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). It is known 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, and particularly, toothed instruments require thorough cleaning before sterilisation by autoclaving 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 corneal transplantation, 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 classic sporadic CJD 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.

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 be considered, 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, these guidelines, 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.

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Reply

EDITOR,—I thank Tullo and Taylor for their interest in our commentary and for highlighting the importance of the future of 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 of 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 instrumentation 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,

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Central serous chorioretinopathy complicated by massive bilateral subretinal haemorrhage

EDITOR,—We read with interest the report by Lip et al., describing a 43 year old Asian man with central serous chorioretinopathy (CSCR) complicated by massive bilateral subretinal haemorrhage. The authors attributed the massive haemorrhage to CSCR itself. As the authors have pointed out, massive subretinal macular haemorrhage could be due to several causes, including idiopathic polypoidal choroidal vasculopathy (IPCV). In their article, there is a colour fundus photograph of the left eye (Fig 3A) showing a small red nodule in the centre of fovea with surrounding subretinal hemorrhage. The lesion corresponds to the hyperfluorescent spot in the fluorescein angiogram (FA) and indocyanine green angiogram (ICGA) in the same figure (Fig 3B, C). These clinical pictures are still compatible with the diagnosis of IPCV, although the presence of massive subretinal haemorrhage precludes the visualisation of other classic features of IPCV. Recently, we have had the opportunity of examining a similar patient with massive subretinal haemorrhage in one eye, with a history of CSCR documented by FA. ICG of the other eye showed the presence of classic signs of IPCV including dilated choroidal vessels with terminal polyps. As CSCR and IPCV are both choroidal vascular diseases, their presence in the same eye or same patient is possible.

Financial and proprietary interest: Nil

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Reply

EDITOR,—We 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, bears 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
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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 ocularometry variables in Korean children of very preterm delivery. As for the sample under study (n=65) there are certain points to state. A main finding is that 17 eyes had cicatricial sequelae of the retina, the narrow definition apparently being dragging of the macula.

In this context one may wonder why the authors preferred Reese’s classification of the early 1950s, and not its acknowledged successor regarding cicatricial ROP. It even appears as if the Reese classification was not quite followed to the letter.

For comparison, in the same issue of BJ O in the US university clinic material published by Saunders et al 143 preterm subjects were collected over 13 months and 12% acquired threshold or prethreshold ROP. To our knowledge there is no reason to assume that the Korean university clinics are not on quite such a developed level, nor that the infant susceptibility regarding ROP would 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 setup, and with emphasis on subsequent refractive and ocularometry keratometry results. 1 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 indicated by the published main factor—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 6 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 involvement that myopia of prematurity seems to represent. Otherwise, the cryotherapy itself has been blamed for generating myopia, 2 but here it seemed to be subordinate to the severity of the eye disease for which the ablation therapy was applied.

HANS C FLEDELIUS
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Cell subpopulations in failed human corneal grafts

EDITOR,—In the well illustrated paper by Kuf- fova and co-authors, 1 conclusions are present on the role of different inflammatory cell phenotypes based on immunohistochemical findings in excised corneal transplants. The detailed pathological findings should be interpreted with caution as insufficient information is presented to support the clinical diagnosis of rejection in some of those patients with graft inflammation.

In several patients in Table 2, and all in Table 3, surface wound healing problems, graft melting, and spontaneous perforation are listed as postoperative complications. However, none of these are clinical features of graft rejection, even in experimental models of unmodified rejection. They are signs typical of HSV epithelial or necrotising stromal keratitis, which can complicate transplantation in patients taking postoperative steroid treatment, particularly in whom HSV keratitis is the primary corneal diagnosis. This possibility would be less likely if the indication for transplantation was a corneal disorder other than HSV or if viral infection was excluded by pathological study of the corneal specimens. It is also possible that in these specimens the immunological and clinical findings represent HSV recurrence accompanied by allograft rejection. However, I question the validity of the conclusions relating to rejection in specimens from those patients with signs indicating possible viral keratitis. This may explain in part, for example, the counterintuitive finding that the number of CD1a/MHC class II positive cells was not significantly higher in a group with severe inflammation at the time surgery than in the group with no inflammation.

