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*References*

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Sir,

We thank Buckley *et al.* for their comments regarding our paper entitled 'How much blame can be placed on laser photocoagulation for failure to attain driving standards?'[1]

We agree that pre-existing visual field loss can occur prior to laser treatment in patients with diabetes; however, the degree of any loss will depend on the degree of binocular enhancement and the sensitivity of the test employed.

Absolute or relative scotomas in one eye[2] can be cancelled by areas of normal sensitivity in the other eye. In addition, the binocular visual field is often enhanced such that the score is greater than that of both monocular visual fields when merged.[3]

Trick *et al.*[4] employed a visual field program which has a standard stimulus size parameter III, which at a stimulus-to-background ratio of 20 dB converts to Goldmann III 2e equivalent. The Esterman test which we employed uses a Goldmann III 4e equivalent which corresponds to 10 dB – a target of twice the contrast. If the Esterman test was performed pre-operatively, we would suggest that any field losses recorded would most likely be minimal.

With regard to intensity of burns, the first 25 consecutive patients had fully documented records of laser treatment. Intensity was individually applied to produce a greyish/white 200 μm burn and averaged 350 mW. This initial treatment protocol for panretinal photocoagulation was adopted for all subsequent patients and is similar to burns of moderate intensity used in the Seiberth study.[5]

We agree with Buckley *et al.* that deducing the optimum strategies which combine effective treatment with a wide functional visual field are complex and have yet to be established. However, we feel we have achieved the aims of our study to determine the prevalence of failure to attain driving standards and to determine the contribution of field loss solely attributable to treatment. We utilised a newly approved Esterman visual field test and gave guidelines relating to its score output.

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Sir,

In their paper entitled 'A novel conjunctival incision for horizontal strabismus surgery' (*Eye* 1995;9:282–4), Callear and Eagling recommended routinely performing conjunctival peritomy in standard strabismus procedures from 2 o'clock to 10 o'clock inferiorly, to allow access to the horizontal rectus muscles from below, the main advantages of this procedure over conventional surgery being a reduction in time taken to perform surgery and decreased discomfort in the post-operative period, with apparently no alteration in the long-term cosmetic effect. This technique, however, abandons the use of limbal stay sutures during the procedure. We would, there-

fore, like to emphasise the advantages of routinely employing limbal stay sutures during strabismus surgery:

(1) Placement of stay sutures at the 12 and 6 o'clock position at the limbus provides a fixed landmark and accurate reference point when determining the location and position of a muscle during surgery. This is particularly important when locating a muscle during reoperation, as well as aiding the identification of congenital anomalies of insertion, thereby minimising the risk of operating on the wrong muscle. Stay sutures are also useful in aiding accurate positioning of the globe when operating on muscles other than the horizontal recti, and in particular for procedures on the inferior oblique.

(2) Limbal stay sutures also facilitate accurate and reproducible traction testing. Forced duction tests performed at the start of the procedure are aided by gentle anteropulsion of the globe (produced by tension on stay sutures), thus resisting retropulsion which may give rise to a false negative response. Once the conjunctiva is opened, traction testing assesses the conjunctival and muscle components of any mechanical restriction. Equally, in the reverse situation, following reattachment of muscle and conjunctiva, traction testing with limbal stay sutures will identify mechanical restrictions due to tight conjunctiva or muscle. The gauging of a conjunctival recession is facilitated by using the stay sutures to maintain the eye in the direction opposite to the muscle being operated on.

(3) During the procedure of muscle recession, selective tension on the upper stay suture facilitates the placement of the upper muscle suture by creating a space between the muscle insertion site and the muscle hook, and likewise for the lower suture. Also, during muscle resection, when reattaching the muscle to the eye, stay sutures are used to maintain the eye in a position opposite to the muscle being operated on, so allowing the surgeon to gauge accurately whether any mechanical restrictions are being caused by the resection procedure. This helps to avoid the common complication of causing mechanical restriction of abduction, following a medial rectus resection.

Finally, in view of the many advantages incurred by the use of limbal stay sutures, we would strongly recommend that they be used as standard practice in strabismus surgery.

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Sir,

We are grateful to A. M. McElvanney and A. M. Ansons for their comments on our recent paper 'A novel conjunctival incision for horizontal strabismus surgery'. They draw attention to the many advantages of limbal stay sutures.

We wish to stress that our technique is advocated only for routine, primary strabismus surgery, and would not be considered in complicated cases.

In answer to some of their specific comments, we point out that the 2 and 10 o'clock positions marked by the extent of our conjunctival incision provide excellent landmarks for orientation during surgery.

An inferior peritomy allows direct visualisation of the Tenon's sheath surrounding the inferior oblique muscle if surgery on this muscle is planned.

There are many descriptions of forced duction testing in the literature. The forceps which grasp the sclera during the test may be used to provide anterior traction prior to rotation of the globe. This method is preferred by the authors.

During horizontal strabismus surgery we find that a combination of gentle manipulation using St Martin's forceps on bare sclera and traction on muscle hooks provides excellent exposure for identification and cleaning of muscles. A small degree of rotation of the muscle hook about the axis of its shaft aids easy placement of sutures prior to recession.

We recognise that the surgical details of strabismus surgery should vary according to individual preference. However, we are happy to say that we have found no reason to return to the routine use of stay sutures since adopting the technique that we describe.

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Sir,

The first individual I know of who reported that nasally sited filtration resulted in lowering intraocular pressures was Christina Raitta, who did an elegant study in *Ophthalmic Surgery* which reported this phenomenon.

Vernon and Spencer noted the same phenomenon in their interesting article on intraocular pressure control following micro-trabeculectomy.[1] A procedure similar to one they described has been performed at the Glaucoma Service of the Wills Eye Hospital for the last five or so years. Indeed, several of our surgeons utilised scleral flaps that are