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? Is there still a feeling among ophthalmologists that they continue to live in the halcyon days when being a doctor meant solely practising clinical medicine, while leaving the mundane business of getting the service to the patients to others. Doctors see themselves rightly as leaders of the clinical team which in turn exists for the purpose of serving the patient. Delay in the processing of forms for registration may mean little to the professionals but a great deal to the patient. Whose responsibility is this? Do doctors communicate sufficiently with social services which should play such an important part in the follow up service. Do doctors resent the fact that social services hold the statutory powers? Do they know what statutory power is?

Of all those using the National Health Service the patients are the most disempowered. Regrettably, as experience has shown, major changes in doctors' attitudes and practices are all too often brought about by events overtaking them.

Firstly, the ageing explosion, then the cataract explosion and soon, if patients' hopes are realised, the macular disease explosion. Ever increasing workloads for doctors and ever lengthening waiting times for patients solve nothing. Setting priorities, identifying problems, and making decisions for the future—in short, management, may be an unwelcome alternative for clinicians but it is likely to be more productive.

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Randomised controlled trial of corticosteroid regimens in endothelial corneal allograft rejection

EDITOR,—In the abstract of their paper Hudde *et al*[1] conclude that "In treatment of graft rejection, additional systemic treatment with 500 mg of methylprednisolone yields no significant benefit over intensive local corticosteroids alone."

The authors based their statement on the findings that a first episode of endothelial graft rejection could not be reversed in three of 19 patients (16%) treated with local steroids alone, while none of 17 failed to reverse when given additional systemic steroid.

Even though the benefit of the additional steroid therapy may not have been *statistically* significant because of the small numbers, there is no indication that with larger numbers it might not very well become significant. The authors did not, however, limit their dismissal to a lack of *statistical* significance of the outcome, but broadened it to the wider summary statement of "no significant benefit". Their data do not support such a sweeping condemnation. Reversal of the first graft rejection episode without a single failure in 17 patients would certainly constitute a strong clinical argument in favour of additional treatment with systemical steroids.

The authors do themselves admit that the statistical power of the study was such that it would only have been able to detect a difference in outcome of the order of 40%. Do they then reason that a difference in outcome of less than 40% is to be regarded as clinically irrelevant? Why was such an arbitrary statistical straightjacket chosen for this study?

Considering that no adverse effects of the systemic steroid treatment were observed, I regard the outcome of the study of clinical relevance, particularly since an increased cure rate of the first (and possibly successive) rejection episode is also likely to affect the long term outcome of these grafts.

In my opinion, this study does not disprove the efficacy of additional systemic steroid treatment for initial episodes of graft rejection.

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1 Hudde T, Minassian DC, Larkin DFP. Randomised controlled trial of corticosteroid regimens in endothelial corneal allograft rejection. *Br J Ophthalmol* 1999;**83**:1348–52.

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 so 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 four disc areas; 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.[2]

Furthermore, a marked disproportion between eyes with pigment epithelial detachment (PED) (two cases) and those without PED (the remaining 19), not reflecting the data provided by Guyer and colleagues in 1000 consecutive eyes,[3] characterises the examined population. The authors present the final anatomical and visual outcomes by considering all eyes as a single group; this method is questionable, since vascularised PED and RPE are definitely two distinct entities. Occult CNV with PED has a higher frequency of recurrence, probably due to the greater exudative activity of primary CNV[4] and, even if anatomical outcome of laser photocoagulation is satisfactory, the functional result is usually poor.[5] Then the encouraging final visual acuity reported in the paper is probably biased by anomalous 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 patterns, with regard to both anatomical and visual variables.

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1 Weinberger AWA, Knabben H, Solbach U, *et al.* Indocyanine green guided laser photocoagulation in patients with occult choroidal neovascularisation. *Br J Ophthalmol* 1999;**83**:168–72.
2 Guyer DR, Yannuzzi LA, Ladas I. Indocyanine green guided laser photocoagulation of focal spots at the edge of plaques of choroidal neovascularization. *Arch Ophthalmol* 1996;**114**:693–7.
3 Guyer DR, Yannuzzi LA, Slakter JS, *et al.* Classification of choroidal neovascularization by digital indocyanine green videoangiography. *Ophthalmology* 1996;**103**:2054–60.

