Discussion

There might be the need for a high index of suspicion for retinal pigment epithelium tears in patients who report significant visual deterioration after intravitreal injection of anti-VEGF agents. Though retinal pigment epithelial tear following intravitreal injection of pegaptanib sodium has been reported by Dhalla *et al*.[6]

In view of the fact that the natural history of subfoveal minimally classic choroidal neovascularisation associated with or without fibrovascular PED is considered to be poor with respect to visual outcome and PDT results in this subgroup of patients have been unsatisfactory,[4] anti-VEGF therapy with bevacizumab was offered to the patient with full-informed consent while vision was still at an acceptable level.

Deterioration of vision did not occur in our patient because the fovea had been spared by the RPE tear and as shown by the OCT scans, it has remained apposed to the RPE (Figure 1f).

This is the first report where a retinal pigment epithelial tear has occurred following an intravitreal injection of bevacizumab. Further studies are required to determine whether specific angiographic subtypes of choroidal neovascularisation are more susceptible to developing retinal pigment epithelium tears after treatment with anti-VEGF agents.

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Eye (2007) **21,** 1004–1005; doi:10.1038/sj.eye.6702805; published online 4 May 2007

Sir,

Perceptions of patients to extending prescribing to nurses and pharmacists

An editorial, contained with the *British Medical Journal*,[1] suggested that the legislation passed by the Department of Health to extend prescribing rights to nurses and pharmacists, with adequate training, limited to specialist areas, could provide benefits to the patient by easing access to treatment. Current training programmes were deemed to be too short and unsatisfactory for subspeciality areas.

The perceptions of patients, regarding this legislation, have not yet been fully established. Four hundred patients in general and subspeciality clinics were interviewed by a doctor and invited to answer a questionnaire, in Ophthalmology departments in four hospitals. The questionnaire asked, whether patients felt confident in nurses and pharmacists prescribing medications to them, independently, if they were trained in a particular speciality, and if they were not trained in a particular speciality.

If they were not confident, they were asked to provide possible reasons why—whether they felt there was a lack of appropriate medical training for nurses or pharmacists or whether this was due to a lack of familiarity or a lack of supervision of the professionals involved.

Approximately 60% of patients were confident in trained specialist nurses (238/400) and pharmacists (241/400) prescribing medications independently to them. However, patients were mostly uncomfortable with the notion of untrained nurses (328/400, 82%) or pharmacists (340/400, 85%) prescribing medications to them. The reasons given by those patients answering negatively were as follows: 64% (249/400)—lack of appropriate medical training by nurses or pharmacists, 12% (46/400)—lack of familiarity with the prescriber, 6% (24/400)—lack of supervision and 18% (68/400)—all of the above reasons.

In addition, patients were asked whether they brought their medications or a list of medications with them, and were asked whether they understood their diagnosis, 77% correctly named their diagnosis. Only 19% of patients, however, brought a list of medications with them, which raises a concern that nurses or pharmacists may not be aware of other medications used, and hence not able to account for interactions.

In summary, a significant proportion of patients (40%) are not confident that nurses or pharmacists, with specialist training, can prescribe their medication. A larger proportion of patients (85%) do not appear to be confident with these professional groups prescribing, without additional training. This constitutes a major problem as the authority of specialist nurses or pharmacists will undoubtedly be in question.

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Eye (2007) **21,** 1005–1006; doi:10.1038/sj.eye.6702806; published online 13 April 2007

Sir,

Acute central retinal artery occlusion in Adamantiades-Behçet disease

Visual loss in Adamantiades-Behçet disease (ABD) usually results from chronic relapsing panuveitis. We report that ABD can be acutely blinding.

Case report

A 43-year-old male immigrant from Kosovo presented with acute, painless visual loss in the right eye, perceived on awakening. BCVA was hand movements in the right eye and 20/20 in the left eye, associated with a right afferent pupillary defect. Intraocular pressure was 10 mm Hg in both eyes. Few cells were found in the anterior chamber of both eyes and the vitreous of the right eye. Ophthalmoscopy showed a right retinal oedema with relative cilioretinal sparing, mild papillary hyperaemia and venous congestion. Multiple dot–blot haemorrhages were not present initially but developed within a few days (Figure 1). No clinical signs of previous intraocular inflammation could be seen in either eye.

The medical history of this patient revealed few episodic, ill-defined external eye inflammations, recurrent arthralgias, genital and oral ulcerations and diarrhoea. Echocardiography and carotid ultrasound showed no evidence of a source of embolism. Neither systemic hypertension nor diabetes was present.

A clinical diagnosis of ABD was established. Treatment with systemic corticosteroids (prednisolone 100 mg/d) was started and later replaced by interferon-α2a (3×9 MioIE/week). Optic atrophy developed within several weeks and final VA was 20/400 but no further ocular inflammatory episode was noted during a 3-year follow-up.

Comment

In our patient, acute CRAO was the first ocular event that led to clinical evaluation and diagnosis of ABD. Venous congestion and increasing retinal haemorrhages were indicative of co-existing obstruction of the central retinal vein and speak against an embolic event. In ABD, occlusive vasculitis and perivasculitis have been described histopathologically. We postulate that a focal arteritis in the anterior optic nerve and an involvement of the central vein through direct inflammation or secondary compression has occurred in this case.

To our knowledge this is the first report of CRAO without additional signs of previous intraocular inflammation in ocular ABD, although involvement of the optic nerve head in ABD is well described.[1] CRAO has been reported only once as a complication of advanced ocular ABD.[2]

Our case highlights that ABD contributes to the differential diagnosis of acute CRAO in a young patient.

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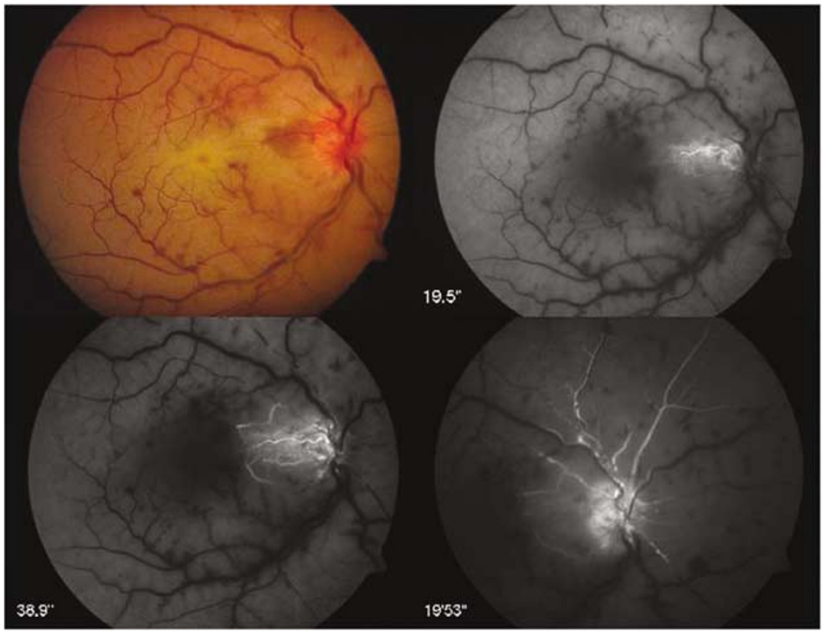

Figure 1 Fundus photography and fluorescein angiography obtained 3 days after presentation. Note grossly impaired perfusion, retinal whitening and relative cilioretinal sparing.