

subjects on initial testing. Repeat perimetry using the same screening test at an interval of 2 weeks found abnormal results in only 7.8% of subjects. Goldmann perimetry by a skilled perimetrist subsequently confirmed a glaucomatous visual field defect in only 1.1% of subjects. Thus, individuals referred with an isolated visual field defect without confirmatory repeat perimetry comprised another source of unnecessary false positive referrals in our study.

We acknowledge that increased perimetric threshold variability may be an early indication of glaucomatous loss of visual function with static achromatic perimetry. It is therefore possible that some cases of early glaucoma were incorrectly labelled as false positive referrals in our study. However, the learning effect is a far more common cause of perimetric variability in population screening given the low prevalence of glaucoma. It is therefore customary to consider that an individual does not have glaucoma if repeat perimetry demonstrates a normal field. This approach has generally been adopted in studies of visual field screening, including those referenced by Dr Spry.^{2,5}

References

1. Newman DK, Anwar S, Jordan K. Glaucoma screening by optometrists: positive predictive value of visual field testing. *Eye* 1998;12:921-4.
2. Katz J, Tielsch JM, Quigley HA, Javitt J, Witt K, Sommer A. Automated suprathreshold screening for glaucoma: the Baltimore Eye Survey. *Invest Ophthalmol Vis Sci* 1993;34:3271-7.

3. Dielemans I, Vingerling JR, Wolfs RC, Hofman A, Grobbee DE, de Jong PT. The prevalence of primary open-angle glaucoma in a population-based study in the Netherlands: the Rotterdam Study. *Ophthalmology* 1994;101:1851-5.
4. Vernon SA, Henry DJ, Jones SJ. Calculating the predictive power of the Henson field screener in a population at increased risk of glaucomatous field loss. *Br J Ophthalmol* 1990;74:220-2.
5. Harper RA, Reeves BC. Glaucoma screening: the importance of combining test data. *Optom Vis Sci* 1999;76:537-43.

D.K. Newman ✉
S. Anwar
K. Jordan

Department of Ophthalmology
West Suffolk Hospital
Hardwick Lane
Bury St Edmunds
Suffolk IP33 2QZ, UK

Sir,

I noted an inaccuracy in the article on cataract surgery by Tan *et al.*¹ In this article they use the term 'extracapsular cataract surgery' for manual extracapsular cataract surgery. According to my definition of extracapsular cataract surgery, phacoemulsification is also a form of extracapsular cataract surgery.

I have observed this nomenclature in other medical literature. Is it not time we applied more accurate terms to describe our operations? I would suggest

'manual extracapsular surgery' to more accurately describe this operation, to distinguish it from extracapsular cataract surgery performed with the aid of phacoemulsification.

Reference

1. Tan JHY, Newman DK, Klunker C, Watts SE, Burton RL. Phacoemulsification cataract surgery: is routine review necessary on the first post-operative day? *Eye* 2000;14:53-5.

N.C. Andrew, FRCS, FRCOphth ✉
Ophthalmology Department
Kent and Canterbury Hospital
Ethelbert Road
Canterbury CT1 3NG, UK
Tel: +44 (0)1227 766877
Fax: +44 (0)1227 864178

Sir,

We acknowledge that phacoemulsification cataract surgery is a form of extracapsular cataract surgery. The term 'manual extracapsular surgery' could be usefully applied to distinguish it from extracapsular cataract surgery performed with the aid of phacoemulsification.

J.H.Y. Tan ✉
D.K. Newman
C. Klunker
R.L. Burton

Department of Ophthalmology
Leicester Royal Infirmary
Leicester LE1 5WW, UK
Tel: +44 (0)116 254 1414
Fax: +44 (0)116 258 5927