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At the time of writing this paper both authors were working at Altnagelvin Area Hospital, Derry.

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Sir,

Listing of cataract patients by optometrists

We see in the *Short Notes from Council* (12 September 2003) that the College felt that 'medical intervention was vital in order to ensure that the diagnosis and indications for surgery were appropriate, at a stage *before the actual day of surgery*'.

At Peterborough, we have been running a one-stop cataract surgery project since September 1999 where patients are listed by trained optometrists. Patients have their surgery on the first day they come to the eye department, following a brief examination by the surgeon at the slit lamp after mydriasis.

We recently looked at the difference of rates of cancellation of surgery on the day for 'one-stoppers' and conventionally listed patients for the period January 2002–August 2003. This difference would be a broad measure of the appropriateness of listing of the one-stoppers.

Of roughly 600 one-stoppers, 67 (11%) were cancelled on the day. This compared with 153 (8%) of around 1800 conventionally booked patients cancelled on the day. This 3% difference equates to the loss of 18 surgical slots, but our theatre coordinators estimate that they refill 90% of slots with patients prepared to come in at short notice, or even with patients just listed during the same session by other surgeons in clinic. This comes as a surprise for the patient concerned, but is not compulsory and saves a theatre slot.

Thus, over the given period, without medical intervention before the day of surgery, we have lost about two operating slots, but saved 600 outpatient appointments.

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Sir,

Successful combined cataract surgery and drainage of a needling-induced chronic ciliochoroidal detachment

Needle revision is an accepted method of management for failed or poorly functioning trabeculectomy blebs.[1–3] We report a case of chronic ciliochoroidal effusion occurring after needle revision of failed trabeculectomy bleb in an only eye with poor vision due to cataract. The effusion failed to resolve with conservative management and required subsequent surgical intervention.

Case report

An 80-year-old-woman was referred to a glaucoma team for further management of her glaucoma. She was blind in her left eye from uncontrolled glaucoma. She had had an unaugmented fornix-based right trabeculectomy 8 years previously that had failed. The intraocular pressure (IOP) in the right eye was uncontrolled despite maximal tolerated medical therapy (Guttae Timoptol 0.25% b.d., Guttae Xalatan nocte, and Guttae Trusopt 2% bd).

At presentation she had a flat, scarred right trabeculectomy bleb, the IOP was 22 mmHg OD, and the optic disc was cupped with a vertical cup–disc ratio of 0.8. A right nuclear sclerotic cataract (grade 2+) was noted with almost 360° posterior synechiae. Angles were open with a patent sclerostomy. Snellen visual acuities were 6/36 OD and PL OS.

In order to maximise residual vision, a right phacoemulsification of cataract was planned. A target IOP was set at less than 15 mmHg and the option of combined cataract extraction and trabeculectomy was considered. Prior to any final decision with regards surgical procedure, it was decided to carry out a needle revision of the trabeculectomy bleb. If the bleb could be salvaged and satisfactory IOP control achieved, a combined procedure would be unnecessary.

The patient underwent slit-lamp needling of trabeculectomy bleb with injection of 5-fluorouracil (5-FU). A good flow of aqueous was visualised with reformation of a bleb. At 1 week the bleb had once more flattened and the IOP was 26 mmHg. A further needling with 5-FU injection was undertaken. Postprocedure, the IOP was 6 mmHg with an elevated bleb. After 2 days, the IOP had risen to 12 mmHg and the anterior chamber was