

only 1 patient (0.59%) may have benefited from that follow-up visit. The authors rightly do not draw the conclusion that the retinal tear developed between the first and second examination. Although this is a possibility, the second examination was carried out by more experienced personnel and it is equally likely that the tear was present at the first examination. Therefore an alternative approach would be to ensure that patients with flashes and floaters are examined by an experienced funduscopist at the first visit. Patients should be educated about the symptoms of retinal detachment, and encouraged to re-attend promptly. Even if we do accept that tears can develop subsequently, the data in this study does not form a basis on which to formulate a rational follow-up policy.

The diagnosis of posterior vitreous detachment was made if the 'posterior face was seen to be separate from the retina'. We consider that the presence of a Weiss ring is essential for the diagnosis of posterior vitreous detachment, and this is not commented on.² Thus, it would seem reasonable to include all cases presenting with 'flashes and/or floaters'. This would give a diagnostic yield of 1/295 (0.34%).

When an audit is performed, completing the audit cycle and implementing change in procedures if indicated by the evidence provided is essential.³ Medical practitioners have an increasingly active role in distributing precious health care resources within the NHS. The evidence from this study does not justify the large volume of out-patient resources for follow-up examinations that the authors recommend.

J. F. Kirwan
G. W. Aylward
J. Downie
G. M. Thompson

St George's Hospital
Blackshaw Road
London SW17 0QT
UK

References

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Sir,
We thank Kirwan and colleagues for their interesting comments and for the chance to reply to some of the points that they raise.

We do not conclude that all patients who present with a symptomatic posterior vitreous detachment require follow-up but simply state that, given the potentially serious consequences of a missed retinal break, we feel justified in continuing to review these patients in our department on the basis of finding retinal breaks in 3 (1.9%) of the 157 patients who attended for follow-up. We agree that it cannot be shown whether the only tear which definitely required treatment (a horseshoe tear) occurred after the initial visit. In our large department the eye casualty is staffed by senior house officers and, although ideal, examination at presentation by senior staff of all patients presenting with flashes and floaters would be difficult to accommodate. The decision whether to carry out a 6 week review is for each individual department to make, and if the initial examination is made by a senior ophthalmologist we concur that a decision to abandon follow-up can arguably also be justified on the basis of our findings.

It is worth noting, however, that of the 55 patients (35%) who returned prior to their appointment due to a recurrence of symptoms, only 1 (1.8%) had any new pathology (a round hole which was lasered) – a percentage yield of pathology per number of patients examined similar to that identified at the 6 week appointment. Three breaks were identified in the remaining 102 (65%) asymptomatic patients at follow-up suggesting that, at least in our department, routine follow-up detects a larger number of patients with retinal breaks than giving a retinal detachment warning alone.

M. R. Dayan
D. G. R. Jayamanne
D. G. R. Andrews
P. G. Griffiths

Department of Ophthalmology
Royal Victoria Infirmary
Queen Victoria Road
Newcastle upon Tyne NE1 4LP
UK

Correspondence to:
Miss M. R. Dayan
Department of Ophthalmology
Royal Victoria Infirmary
Queen Victoria Road
Newcastle upon Tyne NE1 4LP
UK

Sir,
In their article 'Retinopathy in haemoglobin C trait' Hingorani *et al.*¹ report three cases in which haemoglobin C trait was associated with significant peripheral vascular occlusion and sea fan formation-retinal changes similar to those seen in patients with