

Sir,
Reply to Corneal hysteresis in eyes undergoing phototherapeutic keratectomy

We appreciate the insightful comments of Drs Qiu and Zhang on our published article.¹ We had shown earlier that eyes with higher intraocular pressure (IOP) are more predisposed to having lower corneal hysteresis (CH), indicating that IOP levels may affect the measurement of CH.² After phototherapeutic keratectomy (PTK), we topically administered the steroid, fluorometholone (0.1%), four times daily for 1 week, the dose being gradually reduced thereafter. However, the corneal compensated IOP measured with an Ocular Response Analyzer (Reichert Ophthalmic Instruments, Depew, New York, USA) was 15.8 ± 3.8 mm Hg preoperatively and 16.3 ± 3.9 mm Hg 3 months postoperatively. No significant IOP rise as a result of the response to the steroid occurred in any eye during the follow-up period. Accordingly, we consider that IOP did not significantly affect the measurement of CH in eyes undergoing PTK in this study.

Conflict of interest

The author declares no conflict of interest.

References

- 1 Kamiya K, Shimizu K, Ohmoto F. The changes in corneal biomechanical parameters after phototherapeutic keratectomy in eyes with granular corneal dystrophy. *Eye* 2008; 19 December 2008 [e-pub ahead of print].
- 2 Kamiya K, Hagishima M, Fujimura F, Shimizu K. Factors affecting corneal hysteresis in normal eyes. *Graefes Arch Clin Exp Ophthalmol* 2008; **246**: 1491–1494.

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Sir,
Features of common variable immunodeficiency

I read with interest the article by Harsum *et al.*¹ The authors state that the diagnosis of common variable immunodeficiency (CVID) is made on the clinical history of recurrent infection, usually of the respiratory tract, in the context of reduced total IgG. However, Some points need to be clarified. Other causes of hypogammaglobulinaemia, for example, nephrotic syndrome and haematological malignancies, must be ruled out before the diagnosis of CVID has been made. So complete blood count with differential, urine protein

analysis must be performed.² History of medications is also crucial. Corticosteroids, gold salts, penicillamine, antimalarial drugs, sulphasalazine, fenclofenac, phenytoin, and carbamazepine can contribute to hypogammaglobulinaemia.²

References

- 1 Harsum S, Lear S, Wilson P. CVID causing a granulomatous uveitis and optic disc neovascularisation mimicking sarcoid. *Eye* 2009; **23**(1): 241–242.
- 2 Park MA, Li JT, Hagan JB, Maddox DE, Abraham RS. Common variable immunodeficiency: a new look at an old disease. *Lancet* 2008; **372**(9637): 489–502.

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Sir,
Response to Kittisupamongkol

We thank Dr Kittisupamongkol¹ for his interest in our case and for drawing attention to a key aspect of diagnosing primary immunodeficiency—serum antibody levels reflect rate of production and loss and this can be influenced by a long list of pathologies which must be excluded before diagnosing CVID. We can confirm that our case meets full diagnostic criteria as outlined by the European Society of Immunodeficiency,² and that further investigation was undertaken to identify new pathologies such as mycobacterial infection.

Where immune deficiency is suspected, an initial panel of investigations should be undertaken to exclude haematological malignancy autoimmune disease, renal disease, and HIV. A thorough medical, surgical, and drug history should identify iatrogenic immune deficiency. Further investigations to exclude defined cellular immunodeficiency or genetic disorders can be undertaken by the immunology laboratory.³

Conflict of interest

The authors declare no conflict of interest.

References

- 1 Kittisupamongkol W. Features of common variable immunodeficiency. *Eye* 2010; **24**: 744.
- 2 www.ESID.org. Date accessed 14/06/09.
- 3 de Vries E. Clinical Working Party of the European Society for Immunodeficiencies (ESID). Patient-centred screening

for primary immunodeficiency: a multi-stage diagnostic protocol designed for non-immunologists. *Clin Exp Immunol* 2006; **145**: 204–214.

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Sir,
Ensuring the quality of cataract referrals

We read with interest the article by Park *et al*¹ 'evaluating a new cataract referral pathway' and would like to advocate the importance of GP involvement in the direct referral pathway. At 12 months after introducing the direct referral forms to optometrists in the catchment area served by Frimley Park Hospital, we compared the quality of referrals with that obtained through the traditional GP route.

Comparison of 54 age- and date-of-referral-matched referrals showed that direct optometrist referrals documented the symptoms and Snellen visual acuity adequately compared with the traditional GP route (100 vs 97.4%). In agreement with Park *et al*, past medical history was more often documented on the traditional referral forms compared with the direct referral forms (66.6 vs 22.5%). Traditionally, patients diagnosed by their optometrist with cataracts would be referred to their GP and then onto the hospital eye service (HES). A comparison of the time to HES from diagnosis, showed a significant reduction in time-to-first appointment with direct optometrist referrals (74.9 vs 94.9 days),² indicating that streamlining the referral pathway does reduce waiting times. Nevertheless, the involvement of the GP in the referral ensures access to the medical and social history of the patient. Although, this information did not seem to affect the outcome of surgery in the Park *et al* study, this is probably because the information is subsequently obtained from the patient by the ophthalmologist before surgery and appropriate action undertaken. General medical and social history is certainly useful for triaging patients and referral to the appropriate ophthalmic sub-specialist. GP involvement is invaluable in ensuring the quality of the referral and should be an integral part of education on cataract referrals from community services. We conclude that direct referral through the optometrist is effective but requires participation and co-ordination between services to ensure and maintain quality.

Conflict of interest

The authors declare no conflict of interest.

References

- 1 Park JC, Ross AH, Tole DM, Sparrow JM, Penny J, Mundas MV. Evaluation of a new cataract surgery referral pathway. *Eye* 2009; **23**: 309–313.

- 2 Sim D, Dinah C, Menon G. Streamlining cataract services: a long-lived change? *Br Med J*, accessed 22 January 2007.

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Sir,
Response to Dinah *et al*

We would like to thank Dinah *et al* for their helpful discussion in relation to our cataract referral study.¹ We were most interested to find that in Frimley Park Hospital, in agreement with our Bristol study, traditional cataract referrals are more likely to detail the past medical history than direct cataract referrals, emphasising yet again on the importance of collaboration between the patient's general practitioner and hospital eye service (HES).

We agree that at the time of cataract referral review by the HES it is most useful to have the past medical history, drug history and social history, which is used to identify patients that need more urgent surgery or have special needs in relation to their surgery, such as an in-patient stay or need of a senior surgeon because of anticipated surgical hurdles. To ensure this, in Bristol we have devised a combined, direct referral form, which combines the requisite information from both the GP and community optometrist onto a single, unified form. Initially, this will be in paper format, and in due course be managed electronically.

We hope to re-audit our outcomes (and in particular assess the rates of conversion to surgery and reasons for not proceeding to surgery) to see if this combined, direct referral form further improves the standard of care.

Conflict of interest

The authors declare no conflict of interest.

Reference

- 1 Park JC, Ross AH, Tole DM, Sparrow JM, Penny J, Mundas MV. Evaluation of a new cataract surgery referral pathway. *Eye* 2009; **23**: 309–313.

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