MAILBOX

Age related macular disease

EDITOR,—I am a retired doctor who suffers from the wet form of age related macular disease (ARMD) in both eyes. In the triangle of doctor, patient, and ARMD what are the implications for one of the key role holders, the ophthalmologists? Is there any longer a place for the phrase oft used by them “I am sorry I can do nothing further for you”? There is in fact a lot doctors can do both in practical terms and in more subtle shifts of attitudes and behaviour. For example, general practitioners often admit they know little of the disease and may refer a case which requires an early opinion through the usual channels, which may take weeks. Opticians may not refer at all when necessary. Who better to educate and remedy these deficiencies but the experts, the ophthalmologists. Likewise, much needed low vision clinics are more likely to be achieved if promoted by a consultant rather than by a pressure group of patients. Or a rethink on how to make the loss of eyesight more easily interpreted to patients for whom the word “Snellen” has little meaning—present criteria are primarily geared to use by professionals. Or an explanation that being registered blind has a different connotation from being totally blind and so on.

No general surgeon or physician nowadays would use such chilling words to a patient with a terminal or degenerative condition.

It has been said that everyone in the health service including patients is a manager. Do all doctors realise the word manager also applies to them? Who do they know what statutory power is? Do they know what statutory power is? Are social services hold the statutory powers? Do doctors see themselves as leaders of the clinical team which in turn exists for the purpose of serving the patient. Delay in the processing of forms for the purpose of serving the patient. Whose right exists for the purpose of serving the patient. Who do they think—present criteria are primarily geared to use by professionals. Or an explanation that being registered blind has a different connotation from being totally blind and so on.

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Reply

EDITOR,—Dr Teichmann is correct in stating that a larger sample size might possibly have demonstrated that graft recipients treated with systemic, in addition to topical, steroid have statistically significant improvement in outcome. However, as stated in the conclusion of the paper, we do not believe that our data are evidence of a major beneficial effect. If there is a small benefit, it is for readers to judge whether it justifies systemic steroid in addition to topical steroid. Weighing up possible benefits with risks, inconvenience, and cost is a decision often encountered throughout therapeutic medicine.

We would make two further points in response. Firstly, in our study the rejection episode was reversed in a much higher proportion of patients than in previously reported studies; the power calculation used in planning the trial was based on these reports. Secondly, our analysis of combined graft survival and rejection-free survival in the two treatment groups (Fig 4 in the paper) took into account the reversal of rejection in all systemic steroid treated patients, yet indicated very similar outcomes (indeed, marginally superior survival in the topical treatment group, not statistically significant) at 24 months from recruitment, when follow up was terminated.

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Indocyanine green guided laser photocoagulation in patients with occult choroidal neovascularisation

EDITOR,—I read with interest the paper by Weinberger et al.1 In this pilot study about ICGA guided photocoagulation of occult choroidal neovascularisation (CNV) in AMD, the authors provide evidence for a beneficial effect on visual prognosis by treating this CNV pattern. However, some issues can be raised about both inclusion criteria and patients’ selection and then about results.

On ICGA, all eyes included in the study show a choroidal neovascular network, with CNV size smaller than for the authors do not specify how many hot spots, plaques, or mixed lesions are in their sample. Indications for treatment, visual prognosis, and recurrence rate in these three CNV morphological types are quite different.1

Furthermore, a marked disproportion between eyes with pigment epithelial detachment (PED) (two cases) and those without PED (the remaining 19). We would make two further points in this method is questionable, since vascularised PED and RPE are definitely two distinct entities. Occult CNV has PED with a higher frequency of recurrence, probably due to the greater excitative activity of primary CNV and even if anatomical outcome of laser photocoagulation is satisfactory, the functional result is usually poor. Then the encouraging final visual acuity reported in the paper is probably biased by an anomaly sample composition and by improper grouping.

In order to draw definite conclusions and provide guidelines about ICGA guided laser treatment of occult CNV, there is a clear need for a randomised prospective, controlled clinical trial, with a larger population and a more realistic proportion between occult CNV with and without PED, and presenting separate final results for the two groups with regard to both anatomical and visual variables.

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Reply

EDITOR,—We thank Dr Da Pozzo for his inter-est in our paper. He raised a number of inter-esting points.

Patient selection for ICG guided laser pho-toacoagulation is extremely crucial. Functional results from different pilot studies on ICG guided laser photoacoagulation show various outcomes.1,2 This may be explained either by the patient selection or by the indications for ICG guided treatment. Especially, the defini-tion of the choroidal neovascular network in ICG angiograms is crucial since the interpre-tation of ICG angiograms is still under discus-sion.

Our interpretation of ICG angiograms for the detection of a CNV is based on the choroidal transit and recirculation phase of the detection of a CNV is still under discus-sion. ICG angiograms is crucial since the interpret-ation of ICG angiograms is still under discus-sion. Our interpretation of ICG angiograms for this study was not cited as a reference.

