

The biopsy showed embryonal rhabdomyosarcoma. These account for 83% of rhabdomyosarcoma cases.⁵

Current treatment modalities have greatly improved the prognosis for these tumours with the reported 5-year survival rate of embryonal rhabdomyosarcoma up to 94%.⁶

References

- 1 Brichard B, De Potter P, Godfraind C, Vermeylen C. Embryonal rhabdomyosarcoma presenting as conjunctival tumor. *J Paediatr Haematol/Oncol* 2003; **25**: 651–652.
- 2 Taylor D, Hoyt C. *Practical Paediatric Ophthalmology*. Blackwell Science: Oxford, 1997.
- 3 Joffe L, Shields JA, Pearah JD. Epibulbar rhabdomyosarcoma without proptosis. *J Paediatr Ophthalmol* 1997; **14**: 364–367.
- 4 Shields C, Shields J, Hanovar S. Clinical spectrum of primary ophthalmic rhabdomyosarcoma. *Ophthalmology* 2001; **108**: 2284–2292.
- 5 Sekundo W, Roggenkämper P, Fischer HP, Fleischhack G, Flühs D, Sauerwein W. Primary conjunctival rhabdomyosarcoma: 2.5 years' follow-up after combined chemotherapy and brachytherapy. *Graefes Arch Clin Exp Ophthalmol* 1998; **263**: 873–875.
- 6 Kodet R, Newton WA, Hamoudi AB, Asmar L, Wharam MD, Maurer HM. Orbital rhabdomyosarcomas and related tumours in childhood: relationship of morphology to prognosis—an Intergroup Rhabdomyosarcoma Study. *Med Pediatr Oncol* 1997; **29**: 51–60.

A Smith, A Gupta, R Bonshek and B Leatherbarrow

Department of Ophthalmology, Manchester Royal Eye Hospital, Oxford Road, Lancashire M13 9WH, Manchester, UK

Correspondence: A Smith,
Tel: +44 0161 276 1234;
Fax: +44 0161 276 4753.
E-mail: amysmith1@talk21.com

Commercial interest: None

Eye (2007) **21**, 281–283. doi:10.1038/sj.eye.6702528;
published online 28 July 2006

Sir,
Forniceal conjunctival pedicle grafts

We have read with interest the article on Superior Forniceal Conjunctival Advancement Pedicles by T Sandinha *et al*¹ in the January 2006 issue of *Eye*.

While we appreciate the authors' work, we would like to state that the surgical procedure discussed therein has given encouraging results in our hands as well, in cases of impending and acute corneal perforations due to different aetiologies. The various advantages of the procedure, which is indeed a true transposition of the conjunctiva as compared to a rotation or gliding of the conjunctiva to an adjoining area, are very well highlighted in the above article.

We would like to illustrate one particular case where an inferior forniceal conjunctival transposition flap was performed by us in treating a paracentral perforation of the inferior cornea in a lady with Sjogren's syndrome secondary to rheumatoid arthritis (Figure 1). When all conventional treatment failed and a therapeutic graft to save the eye was the next option, a transposition conjunctival pedicle graft from the inferior bulbar conjunctiva was carried out under subconjunctival and limbal anaesthesia to cover the perforation. One month after the conjunctival flap surgery, her vision had

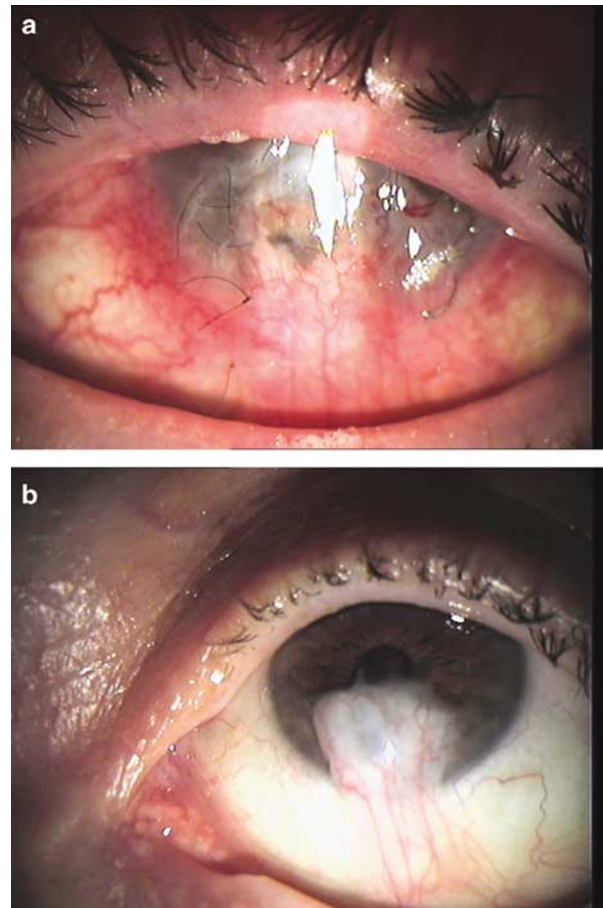


Figure 1 Transposition flap from lower bulbar conjunctiva. (a) Immediate post-operative photograph. (b) Photograph at 1 month post-operative period.