D F P LARKIN
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Reply

EDITOR,—Larkin’s letter questions the pri-
mary diagnosis in the patients listed in Tables 2 and 3 and suggests possible herpes virus or-
igin from infiltration due to chronic epithelial film deficiency than to infectious causes. In our patients graft epithelial healing problems are more advanced retinal detachment. The remaining 30 eyes with cryotherapy were even reported as having no cicatricial ROP. With follow up at the ages of 3 months, 5 years, and 6 years. With the overall ROP severity recorded, it is important to state that 27% of the ROP cases had cicatricial sequelae of the retina, the narrow definition apparently being dragging of the macula.

In several patients in Table 2, and all in Table 3, surface wound healing problems, graft melting, and spontaneous perforation are listed as postoperative complications. However, none of these are clinical features of graft rejection, even in experimental models of unmodified rejection. They are signs typical of HSV epithelial or necrotising stromal keratitis, which can complicate transplantation in patients taking postoperative steroid treatment, particularly in whom HSV keratitis is the primary corneal diagnosis. This possibility would be less likely if the indication for transplantation was a corneal disorder other than HSV or if viral infection was excluded by pathological study of the corneal specimens. It is also possible that in these specimens the immunological and clinical findings represent HSV recurrence accompanied by allograft rejection. However, I question the validity of the conclusions relating to rejection in specimens from those patients with signs indicating possible viral keratitis. This may explain in part, for example, the counterintuitive finding that the number of CD1a/MHC class II positive cells was not significantly higher in a group with severe inflammation at the time surgery than in the group with no inflammation.

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1 Kuffova L, Holivá V, Lumdsen L, et al. Cell sub-
populations in failed human corneal grafts. Br J
deficiency was the cause of the epithelial healing problem and subsequent graft melting.

MARTIN FILIPPEC

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/Merotoja 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 1999.1 We described a classic case of Merotoja 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 indeed the condition can occur elsewhere.

In our patient, immunocytocytochemistry of the corneal button removed at keratoplasty showed no labelling of the amyloid deposits with antibodies to pre-albumin, amyloid A, and gelsolin. This was in contrast with other studies where amyloid stained with antisera to gelsolin.1 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.


Topical analgesia during retina laser photocoagulation

EDITOR.—We read with interest the report by Weinberger et al. evaluating the analgesic effect of topical 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. They agreed 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 of 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 asthmatics 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


As part of the Basic Bookshelf for Eyecare Professionals series Denise Cunningham’s contribution on clinical ocular photography does 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.

The photographs used to illustrate various viewpoints are excellent and ingeniously devised—for example, use the 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 indocyanine 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 ultrasound. It is intended to be a diagnostic atlas of the scanning techniques and labelling formats are described with clarity in the opening chapter. The techniques described are based on those of Karl Ossoinig, 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 advantage of a dedicated eye scanner is that they 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 conclusions 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 a “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 is so 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 incision. The information on the 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 entering a home with earlier reports on phacoemulsification 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.
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 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 ophthalmologic 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: cephsource@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 Acher, 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 Keeffe, Centre for Eye Research Australia at the Royal Victorian Eye and Ear Hospital, 32 Gibson Street, East Melbourne 3002, Australia (tel: +61 3 9929 8360; fax: +61 3 9962 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, MGR Congress, 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, Schleißngerstrasse 12, 72076 Tuebingen, Germany. Further details: WIT-Wissenstransfer, Universitäat Tubingen (tel: ++49 7071-29 76439; fax: ++49 7071 29 5051; email: wit@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 CB2 4EL (tel: 0223 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: 205-975-0010; 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 Las Vegas, Nevada, on 3–5 November 2000 at the Institute of Psycho-Analyis, London. Further details: Stacey O’Keeffe, 67 Arenvll Road, London N5 1BT (tel: 020 7288 2139; email: okeeffe@ukgateway.net).

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 Arenvll Road, London N5 1BT (tel: 020 7288 2139; 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.snc10.com.sg).

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).

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).