Figure 2 Mean IOP and 95% confidence intervals before and after diode laser TSCPC.

(45%) had systemic hypertension (HTN) and eight (16%) had both HTN and diabetes mellitus.

Postoperative IOP was significantly lower ($P < 0.01$). At the first postoperative visit, 21/49 (43%) patients had an IOP of ≤ 21 mm Hg and 25/49 (51%) had $> 50\%$ reduction in IOP (Figure 2). There was a strong correlation between the energy used and the percent IOP reduction at postoperative visit 1 (Pearson correlation -0.443 , $P = 0.016$). Analysis of variance did not identify higher preoperative ($F = 0.7511$, $P = 0.48$) or postoperative IOP ($F = 1.449$, $P = 0.25$) in the groups with systemic disease. In all, 4/49 (8%) patients had IOP < 5 mm Hg. Three of these eyes were NLP before TSCPC. No choroidal hemorrhage, retinal or choroidal detachment was recorded.

Conflict of interest

The authors declare no conflict of interest.

References

- 1 Egbert PR, Fiadoyor S, Budenz DL, Dadzie P, Byrd S. Diode laser transscleral cyclophotocoagulation as a primary surgical treatment for primary open-angle glaucoma. *Arch Ophthalmol* 2001; **119**: 345–350.
- 2 Preussner PR, Ngounou F, Kouogan G. Controlled cyclophotocoagulation with the 940nm laser for primary open angle glaucoma in African eyes. *Graefes Arch Clin Exp Ophthalmol* 2010; **248**: 1473–1479.
- 3 Agrawal P, Dulku S, Nolan W, Sung V. The UK National Cyclodiode Laser Survey. *Eye (Lond)* 2011; **25**: 168–173.
- 4 Spencer AF, Vernon SA. "Cyclodiode": results of a standard protocol. *Br J Ophthalmol* 1999; **83**: 311–316.
- 5 Lin P, Wollstein G, Glavas IP, Schuman JS. Contact transscleral neodymium:yttrium-aluminum-garnet laser cyclophotocoagulation Long-term outcome. *Ophthalmology* 2004; **111**: 2137–2143.

N Mavranakas¹, K Dhalla², I Kapesa², A Alibhai^{2,3} and I Murdoch^{1,4}

¹Glaucoma Service, Moorfields Eye Hospital, London, UK

²Comprehensive Community Based Rehabilitation for Tanzania (CCBRT) Disability Hospital, Dar es Salaam, Tanzania

³Faculty of Health Sciences, Western University, London, Ontario, Canada

⁴Department of Epidemiology and International Eye Health, Institute of Ophthalmology, University College London, London, UK

E-mail: i.murdoch@ucl.ac.uk

Eye (2013) **27**, 453–454; doi:10.1038/eye.2012.269; published online 11 January 2013

Sir,

This is a letter to the editor

In *Eye* 2012 (correspondence section), there is a letter written by B Drury and F Imrie¹ which I would like to address. In this correspondence, they describe an unfortunate accident in which the parent of a child undergoing vision therapy was struck by a screw when performing tasks with a ball attached to a string. The authors use this as an opportunity to strike out at all of behavioural optometry, calling into question the methods they use; they even go one leap forward and question the efficacy of vision therapy.

The question at hand is not the efficacy of the procedures used, but the obvious bias on the part of the authors in this attack. When performing a therapy task, no activity is failsafe. This is true for vision therapy, occupational therapy, physical therapy, and so on. If a patient receiving orientation and mobility training after losing sight bangs into something and gets a cut, should we then question the efficacy and safety of that type of training as well?

In closing, while I am sorry to hear of the incident that took place, I implore the authors and readers to simply look up the word 'accident' in the dictionary or online.

Conflict of interest

The author declares no conflict of interest.

Reference

- 1 Drury B, Imrie F. An unexpected complication of behavioural vision therapy. *Eye* 2012; **26**(11): 1495.

MB Taub

Southern College of Optometry, Memphis, TN, USA
E-mail: mtaub@sco.edu

Eye (2013) **27**, 454; doi:10.1038/eye.2012.271; published online 18 January 2013