adherent leucoma has been described,[5] but these spontaneous perforations were precursor events. SO has been reported on several occasions following cyclodestructive procedures,[6] but almost all patients had previously undergone intraocular surgery. Malignant melanoma has been associated with SO, either primarily (albeit in association with spontaneous perforation[7]) or following irradiation and nonpenetrating surgery.[8] A blunt injury with hyphaema also led to SO.[9]

In our case, characteristic histological changes of SO were confirmed in the evisceration specimen. These changes, particularly the development of epithelioid granulomata, probably could not have occurred in the 3-day period between spontaneous perforation and evisceration, therefore preceded it.

We hypothesise that this chronic severe infection, with limbal involvement, allowed the diffusion of intraocular fungal antigens and proinflammatory mediators which allowed access through a disturbed blood-retinal barrier to expose retinal antigens and allow the development of SO. Fungal antigens may have played an adjuvant role in its development.

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Sir,

Letter regarding correlation of retinal sensitivity measured with fundus related microperimetry to visual acuity and retinal thickness in eyes with diabetic macular oedema

We like to congratulate Dr Okada and associates for their work on the microperimeter (MP 1). With the commercial unavailability of the SLO microperimter, MP 1 is the only alternative to study macular functions including light sensitivity threshold, fixation pattern, and stability.[1–3] Our initial study with the MP 1 on eyes with macular pathology revealed similar correlation of mean retinal sensitivity and visual acuity.[2] In another study, we found that the mean sensitivity of the macular area was approximately 18 dB in normal subject, which reduced with increasing age (unpublished data). 18 dB is higher than median sensitivity (15 dB) reported by the authors.

We would like to make certain comments regarding this study. In the methods section the testing conditions have not been described. This may affect the retinal sensitivity measured by the MP 1. If the test room is lighted, the retinal sensitivity measured could be lower than when measured in the darkroom with less interference of surrounding light during the test. The demographics of the patients have not been mentioned, especially the age. It is well known that the retinal sensitivity reduces with age in the normal subjects both by the SLO microperimeter and conventional perimetry. Whether the control normal subjects were age matched or not would affect the results and interpretation. The other reason the retinal sensitivity could be lower in this study compared to our data is the consequence of learning effect. Subjects tend to do better in subsequent field tests than the initial one due to the learning effect. In our

prospective study, we allowed every patient experience with machine in form of test stimuli before starting the test and we would only start the real test once the patient feels comfortable with the whole procedure. We feel lack of familiarity with the machine will affect the mean retinal sensitivity. The authors have not mentioned the initial level of sensitivity they used as the MP 1 allows the examiner to select this setting before test is initiated. This is important as in patients with diabetic macular oedema with mean sensitivity of 2 dB. If the test was started at 16 dB, then it would take a longer time to complete the test. The prolonged time could result in decreased patient cooperation parameters such as false-positives or fixation stability and these parameters have not been reported in this study. This data would be helpful in interpreting the reliability of the results.

The 4–2 strategy is faster but we believe when measuring the macular sensitivity 4-2-1 strategy is superior. We did not understand the rationale behind using the 12° cross for fixation. It would have helped significantly if the authors compared the retinal thickness at each quadrant surrounding the fovea and correlated the retinal sensitivity to thickness both in diabetic macular oedema and normal eyes.

We read this paper with great interest and would like to once again congratulate the authors on their important work in establishing anatomic and functional correlation in the diabetic macular oedema eyes.

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Sir,

Response to Shah and Chalam

We appreciate the interest of Drs Shah and Chalam in our article and thank them for their comments. Our study was a pilot study to examine how the retinal sensitivity measured with the MP-1 correlates with other parameters, such as retinal thickness and visual acuity. From our experience, we feel that the testing conditions should be further modified especially for patients with poor visual acuity. In this study, the age of diabetic patients ranged from 25 to 76 years, and that of the controls from 42 to 76 years, as described in the Subjects and methods section. The reduced sensitivity may be due to the ages of the normal subjects. All tests were performed in a lighted room. In order to obtain more reliable data from patients with poor VA, we used a larger cross for fixation, and allow patients to learn the test. We also appreciate the other suggestions for further studies.

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Sir,

The subluxated lens: a patient's perspective

There are several camera systems available to the ophthalmologist for documenting ocular conditions. However, it is difficult to document what the patient