

for cataract surgery and can help us to further improve our outcomes.

References

- 1 Hospital Episode Statistics HES England 2007/08, 25/02/2009.
- 2 Narendran N, Jaycock P, Johnston RL, Taylor H, Adams M, Tole DM *et al.* The Cataract National Dataset electronic multicentre audit of 55 567 operations: risk stratification for posterior capsule rupture and vitreous loss. *Eye* 2009; **23**: 31–37.
- 3 Kuchle M, Viestenz A, Martus P, Handel A, Junemann A, Naumann GO. Anterior chamber depth and complications during cataract surgery in eyes with pseudoexfoliation syndrome. *Am J Ophthalmol* 2000; **129**: 281–285.

S Goverdhan, L Anderson, A Lockwood and J Kirwan

Department of Ophthalmology, Queen Alexandra Hospital, Portsmouth, UK
E-mail: james.kirwan@porthosp.nhs.uk

Eye (2010) **24**, 389–390; doi:10.1038/eye.2009.121; published online 5 June 2009

Sir,
Responding letter

This article has highlighted and quantified another important risk factor for posterior capsular rupture (PCR) that was not analysed as a part of our series of 55 567 cases as ACD is not currently a part of the Cataract National Dataset. Adding this variable to the risk stratification model would undoubtedly improve its predictive value and we will therefore include it in the future rounds of multi-centre data collection. I also intend to incorporate the risk stratification model within the Medisoft electronic medical record so that clinicians can have access to an accurate estimate of the risk of PCR when planning surgery.

Conflict of interest

The author is the Medical Director of Medisoft Limited.

R Johnston

Ophthalmology Department, Cheltenham General Hospital, Cheltenham, Glos, UK
E-mail: rob.johnston@glos.nhs.uk

Eye (2010) **24**, 390; doi:10.1038/eye.2009.124; published online 5 June 2009

Sir,
The Cataract National Dataset

We congratulate Narendran *et al*¹ on their study of the risk factors for posterior capsule rupture (PCR) and/or vitreous loss (VL), using data from the Medisoft electronic patient record (EPR). The multicentre analysis includes data from our own unit, and findings are broadly in line with our clinical experience. The authors state that ‘completeness of these (EPR) records is detailed and unusually high’, although there was no attempt to quantify the accuracy of clinical data. If these data are inaccurate, then the assessment of risk may also be inaccurate.

We attempted to quantify the accuracy of data entry for ‘ocular risk factors’ by sending an anonymous questionnaire to ophthalmologists in our unit. We asked whether, when recording a cataract operation on Medisoft, risk factors were recorded ‘always’, ‘sometimes’, ‘never’, or ‘only if complications occurred’. The response rate was 55% (11/20). One respondent did not use Medisoft; thus 10 responses were analysed.

Only one respondent (10%) stated that they ‘always’ entered all data on risk factors, although no respondent ‘never’ entered any of these data. One respondent admitted to only recording certain risk factors if a complication occurred. Recording rates were different for each risk factor (Table 1).

This small pilot study does indicate a significant degree of under-reporting of ocular conditions, by ophthalmologists who use Medisoft. The fact that some will record a risk factor ‘only if a complication occurs’ is a

Table 1 Recording rates for different risk factors

Risk factor	Glaucoma	Diabetic retinopathy	Brunescent/white cataract	Vitreous opacities/No fundal view	Pseudo-exfoliation/phacodonesis	Small pupil	Medium pupil
Proportion of respondents who ‘always’ record this risk factor, when present	6/10	7/10	3/10	5/10	3/10	1/10	1/10
Proportion of respondents who ‘never’ record this risk factor, when present	1/10	0/10	3/10	2/10	2/10	3/10	4/10
Proportion of respondents who record this risk factor, when present, ‘only if there is a complication’	0/10	0/10	0/10	0/10	0/10	1/10	1/10
Overall proportion of respondents that record risk factor ^a	77.5%	90.5%	49.5%	64.5%	58.5%	40.5%	31.5%

^aThis is the sum of ‘always’ and ‘sometimes’.