infection, haemorrhage, dropped nucleus, blindness and loss of eye) was poor in both the groups. Patients in our study were questioned on the day of surgery, which is earlier than most of the other studies;[3,4] still the recall of information was poor. It could be argued that the anxiety provoked on the day of surgery might have prompted them to give wrong answers. However, a previously published study[5] has shown that the mean anxiety provoked by cataract surgery is more on the day of preassessment than on the day of surgery itself.

Cognition and memory in this elderly group of patients (mean age 76.6±8.2 years) was not measured. Elderly patients and impaired cognition have been associated with poor information recall[6] and we believe that these factors played a role in poor information recall. Our study shows that patient's recall minimal of the preoperative discussion. It highlights the importance of ophthalmologists to pursue at exceeding length their patient's education. Verbal and written information supplied to a patient may be understood, but is easily and quickly forgotten.[7] To realise the full potential of informed consent, the preoperative discussion must undergo further changes in order to avoid any misunderstanding and potential medico-legal litigations.

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Sir,

Cataract surgery in latex allergy patients

In Cheung and Gillow's[1] comprehensive review of latex allergy, they cite their own 'brief telephone audit' to assert that the awareness of latex allergy in ophthalmic theatres is 'fairly low'. In my experience in three UK regions, the reverse is true. There is a heightened awareness of latex allergy among theatre staff, leading to a distorted risk assessment and an over-reactive response in the majority of cases. This can lead to unnecessary cancellations, last-minute disruption to theatres and theatre lists, and exposure of patients to the risks involved in their surgeon using unfamiliar gloves and equipment.

As the authors point out, a history of 'latex allergy' is nonspecific and often relates to a contact irritant dermatitis. However once elicited, this usually leads uncritically to latex allergy precautions. The disruption and costs involved in creating a 'latex free' environment could be avoided in many cases if healthcare staff distinguished between irritant dermatitis and true allergic skin reactions, or anaphylaxis. As with penicillin allergy, the true prevalence is much lower than that reported by patients; with penicillin it is less than 5% of those claiming allergy.[2,3] The presence of latex antibodies, or positive skin patch testing is no guide to clinically relevant latex allergy.[1] In fact, there is no correlation between them.[4] It seems that a history of actual allergic reactions has to be relied upon for guiding clinical practice and precautions.

Latex allergy is rare, even among health workers regularly exposed to latex.[5,6] The prevalence may or may not be increasing. What does appear to be increasing is the number of patients citing a history of latex allergy.

A search of the medical literature reveals no reported cases of allergic reactions to latex following an ophthalmic surgical procedure; only a local reaction from a Tonopen cover.[7] This suggests that precautions in latex allergy should extend to instruments and products that come into direct contact with the patient, or gases they breath, that is, from anaesthetic equipment. Some of the precautions enforced for latex allergy cases seem excessive, and are unwarranted by the evidence.

The disruption and delay caused by these cases will have been experienced in most ophthalmic theatres, and

according to the evidence of potential harm, appear to be out of proportion to the risks involved. It is not clear whether patients with a history of atopy, eczema, or food allergies require referral to dermatologists prior to surgery as Cheung and Gillow seem to suggest, particularly as there is no correlation between *in vitro* and *in vivo* testing, and allergic symptoms.

Practice in this area seems to be driven by caution rather than evidence, and is not being led by surgeons, who are often presented with a *fait accompli*. Should we not inject some reason into latex allergy practice?

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Sir,

Use of the 60 D lens to view the fundus with the operating microscope after cataract surgery

In dense cataract extractions, a fundal view may have been difficult preoperatively. It is easy to examine the posterior pole at the end of surgery by standing up, raising the operating microscope, and using a fundus lens. We have compared several types of lenses for this purpose and would recommend a 60 D.

The optics are those of indirect ophthalmoscopy.[1] The stronger the diopteric power of the lens, the wider the field of view but less magnification is achieved. In addition, the higher the power of the lens, the smaller the working distance (Table 1). In our experience, although a tall surgeon can focus the 20 D with the operating microscope, those of us who are more vertically challenged may find a higher power lens more manageable.

The reason for viewing the fundus under these circumstances is to assess the disc and macula. With the patient looking directly at the operating light, the 60 D offers a bright, slightly magnified view of the disc and macula out to the vascular arcades.

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Table 1

Lens	*20 D*	*60 D*	*78 D*	*90 D*	*Superfield*
Magnification	3.13	1.15	0.93	0.76	0.76
Field of view (deg)	46–60	68–81	81–97	74–89	95–116
Working distance (mm)	50	13	8	7	7
Approximate distance from microscope to cornea (mm)	220	160	155	140	160