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Sir,  
**Retinal detachment surgery audit. Is it failure or success?**

Dinakaran *et al*<sup>1</sup> raise an interesting question as to success rates in retinal reattachment surgery in their letter published in the May issue of *Eye*. They refer to earlier work, including audit, conducted by ourselves, so we may perhaps be permitted to comment further.

The authors refer to results quoted from our service and those from Sullivan *et al*.<sup>2</sup> The latter suggested that a success rate of 75% was acceptable. We disagreed on the grounds that there had been no reported improvement in their retinal reattachment success rate since an audit conducted at the same hospital and published 25 years before.<sup>3</sup>

Retinal reattachment audit in East Anglia was conducted for the first time in four hospitals between 1 January 1989 and 31 December 1990. District general hospitals achieved between 47 and 75% success rate compared with the specialist unit's 88%. All surgery included in that audit was carried out using scleral buckling techniques. As a result, the majority of retinal detachments were thereafter referred primarily to the specialist unit.

A repeat independent audit of the specialist unit was conducted between 1 September 1995 and 31 March 1997. In all, 87% of scleral buckles were successful and for the first time patients treated by vitrectomy with both gas and silicone tamponade were included. In total, 91% of these were successful at the first operation.

Results that we quoted in our letter<sup>4</sup> in response to the paper reporting audit results from Sullivan *et al* were based on independently conducted audit, published later.<sup>5</sup> We believe that this is an important aspect of any assessment of results.

Dinakaran and colleagues refer to the improvement in results when the junior was supervised. The 'junior' in question was in fact an experienced senior registrar appointed as Fellow to the vitreoretinal service. At the time of the first audit, he operated unsupervised in keeping with practice prevailing at the time and still in current use in some institutions. Patients were largely unselected. The improvement in results from 78 to 94%

when supervised by the consultant led to a change of practice in which all surgery was either conducted by or supervised at all times by the consultant. We believe that supervision of Fellows by an experienced vitreoretinal specialist consultant is vital to the achievement of best results.

The results of our most recent audit of 319 unselected consecutive primary detachments between 1 January 2001 and 31 July 2002 covered a period of time when a more graded supervision of inexperienced juniors (SpR and SHO) was undertaken.<sup>6</sup> Juniors achieved a 96.6% success rate overall. This included both conventional buckling procedures and vitrectomy using the indirect ophthalmoscope. The overall success rate for the vitreoretinal unit was 88.4% for a single procedure.

Dinakaran and colleagues are to be congratulated on an 81% success rate for primary scleral buckling surgery with a final figure of 90%. The total number of 58 patients operated over a 5-year period does perhaps reflect one of the problems that general ophthalmologists operating on retinal detachments experienced in the past; that of low numbers. We would guess that this was perhaps one of the factors that led them to refer all patients to the regional vitreoretinal service once it had been set up.

We believe that it would be preferable to discuss results in terms of failure rather than success, since patients expect us to get it right all of the time. If we do not succeed at the first operation, then it is failure; however, one dresses up the terminology to comfort ourselves.

Goals should always be set beyond those currently attainable in order to stimulate endeavor and prevent complacency. If we do not have a 0% failure rate after the first operation as our ultimate goal, we shall have failed a significant number of our patients. The way to achieve this is to identify the reasons for failure and to remedy them. Many failures are due to inaccurate surgery<sup>2</sup> and some to new retinal breaks. The former is obviously remediable; the latter requires further research into the causation of the very many variety of retinal breaks. A clear understanding of how retinal integrity breaks down leading to detachment still eludes us.

## References

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Sir,  
**Primary retinal detachment surgery**

Thank you for giving us the opportunity to comment upon the letter by Scott and colleagues on success rates following primary retinal detachment surgery. The authors' comment on aiming for 0% failure rate following primary surgery, although unachievable at this time, is something that we should aspire for. The goal should be set high as in the present day the vast majority of retinal detachment surgery is carried out in specialist vitreoretinal units. In addition to achieving anatomical success, functional results should also be considered. The referral service arrangements should be such that patients with macula-on detachment are dealt with on an urgent basis to reduce the risk of macula-on detachment becoming macula-off while awaiting transfer to the specialist unit. Such an arrangement presently exists in the North Trent region benefiting this group of patients.

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Sir,  
**Intravitreal triamcinolone acetonide in Eales' disease:  
a case report**

Eales' disease is commonly seen in young individuals in Indian subcontinent. It manifests as retinal periphlebitis and in many instances progress to retinal ischaemia and neovascularization.<sup>1</sup> The clinical manifestation and management depends upon the stage of the disease. Corticosteroids are the mainstay of treatment in active periphlebitis stage.

We report about a patient of Eales' disease treated with intravitreal triamcinolone acetonide (IVTA) where oral corticosteroid was contraindicated because of co-existing peptic ulcer.

#### Case report

A 23-year-old man was seen at our institute with complaints of reduction of vision in the right eye since 1 month. On examination, the best-corrected visual acuity was 20/30, N6 in the right eye and 20/20, N6 in the left eye. The anterior segment examination was normal in both eyes and intraocular pressure was 14 mmHg in both eyes. The fundus examination of the right eye showed mild vitreous haze, hyperaemic disc, active periphlebitis, perivascular exudates, and intraretinal haemorrhages in the inferior and superonasal quadrants (Figure 1a). The left eye fundus was normal. Haematological investigations for complete blood count, erythrocyte sedimentation count, random blood sugar, serology for syphilis, ELISA for HIV, antinuclear antibody test, basic coagulation profiles were within normal limits. Mantoux test and chest X-ray were normal. The fundus fluorescein angiography (FFA) of the right eye showed staining of the vessels with late extravasation of the dye, areas of capillary nonperfusion in all quadrants, late staining of the disc and an area of neovascularization in the inferonasal quadrant (Figure 1b). The left eye angiogram was normal. Central macular thickness was 260  $\mu\text{m}$  on optical coherence tomography (OCT). Oral corticosteroids were ruled out in the presence of peptic ulcer.