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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Eye (2004) **18**, 791–792. doi:10.1038/sj.eye.6701317
Published online 23 January 2004

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 dioptric 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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Eye (2004) **18**, 792. doi:10.1038/sj.eye.6701596
Published online 4 June 2004;

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