

well-localised basal cell carcinomas. Like Mohs technique our approach facilitates reconstruction without increasing the risk of tumour recurrence. Multifocal, morphoeic or recurrent tumours, however, deserve either a wider excision margin or Mohs technique as advocated by Inkster *et al.*

References

1. Inkster C, Ashworth J, Murdoch JR, Montgomery P, Telfer NR, Leatherbarrow B. Oculoplastic reconstruction following Mohs surgery. *Eye* 1998;12:214–8.
2. David DB, Gimblett ML, Potts MJ, Harrad RA. Small margin (2 mm) excision of periocular basal cell carcinoma with delayed repair. *Orbit* (in press).

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Sir,

We thank Harrad *et al.* for their comments on our paper.¹ We appreciate that this country is currently underserved for Mohs surgery, and in its absence welcome any treatment modality which improves outcome. However, we would like to add a word of caution with respect to any surgical technique which reduces the size of excision margin without the benefit of total margin control. Although Harrad *et al.* are to be congratulated on their lack of recurrences to date, basal cell carcinoma may recur many years after the original treatment. In fact in our series, the recurrent tumours we treated had occurred up to eleven years after the initial treatment. Patients should be carefully counselled about the potential risks of undergoing a surgical procedure which may increase their chance of tumour recurrence.

We continue to recommend Mohs surgery for all tumours which are large, recurrent, morphoeic, at the medial canthus or present in younger patients.

Reference

1. Inkster C, Ashworth J, Murdoch JR, Montgomery P, Telfer NR, Leatherbarrow B. Oculoplastic

reconstruction following Mohs surgery. *Eye* 1998;12:214–8.

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Sir,

The paper by Gonglore and Smith (*Eye* 1998;12:976) made fascinating reading to a 'dinosaur' in his sixty-fourth year who converted to 'phaco' after 60+.

The history of the conversion was:

- (i) Phaco course 1974 under the auspices of Mr Arnott *et al.*, Charing Cross Hospital.
- (ii) 1975 (during the intracapsular era and iris-supported lenses), asking Mr Binkhorst whether he felt phacoemulsification was of benefit to his then novel technique of adhering his implant to the posterior capsule. (Audience in Cardiff and speaker somewhat bemused.)
- (iii) The discarding of phaco technique for twenty years, when the advent of sutureless, bloodless, clear corneal implantation of foldable lenses was added to: (a) viscoelastic protection of endothelium and posterior capsule, (b) the established benefit of rhexis, (c) the evolution of in-the-bag nucleofractis techniques, (d) the perfection of posterior segment in-the-bag implantation. (I remember a paper by Mr Kelman listing reasons why implants should be in the anterior chamber!)

I do not regret missing out on phaco in the 1980s. Sutures were still in use and corneal decompensation apparently became the most common cause of a graft in the USA.

I do regret having missed a few years of scleral sutureless surgery with 5 mm rigid lenses, and had I known that the laterally placed 5 mm clear corneal, uniplanar valve was stable without sutures (Khatib and Karseras, unpublished 1998) I would certainly have converted before foldables.

I do hope this 'dinosaur' has been of some ophthalmological archaeological interest.

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Sir,

The dubious accolade of 'dinosaur' is usually awarded to those who, by being unable or unwilling to adapt to change, are at risk of failing to meet current standards of best practice. Mr Karseras has rightly pointed out that the change from extracapsular cataract extraction to phacoemulsification is only one of a number of advances in cataract surgical technique which have come about during the last 25 years. He also makes the very important point that, although it would have been possible to convert directly from intracapsular cataract extraction to phacoemulsification in the early 1970s, the results would probably have compared unfavourably with the best practice of the time. It was therefore right to regard phacoemulsification as an experimental technique until the many advances in equipment, lens implant materials and surgical technique of the 1970s and 1980s had ensured reliable results.

Mr Karseras has successfully managed the transitions from simple intracapsular extraction through intracapsular extraction with iris-supported implant, through extracapsular extraction with posterior chamber implant to phacoemulsification with foldable implant during his professional career. The fact that the last transition has taken place after the age of 60 is proof in itself that he is no 'dinosaur'.

Personal observation suggests that adaptability amongst ophthalmologists correlates poorly with chronological age and has more to do with quality of training and personality. We are living in an era where there is intense competition for training places in ophthalmology and strong encouragement to train towards excellence in sub-specialty areas. Are we selecting and training the innovators of the future, or are we breeding tomorrow's 'dinosaurs'? More research is needed.

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