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Sir,

Peer-reviewed publication of abstracts presented at the Royal College of Ophthalmologists (RCOphth) Annual Congress

Approximately 50% of the abstracts initially presented at scientific meetings will never be published in peer-reviewed journals.[1] Such unpublished research is therefore not available via electronic databases (eg, MEDLINE) to clinicians or to those undertaking systematic literature reviews.

The Cochrane review[1] included 79 studies, only three from ophthalmic meetings, all being from North America in the 1980s. We therefore conducted a PubMed literature search using each author from the abstracts of the 'Final Programme and Abstracts' RCOphth Congress 2004 (search performed 61 months after the congress submission closing date). A publication was deemed to relate to the same work as the abstract if at least one author, methodology, or at least one of the conclusions of the study were the same to allow for subsequent continued recruitment.[2]

Of the 179 abstracts, 64 (35.8%; 95% CI 29–43%) reached full publication in peer-reviewed journals, most frequently *Eye* (23/64) and *British Journal of Ophthalmology* (18/64). The mean time that elapsed between Congress 2004 and the publication was 20.1 months (95% CI 16.9–23.4 months) (see Figure 1).

Multivariate analysis of the factors influencing publication revealed that the number of authors showed significant positive correlation with subsequent publication rate: abstracts with only one or two authors (26% subsequently published) compared with 36% for 3–5 authors and 50% for 6-or-more authors.

Other factors analysed failed to show any significant difference in subsequent publication rates; posters only (35% later published)/podium presentations (41%); prospective studies (33%)/retrospective (33.9%); UK only research (35%)/international collaboration (45%); basic-science research (41.7%)/clinical research (36.5%)/service delivery-related studies (26.3%). Publication bias is a well-recognised phenomenon, but research reporting statistically significant (44.4%) and non-significant (43.6%) results were equally likely to be published.

Lead authors based in a teaching hospital or university were more successful (39.5%) in getting papers published than those working in non-academic settings (28.3%).

Nearly two-thirds of the studies presented at the abstract at the RCOphth Congress 2004 had not been published in peer-reviewed journals more than 5 years after the closing date for submission. Studies with larger numbers of authors were more likely to reach publication, possibly because involvement of more authors may mean that there are more people to scrutinise the design and conduct of the research, review drafts, and improve overall quality.

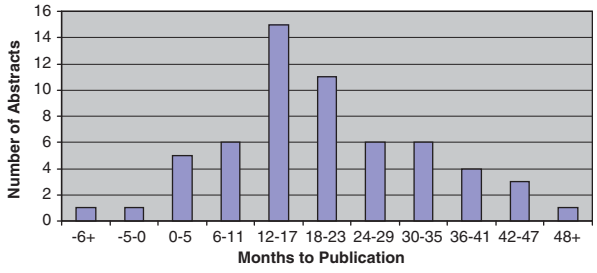

Figure 1 Time elapsed to publication following RCOphth Congress 2004.

Conflict of interest

The authors declare no conflict of interest.

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Sir,

Response to 'Spontaneous sub-conjunctival haemorrhage in patients using long-term topical corticosteroids'

I read with interest the article by Mercieca *et al*[1] describing a higher incidence of subconjunctival haemorrhage in a cohort of uveitic patients who were on long-term topical steroid therapy compared with a comparison group of patients using glaucoma medication. Although they describe systemic hypertension as a risk factor for subconjunctival haemorrhage, they did

not record if hypertension was present or whether anti-hypertensive medication was being used in their methods. In the 24 patients who developed a subconjunctival haemorrhage, was hypertension present as a confounding factor? If so, was it well controlled or prone to wide fluctuations? This is particularly important to know in the five patients who had recurrent episodes. Diabetic patients are also prone to developing subconjunctival haemorrhage and this would be important to exclude in the uveitic subgroup of patients, some of whom may have been on oral steroid therapy at a certain point.

Without excluding co-existing hypertension or diabetes, the conclusion that steroid-induced vascular fragility is the sole cause of subconjunctival haemorrhage in this study is less valid. Perhaps it is the patients with a background of hypertension or diabetes and long-term topical steroid use who are most at risk.

Conflict of interest
The author declares no conflict of interest.

Reference
1 Mercieca K, Sanghvi C, Jones NP. Spontaneous sub-conjunctival haemorrhage in patients using long-term topical corticosteroids. *Eye* 2010; **24**: 1770–1771.

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Sir,
Reply to Mangat

We thank Dr Mangat[1] for his comments regarding our study.[2]

We would like to point out that hypertension and diabetes were part of a list of exclusion criteria in our study, as was smoking. We therefore stand by our hypothesis that steroid-induced vascular fragility seems to be the likely cause of spontaneous subconjunctival haemorrhage in these subjects.

Conflict of interest
The authors declare no conflict of interest.

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1 Mangat SS. Response to 'Spontaneous sub-conjunctival haemorrhage in patients using long-term topical corticosteroids'. *Eye* 2011; **25**: 958–959.
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Sir,
Optical coherence tomography in desferrioxamine ocular toxicity: a place in screening and monitoring?

Desferrioxamine (DFO) is a chelating agent for the treatment of iron overload with well recognised ocular and ototoxicity. This case report illustrates an optic neuropathy in DFO ocular toxicity undetected on slitlamp biomicroscopy examination but illustrated by optical coherence tomography (OCT).

A 74-year-old female myelofibrosis patient weighing 10.5 stones on 1.5 g of subcutaneous DFO presented with deteriorating vision associated with moderate neurosensory deafness. DFO toxicity was diagnosed and treatment ceased.

At presentation, visual acuity had reduced from 6/6 to 6/12 in the right and 6/9 in the left. Ishihara was reduced with 2/13 plates identified. Humphrey 24-2 visual field assessments showed bilateral peripheral losses. Slitlamp biomicroscopy was normal. A relative afferent papillary defect was absent.

OCT imaging of the macula and retinal nerve fibre layers (RNFLs; Figure 1) were obtained with a Stratus OCT machine (Carl Zeiss Meditec Inc., Dublin, CA, USA). Macula OCT scan had a normal foveal dip with no signs of fluid or retinal thickening. OCT RNFL scans were obtained with reference planes at 150 μm above the level of RPE revealing a thickened OCT RNFL.

Over 10 months, visual acuity (6/7.5 bilateral) and colour vision (13/13 bilateral) improved with a reduction in OCT RNFL thickness.

Peripapillary atrophy and fine pigmentary changes in both posterior poles were now visible.

Discussion
DFO ocular and ototoxicity in our patient was in keeping with descriptions from previous reports.[1–3]

In 1984, Lakhanpal *et al*[2] reported retinal pigmentary degeneration and a presumed optic neuropathy with DFO. Interestingly, he presented patients with presumed retrobulbar optic neuropathy based on the central scotomas and colour vision abnormalities experienced.[2] Our case report supports the suggestion that previously undetected optic neuropathy may be part of the DFO ocular toxicity spectrum.

Often DFO ocular toxicity is diagnosed by a clinical history and a reduction in visual function. Subtle early signs makes detecting and screening for DFO toxicity difficult. Monitoring disease progression is hindered by late pigmentary changes emerging after visual function recovery. Hence, non-invasive OCT imaging; a well-tolerated scan; may prove useful in early detection and monitoring recovery. To the best of our knowledge, this is the only case to illustrate DFO optic neuropathy on OCT.

Conflict of interest
The authors declare no conflict of interest.