

Sir,

Re: One stop cataract surgery: the Bristol Eye Hospital experience 1997–1999. *Eye* 2001; 15: 306–308

Thank you for forwarding the comments of Mr Shankar (published in *Eye* Vol 16, 2002, 108). It is important to note that reducing the number of hospital visits does not necessarily provide more effective use of time and resources. The 'one-stop' patients spent a whole day at the hospital as opposed to two half-days for clinic/pre-assessment and then subsequently surgery. They still require the appropriate amount of ophthalmic and medical work-up and counselling which in the case of our system was done by a senior house officer who spent a morning dedicated to the assessment of eight to ten 'one-stop' patients. So, although there is an obvious patient-oriented benefit in reducing the number of visits, the absolute workload for hospital staff is probably unchanged.

Regarding those patients not prepared for same-day surgery despite receiving appropriate correspondence, Mr Shankar has misinterpreted our data. Of the 34 'one-stop' patients not undergoing surgery on the same day, three (9%) fell into this category. This represents only 1.6% of the total number of 'one-stop' patients.

With respect to poor theatre utilisation, as stated in the article, this was overcome to some extent latterly by including non-'one-stop' patients who are warned that their operation may be performed that day. When patients attend for an operation on their first visit to an eye unit unexpected findings will always arise, and although improving the quality of referrals by optometrists and general practitioners may reduce this, surprises will inevitably still occur which detract from efficient use of theatre time in a 'one-stop' setting.

The authors feel that the best way to ensure that theatre lists are filled is to be able to screen for potential problems at a prior visit and at our unit this currently combines outpatient consultation with preoperative assessment and (usually) dating for surgery.

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Sir,

The National Survey of Trabeculectomy. II. Variations in the operative technique and outcome

The results of the National Survey of Trabeculectomy II¹ of 'first time trabeculectomy' for predominantly primary open angle glaucoma is seriously methodologically flawed, by failing to define success prior to undertaking the study. Rather, once data had been collected, the main success criterion was then defined as: intraocular pressure (IOP) at one year of less than two-thirds the preoperative IOP.

There is no evidence to suggest that reduction of IOP by one third stabilises visual fields in patients with primary open angle glaucoma.

There is ample evidence to suggest an upper limit of IOP of <15 mmHg will minimise further field loss.^{2,3} In order to prevent hypotony and its attendant complications, it is preferable to keep the IOP to >6.5 mmHg.⁴

Re-evaluating the study data using these values (ie, success means IOP between 6.5–15 mmHg), then 'unqualified'¹ (no additional ocular hypotensive medication) and 'qualified'¹ (additional ocular hypotensive medication) success of trabeculectomy in this series was 44.5% and 46.4%, respectively.

These figures cast doubts on continued use of trabeculectomy in the UK, because, put bluntly, they show that trabeculectomy as currently practised, is unlikely to achieve an IOP compatible with field stabilisation.

The situation may be even worse with longer follow-up, as Chen and associates in their study of patients with successful control of the IOP at one year, found control of the IOP reduced with time, with a failure rate of 3% per year.⁵

We would ask the authors of this study to formally respond, either accepting or refuting our analysis of the results. If our analysis is accepted, then individual ophthalmologists who perform trabeculectomy, need to re-assess their own position in relation to success and complication rates, particularly in terms of consent and use of adjunctive antimetabolites. Although antimetabolites improve the results of surgery in terms of IOP, they were used in only 6.4% of cases in this series.^{6,7}

Also it cannot be acceptable that only 57.7% of the patients had visual fields performed during the year following surgery.¹

References

- 1 Edmunds B, Thompson JR, Salmon JF *et al.* The National Survey of Trabeculectomy. II. Variations in operative technique and outcome. *Eye* 2001; 15: 441–448.

- 2 Hitchings R. Primary surgery for open angle glaucoma. *Br J Ophthalmol* 1993; **77**: 445–448.
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Sir,

Success rates in the National Survey of Trabeculectomy

We thank Murthy and Clearkin¹ for their interest in our paper.² Their comment that the main outcome measure was decided only after data collection is incorrect. In the Methods section of our paper, the sentence 'The main outcome measure of trabeculectomy success was defined as an IOP at 1 year following trabeculectomy of less than two thirds the preoperative IOP' was intended to indicate that trabeculectomy outcome was measured one year after surgery, not that the study definition of success was defined at one year following surgery.

Table 5² was provided to allow individual clinicians to assess the national figures using IOP cut-offs of their choice as Murthy and Clearkin have done, and their calculations are correct if we take 'up to 15' to mean 'up to but not including 15' and 'greater than 6.5' to mean 'greater than 6 mmHg'. Murthy and Clearkin highlight the dilemmas of choosing outcome measures for trabeculectomy and re-iterate our point in the conclusions of our methodology paper,³ that emphasis

should be on visual field changes rather than focussing mainly on IOP when making decisions in the management of glaucoma patients. They also support our justification for using an outcome measure that is more discriminating than the traditional cut-off around 21, which, whilst allowing some degree of comparison with the literature, results in higher success rates.

References

- 1 Murthy S, Clearkin L. Correspondence. *Eye* 2002; **16**: 677–678.
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- 3 Edmunds B, Thompson JR, Salmon JF, Wormald RP. The national survey of trabeculectomy. I. Sample and methods. *Eye* 1999; **13**: 524–530.

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Sir,

Mini-autograft for pterygium surgery

The authors Young *et al* in their letter to the editor address several issues regarding the technique of mini-autograft for pterygium surgery.¹ Each of these issues is addressed as follows:

- (1) 'The measurements of the sizes of the pterygia and the criteria for case recruitment and selection were not specified.'

Author response

Size of pterygium The sizes of the pterygia were not an inclusion or exclusion criteria in this series of cases.¹ It included patients who had one, two and three previous pterygium excision surgeries. It also included one patient with diplopia due to restriction in ocular motility secondary to the extensive recurrent