improved from HM before the procedure, to 6/9 with pinhole and the eye was comfortable with the infection having resolved. The conjunctival pedicle was divided at its base 6 months after the initial surgery with good corneal stability and the anterior chamber remains well formed to date. The eye is healthy and functional without the need for a corneal graft, recording an unaided visual acuity of 6/9 despite an inferior leucomatous opacity and localized anterior synechia.

The demonstrable usefulness of this surgical procedure with limbal tissues left undisturbed and providing valuable support to the diseased cornea prompts us to advocate its use in suitable cases more readily from any sector of the bulbar conjunctiva, depending on the site of the corneal pathology. It is also our view that this procedure need not always be a temporary stopgap measure to make an eye safe but can be used to restore structural and functional integrity of the eye.

Reference

1. Sandinha T, Zaher SS, Roberts F, Devlin HC, Dhillon B, Ramaesh K. Superior forniceal conjunctival advancement pedicles (SFCAP) in the management of acute and impending corneal perforations. *Eye* 2006; **20**(1): 84–89.

S Madhusudhan and KP Chandra

Department of Ophthalmology, HM Stanley Hospital, St Asaph, Denbighshire, North Wales, UK

Correspondence: KP Chandra,
Tel: + 1745 589765;
Fax: + 1745 589770.
E-mail: puvanachandra@aol.com

Eye (2007) **21**, 283–284. doi:10.1038/sj.eye.6702531;
published online 25 August 2006

Sir,
The presentation of data relating to visual acuity

We read with interest the excellent article entitled 'Late-onset visual decline following successful treatment of subfoveal choroidal neovascularisation with photodynamic therapy' by Bhatnagar and Musadi (*Eye* 2006; **20**: 491–493).¹ This observational study of four patients developing late increasing size of fibrotic scarring after photodynamic therapy (PDT) is very valuable for clinicians who manage choroidal neovascularisation.

It caught our attention that the visual acuity data were presented in several formats namely: number of lines lost, number of letters lost, and the reciprocal of logMAR (Figure 1). However, nowhere in the paper is the actual logMAR visual acuity shown. Most ophthalmologists (and especially those treating patients with PDT) are familiar with logMAR visual acuity units. If they were not then the reciprocal would surely leave them even more baffled. The only possible explanation was that the authors wished to present declining visual acuity with a negative slope.

LogMAR visual acuity is the accepted scientific means of presenting visual acuity in journals and for carrying out statistical analyses. Many feel that it should become the accepted means of testing vision in clinical practice.² Snellen eye charts suffer from well-known limitations of unequal changes in visual angle per line, letters of differing legibility, and different numbers of letters per line. Snellen charts are insensitive to changes in acuity at the top end of the chart where changes in visual acuity for patients with choroidal neovascularisation are important. The Bailey–Lovie or ETDRS chart was designed to overcome these deficiencies³ and is more reproducible and reliable.⁴ The use of the Snellen chart to define the threshold for PDT has also been questioned. Patients had to achieve 34 letters on a modified ETDRS chart to receive treatment under treatment of age-related macular degeneration with photodynamic therapy (TAP) study inclusion criteria. This is said to be equivalent to 6/60 Snellen, but in fact agreement is variable.⁵ We agree with the authors' avoidance of Snellen acuity.

All four patients reported by Bhatnagar are rightly considered to have had a disappointing result from PDT. Nonetheless, it is interesting to note that one of the four would meet the criterion for success according to such studies as the TAP study by virtue of having lost only 14 letters on the logMAR chart.⁶ Figure 1 in their paper illustrates concern that this criterion for success is of course partly governed by how much vision the patient still has to lose.

Therefore, we feel that journals should be promoting the clear presentation of logMAR visual acuity data. Familiarity with logMAR acuity values should be promoted not least in the field of TAP where logMAR visual acuity is an accepted means of monitoring progress.

References

- 1 Bhatnagar A, Musadiq M, Yang YC. Late-onset visual decline following successful treatment of subfoveal choroidal neovascularisation with photodynamic therapy. *Eye* 2006; **20**: 491–493.