

of globe perforation inherent in sharp-needle intraconal injection (although this was not encountered in Southampton). Clearly we make great efficiency savings by being less reliant on anaesthetic cover, especially when providing theatre time for acute surgical VR work.

The paper goes on to state that 51.7% of the cases included in the study are 'retinopexy + / - vitrectomy'. This could be interpreted as a significant proportion in the LA group simply receiving retinopexy for retinal tear.

Clarification on the above will be welcomed.

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Sir,

### Response to Goldsmith *et al*

We were interested in Goldsmith *et al*'s comments on our recent paper.<sup>1</sup> We are aware that subtenons anaesthesia is used for VR surgery;<sup>2</sup> however, to achieve a rate of 87%, under local anaesthesia, is certainly impressive. The authors are not clear on their own use of sedation. In some units nearly all patients are sedated, and in others it is rarely used. We have tailored our use to measured patient satisfaction outcomes performed over the last 5 years,<sup>3–4</sup> and clearly have a lower threshold for their use than Goldsmith *et al*. This may be because we have access to an experienced anaesthetist for our VR lists.

The Royal College of Ophthalmologists 2004 guidelines on cataract surgery do not specify the necessity of anaesthetist presence where blunt needle subtenons anaesthesia is required, such anaesthetic cover is recommended where sharp needle anaesthesia and/or sedation is required.<sup>5</sup> Arguably in VR surgery anaesthetic cover is more important given the longer and more unpredictable nature of the surgery.

We note with interest Goldsmith *et al*'s comment that grouping all retinopexy patients may bias the results. However, our previous work showed that the laser and

cryopexy were more important determinants of discomfort during vitrectomy than other aspects of the surgery, and so these were analysed as one group.<sup>2</sup>

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Sir,

### The urgency and site of retinal detachment surgery

Four letters in the correspondence section of The Journal prompt me to join the debate about the setting in which retinal detachment surgery is undertaken, both with respect to urgency and surgical facility.<sup>1–4</sup> This is an ongoing debate and has been discussed in This Journal before.<sup>5</sup>

The first fallacy that needs to be highlighted is about the urgency of management of macula-on detachments. Although it is taken for granted that all macula-on detachments should be operated on within hours of

presentation, if not minutes, there is no scientific evidence to support this. The body of published evidence about the timing of surgery roughly divides into two groups. One set of reports indicate that the timing of surgery should be within 1 month of macular detachment.<sup>6-9</sup> The other group of reports indicates that there is no benefit in urgent surgery as long as scheduled surgery can be performed within 7-10 days.<sup>10-13</sup> Thus, best evidence-based practice would dictate that surgery for 'macula-on' detachments should be a scheduled event within 7 days of occurrence. This evidence shows that there is no need for out-of-hours surgery, be it over the weekend, as the outcome has not been scientifically shown to be better. In fact, there is an argument to support the contention that out-of-hours surgery may have worse results for various reasons, including the absence of an appropriate team, limited facilities, and possibly a senior trainee operating unsupervised. Perhaps it is time to heed the 'my mother' test. I recently saw a colleague's mother with a macula on retinal detachment on a Friday afternoon with a 5-day history of acute onset floaters. I offered to operate on her the same night, at which she responded 'what have you been doing all day!' I honestly responded that I had been operating all morning and then had a busy clinic in the afternoon, at which she suggested that I could not be expected to operate at my best that night and she would rather have her surgery on Monday morning.

The second fallacy in this debate is the perceived divide between tertiary centres and district general hospitals. Clearly, the divide should be between surgeons with adequate experience and those without, irrespective of the setting in which they practice. Therefore, a consultant in a district general hospital with the skills and facilities would entirely appropriately operate on retinal detachments but the unsupervised senior trainee (fellow/ASTO) would not, even in a tertiary referral centre.

There needs to be a radical rethinking on the appropriate management of retinal detachments, especially the 'urgent' ones, and this debate needs to be informed by evidence not opinion.

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## Sir, Methylprednisolone pulse therapy in patient with isolated superior oblique myositis

Idiopathic orbital myositis (IOM) is a type of orbital pseudotumour in which one or more extraocular muscles can be involved. However, oblique muscle involvement is much less common than rectus muscle.<sup>1</sup> In a large series of 75 patients with IOM, involvement of lateral rectus muscle was found to be 33% and followed by medial rectus (29%), superior rectus (23%), inferior rectus (10%), inferior oblique (3%), and superior oblique