state whether corneal scrapings were taken or what the culture results of the scrapings were. The fact that they administered topical ofloxacin, however, suggests at least a clinical suspicion of active infection.

My personal experience suggests that sub-Tenon's or other invasive local anaesthetic are not necessary for the procedure of corneal gluing. This can be accomplished quite satisfactorily using topical anaesthesia in every case with which I have dealt. (A highly uncooperative patient would generally be unsuitable for gluing since they also presumably would be uncooperative following the procedure, with a risk of eye rubbing.)

Perhaps, therefore, the main lessons to be drawn from this case report are, firstly, that if invasive local anaesthesia is not necessary, it should not be used, and secondly, that it should be used with extreme caution in the presence of suspected or proven active infection of the external eye.

References

1 Redmill B, Sandy C, Rose GE. Orbital cellulitis following corneal gluing under sub-Tenon's local anaesthesia. *Eye* 2001; **15**: 554–556

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Sir,

The article by Shah *et al* (*Eye* **15**; 616–620) does a service to ophthalmologists by drawing our attention to the existence of this distressing visual symptom in the eyes of young adults with advanced glaucoma. I would concur that the simplest explanation would be that of a circulatory 'steal'. It is worth remembering that the phenomenon is not restricted to this age group, and is probably to be found more frequently among the elderly. In this older age group, not only exercise (of such a trivial nature as climbing stairs) but also hot baths have been reported to me as causing the same symptom. Avoidance of the causative action, aspirin, and stricter IOP control appear to be the safest remedies on offer to reduce the frequency of attacks.

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Sir,

The Royal College of Ophthalmologists Cataract Surgery Guidelines: what can patients see with their operated eye during cataract surgery?

I am indebted to Mr Au Eong for pointing out some inaccuracies in the Information for Patients (Appendix 1) section of the Royal College of Ophthalmologists Cataract Surgery Guidelines and for documenting the clinical studies on the subject.[1] It is of course correct to say that patients *may* lose some or all of their vision after receiving local anaesthetic, particularly if given by the retrobulbar or peribulbar route, and during surgery they may experience a number of visual sensations, most usually a variety of colours.

The challenge however when writing patient information is to keep the advice clear and succinct for the majority, and yet not misleading.

Patients *do* need to be reassured that they are not going to 'see the operation' in detail, and warned that they will be dazzled (in the majority of cases, 100% with topical anaesthesia) by an extremely unpleasant bright light at the beginning of the operation. It is these aspects that are most likely to cause concern without prior warning.

Happily nowadays the more invasive forms of local anaesthesia are becoming increasingly rare in the UK, and hence the advice is most relevant for patients undergoing sub-Tenon's or topical anaesthesia.

I agree that there is a place for additional preoperative counselling in order to cover more completely the variety of sensations that the patient may experience so as to allay potential fears. Once suitably reassured, however,