

Sir,
Reply to GW Aylward

I would like to thank Bill Aylward and Catey Bunce for their helpful comments. Our study was a small clinical study which showed that noncontact slit-lamp examination was less reliable in my hands when compared to indirect ophthalmoscopy with scleral indentation in identifying retinal tears. I believe that peripheral retinal examination is enhanced by scleral indentation. In another surgeon's hands things may be different and I await the study, with or without statistical analysis, which will take an alternative point of view.

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Eye (2005) **19**, 474. doi:10.1038/sj.eye.6701520
Published online 6 August 2004

Sir,
Diagnostic effectiveness of noncontact slit-lamp examination in the identifying of retinal tears

We read with interest the article by Natkunarajah *et al.*¹ We agree that indirect ophthalmoscopy with indentation remains the gold standard for the detection of retinal breaks.

It is not clear if the initial examination by trainees was performed on slit lamp biomicroscope or with a binocular indirect ophthalmoscope? It would be easy to pick up relatively 'non-peripheral' tears on slit-lamp biomicroscopy. The authors acknowledge that the high pick-up rate by the consultant using the slit-lamp biomicroscopy could be attributable to the fact that he/she was aware of the presence of a retinal tear. A better alternative would be to examine all patients with symptomatic PVD with slit-lamp biomicroscopy. These patients should then be re-examined by the same observer with an indirect ophthalmoscopy to see whether any more tears can be detected. This would avoid the examination bias mentioned in the article and may be a truer reflection of the sensitivity of slit-lamp biomicroscopy in the detection of peripheral retinal tears.

We are concerned that in majority of consulting offices, no flat couches are available to lie the patient down for examination with binocular ophthalmoscope and indentation. There is a tendency to examine the patients with a 90D lens and less incentive to perform indirect ophthalmoscopy that might involve taking the patient to another room. The Royal College Higher Specialist Training curriculum only requires assistance in vitreoretinal procedures and none to be performed. With fewer opportunities to perform scleral buckling surgery, trainees are less likely to gain experience in indirect ophthalmoscopy and indentation. In most units, rigorous preoperative evaluation using the binocular indirect ophthalmoscope and detailed retinal drawing has given way to intraoperative search for retinal breaks. With this trend, newly trained consultants are likely to be less proficient in indirect ophthalmoscopy and as an extension, less likely to pass on this valuable skill to their juniors.

References

- 1 Natkunarajah M, Goldsmith C, Goble R. Diagnostic effectiveness of non-contact slit lamp examination in the identifying of retinal tears. *Eye* 2003; **17**: 607–609.

J Shankar and N Kaushik

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Eye (2005) **19**, 474. doi:10.1038/sj.eye.6701521
Published online 6 August 2004

Sir,
Reply to J Shankar and N Kaushik

I would like to thank Messrs Shankar and Kaushik for their interesting letter. Their suggestion for a 'better alternative' was in fact what was undertaken. A single examiner (RRG) first examined the patient at the slit lamp, recorded his findings, and then used the indirect ophthalmoscope before completing a second retinal diagram.

I apologise if this is unclear in the text.

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Eye (2005) **19**, 474–475. doi:10.1038/sj.eye.6701522
Published online 6 August 2004

Sir,
Reference: Community refinement of glaucoma referrals

The article by David Henson and colleagues (*Eye* (2003) **17**: 21–26) regarding employment of specially trained optometrists to screen glaucoma referrals from community optometrists attempts to show that this is cheaper than a visit to the hospital eye department.

The cost of an eye department outpatient visit is estimated at £55, which does seem high. I wonder how the group arrived at this figure and whether it could possibly be a hospital wide average outpatient cost. Costings in the NHS are notoriously difficult to pin down, but it is very important to be sure that there is a cost advantage in eye care outside the hospital setting before these schemes are more widely recommended. In our hospital I estimate that the real cost of an outpatient visit to the glaucoma clinic is between £5 and £10 including staffing costs, overheads, and disposables. Interestingly, we have also set up an optometrist-managed secondary screening clinic for glaucoma referrals, but we use hospital-employed optometrists who work in the eye department premises. In this clinic, patients are prioritised and referred to the glaucoma clinic, and are discharged if there are no abnormal findings. Audit data on 200 patients passing through this clinic indicate a discharge rate of approximately 15%, which is considerably less than the 40% nonreferral rate in Henson's study. This variance could indicate a regional variability in the quality of optician's referrals.

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Eye (2005) **19**, 475. doi:10.1038/sj.eye.6701517
Published online 6 August 2004

Sir,
Costs of shared care

The glaucoma referral refinement scheme reported from Manchester (*Eye* (2003) **17**: 21–26) has potential benefits for hospital glaucoma clinics that are struggling to keep abreast of the tide of new suspect glaucoma referrals. But the alleged cost savings are doubtful. For example, the savings to the GP of £11 700 are presumably based on an estimate of GP time and expenses in passing the referral on to the hospital: is this a realistic figure?

Hospital-based screening clinics may be a cheaper alternative. For 7 years, I have run a Nurse-led Glaucoma screening clinic to assess the urgency of referrals from optometrists. Patients attend the clinic and records are taken of the history (including details of family history and medications), visual acuity, visual field (Humphrey 24-2 threshold strategy), intraocular pressures by applanation tonometry (Perkins), and nonmydriatic optic disc photographs (Topcon). The records are examined and I write to the patient, general practitioner, and optometrist recommending follow-up by the optometrist or in the glaucoma clinic according to the findings. The clinic is audited annually.

We need to allow more responsibility to optometrists and ensure there is no financial disincentive to the follow-up of glaucoma suspects in the community. In particular, visual field defects are often artefactual rather than real, and improve when the field test is repeated. Visual field tests need careful explanation, supervision, and interpretation. Noncontact tonometry should not be performed by untrained personnel. It is good practice for an optometrist to repeat both tonometry and field tests to help reduce the false positive rate. Optometrists should be able to exercise clinical judgement and not refer nonprogressive field defects in people with anomalies, for example, optic disc drusen, tilted discs, colobomas.

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