who present with mild to moderate degrees of CRVO. In these patients, the term 'papillophlebitis' has been used by some authors.⁶ The typical presentation is that of normal or slightly reduced visual acuity, marked disc swelling, and retinal haemorrhages largely confined to the posterior fundus. It is thought that the venous obstruction is secondary to venous compression caused by disorders producing optic nerve and disc swelling, rather than a primary venous thrombosis occurring at the level of lamina cribrosa, as is usually the case in older patients. In our series, Case 2 was treated with a combination of panretinal photocoagulation and a short course of oral steroids. However, the visual acuity did not improve.

The pathogenesis of exudative retinal detachment following retinal vein occlusion appears multifactorial and includes vascular leakage from vascular damage, which in the two patients described here manifests not only by the marked volume of subretinal fluid but also by the presence of subretinal exudation, impaired retinal pigment epithelial and retinal capillary absorbing function, increased hydrostatic pressure, and absence of retinal venous collaterals.^{1,2,7} The mechanism of reattachment following photocoagulation may be owing to disruption of the retinal pigment epithelium thus allowing absorption of subretinal fluid, ablation of viable but pathologic tissue, or obliteration of the leaking capillaries.^{8,9}

Our cases illustrate that exudative retinal detachment following CRVO is associated with severe visual loss. Although panretinal photocoagulation is effective in absorption of subretinal fluid and exudation and regression of rubeosis iridis, the visual prognosis remains poor.

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Sir,

One-stop cataract clinics: feasible but flawed?

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An escalating elderly population and earlier surgery is increasing the demand for cataract surgery. It is suggested that the process of cataract surgery must be streamlined to maximise use of resources.¹ Prasad *et al*² in 1998 examined the current process used in most hospitals. A 'three-stop' arrangement is the norm; a clinic consultation including listing for surgery, a subsequent preassessment clinic, and finally surgery. Prasad *et al*² proposed a modified 'two-stop' process; a clinic consultation including biometry/tests and subsequent surgery.

Two-stop surgery has progressed in some centres to 'one-stop' surgery. Patients are assessed and attend theatre the same day. Gaskell *et al*³ undertook an education programme with local optometrists who referred directly into a 'one-stop' facility. With the additional involvement of nurse practitioners telephoning patients prior to admission, they achieved a listing rate of 96%. Hughes *et al*⁴ listing rate was 82.1%, with an average of 6.5 patients operated on each day (range 4–8 patients). Currently in our eye unit, there is a 'two-stop' process in place. The purpose of our study was to assess the feasibility of one-stop cataract surgery without prior training requirements or additional resources.

Study

A retrospective study was carried out on cataract clinics held between May 2001 and February 2002. Information was collected including details of referral quality and the

Table 1 Quality of referral information from each source

	VA specified	Funduscopy specified	Ocular comorbidity specified	Cataract symptoms specified
GOS18				
45 (27%)	43 (95.5%)	17 (37.7%)	15 (33.3%)	14 (31%)
GP letter				
43 (26%)	8 (18.6%)	7 (16%)	11 (25.5%)	18 (41.8%)
BOTH				
78 (47%)	73 (93.5%)	23 (29.4%)	16 (20.5%)	30 (38.4%)

VA=visual acuity; GP=general practitioner. GOS18=general optical service form number 18.

outcome of the clinic visit. For patients who were listed, it was assessed if coexistent problems precluded same day surgery. Ten cataract clinics took place with 191 patients invited to attend. Referral information received is shown in Table 1. Did-not-attend (DNA) rate was 9.4% (range 5–25% per clinic) with 173 patients attending. Surgery for cataracts was not required in 45 patients. Of these, 26 had asymptomatic cataracts and eight had a minimal cataract with age-related macular degeneration. In total, 128 (67%) patients were listed for surgery with a range of 42–80% (8–16 patients per clinic). However, of those listed, 17 were not suitable for same day surgery. This lowered the average 'same day' listing rate to 56.6% with a range of 26–80%. This is illustrated for each clinic in Figure 1. Of the 17 patients not suitable for same day surgery, 15 had uncontrolled hypertension (88%) and two had severe blepharitis (12%).

Comment

The listing rate was calculated to include DNA patients because one would have to make theatre allocation for all patients invited to attend clinic. The listing rate is lower than that found by Hughes *et al*⁴ (82.1%) and Gaskell *et al*³ (96%). Gaskell *et al*'s³ impressive listing rate is due to optometrist training and telephone preassessment; both requiring additional resources. Of those optometrists invited to participate, only 67% agreed leaving a significant short fall for a universal service. It has been suggested that a one-stop service does not necessarily provide more effective use of resources as the same staff time, counselling, etc are needed irrespective of the number of visits.⁵ Patient orientated benefit is cited as a reason to pursue a 'one-stop' service. However, Hughes *et al*⁴ found that patient satisfaction was equal between one-stop cataract surgery patients and those attending for three hospital visits. Before developing a one-stop service, the variability in the listing rate would have to be improved. An extensive programme of training together with telephone preassessment may allow reasonable theatre utilisation, but with current referral quality and

Figure 1 Listing rates at dedicated cataract clinics.

available resources, the wide range in listing rate makes planning efficient use of theatre impossible. While one-stop cataract surgery is technically feasible, at the moment it has two major flaws: the resources required and the lack of evidence of improved patient satisfaction.

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