readily accessible treatment method. It should therefore be mentioned as a valid alternative in units who do not have easy access to PTK.

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Sir,

Minimising blinding complications of cyclodiode laser in high risk and only eyes

We read with great interest the article by Tay *et al*[1] reporting the first case of suprachoroidal haemorrhage as a blinding complication of cyclodiode laser. The use of cyclodiode laser has been increasing over the last decade as an effective management of complicated glaucoma. This phenomenon has unmasked uncommon but potentially blinding complications such as suprachoroidal haemorrhage,[1] scleral perforations with[2] or without[3,4] choroidal haemorrhage, necrotising scleritis,[5] malignant glaucoma,[6] and pan-ophthalmitis.[4]

Figure 1 Debris arising from the ciliary body post-cyclodiode laser (arrow).

Certainly ultrasonically, debris can be seen arising from the ciliary body post-cyclodiode (Figure 1).

It is worthwhile noting that these reported complications had occurred in the setting of scleral thinning and/or high laser power setting (2000 mW power and 2000 ms duration) with audible 'pops'. Tay *et al*[1] treated their eye (only functioning eye, other eye count fingers) with 60 applications of 2000 mW power and 2000 ms duration to 360°. It was suggested that hypotony was the initiating event resulting in suprachoridal haemorrhage. Our default laser setting is 1500 mW and 1500 ms, titrated down by 250 mW if there is an audible 'pop'.

In only eyes and in high-risk eyes, such as a history of hypotony post-cyclodiode laser treatment to the same or fellow eye, large eyes (eg buphthalmos, high myopes), aphakes, uveitic eyes, history of multiple ocular surgery, and connective tissue disease, we propose a sequential titrated cyclodiode laser treatment. In these eyes, we initially start with one quadrant, leaving the other three quadrants untreated. We may even start at laser setting of 1000 mW and 1000 ms. Palmer *et al*[7] found that about 40% less energy is required to achieve ciliary photocoagulation in thin sclera compared to normal thickness sclera in cadaveric eyes. Another important practical point is checking the tip of the probe so that there is no debris or carbonisation, which increases laser delivery. Even with the recommended single use probe (a new probe for each eye), carbonisation can still occur during any one of the applications on the one eye.

We understand that this may involve more treatment sessions to achieve the target intraocular pressure. However the alternative regimen of sequential titrated cyclodiode laser treatment offers an increased safety profile in high-risk eyes prone to hypotony and may help to prevent the devastating blinding complications that can occur in these eyes.

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Sir,

Utilization of an ophthalmic casualty—a critical review

Most eye casualty departments provide a service far in excess of their capacity;[1,2] and review patients having non-urgent problems more appropriate for primary care or outpatient clinics.[2–8] Historically, the accident and emergency (A&E) department at the Wolverhampton Eye Infirmary (WEI) has provided an open access casualty service from 0900–2100, on all days of the week. All patients are triaged at presentation by a nurse practitioner using the local triage practice. We studied the current utilization of our eye casualty services with special emphasis on the out-of-hours attendance.

Methods

All new patients attending the casualty at WEI over a 4-week period (1–31 October 2004) had information collated on: demographic data, referral source, presentation time, symptom duration, diagnoses, and management. Out of hours was defined as after 1700 till 2100.

Results

Out of 2546 patient contacts in the study period, 1597 patients were new and 949 patients had review appointments. Data collection was complete for 1295 (81%) new patients.

The mean daily new patient attendance rate (+/− SD) in the eye casualty was 50 +/− 14 during this period. This was lower on the weekend (Saturday: 39 +/− 7, Sunday: 29 +/− 5).

Time of presentation, duration of symptoms, and diagnosis are shown in Figures 1 and 2 and Table 1, respectively.

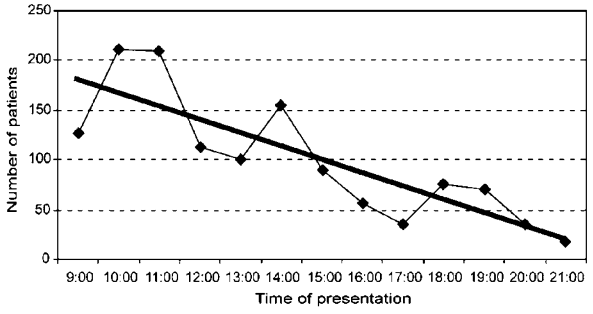

Figure 1 Eye casualty presentation pattern.

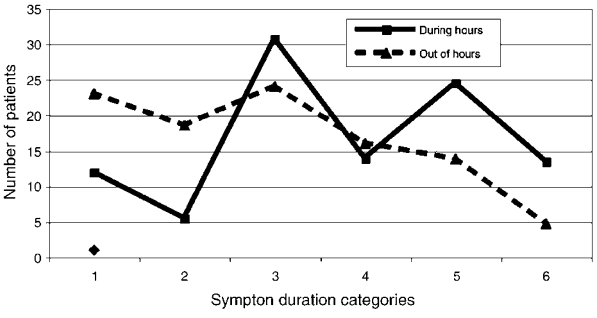

Figure 2 Duration of presenting symptoms in the eye casualty. Symptoms duration categories: 1—up to 6 h, 2—>6 h up to 12 h, 3—>12 h to 1 day, 4—>1 day and up to 2 days, 5—>2 days to 1 week, and 6—>1 week.