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Phacoemulsification combined with silicone oil removal through posterior capsulorhexis

EDITOR,—We read with interest the report by Fra et al and that our recent article in Ophthalmology was not cited as a reference.3 In this article we reported our experience at Moorfields Eye Hospital with 34 eyes pros-pectively evaluated to look at the efficacy and potential complications of combined cataract extraction and silicone oil removal with poste-rior chamber lens implantation. We also reported the method of Restori, ophthalmic ultrasound specialist at Moorfields Eye Hospi-tal, for calculating the IOL power in an oil filled eye. The procedure was safe and effective for these eyes that had often had many previous surgeries. The visual outcome in these eyes was generally good with improve-ment in visual acuity, even with recurrent reti-nal detachment secondary to macular pathology. We also concluded that it was safer to place a rigid posterior chamber implant after silicone oil removal due to potential contrac-tion of the anterior capsule limiting the view of the retina postoperatively. Our technique was a passive technique but might easily be done with the I/A handpiece as this group reported. We feel that it would have been appropriate for them to make reference to our study since it presents a much larger series with more detailed follow up.

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Susceptibility to ocular autoimmune disease

EDITOR,—We read with interest the Newsdesk piece in the March 2000 issue of the BJO,1 commenting on recent studies indicating a conceptual shift in the understanding of the molecular basis of differential susceptibility to organ specific autoimmune diseases. How-ever, we were disappointed that the Newsdesk piece was restricted to studies of the animal model of multiple sclerosis and not that of uveitis. In a paper published in 19972 we demon-strated that ocular specific antigens (S-antigen (arrestin) and interphotoreceptor retinoid binding protein (IRBP)), which are targets for pathogenic autoimmune processes, are expressed in the thymus of certain animals. Furthermore, we found that animals which express S-antigen or IRBP in their thymi are resistant to experimental autoim-mune uveoretinitis induced by the corre-sponding molecule, whereas the absence of thymic expression correlates with susceptibil-ity.

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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, 11–43 Bath Street, London EC1V 9EL. (Tel: (+44) (0) 20-7608 6909/ 6910/6923; fax: (+44) (0) 7250 3207; email: evy.resource@ucl.ac.uk). An annual subscription is £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.

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 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, Schleichstrasse 12, 72076 Tuebingen, Germany. Further details: WIT-Wissenstransfer, Universität Tuebingen (tel: ++49 7071-29 76439; fax: ++49 7071 29 5051; email: w.it@unituebingen.de; witt).

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 AF French. Further details: COS Secretariat, Cambridge Conferences, The Lawn, 33 Church Street, Great Shelford, Cambridge CB2 5EL (tel: 01223 847464; fax: 01223 847465; email: b.ashworth@easynet.co.uk).

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@jmed.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 Las Vegas, Nevada, on 3–5 November 2000. Further details: Stacey Bessling, Public Relations Coordinator, AIUM, 14750 Switzer Lane, Suite 100, Laurel, MD 20707-5906, USA (tel: 301-498-4100; email: sbessling@aium.org).

Mind’s Eye 2—Psyche and Sight Loss


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 Xianlie Nan Road, Guangzhou 510060, PR China (tel: +86-20-8760 2402; fax: +86-20-8777 3370; email: bbruicv@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.sne.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 9126; fax: (852) 2715 0089; email: cohk@netistrator.com).

American Institute of Ultrasound in Medicine—Millennium Ultrasound Course Series

A course entitled “Ocular Ultrasound” will be held in Marina del Rey, CA, on 12–14 January 2001. Further details: Stacey Bessling, Public Relations Coordinator, AIUM, 14750 Switzer 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 optomotists to examine eye care in East Africa. It will take place from 28 January to 10 February 2001. Further details: Master Travel, Croxted, 288 Croxted Road, London SE24 9BY (tel: 0208 678 5320; fax: 0208 574 2712; email: tours@mastertravel.co.uk).

First International Congress on Non-Penetrating Glaucoma Surgery

The First International Congress on Non-Penetrating Glaucoma Surgery will take place in Lausanne, Switzerland on 1–2 February 2001. Further details: Dr Tarek Shaarawy, Organising Committee, University of Lausanne, Hospital Ophthalmique Jules Gonin, Avenue de France 15, 1004 Lausanne, Switzerland (tel: 41 21 626 81 11; fax: 41 21 626 88 88; website: www.glaucoma-lausanne.org).

Call for papers—6th European Forum on Quality Improvement in Health Care, 29–31 March 2001, Bologna, Italy

Further details: BMA/BMJ Conference Unit, BMA House, Tavistock Square, London WC1H 9JP, UK (tel: ++44 (0) 20 7383 6409; fax: ++44 (0) 20 7383 6869; email: quality@bma.org.uk; website: www.quality.bmjgp.com).

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 Switzer Lane, Suite 100, Laurel, MD 20707-5906, USA (tel: 301-498-4100; email: sbessling@aium.org).

CORRECTION

In the April issue 2000 of the BJO there was a subediting error in Table 1 (p 433) of the paper by Frost and Sparrow (2000;84:432–4). The word “operated” should have been removed from lines 4 and 7 in the body of the table. We apologise to the authors and readers for this error.