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Sir,

Retinal detachment surgery outside specialist centres

I read with interest the correspondence by Dr Dinakaran and others concerning the papers in the July 2002 edition of Eye by Sullivan and Snead.

It seems quite clear that vitreoretinal surgeons in tertiary referral units achieve higher rates of primary success following detachment surgery. I agree that the trend over modern times has been for district general ophthalmologists to no longer operate on retinal detachments and for these to be referred to tertiary referral units. No doubt the anatomical success rate is higher in these units, however, I would not wish to restrict the definition of success to anatomical success.

Until we have an audit demonstrating that the visual outcome in terms of visual acuity is also better in tertiary centres, the concern always remains that detachments referred with the 'macula-on' may become 'macula-off' upon arrival in a metropolitan centre. While this may lead to a higher primary rate of success, I do not think we will have done the patient necessarily a service. Certainly I would prefer a 75% chance of a primary repair of superior bullous detachment while the macular was still on to a 90% success rate with a macula-off detachment. I think this area is rarely discussed and I certainly know anecdotally of cases where the vision has deteriorated over the time taken to arrive from a referring unit to a tertiary unit, particularly when the journey involved is prolonged and makes posturing impossible.

With the decline of detachment surgery in district general ophthalmology units, I suspect that there is an ever-decreasing pool of ophthalmologists willing or able to take on this work and if they rarely get to operate on retinal detachments, then they are unlikely to maintain the level of skill required to achieve a reasonable success rate with macula-on detachments. In the meantime, I think that district general hospital consultants who feel confident to operate on macula-on superior detachment-threatening fixation are quite justified in their actions and may well be acting in the best interests of their patients. I see no reason that this could not be incorporated into informed consent explaining that while the success rate is a little lower, there are potential advantages in terms of preserving vision.

I think that guidelines should not be interpreted as inflexible rules, and that while as a general rule it is reasonable to refer to a subspecialist, consultants should feel that they will be supported if deviating from these rules in the patient's interest.

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