I can confirm that Case 1 had both a central 24/2 Humphrey visual field and the standard DVLA binocular Esterman visual field test. As you mention, Case 1 passed her driving test without being aware of any field defect. With regard to Case 2, I am unable to trace any disc photographs. I was in touch with the DVLA and their ophthalmological advisers regarding Case 1 and can report that her driving licence was returned to her approximately 6 months ago, after a great deal of negotiation.

We hope that the recent modifications in field standards proposed by the DVLA, dated 7.7.02, will reduce the risk of peremptory loss of licence and livelihood in the future.

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Sir,

Congenital nasolacrimal duct obstruction requiring external dacryocystorhinostomies in a child with foetal valproate syndrome

Congenital nasolacrimal duct (NLD) obstruction is usually an isolated defect, but may be associated with craniofacial abnormalities. We present a case of bilateral congenital nasolacrimal duct obstruction treated by external dacryocystorhinostomy (DCR) in a 15-month-old child with foetal valproate syndrome. Multiple ocular associations with foetal valproate syndrome have been reported including strabismus, myopia, nystagmus, epicanthic folds, infraorbital creases and dry eye, but nasolacrimal duct obstruction has not previously been reported.[1,2]

Case report

A 15-month-old boy with dysmorphic features presented to the eye department with recurrent eye infections. Ocular examination was normal, and refraction showed myopic astigmatism and anisometropia. Syringing and probing of the tear passages under general anaesthetic confirmed the presence of bilateral lacrimal sac mucocoeles with bony nasolacrimal duct obstruction at 28 mm from the puncta in the right and 25 mm in the left. A dacryocystogram confirmed dilated lacrimal drainage systems bilaterally. Bilateral external DCRs without tubes produced a complete resolution of his symptoms. Figure 1 shows the patient following the right DCR and before the left DCR.

He was born at 32 weeks gestation with a birthweight of 1.69 kg. His mother had epilepsy (treated with sodium valproate), smoked cigarettes, and was a nondrinker. On examination he was found to have hypotonia, developmental delay, and dysmorphic facial features including a broad nasal bridge, congested face, narrow palpebral fissures, low-set ears and redundant skin folds on his forehead (Figure 1). He also had bilateral clinodactlyly, single palmar creases, bilateral undescended testes, hypospadius, broadly spaced second and third toes, and a large atrial septal defect with pulmonary artery stenosis. Evaluation for chromosomal aberrations, inborn errors of metabolism, and congenitally acquired infections was unremarkable. A clinical geneticist diagnosed foetal valproate syndrome.

Comment

Congenital NLD obstruction is a common clinical problem affecting 5–6% of newborns, many of which

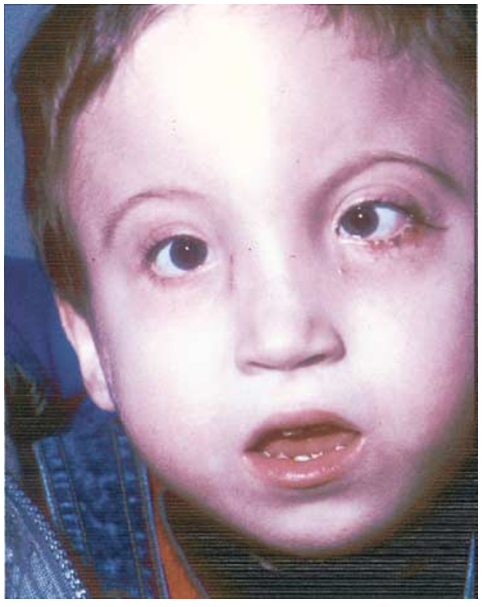

Figure 1

resolve spontaneously by the age of 12 months.[3] The lacrimal outflow system begins to develop early in embryogenesis, and genetic or environmental factors (teratogens, eg sodium valproate) that influence the development at this stage are likely to result in lacrimal disorders.[4] Sodium valproate is a popular anticonvulsant drug because of its broad range of anticonvulsant effects and relative freedom from sedative and behavioural effects. It is also a teratogen shown to cause neural tube defects in animals, which are prevented by folic acid supplementation. A distinctive dysmorphic syndrome is seen in some cases in humans.[5] The proportion of infants affected when the mother is on monotherapy is said to lie between 2.5 and 10%. There seems to be a genetic predisposition to teratogenic effects of valproate, and the recurrence risk to siblings of an affected child seems to be greater. The craniofacial features consist of brachycephaly with a high forehead, shallow orbits, and prominent eyes. The eyebrows are thin or 'neat'. There is said to be an unusual fold of skin below the lower eyelid. The mouth is small, the upper lip long and thin, and the lower lip prominent.[6]

Epiphora is common in children with craniofacial syndromes and may be due to soft tissue abnormalities (such as lateral displacement of the medial canthi or displacement of the puncta) or bony abnormalities (such as maxillary hypoplasia).[7] For the paediatric patient with abnormalities of the lacrimal drainage system that do not respond to probing or other less invasive methods, DCR may be performed with minimal morbidity and a high degree of success, particularly in the absence of canalicular disease (96% in a large series by Hakin *et al*[8]). When planning surgery, the expected benefits must be weighed against the possible anaesthetic risks in these children who frequently have systemic abnormalities as in this case.[9] The surgical failure rate in children is not significantly higher in adults and the causes of failure are the same. The success rate in children with developmental anomalies was 94% in a large series, which was better than in children with infections (88%), trauma (89%), and functional epiphora (50%).[9]

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Sir,

Primary retinal detachment surgery

We read with interest the recent issue of *Eye* (July 2002) that included the papers of the Cambridge Ophthalmological Symposium on the various aspects of retinal detachment. In particular, the editorial by Scott[1] and the article by Asaria and Gregor[2] caught our interest.

It seems now an accepted practice that all retinal detachment surgery is performed in tertiary referral centres or by vitreoretinal surgeons carrying out surgery in district general hospitals. In this light, we would like to share with your readers the results of an audit carried out in a district general hospital on the outcome of primary retinal detachment surgery performed by general ophthalmologists. This audit coincidentally preceded a decision by the department to refer all patients with retinal detachment to the regional vitreoretinal centre when their services were established.

This retrospective audit included all the patients who underwent retinal detachment surgery in the hospital during a 5-year period ending in 1999. All of the 58 patients underwent conventional scleral buckling