Sir,

'Hyperacute' unilateral anterior uveitis and secondary glaucoma following streptokinase infusion

I read with interest Ah Kiné and Adams'[1] report of marked anterior uveitis following streptokinase infusion. I have been involved with a similar case recently that was bilateral. The onset was also within 12 h of the streptokinase infusion, and the patient had bilateral hypopyons. I agree that the rapidity of the immune response suggests previous exposure to streptococcal antigen.

When I presented this case at our regional postgraduate meeting, it transpired that two other cases were known within the region in the preceding 12 months. It seems likely that anterior uveitis secondary to streptokinase infusion is more common than is generally recognised.

References

1 Ah Kiné D, Adams W. 'Hyperacute' unilateral anterior uveitis and secondary glaucoma following streptokinase infusion. *Eye* 2001; **15**: 804–805.

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Sir,

What do your authors do?

It is the custom in *Eye* to state where the authors work but not what they do. Their qualifications are not mentioned at all. I refer as an example to:

Habib NE, Balmer HG, Hocking G. Efficacy and safety of sedation with propofol in peribulbar anaesthesia. *Eye* 2002; **16**: 60–62.

All the authors work at the Royal Eye Infirmary in Plymouth, UK. Correspondence is directed to Mr Habib and we are told that he is a consultant ophthalmic surgeon, but we are told nothing more about Mr/Dr Balmer and Mr/Dr Hocking. The importance of this is buried in the paper where it states that 'Sedation and anaesthesia were administered by …a single…anaesthetist.

There is so much to read nowadays that some readers, including me, go through a journal only reading the title, author, and then the abstract or even just the summary. Then they read more of the few papers of interest to them, as I have done with this one.

In this paper, an abstract-only reader would miss the extremely important fact that sedation should only be administered by someone trained in managing the airway of an unconscious patient. Patients are individuals and I have rendered such a patient totally unconscious with an obstructed airway with just 1 mg of midazolam—an amount so small that I anticipated almost no effect. If it was obvious at the start of the paper that either Dr Balmer or Dr Hocking was an anaesthetist, this message would be more likely to get through.

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Sir,

Re: Confusion between similarly named eye drops

Over the last week I have come across two patients who were using the wrong medications. One had been prescribed Predsol but was using Predsol-N, the other had been on Cosopt for some time, but had recently received Trusopt from his pharmacist.

It is clear that there is considerable room for confusion by general practitioners when renewing long-term prescriptions and by pharmacists at the point of sale when similarly named drops are concerned. The wrong medication may have significant consequences for the course of a patient's ocular condition, especially if a steroid is unnecessarily added or if a component in a combination glaucoma preparation is dropped.