laurel, MD 20707-5906, USA (tel: 301-498-4100; email: sbessling@aium.org).

Contributors please note:
Communications from all countries except the UK and Republic of Ireland should be sent to Professor C Hoyt, Editor, British Journal of Ophthalmology, University of California, Department of Ophthalmology, 10 Kirkham Street, K 301, San Francisco, CA 94143-0730, USA (tel: 001 415 502-6871; fax: 001 415 514-1512).

Manuscripts from the UK and the Republic of Ireland should be sent to Professor Andrew Dick, UK Editor, British Journal of Ophthalmology, Division of Ophthalmology, University of Bristol, Lower Maudlin Street, Bristol BS1 2LX (tel: +44 (0)117 929-4496; fax: +44 (0)117 929-4607).