

the unusual ERM appearance in our patient presumably reflects this situation. Interestingly, experimental subretinal injection of PFCLs results in phagocytosis of PFCL by RPE within 3 h of injection,<sup>4</sup> which may help explain the appearances of the epiretinal RPE in our patient.

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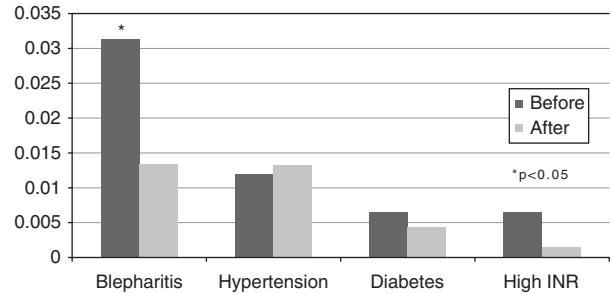
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Sir,  
**Reducing the rate of cataract surgery cancellation due to blepharitis**

On-the-day cancellation of cataract surgery causes much distress for the patient and increases the burden on already stretched services, in addition to significant financial implications. A primary risk factor for endophthalmitis is thought to be local eyelid disease, with the majority of cases attributable to the patients' own flora.<sup>1,2</sup> Current guidelines therefore suggest that surgery is postponed pending disease control, usually with a lid hygiene regimen.<sup>3</sup> We recently assessed the efficacy of applying a blanket policy of lid hygiene advice to all pre-operative cataract patients with a view to reducing the number of cancellations due to blepharitis.

In audit cycle 1 ( $n = 960$ ), case notes were reviewed retrospectively over a 5-month period and the reasons for on-the-day cancellation were recorded. Subsequently, all patients received both verbal and written advice about how to clean their eyelids and why it was necessary. Cancellation data were then collected prospectively over a 4-month period ( $n = 677$ ). A significant reduction in the incidence of cancellations due to blepharitis was noted ( $P = 0.03$ , odds ratio 0.45) Figure 1.



**Figure 1** Proportion of operations cancelled before and after instituting lid hygiene measures.

Unfortunately, diagnosis of significant blepharitis is based on a subjective assessment that makes generating any strict audit criteria difficult and introduces a potential confounding factor. However, on an intention-to-treat basis we believe that providing all preoperative cataract patients with lid hygiene advice can help reduce cancellation rates. Although it is difficult to prove this would reduce endophthalmitis rates (there were no cases in either audit period) one would intuitively believe so. Assuming a constant cancellation rate from the first audit cycle (3%), this simple, non-invasive policy is estimated to have saved our trust £11 000 over a 4-month period.

**Conflict of interest**

The authors declare no conflict of interest.

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Sir,  
**Ocular hypertension and glaucoma in Graves' orbitopathy**

I read with interest the article by Silva *et al.*<sup>1</sup> The authors are not aware of corticosteroids usage in the study. Although corticosteroids may be used to treat Graves'

orbitopathy,<sup>2</sup> such medications are also associated with increased intraocular pressure and glaucoma.<sup>3</sup> Failure to consider this, would bias the frequency of ocular hypertension and glaucoma in patients diagnosed with Graves' orbitopathy.

#### Conflict of interest

The author declares no conflict of interest.

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Sir,

#### Response to Kittisupamongkol. Graves orbitopathy: frequency of ocular hypertension and glaucoma

Thank you for the opportunity to respond to Dr Weekitt Kittisupamongkol's comments. In our service, steroids are used only during small periods of time (typically 15 days) to treat patients with the active phase of Graves' orbitopathy. None of the 107 patients studied presented with this condition. All the patients included in the study were in the chronic (cicatricial) phase of the disease and thus were not using steroids. We apologize for not including in the paper the information that the presence of active orbitopathy was an exclusion criterion.

#### Conflict of interest

The authors declare no conflict of interest.

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#### Sir, Corneal hysteresis in eyes undergoing phototherapeutic keratectomy

We have read with interest the excellent work by Kamiya *et al*,<sup>1</sup> which investigated the corneal biomechanical properties in eyes undergoing phototherapeutic keratectomy (PTK) for the treatment of granular corneal dystrophy. In the study, corneal hysteresis (CH) was measured with an ocular response analyser before and 3 months after surgery. One of their main results was that the CH was significantly decreased from  $10.2 \pm 2.2$  to  $8.7 \pm 1.8$  mmHg after PTK.

Previous studies have investigated the relationship between CH and intraocular pressure (IOP). Kamiya *et al*<sup>2</sup> found that eyes with higher IOP are more predisposed to having lower CH. In another study, González-Méijome *et al*<sup>3</sup> reported that average changes in CH over time correlated well with the changes in IOP values. Although the relationship between CH and IOP has not been fully investigated, the current literature implies that IOP levels may affect the measurement of CH.

Kamiya *et al*<sup>1</sup> in their study mentioned that steroidal medications were topically administered postoperatively. The use of the medications may potentially lead to the elevation of IOP. The authors did not mention the IOP levels in eyes before and after PTK. On account of the potential effects of IOP levels on CH measurements, the decrease of CH may be because of the elevation of IOP. Thus, we suggest that the authors show IOP data and make a comparison of IOP levels before and after PRK.

#### Conflict of interest

The authors declare no conflict of interest.

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