4 Slakter JS, Yannuzzi LA, Sorenson JA, *et al.* A pilot study of indocyanine green videoangiography-guided laser photocoagulation of occult choroidal neovascularization in age-related macular degeneration. *Arch Ophthalmol* 1994;**112**:465–72.
5 Lim JI, Aaberg TM, Capone A, *et al.* Indocyanine green angiography-guided photocoagulation of choroidal neovascularization associated with retinal pigment epithelial detachment. *Am J Ophthalmol* 1997;**123**:524–32.

Reply

EDITOR,—We thank Dr Da Pozzo for his interest in our paper. He raised a number of interesting points.

Patient selection for ICG guided laser photocoagulation is extremely crucial. Functional results from different pilot studies on ICG guided laser photocoagulation show various outcomes.[1–3] This may be explained either by the patient selection or by the indications for ICG guided treatment. Especially, the definition of the choroidal neovascular network in ICG angiograms is crucial since the interpretation of ICG angiograms is still under discussion.

Our interpretation of ICG angiograms for the detection of a CNV is based on the choroidal transit and recirculation phase of ICG dye recorded with a scanning laser ophthalmoscope.[4] We consider this to be more accurate in determining the size, location, and geometry of CNV than the late phase. We have demonstrated that occult CNV defined by the MPS standards could be converted into visible neovascular membranes in up to 50% of cases independent of the presence of PED.[5 6] Using other imaging techniques, hot spots and plaque hyperfluorescence were used to convert occult CNV into visible CNV.[7 8] Previous studies on ICG guided laser photocoagulation rely almost exclusively on this interpretation of ICG angiograms.[1 2] However, it has recently been demonstrated that many eyes with hot spots in late ICG angiograms have polypoidal choroidal vasculopathy (PCV).[9] Since previous studies[1] did not differentiate between eyes with PCV and AMD, a quite significant proportion of eyes included in these studies may have had PCV instead of AMD (Slakter 1999, personal communication). This may have influenced their findings, since it is important to differentiate AMD from PCV because there are significant differences in the demographic risk profile, natural course, visual prognosis, and management of these patients.

Our study involved 175 consecutive patients undergoing ICG angiography for occult CNV secondary to AMD. We performed ICG guided laser photocoagulation only in eyes with occult CNV that demonstrated a visible extrafoveal or juxtafoveal neovascular network in the early ICG angiogram. In these eyes no hot spots or plaque hyperfluorescence were detected in the late angiograms. Only two eyes with PED were included in the study according to the inclusion criteria. This small number allowed no subgroup analysis. However, by analysing the 19 eyes without PED the results are even more promising.

We are aware that the eyes included in our pilot study may represent a special subgroup of eyes with occult CNV as pointed out in the original manuscript.[3] Additionally, this is well demonstrated by the small number of patients included in the study. However, reviewing our quite encouraging final visual results we feel very comfortable with ICG guided laser photocoagulation following our interpretation of ICG angiograms in occult CNV secondary to AMD.

We totally agree that there is a clear need for a randomised prospective, controlled clinical trial to prove the efficacy of ICG guided laser photocoagulation for occult CNV. Based on our promising results we would suggest following our approach for imaging and interpretation of ICG angiograms for this study.

