In our study, a significant reduction in oxygen saturation was not observed in the treatment group. We agree that the draping duration was longer than an average time especially for phacosurgeons. The cases of transition to phacoemulsification had been included in the study. The duration of draping may be an example of several conditions such as resident cases, hard or complicated cases, etc. The study may also be a guide to other ophthalmic surgeries such as cataract surgery combined with glaucoma surgery, vitreoretinal surgery, etc. It has been shown that carbon dioxide concentration under the drape 15 min after covering reached 3.5% in unsedated subjects.[3] This means that even in shorter-time cataract surgery, CO_2 retention under surgical drape is quite possible. Without suction system, 5–10 l O_2, which can cause drying in mucous membranes and air insufflation may disturb the patients, may be preferred, but with suction system high O_2 flow is not needed and CO_2 is removed off from the environment.[4–6] As seen in previous studies, not even fresh gas flows up to 10 l/min prevented the accumulation of CO_2 under the drapes. The rate of CO_2 in expired air, and thus CO_2 rate in inspired air is reduced.[3,7] Suction system is a simple equipment, easy to handle and does not necessitate so much effort. Suction of surrounding air combined with low-dose oxygen supply seems to be an adequate means of preventing CO_2 retention.[3–6] The suction system will be especially helpful in patients with pre-existing severe cardiovascular and pulmonary disorders that were not included in our study or in patients having prolonged draping duration.

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Eye (2004) **18,** 789–790. doi:10.1038/sj.eye.6701305
Published online 27 February 2004

Sir,

What patients recall of the preoperative discussion before cataract surgery: results of a questionnaire survey

Ophthalmologists have an ethical and legal obligation to give a fully informed consent so that the patients can make an intelligent decision prior to cataract surgery.[1] Serious errors in patient's understanding and recollecting the information given pre-operatively can lead to medical malpractice litigations.[2] This prospective study was undertaken to determine the percentage of preoperative information, about cataract and cataract surgery-related complications surgery, retained on the day of surgery.

In all, 82 patients undergoing elective phacoemulsification with intraocular lens implantation were included in this study. At 2 weeks prior to the operation, each patient received a standardised written and verbal explanation about cataract surgery and the possible complications. There were 55 patient's undergoing surgery for the first eye and 27 for the second eye. A study questionnaire was designed to check patient's recall of preoperative information provided on the day of surgery. A trained nurse read out the questionnaire for patient's who had difficulty reading it. Questions, phrasing, and intonation were standardised to avoid any bias. Also, all the questions included a 'don't know' option.

In all, 92.3% of patients found the combined information provided by the nurse on pre-operative assessment visit, and through the booklet to be useful. The mean accuracy of correct information recalled was 38.9% in the first eye surgery and even lower in second eye group at 32.9%. This was surprising as the second group of patients not only had heard the consent before but also had undergone both the preoperative process and the postoperative course. Patient's recall of information relating to the complications (including

infection, haemorrhage, dropped nucleus, blindness and loss of eye) was poor in both the groups. Patients in our study were questioned on the day of surgery, which is earlier than most of the other studies;[3,4] still the recall of information was poor. It could be argued that the anxiety provoked on the day of surgery might have prompted them to give wrong answers. However, a previously published study[5] has shown that the mean anxiety provoked by cataract surgery is more on the day of preassessment than on the day of surgery itself.

Cognition and memory in this elderly group of patients (mean age 76.6±8.2 years) was not measured. Elderly patients and impaired cognition have been associated with poor information recall[6] and we believe that these factors played a role in poor information recall. Our study shows that patient's recall minimal of the preoperative discussion. It highlights the importance of ophthalmologists to pursue at exceeding length their patient's education. Verbal and written information supplied to a patient may be understood, but is easily and quickly forgotten.[7] To realise the full potential of informed consent, the preoperative discussion must undergo further changes in order to avoid any misunderstanding and potential medico-legal litigations.

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Presented as a poster at 15th Congress of Royal College of Ophthalmologists, Birmingham, UK, 2003

Eye (2004) **18,** 790–791. doi:10.1038/sj.eye.6701420
Published online 16 April 2004

Sir,

Cataract surgery in latex allergy patients

In Cheung and Gillow's[1] comprehensive review of latex allergy, they cite their own 'brief telephone audit' to assert that the awareness of latex allergy in ophthalmic theatres is 'fairly low'. In my experience in three UK regions, the reverse is true. There is a heightened awareness of latex allergy among theatre staff, leading to a distorted risk assessment and an over-reactive response in the majority of cases. This can lead to unnecessary cancellations, last-minute disruption to theatres and theatre lists, and exposure of patients to the risks involved in their surgeon using unfamiliar gloves and equipment.

As the authors point out, a history of 'latex allergy' is nonspecific and often relates to a contact irritant dermatitis. However once elicited, this usually leads uncritically to latex allergy precautions. The disruption and costs involved in creating a 'latex free' environment could be avoided in many cases if healthcare staff distinguished between irritant dermatitis and true allergic skin reactions, or anaphylaxis. As with penicillin allergy, the true prevalence is much lower than that reported by patients; with penicillin it is less than 5% of those claiming allergy.[2,3] The presence of latex antibodies, or positive skin patch testing is no guide to clinically relevant latex allergy.[1] In fact, there is no correlation between them.[4] It seems that a history of actual allergic reactions has to be relied upon for guiding clinical practice and precautions.

Latex allergy is rare, even among health workers regularly exposed to latex.[5,6] The prevalence may or may not be increasing. What does appear to be increasing is the number of patients citing a history of latex allergy.

A search of the medical literature reveals no reported cases of allergic reactions to latex following an ophthalmic surgical procedure; only a local reaction from a Tonopen cover.[7] This suggests that precautions in latex allergy should extend to instruments and products that come into direct contact with the patient, or gases they breath, that is, from anaesthetic equipment. Some of the precautions enforced for latex allergy cases seem excessive, and are unwarranted by the evidence.

The disruption and delay caused by these cases will have been experienced in most ophthalmic theatres, and