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Sir,

The impact of national diabetic retinopathy screening on ophthalmology: the need for urgent planning

We read with interest the article 'The impact of national diabetic retinopathy screening on ophthalmology: the need for urgent planning' by S Harding *et al.*¹ They report the need for a systematic screening system in view of the introduction of the National Service Framework recommendations. We would like to describe a scheme used in King's College Hospital and University Hospital Lewisham, which has been adapted to streamline the service.

Methods

Photographic screening images are graded by a trained level 1 screener. Screen-positive images (evidence of sight-threatening retinopathy, ungradeable image due to media opacity or evidence of other eye disease) are then reviewed by a more experienced, level 2 screener. If they are confirmed to be positive, they would normally be referred to the HES at this stage. In our scheme, these images are instead passed to the referring retinal specialist for further advice. Confirmation of diagnosis results in acceptance into the HES (with guidance on urgency). If HES review is not required then they receive either annual or 6 monthly recall in the screening service. Allocation of patients with cataract or other eye diseases to alternative clinics ensures that appropriate and timely follow-up is achieved without overloading the retinal specialist clinics.

Results

Of the 2260 patients screened from November 2004 to April 2005, referral was requested on 186 patients (8.2%). Of those, 94 (50.5%) were accepted for further examination for possible early treatment with laser. The most common reason that referral was not required was early maculopathy with no clinically significant macular oedema, fundal lesions of no consequence, and previously treated, inactive maculopathy.

Conclusion

This method has allowed for a 50% reduction of the referrals to the HES, thus allowing space for an ever-increasing population of diabetics.

We continue to use this method to reduce the referral rate; however, it has the added advantage of providing helpful feedback allowing further development of experience for the screeners, therefore continually improving the service we can offer to patients.

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Sir,
Reply: The first cut is the deepest: basic surgical training in ophthalmology

I read with interest the article by Gibson *et al.*¹ It is indeed a difficult time for trainees in ophthalmology, specialist registrars (SPRs) and senior house officers (SHOs) alike. As mentioned by Gibson *et al.*,¹ the issues of clinical governance and implementation of the European Working Time Directive have done little to aid in improving surgical training in ophthalmology. Over the past 18–24 months, government initiatives and the introduction of ISTCs have further spiralled surgical training to negligible levels in some units across the UK.

However, it is disappointing that comments made by SHOs were mainly negative. With change come new challenges, and ophthalmology is at the forefront of change. While an SHO in Manchester, during the same period of study as referred to by Gibson *et al.*,¹ intraocular procedures were indeed difficult to come by. Among the six SHOs, all with over 14 months experience in ophthalmology, only two achieved more than two full intraocular procedures per month during an 8-week prospective study of surgical experience. The remaining four achieved just 11 part/full cases between them during the same period. Similar

negative comments were made by these SHOs as described by Gibson *et al.*¹ Interestingly, I also showed during this study that the time taken from the patient entering the theatre to removing the drape did not vary significantly relative to the experience of the surgeon. SHOs, on average, took 36 min, SPRs 35 min, and consultants 34 min. This implies that the grade of surgeon has little impact on the time per patient episode, which is related to multiple other factors relating to efficiency of usage of theatre time. It is therefore wrong to assume that heavily booked lists leave little time for training. In fact, larger lists, if handled efficiently, will allow greater exposure and opportunities for surgery than shorter lists.

Interestingly, after presenting the findings of the above prospective study, several changes were implemented. The department gained awareness of the lack of surgery and actively helped to reverse this trend. Special teaching lists were set up and SHOs were encouraged to approach the team leader and specify which case would be suitable for them on that list. Miraculously, over the next 12 months, all six SHOs had performed over 100 complete cataract procedures!

It is important for trainees to realise that the Royal College of Ophthalmologists has guidelines on basic surgical training. However, in this increasingly difficult time with major changes in medical training, it is important that trainees start to take the initiative and target their own training. Negative comments are unproductive and trainees within departments must look for and aid in instigating change to ensure that the surgeons of tomorrow are trained to the high standard expected by our patients.

Reference

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