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1 Slakter JS, Yannuzzi LA, Sorenson JA, *et al.* A pilot study of indocyanine green videoangiography-guided laser photocoagulation of occult choroidal neovascularization in age-related macular degeneration. *Arch Ophthalmol* 1994;**112**:465–72.
2 Lim JI, Aaberg TM, Capone A, Jr, *et al.* Indocyanine green angiography-guided photocoagulation of choroidal neovascularization associated with retinal pigment epithelial detachment. *Am J Ophthalmol* 1997;**123**:524–32.
3 Weinberger AWA, Knabben H, Solbach U, *et al.* Indocyanine green guided laser photocoagulation in patients with occult choroidal neovascularisation. *Br J Ophthalmol* 1999;**83**:168–72.
4 Wolf S, Wald KJ, Elsner AE, *et al.* Indocyanine green choroidal videoangiography: a comparison of imaging analysis with the scanning laser ophthalmoscope and the fundus camera. *Retina* 1993;**13**:266–9.
5 Wolf S, Knabben H, Krombach G, *et al.* Indocyanine green angiography in patients with occult choroidal neovascularization. *Ger J Ophthalmol* 1996;**5**:251–6.
6 Wolf S, Remky A, Elsner AE, *et al.* Indocyanine green video angiography in patients with age-related maculopathy-related retinal pigment epithelial detachments. *Ger J Ophthalmol* 1994; **3**:224–7.
7 Yannuzzi LA, Slakter JS, Sorenson JA, *et al.* Digital indocyanine green videoangiography and choroidal neovascularization. *Retina* 1992;**12**: 191–223.
8 Guyer DR, Yannuzzi LA, Slakter JS, *et al.* Digital indocyanine-green videoangiography of occult choroidal neovascularization. *Ophthalmology* 1994;**101**:1727–37.
9 Yannuzzi LA, Wong DW, Sforzolini BS, *et al.* Polypoidal choroidal vasculopathy and neovascularized age-related macular degeneration. *Arch Ophthalmol* 1999;**117**:1503–10.

Phacoemulsification combined with silicone oil removal through posterior capsulorhexis

EDITOR,—We read with interest the report by Frau *et al* and noted that our recent article in *Ophthalmology* was not cited as a reference.[2] In this article we reported our experience at Moorfields Eye Hospital with 34 eyes prospectively evaluated to look at the efficacy and potential complications of combined cataract extraction and silicone oil removal with posterior chamber lens implantation. We also reported the method of Restori, ophthalmic ultrasound specialist at Moorfields Eye Hospital, for calculating the IOL power in an oil filled eye with correction for the specific gravity of silicone oil taken into consideration. Our findings were that 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 improvement in visual acuity, even with recurrent retinal detachment or pre-existing macular pathology. We also concluded that it was safer to place a rigid posterior chamber implant after silicone oil removal due to potential contraction 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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1 Frau E, Lautier-frau M, Labétoulle M, *et al.* Phacoemulsification combined with silicone oil removal through posterior capsulorhexis. *Br J Ophthalmol* 1999;**83**:1406–7.
2 Larkin G, Flaxel CJ, Leaver P. Phacoemulsification and silicone oil removal through a single corneal incision. *Ophthalmology* 1998;**105**: 2023–7.

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. However, 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 1997[2] we demonstrated 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 thymus are resistant to experimental autoimmune uveoretinitis induced by the corresponding molecule, whereas the absence of thymic expression correlates with susceptibility.

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PUWAT CHARUKAMNOETKANOK
IGAL GERY
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1 Newsdesk. Susceptibility to autoimmune disease explained? *Br J Ophthalmol* 2000;**84**:238.
2 Egwuagu CE, Charukamnoetkanok P, Gery I. Thymic expression of autoantigens correlates with resistance to autoimmune disease. *J Immunol (Cutting Edge)* 1997;**159**:3109–12.

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: eyeresource@ucl.ac.uk) Annual subscription £25. Free to workers in developing countries.

Residents' Foreign Exchange Programme

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

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, Universitat 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 5EL (tel: 01223 847464; fax: 01223 847465; email: b.ashworth@easynet.co.uk).

Ophthalmic Anesthesia Society—14th Annual Meeting

The Ophthalmic Anesthesia Society will hold its 14th annual meeting on 15—17 September 2000 at the Wyndham Chicago Hotal, Chicago, Illinois, USA. Further details: Allied Management Associates (tel: 760-751-8841; fax: 760-751-8842; we: www.amianc.com).

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 Las Vegas, Nevada, on 3–5 November 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).

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-Analysis, 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 Xianlie 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.snec.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 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).

Optometry Study Tour to Kenya, Tanzania, and Zanzibar

The tour offers a wonderful opportunity to optometrists and opthamologists 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 674 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, Hopital Ophtalmique 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.bmjpg.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 Sweitzer Lane, Suite 100, Laurel, MD 20707-5906, USA (tel: 301-498-4100; email: sbessling@aium.org).

CORRECTION

In the April 2000 issue 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.