Sir,

Representative data remains the key for national benchmarks

We congratulate the authors Johnston *et al* for their very informative paper on the risk of posterior capsular rupture among grades of surgeons with varying levels of experience.[1] We are in full agreement about the benefits of electronic medical record (EMR) in a cataract service and we routinely use the software application used in the study, in our own practice. However, EMR is yet to be widely taken up across the country and we do observe differences in their uptake even within the same region as ours.

We are concerned about the selection bias in these studies as adoption of EMR and regular data input in the UK tends to currently favour highly geared and well-resourced departments alone. Many units where high-volume surgery happens, demographically higher risk (eg, ethnicity,[2] increased age[3]) patient groups and late presentation exist, have not contributed to the dataset owing to the non-availability of EMR. The headline figure of posterior capsular rupture rate of less than 2%, therefore, might be less rosy in reality when compared with the data generated from the contributors to the dataset.

It, nevertheless, is a very good effort and largely in concordance with results available from centres with comparable populations,[4] and we would recommend more wider uptake of the EMR, preferably, in a standardised software platform which when linked to a national body as the Royal College of Ophthalmologists could then act as a data guardian and provide a more realistic and accurate benchmark for everyone to compare their standards against.

Conflict of interest

The authors declare no conflict of interest.

References

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Sir,

Responding letter

I would like to thank PT Ashwin and SR Mohamed for their interest in our article on variance in posterior capsular rupture rates between surgeons and grades of surgeons. As described in the first paper in this series[1]: 'The majority of the data (86%) from the 12 participating trusts were collected between January 2004 and July 2006, with no individual surgeon having performed more than 4.6% of the operations and no unit having contributed more than 20% of all operations'. The basic demographic details in this large sample of 55 567 operations and 406 surgeons were also nearly identical to the National Hospital Episode Statistics for this period. This reassures us that despite the contributing centres being at the forefront of the electronic medical record (EMR) use, their casemix is probably representative of the UK.

The same EMR system used in this study has now been adopted at more than 50 Trusts in the UK performing close to 100 000 cataract operations per annum. A National Ophthalmology Database capable of accepting pseudoanonymised data from all centres that use EMR systems is being built under the auspices of the Royal College of Ophthalmologists for the purposes of audit, revalidation and epidemiological research. If all centres agree to contribute data, we will soon be able to establish unequivocally accurate benchmark standards for the UK population.

Conflict of interest

The author declares no conflict of interest.

Reference

1 Jaycock P, Johnston RL, Taylor H, Adams M, Tole DM, Galloway P *et al*., UK EPR user group. The Cataract National Dataset electronic multicentre audit of 55 567 operations: updating benchmark standards of care in the United Kingdom and internationally. *Eye* 2007; **23**: 38–49.

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Sir,

Re: The report 'irrigation of the capsular bag using a sealed-capsule irrigation device and 5-fluorouracil' by Milverton

Although posterior capsule opacification has been much reduced by changes in intraocular lens design, it still remains a problem and, therefore, the report 'Irrigation of