ulcer have been proposed, implicating dry eyes owing to sicca syndrome as a complication of cGVHD. We also observed CD8-positive cells in both the LKP graft and host stroma, and no other types of lymphocytes. CD8-positive cells play a central role in the tissue injury of cGVHD.[3] Our histological observations strongly suggest that stromal melting was not derived from allograft rejection but resulted from immunological cytotoxic reaction by CD8-positive cells, compatible with cGVHD pathology in addition to dry eye, because rejected corneas were invaded by a mixture of CD4-positive and CD8-positive T cell.[4] This report is the first to demonstrate CD8-positive cell infiltration in corneal disorder after BMT patient.

Finally, sterile corneal ulceration may develop after BMT, leading rapidly to thinning and perforation. We emphasize that close cooperation between oncologist and ophthalmologist is needed to follow patients after BMT. Although the reasons why the pathological site is the paracentral region remains unknown, this case serves as a reminder that even the paracentral part of cornea can be target in BMT patients.

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Sir,

**Does the scrub nurse matter?**

Surgical interventions are increasing every year[1] with increasing pressures to reduce waiting times for surgery.[2] This has led to rising absenteeism and loss of job satisfaction among the nursing and medical profession.[3]

The operating team all have to interact at many levels for surgical procedures to run smoothly and achieve good outcomes.[4] It is also recognised that all members of the team are important in the management of complications when they do occur.[5,6] This study was designed to ascertain if the experience of one member of the team, the scrub nurse, had any influence on the short-term outcome of complicated cataract surgery.

In cataract surgery, the scrub nurse is of particular importance as she/he not only performs scrub nurse duties but also acts as first assistant.

### Methods

A retrospective study was undertaken in a designated cataract theatre at a single-site, eye hospital from January 2001 to December 2003.

We included cataract operations complicated by a posterior capsule rupture with an anterior vitrectomy and cataract operations performed by consultant ophthalmologists.

We excluded operations with other complications and operations not performed by a consultant.

Posterior capsule rupture was used as an indicator of intraoperative complications as it is easily recordable, potentially sight threatening, and representative of intraoperative problems, that is, it cannot happen pre- or postoperatively.

The scrub nurses involved with each case and their experience in years were identified using the hospital database. All the nurses had gained their cataract experience in the same theatre. The patients who then underwent a secondary procedure during a different theatre session were then identified. A 'good' outcome was defined as a case that required only one operative procedure.

### Results

One hundred complicated cases were identified. Fifty cases were dealt with by 'more experienced' nurses and 32 cases by 'less experienced' nurses. A 'more experienced' scrub nurse was defined (arbitrarily) as having $\geq$10 years of cataract surgery experience and a 'less experienced' scrub nurse, $\leq$7 years experience. This division was apparent after analysing the data as all the scrub nurses, except one, fell into these two categories.

**Table 1** Number of patients requiring a secondary procedure following posterior capsule rupture

| | *More experienced (50)* | *Less experienced (32)* |
|---|---|---|
| Further anterior Vitrectomy (with IOL already *in situ*) | 3 | 6 |
| Resuturing of corneal wound | 1 | 0 |
| Iris prolapse repair | 1 | 0 |
| Secondary IOL (no further vitrectomy required) | 2 | 4 |
| Total | 7 (14%) | 10 (31%) |

This nurse had 8 years experience and was therefore excluded from further analysis.

When an experienced nurse was involved with the complicated case, 14% of these patients went on to a secondary procedure. When a less experienced nurse was involved, 31% of these patients went on to secondary procedures (19% *pars plana* vitrectomy).

These results are shown in Table 1.

Case mix was similar for the two groups and all of the operating surgeons had similar operating experience. No other assistant, for example, junior doctor, was involved in any of the operations.

## Comment

This study was *not* designed to examine correct surgical technique in complications but to analyse the situation where an anterior vitrectomy is required. If the surgical conditions are favourable, then completion of the primary procedure may be preferable. This can lead to a quicker visual recovery, reduce the chance of intraocular infection, and reduce the associated stresses of returning to hospital for further procedures.[7–9]

The results of our study suggest that when a 'more experienced' scrub nurse is assisting, then he/she seems to facilitate the surgeon being able to complete the surgery in one procedure.

Possible explanations for these findings are:

1. A 'more experienced' scrub nurse is able to react more effectively when a complication occurs.
2. A 'more experienced' scrub nurse may perhaps give the surgeon the confidence to perform a more meticulous anterior vitrectomy and attempt placement of a sulcus lens.
3. In high-volume cataract surgery, the surgeon will be more comfortable to continue with the primary procedure when being assisted by an experienced scrub nurse.

