Dr Tsakok endeavoured to prove his point by applying his test to data that appears in several publications.[1,6,7] According to his findings, we failed to detect significant differences in the total number of breaks and in the best-corrected visual acuity between scleral buckling and vitrectomy 6 months after surgery (Table 3[1]).

We used the widely applied statistical package SPSS 11.5 (Chicago, IL, USA). The data were tested for normality of distribution using the Shapiro-Wilks test, and the equality of variance was confirmed using Levene's test. SPSS computes two-test statistics for the two-sample *t*-test: one for cases in which the variances in both groups are equal, and the other for cases in which they differ. If the variances differed significantly, we implemented the latter test in conjunction with the relevant significance values. Furthermore, due to the retrospective nature of our study, we stressed that the findings might not be generally applicable.[1] According to currently widely accepted standards,[8,9] we are still convinced that the statistical methodology employed in our study was appropriate.

We agree with Dr Tsakok respecting the importance of the Behrens-Fisher problem. According to our literature search, the Tsakok test has as yet neither generally been recognized within the scientific community nor widely applied for the solution of comparable statistical problems. It may well prove to be superior to the statistical tests currently applied to clinical data, but it must first be validated by independent statisticians.

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Eye (2007) **21,** 101–102. doi:10.1038/sj.eye.6702402; published online 19 May 2006

Sir,

Response

In the Tables of our article, we gave the values of CRP, IL-6, and VCAM-1 as medians and interquartile ranges due to the skewed distribution of these markers. Giving the values in actual serum concentrations enables other investigators to compare their findings to ours. After log transformation to correct skewness, these variables conformed in a satisfactory manner to Normal distribution and were therefore analysed with parametric tests. We did not give the values of the means and standard deviations of the log transformed values because it would not be clinically useful. We trust the medians and interquartile ranges are enough to describe the levels and variances of the measured values.

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Eye (2007) **21,** 102. doi:10.1038/sj.eye.6702403; published online 5 May 2006

Sir,

Advantages of modular phacoemulsification training

Modernising Medical Careers will require rapid and effective training of tomorrow's ophthalmologists, but a recent survey showed that only 42% of trainees reach the Royal College's target of 50 completed phacoemulsifications within 2 years.[1]

We advocate modular phacoemulsification training, in which the procedure is broken down into component modules. The trainee performs a given module, starting with the easiest, for all suitable patients on a list.[2] The learning curve for each stage of phacoemulsification is steepest during the first attempts, and modular training allows morale-boosting improvements in speed and proficiency during a single list. As only a single module is learnt at a time, advice from the trainer can be exacting without the SHO being overburdened, and can immediately be implemented during the next case. Additional lists can be devoted to gaining competence in a module that is causing problems.

If offered a single procedure per week, we suggest that trainees experience heightened stress when operating, and may attempt to rush parts of the procedure if a time limit is imposed. By contrast, a modular system allows trainees to perform a single part of each procedure carefully without causing delays. If experiencing difficulties, the trainee can ask the trainer to take over, knowing that they will usually have further opportunities to operate on the same list.

As the speed of performing each module improves, the trainee can perform several modules during each procedure without causing the list to overrun. In our experience, within 10 weeks of modular training, first year SHOs can learn to perform complete phacoemulsification procedures quickly and safely. Over 6 months, two consecutive first-year senior house officers underwent modular training in our DGH. Of 149 phacoemulsification procedures, 34.2% were observed by an SHO, 50.3% part performed by an SHO, and 15.4% performed by an SHO alone (a mean of 3.8 procedures per week). One case performed by an SHO (0.67%) required a suture to ensure wound stability.

We would encourage trainers to consider a modular approach, having found that it allows rapid progress in learning phacoemulsification without compromising efficiency or patient safety.

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No funding received. No proprietary interests declared. This material has not previously been presented elsewhere

Eye (2007) **21,** 102–103. doi:10.1038/sj.eye.6702404; published online 12 May 2006

Sir,

Use of the operating microscope for scleral buckling

A limited number of reports exist in the literature regarding the use of the operating microscope in conventional retinal detachment surgery.[1]

Case report

The majority of surgeons use magnifying loupes or their naked eye when performing scleral buckling surgery. Complications arising from scleral perforation can, however, compromise the anatomic and visual outcome of retinal detachment surgery.[2,3] We performed a case note review of 377 consecutive patients undergoing scleral buckling between June1996 to December 2002 to evaluate the incidence of inadvertent scleral perforation when using the operating microscope. Scleral perforation was recognized by the sudden release of subretinal fluid with softening of the eyeball, presence of fluid vitreous during the passage of the scleral suture, or unusual lack of resistance during the passage of the needle with nonvisualization of the tip of needle. This was confirmed by the presence of choroidal, subretinal, or vitreous haemorrhage on indirect ophthalmoscopic examination.

An Ethibond-spatulated (5/0) suture was used to secure the buckling element to the sclera.

Two patients (0.53%) had inadvertent scleral perforation during circumferential placement of a scleral suture by a trainee surgeon. No macular haemorrhage was seen. The clinical features of these patients after 2 months follow-up are summarized in Table 1.