of globe perforation inherent in sharp-needle intraconal injection (although this was not encountered in Southampton). Clearly we make great efficiency savings by being less reliant on anaesthetic cover, especially when providing theatre time for acute surgical VR work.

The paper goes on to state that 51.7% of the cases included in the study are 'retinopexy +/− vitrectomy'. This could be interpreted as a significant proportion in the LA group simply receiving retinopexy for retinal tear.

Clarification on the above will be welcomed.

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Sir,

Response to Goldsmith *et al*

We were interested in Goldsmith *et al*'s comments on our recent paper.[1] We are aware that subtenons anaesthesia is used for VR surgery;[2] however, to achieve a rate of 87%, under local anaesthesia, is certainly impressive. The authors are not clear on their own use of sedation. In some units nearly all patients are sedated, and in others it is rarely used. We have tailored our use to measured patient satisfaction outcomes performed over the last 5 years,[3–4] and clearly have a lower threshold for their use than Goldsmith *et al*. This may be because we have access to an experienced anaesthetist for our VR lists.

The Royal College of Ophthalmologists 2004 guidelines on cataract surgery do not specify the necessity of anaesthetist presence where blunt needle subtenons anaesthesia is required, such anaesthetic cover is recommended where sharp needle anaesthesia and/or sedation is required.[5] Arguably in VR surgery anaesthetic cover is more important given the longer and more unpredictable nature of the surgery.

We note with interest Goldsmith *et al*'s comment that grouping all retinopexy patients may bias the results. However, our previous work showed that the laser and cryopexy were more important determinants of discomfort during vitrectomy than other aspects of the surgery, and so these were analysed as one group.[2]

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Sir,

The urgency and site of retinal detachment surgery

Four letters in the correspondence section of The Journal prompt me to join the debate about the setting in which retinal detachment surgery is undertaken, both with respect to urgency and surgical facility.[1–4] This is an ongoing debate and has been discussed in This Journal before.[5]

The first fallacy that needs to be highlighted is about the urgency of management of macula-on detachments. Although it is taken for granted that all macula-on detachments should be operated on within hours of