The results show the influence a scrub nurse has on enabling the operations to run smoothly whenever the unfortunate event of a complication is encountered.

The study does have some potential biases:

- Experience, in this study, is chosen as a measure because it is easily attainable, but experience in years does not necessarily correspond with ability. Although there is a marked difference between the second procedure numbers for 'more experienced' and 'less experienced' scrub nurses, it must be remembered that the numbers are relatively small.
- Secondary procedures are only performed, with the patient's consent, if they are fit for surgery, so it may be that a second procedure was not performed in this study, despite poor vision, because the patient is unwilling or unable to have further surgery. A further investigation into the management of cataract complications continues in our theatre.

## Conclusions

All members of the surgical team are important and there is evidence of the effect that individual experience[4] has on the daily running of lists. These results suggest that when complicated cataract surgery is encountered, fewer patients need secondary procedures when a more experienced scrub nurse is present in theatre. This is the first time, as far as we are aware, that the experience of the scrub nurse has been shown to influence the management of complications. Management of complications might be improved by considering the following recommendations:

1. A less experienced scrub nurse on a list should have a nurse with more experience available for advice within the theatre complex.
2. Surgical training via simulators dealing with the management of complications should be widely available. All members of the operating team, not only the surgeons, may find simulators useful for training.

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Sir,

**Benign episodic unilateral mydriasis**

A unilaterally dilated pupil is often viewed as an ominous sign. However, a majority of patients with a neurologically isolated unilateral mydriasis have a benign process.[1] Detailed history and examination can help avoid referral for an expensive neurological work-up. We present a patient with intermittent dilation of the pupil with no apparent cause.

***Case report***

A 39-year-old lady presented to the casualty with a traumatic corneal abrasion to the left eye. She was systemically well, except the occasional classical migraine. Vision was 6/12 in the right eye and 6/36 in the left. Examination revealed bilateral congenital cataracts. No other abnormality was found. The abrasion healed in 2 days with vision improving to 6/18. The right pupil, however, remained dilated (Figure 1a). This was interpreted as an abnormally prolonged response to tropicamide drops. The patient was discharged. Six months later, she was referred to us with a dilated left pupil. A detailed history revealed no trauma and no possibility of pharmacological dilation. Her vision was unchanged from her last visit to the department. The anisocoria was more marked in light. There was no ptosis and full ocular motility. There was no other ocular abnormality, except for the previously noted cataracts. It was observed that 0.125% Pilocarpine did not constrict the pupil, whereas 1% Pilocarpine constricted both pupils well. The anisocoria spontaneously disappeared in 3 days. Over the next 2 years, this patient presented four times with similar episodes of unilateral mydriasis, twice affecting the left eye (Figure 1b). Three of these episodes were accompanied by headache and two by ocular pain. Each time there were no other significant findings and pharmacological tests were negative.

**Comment**

The features of our patient were consistent with a rare but innocuous condition termed 'benign episodic unilateral mydriasis.'[2] The affected individuals, usually women, often have a history of migraine.[2] The episodes may be accompanied by blurred vision, orbital pain, headache, or photosensitivity.[2] The dilated pupil is the only ocular finding. The cataracts in our patient were an incidental finding.

Anisocoria is often viewed as a worrying sign. A systematic approach is required to examine and investigate this condition.[3] In the absence of any other

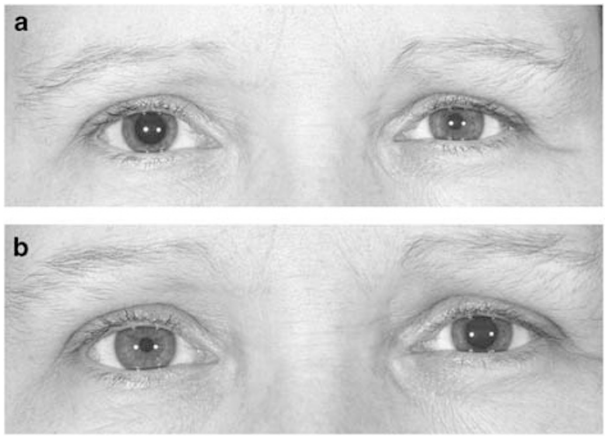


**Figure 1** Episodic unilateral mydriasis. Either pupil may be dilated during an episode.