lesions, 24% palpebral–conjunctival involvement, 12% conjunctival, and 4% palpebral–conjunctival–corneal. Choroidal involvement alone or associated with that of other ocular structures, as retina and iris, has been described even less frequently and is seen clinically as yellowish-white subretinal lesions, as shown earlier in the course of the disease in our patient.[7]

The diagnosis of this disease is possible by the detection of the fungus on specimens of body fluids or biopsies of lesions.[4] The main other entities that can produce similar ocular picture are syphilis, sarcoidosis, and tuberculosis.[3] The diagnosis of systemic paracoccidioidomycosis was reached in this case by finding the fungus in the sputum and confirmed by double immunodiffusion test. Since other possible causes for similar choroidal lesions had been eliminated, and since the patient positively responded to the specific treatment, the final diagnosis made was of disseminated choroidal paracoccidioidomycosis.

Our patient had a good response to trimethoprim–sulphamethoxazole therapy. The systemic and ocular manifestations resolved, and no evidence of reactivation has been noted on follow-up examination.

Paracoccidioidomycosis should be suspected in patients who lived in endemic areas or with an appropriate travel history. Although rare, ocular dissemination of *P. brasiliensis* also be considered in patients with posterior chorioretinitis and previous or active pulmonary lesions of equivocal nature. Early diagnosis and adequate therapy are essential.

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Sir,

Patient alert system: the Edinburgh experience

We read with interest the article and accompanying editorial on 'The Patient Alert System' (PAS).[1,2] The Edinburgh system was developed 3 years ago and incorporates tactile vibrating feedback through the hand piece once activated. The prototype lacked this feature and was similar to the Manchester device. Evaluation of the prototype showed patients were unsure if staff had noticed an audible alarm amidst the background theatre noises of the phacomachine, music, and conversation. Deaf patients found the tactile vibrating feedback device in the hand piece of particular benefit.

We agree that patient choice should determine if hand-holding or the patient alert system should be used. The latter was the preferred option in approximately 40% of patients in an evaluation of 50 consecutive patients undergoing cataract surgery in our unit. It is preferred by patients who may have poor hand-grip strength, arthritis, or who are unsure about the procedure of increasing grip as a means of attracting attention. This may in part reflect patient anxiety, cognitive dysfunction, and conflicting patient advice. For example, patients are instructed not to move under the drapes, yet when anxious, distressed, and sensorially deprived, moving a limb rather than increasing a squeeze on a hand is an instinctive method of requesting assistance.

The patient alert system is a tool for reducing patient anxiety by ensuring a clear method of communicating distress from patient to surgeon. In order to pre-empt the possibility of patient movement in a population who are likely to have communication difficulties and poor appreciation or ability of increasing hand grip as a method of signifying distress, we suggest the Edinburgh patient alert system as a simple cost-effective strategy.

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Sir,

Patient-controlled alerting device (PAD)

We read with interest the study by Mokashi *et al*,[1] who compared a patient-controlled audible alert device (PAD) with a hand holder as a means of communication and method for reducing anxiety in patients undergoing cataract extraction under local anaesthesia. They are to be commended for designing a safe and effective PAD, which patients found as reassuring as a hand holder.

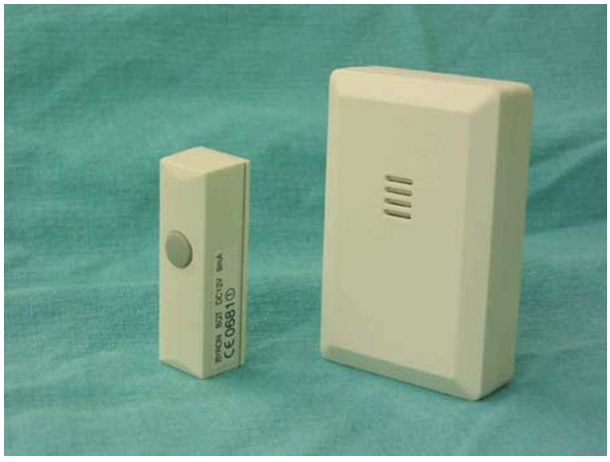

Figure 1 All components of the wireless doorbell.

Figure 2 A theatre nurse demonstrating use of the device.

However, not all units have the skills available to construct a similar device. We have found a cheap alternative in the form of a wireless doorbell that is available from most DIY outlets (Figures 1 and 2). This bell is easy to activate and makes a distinctive chime, familiar to most patients. Before using it in the theatre environment the device was checked by our local Medical Physics Department to ensure it would not interfere with any medical equipment. It should be remembered that the use of a PAD does not remove the requirement for careful monitoring of the patient during the procedure.

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