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Sir,
Initial experience of the Ahmed valved implant in the management of refractory glaucoma

We were interested to read the paper on Ahmed valve implantation in glaucoma secondary to chronic uveitis by Özdal PÇ, Vianna RNG and Deschênes J (*Eye* 2006; **20**: 178–183). We have recently carried out a retrospective audit of 16 eyes that had undergone Ahmed valve (AV) insertion at Stobhill Hospital, Glasgow (May 2001 to September 2004).

Patient demographics, diagnoses, and response to surgery are summarized in Table 1. Mean age was 52.8 years. Ten were female patients and six male patients. The range of follow-up was 12–47 months. Success was defined as postoperative intraocular pressure (IOP) of ≤ 21 mmHg with or without glaucoma medications and without further surgical intervention at the last visit. The estimated probability of success at 12 months was 63%, with a 95% CI of 43–91% (Figure 1). The median number of medications pre- and post-AV insertion were 3 and 1, respectively. Four patients with apparently acceptable IOP underwent surgery because of increasing intolerance to medical therapy, especially oral acetazolamide. In two patients, IOP was documented to be higher following AV insertion; however, control was deemed to be adequate on a single topical glaucoma medication. Visual acuity was improved or stable in most of the patients ($n=9$), five patients lost 1–2 lines and one regained his preoperative vision only after 2 years follow-up. One patient lost 3 lines due to progressive epiretinal membrane. One patient deteriorated from hand

Table 1 Patients' data

| No. | Age (years) | Sex | Diagnosis | Laterality | Preoperative VA | Postoperative VA (12 months) | Preoperative IOP (mmHg) | Postoperative IOP (mmHg) (12 months) |
|-----|-------------|-----|---------------------|------------|-----------------|------------------------------|-------------------------|--------------------------------------|
| 1 | 48 | M | Secondary to trauma | L | 6/9 | 6/18 | 18 | 27 |
| 2 | 62 | F | FHC | L | 6/18 | 6/9 | 30 | 15 |
| 3 | 80 | F | POAG | L | 6/12 | 6/6 | 17 | 12 |
| 4 | 80 | M | POAG | R | 6/60 | 6/24 | 40 | 25 |
| 5 | 40 | F | NG | L | 6/36 | 6/36 | 35 | 13 |
| 6 | 68 | F | POAG | R | 6/9 | 6/24 | 24 | 18 |
| 7 | 61 | M | Aphakic | R | 6/6 | 6/9 | 24 | 15 |
| 8 | 40 | F | FHC | L | HM | CF | 28 | 38 |
| 9 | 64 | F | POAG | R | 6/6 | 6/9 | 24 | 21 |
| 10 | 16 | F | NG | R | HM | NLP | 34 | 8 |
| 11 | 60 | M | POAG | R | 6/9 | 6/12 | 23 | 18 |
| 12 | 71 | M | POAG | L | 6/36 | 6/24 | 30 | 27 |
| 13 | 50 | F | Uveitic | R | 6/36 | 6/36 | 32 | 12 |
| 14 | 16 | F | Congenital | L | 6/36 | 6/36 | 30 | 18 |
| 15 | 15 | M | Uveitic | R | 6/18 | 6/18 | 14 | 13 |
| 16 | 74 | F | NTG | L | 6/6 | 6/12 | 20 | 14 |

F = female; FHC = Fuch's heterochromic cyclitis; HM = hand movement; IOP = intraocular pressure; L = left; M = male; NG = neovascular glaucoma; NLP = no light perception; NTG = normal tension glaucoma; POAG = primary open-angle glaucoma; R = right; VA = visual acuity.

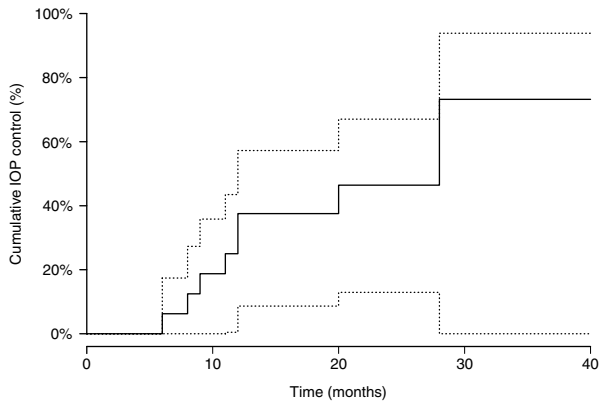


Figure 1 Probability of success over time, based on Kaplan-Meier life-table analysis.

movements to no light perception due to progression of her underlying disease (familial exudative vitreoretinopathy).

The early postoperative complications encountered were hyphaema ($n = 4$), hypotony ($n = 3$), and choroidal effusion ($n = 2$).

Overall, AV insertion resulted in a reduction in mean IOP from 26.4 mmHg (SD 7.1) to 18.3 mmHg (SD 7.6) after 12 months. Although our success rate may appear lower than those reported in some other studies,¹⁻⁴ comparison with published literature is difficult due to a lack of homogeneity in case mix.⁵

We agree with the experience of Özdal *et al*⁴ that AV appears relatively safe and effective in refractory glaucoma.

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Sir, A survey of excimer laser use among consultant ophthalmologists in United Kingdom

Laser refractive surgery is a rapidly evolving field in ophthalmology. We carried out a national UK survey to acquire information regarding surgeon demographics, types of excimer laser utilised (phototherapeutic keratectomy (PTK), photorefractive keratectomy (PRK), laser assisted *in situ* keratomileusis (LASIK), laser epithelial keratomileusis (LASEK)), indications, and the complication rates within the UK by consultant ophthalmologists (accredited independent practitioners from the Royal College of Ophthalmologists (RCO)).

The UK refractive survey¹ (UKRS) in 2005 reported on 61 clinics. The survey stated that 65% of practitioners who performed excimer therapy were ophthalmic consultants. This percentage has increased to 43% in 2004² from 35% in 2003.³

Postal questionnaires were sent to all 903 ophthalmology consultants registered with the RCO in the UK. The questionnaire was anonymous and single paged to encourage a high response rate (Figures 1 and 2).

The overall response rate was 49.1% (443 out of 903) which compares with the response rates from US surveys 11.8-18.4%.⁴⁻⁸ Five per cent of the respondents had performed excimer therapy in the previous month and all were corneal specialists.

Forty-four percent of the consultants treated patients privately alone whereas 48% treated both National Health Service (NHS) and private cases, and 8% did not respond in this regard.

Twenty-three consultants reported on their refractive practice over the previous month. When considering the case load of the surgeons, 34.8% (*vs* 47% in 2004 US Refractive Survey (USRS))⁷ performed more than 20 procedures per month and 26.1% (*vs* 19.6% USRS⁷) conducted less than five procedures per month.

Overall 13.3% (57/429) of patients underwent PTK, 1.6% (7/429) PRK, 59.7% (256/429) LASIK, and 25.4%