patient pathway before the patient is seen by a medical retina specialist. This is likely to be a source of additional delay. In the process outlined above, urgent referrals are sent directly to the medical retina specialist and then the refinement is performed using the knowledge and experience of existing staff within the department. The refinement process does not require additional resources as the assessment can usually be scheduled for a time when there is spare capacity. Patients with treatable disease can then be scheduled directly for priority treatment.

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Sir,

**Reply to low power transpupillary thermotherapy**

We read with great interest the article by AC Hogan and DJ Kilmartin[1] on 'Low power transpupillary thermotherapy' in patients with choroidal neovascularisation (CNV) secondary to age-related macular degeneration (AMD) with great interest. Firstly, we would like to congratulate the authors for highlighting the efficacy of TTT in treatment of patients with CNV who are ineligible for photodynamic therapy while stabilising vision. However, there are a few issues that we would like them to clarify pertaining to their article.

In the materials and methods, they have not mentioned the time interval between fluorescein angiogram and time of treatment. In the low power group of patients, it has not been mentioned as to how they arrived at the required power. Was there any use of a test spot? If so, where was the preferred site of the test spot? In our practice, we generally fire a test shot outside the vascular arcades with the end point being a very faint greying of the retina. If there is any whitening of the retina noted before the end of 1 min, the power is lowered in steps of 100 MW till there is no reaction or a very faint greying. This is in accordance with the method described by Reichel *et al*[2] and Newsom *et al*[3] in their previous studies. Did they treat patients at a subthreshold level such that no end reaction was noted at all? If so, how did they arrive at this end point? What was the difference in the end points between standard power and low power transpupillary thermotherapy? Did the presence of serous elevation and subretinal haemorrhage need increase in power? In our practice, we have noted that there is a need to slightly increase the power when there is increased serous elevation and subretinal haemorrhage. Was the power/retinal diameter coefficient the same for all the patients treated in each group?

In our practice in the Indian eyes, we have noted that titration of the required laser power is dependent on the pigmentation of the choroidal layer which is more in the Asian eyes while compared to the Caucasian eyes. More the pigment, lesser the power required. We generally use power in the range 200–600 MW for almost all of our patients with the end point being a very faint greying of the retina at the end of treatment duration of 1 min. The importance of ocular pigmentation in this modality of treatment has been stressed by Auer *et al*.[4] They reported choroidal atrophy in five of 32 eyes that underwent TTT in pigmented individuals. Similar effects have been shown in animal models.[5] We feel that titration of power is dependant on the level of pigmentation of the choroid and

that determines whether an individual has a low power or a standard power TTT as defined by the authors.

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Sir,

## 'Late' functionally successful repair of Descemet's membrane detachment following phacoemulsification

Descemet's membrane detachment (DMD) was once a common occurrence during cataract surgery.[1] Most peripheral and localized detachments resolve spontaneously.[2] However, large and persistent detachments impair vision and require treatment.We report the successful attachment of DMD diagnosed 14 months after phacoemulsification.

### *Case report*

A 65-year-old male presented to our centre, 14 months after uneventful phacoemulsification. A moderate postoperative visual gain was attributed by the primary surgeon to corneal oedema and was managed conservatively with topical steroids and antibiotics. Three months following surgery, topical acyclovir was added to the existing medication. There was no improvement even after more than 12 months of therapy.

On presentation to us, his best-corrected visual acuity was 20/125 in the right eye (RE) and 20/20 in the left eye (LE). Slit-lamp biomicroscopy revealed increased corneal thickness mostly distributed in the centre and inferior half of the cornea. The examination was remarkable for the absence of corneal vascularization, keratic precipitates, and cellular reaction in the anterior chamber. A shallow central Descemet's membrane detachment (DMD) was observed following instillation of 10% anhydrous glycerine (Figure 1a). It was continuous with the inferior side-port incision.

The DMD was successfully repaired with intracameral injection of perfluoropropane gas (14%). Corneal oedema resolved and visual acuity improved to 20/30 over a period of 7 days (Figure 1b). Confocal microscopy performed after re-attachment revealed an endothelial density of 1880 cells/mm$^2$ in RE and 2112 cells/mm$^2$ in the fellow pseudophakic eye (Figure 2a and b).

### Comment

Localized, non-vision disturbing, DMD is not uncommon and tends to undergo spontaneous re-attachment.[2] Larger DMDs present as a significant visual handicap.[3,4] Shah *et al* [5] reported successful attachment of late DMDs in three patients using perfluoropropane gas. In all three cases, the DMDs were detected 2–3 weeks after surgery. To the best of our knowledge, there is no published report on successful management of DMD diagnosed 14 months after surgery.

Our case highlights two important features. Firstly, DMD should be considered as a differential diagnosis for corneal oedema even in the late postoperative period. Secondly, despite a prolonged period of detachment, the DMD is amenable to surgical repair with good structural and functional outcome.

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