

improved from HM before the procedure, to 6/9 with pinhole and the eye was comfortable with the infection having resolved. The conjunctival pedicle was divided at its base 6 months after the initial surgery with good corneal stability and the anterior chamber remains well formed to date. The eye is healthy and functional without the need for a corneal graft, recording an unaided visual acuity of 6/9 despite an inferior leucomatous opacity and localized anterior synechia.

The demonstrable usefulness of this surgical procedure with limbal tissues left undisturbed and providing valuable support to the diseased cornea prompts us to advocate its use in suitable cases more readily from any sector of the bulbar conjunctiva, depending on the site of the corneal pathology. It is also our view that this procedure need not always be a temporary stopgap measure to make an eye safe but can be used to restore structural and functional integrity of the eye.

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S Madhusudhan and KP Chandra

Department of Ophthalmology, HM Stanley Hospital, St Asaph, Denbighshire, North Wales, UK

Correspondence: KP Chandra,
Tel: + 1745 589765;
Fax: + 1745 589770.
E-mail: puvanachandra@aol.com

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Sir,
The presentation of data relating to visual acuity

We read with interest the excellent article entitled 'Late-onset visual decline following successful treatment of subfoveal choroidal neovascularisation with photodynamic therapy' by Bhatnagar and Musadi (*Eye* 2006; **20**: 491–493).¹ This observational study of four patients developing late increasing size of fibrotic scarring after photodynamic therapy (PDT) is very valuable for clinicians who manage choroidal neovascularisation.

It caught our attention that the visual acuity data were presented in several formats namely: number of lines lost, number of letters lost, and the reciprocal of logMAR (Figure 1). However, nowhere in the paper is the actual logMAR visual acuity shown. Most ophthalmologists (and especially those treating patients with PDT) are familiar with logMAR visual acuity units. If they were not then the reciprocal would surely leave them even more baffled. The only possible explanation was that the authors wished to present declining visual acuity with a negative slope.

LogMAR visual acuity is the accepted scientific means of presenting visual acuity in journals and for carrying out statistical analyses. Many feel that it should become the accepted means of testing vision in clinical practice.² Snellen eye charts suffer from well-known limitations of unequal changes in visual angle per line, letters of differing legibility, and different numbers of letters per line. Snellen charts are insensitive to changes in acuity at the top end of the chart where changes in visual acuity for patients with choroidal neovascularisation are important. The Bailey–Lovie or ETDRS chart was designed to overcome these deficiencies³ and is more reproducible and reliable.⁴ The use of the Snellen chart to define the threshold for PDT has also been questioned. Patients had to achieve 34 letters on a modified ETDRS chart to receive treatment under treatment of age-related macular degeneration with photodynamic therapy (TAP) study inclusion criteria. This is said to be equivalent to 6/60 Snellen, but in fact agreement is variable.⁵ We agree with the authors' avoidance of Snellen acuity.

All four patients reported by Bhatnagar are rightly considered to have had a disappointing result from PDT. Nonetheless, it is interesting to note that one of the four would meet the criterion for success according to such studies as the TAP study by virtue of having lost only 14 letters on the logMAR chart.⁶ Figure 1 in their paper illustrates concern that this criterion for success is of course partly governed by how much vision the patient still has to lose.

Therefore, we feel that journals should be promoting the clear presentation of logMAR visual acuity data. Familiarity with logMAR acuity values should be promoted not least in the field of TAP where logMAR visual acuity is an accepted means of monitoring progress.

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E Doyle and AG Casswell

Sussex Eye Hospital, Eastern Road,
Brighton BN2 5BF, UK

Correspondence: E Doyle,
Tel: +44 (0) 7799448543;
Fax: +44 (0) 8714338914.
E-mail: EdRachie@btinternet.com

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Sir,
Reply to Doyle *et al*

We would like to thank Doyle *et al* for their interest in our reported series of four cases.¹ We agree that logMAR visual acuity measurements should be encouraged especially in situations where measurements using a Snellen chart may not be sensitive enough to recognise a change in the acuity. In keeping with the standard practice we routinely record logMAR visual acuities for all patients undergoing PDT. In the text of our report we have reported the decline in visual acuity in terms of the drop in the number of letters read on the logMAR chart. This is similar to the way results were summarised in the TAP study² where reduction of visual acuity by fewer than 15 letters over a 24-month period was considered as beneficial effect of the treatment. Furthermore, although one of our patients lost only 14 letters, this happened rapidly over a 9-month period in spite of closure of the CNV which is not strictly

comparable with the beneficial outcome reported in the TAP study.

Doyle *et al* have said that nowhere in the paper is the actual logMAR visual acuity shown. We would like to draw their attention to Figures 2 and 3 in our report that clearly mention the actual logMAR visual acuity values for that case. We feel that using the reciprocal of actual logMAR values appropriately illustrates graphically in Figure 1 the steep decline in visual acuity as a downward slope. We do not think that adding a table showing logMAR visual acuities would have added to our message from this small case series that in certain cases visual acuity could decline fairly rapidly in spite of a 'successful' PDT treatment.

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A Bhatnagar, M Musadiq and YC Yang

Wolverhampton Eye Infirmary, Compton Road,
Wolverhampton, WV3 9QR, UK

Correspondence: A Bhatnagar, Wolverhampton
Eye Infirmary, Compton Road, Wolverhampton,
WV3 9QR UK
Tel: +44 7958 582871;
Fax: +44 1902 645018.
E-mail: bhatnagar_ajay@btopenworld.com

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Sir,
Intravitreal triamcinolone staining observation of residual undetached cortical vitreous after posterior vitreous detachment

The use of intravitreal triamcinolone to demonstrate areas of undetached vitreous¹ has gained in popularity in recent years. The authors have not clarified whether their