Case 2

A 71-year-old Afro-Caribbean woman presented with decreased vision LE; BCVA was 20/200. Anterior segments examination was unremarkable. Fundoscopy in the LE disclosed a stage-5 FTMH. Few superficial refractile crystals were visible within the vascular arcades situated at the level of the inner retina (Figure 2). The patient decided against any surgical intervention and 11 months later, the distribution and appearance of crystals remained unchanged.

Comment

Few previous reports have described the association of inner retina refractile opacities with long-standing RDs.^{1,2,5} Ahmed *et al*¹ and Ciardella *et al*² postulated that the crystalline deposits were granules of haemosiderin-laden macrophages adjacent to the internal limiting membrane. Banaee³ had postulated that photoreceptor outer segment particles can be released into the vitreous cavity and this may explain the

deposition of crystals in the cases presented by Ahmed *et al*¹ and Ciardella *et al*.³

On the basis that our patients and the majority of those reported in previous studies^{1,2,4} did not have a history of vitreous haemorrhage, it seems unlikely that the crystals deposition can be attributed to blood-break-down products.

A similar mechanism to that described by Banaee could explain the appearance of crystals in our patients with FTMHs.

Our cases illustrate the rare association of chronic FTMH with the deposition of small refractile crystals on the superficial retina which to the best of our knowledge has never been reported before. The association of crystals with FTMHs strengthens the view that crystal deposits in noninherited, metabolic, or toxic crystalline retinopathy may be attributed to photoreceptor degeneration rather than degenerative by-products of erythrocytes.

Figure 1 Patient 1-LE. Fundus photography showing a FTMH and crystalline deposits in the posterior pole.

Figure 2 Patient 2-LE. Fundus photography depicting small crystalline deposits close to a stage 5 FTMH.

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Sir,
Estimating the potential impact of using intravitreal angiostatic agents for wet macular degeneration on service capacity in a large retinal referral centre
We performed a retrospective review of the angiographic subtype of patients who attended their first fluorescein angiography within a 3-month period in our department, which is a photodynamic therapy (PDT)-providing unit serving a 1.8 million population.

We identified 42 eyes with classic or predominantly classic choroidal neovascularisation (CNV), 40 eyes with minimally classic CNV or occult CNV, and nine eyes with

retinal angiomatous proliferation. A further 13 eyes showed angiographically untreatable lesions (too fibrotic, less than 50% visible CNV due to excessive haemorrhage, or serous pigment epithelial detachment).

Based on these data, we can expect at least a 2.14-fold increase in the number of patients presenting with CNV requiring treatment should anti-angiogenic treatment become available for all lesion subtypes. As the frequency of re-treatment is likely to be more intensive than 3-monthly as in PDT, the number of treatment slots will also need to be planned. We estimated that based on the conservative 2.14-fold increase in number of patients, this will translate into a six-fold increase in treatment slots if monthly injections are required for a 2-year period.

Many factors may affect the above estimates. Visual acuities were not taken into account. There is likely to be filtering effect by the current NICE guidelines, that is, lesions felt to be outside NICE treatment criteria may not have been referred to the PDT centre in the first place. With further understanding and possibility of combination treatment, anti-angiogenic treatments are likely to be required less frequently than originally described.

Nevertheless, we feel our data show what is likely to be the minimum increase, which is still going to have a huge impact on the current service provision, not only in terms of financing of the drug but also on manpower and theatre or clean-room availability.

Epidemiological data have suggested up to four-fold increase in the number of patients may be anticipated, as classic CNV only comprise 24–27% of all lesions.^{1,2} However, many low-grade occult lesions may not cause significant symptoms. We therefore wonder if our data suggest a more realistic picture of how patients may present with CNV. It would therefore be interesting for more units to audit their angiography database to put together a realistic estimate of the likely increase in service need in the near future.

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Sir, Side Saddle cataract surgery for patients unable to lie flat: learning from the past

Patients who cannot lie flat for cataract surgery pose a challenge if general anaesthesia is too risky. The surgeon

is obliged to stand,^{1–3} and bearing weight on one leg to operate the foot pedals is uncomfortable.

Study of the history of cataract extraction, as opposed to couching, shows that the first patients were sat upright during the procedure where, in 1753, Daviel used an inferior section.⁴ His own operating position, with legs either side of the patient's (Figure 1a, <http://www.esccrs.org/Publications/Eurotimes/04October/pdf/ESCRSParisCongress.pdf>), would not suit modern theatre furniture but does prompt a rethink for this difficult group of patients. We suggest an alternative posture for the surgeon, which is not a big change for surgeons familiar with operating from the side.

The patient is positioned with the head rotated towards the surgeon and the foot pedals are placed parallel to the long axis of the operating table (Figure 1b). Written permission was obtained from these patients for publication. Absorbent material is tucked into the patient's collar to protect it from the povidone iodine, which now tracks down the neck instead of towards the ear (Figure 1c). The surgeon uses an infero-temporal

Figure 1 (a) Posture used by Daviel in 1753. (b) A patient unable to lie flat is positioned for cataract surgery. (c) The povidone iodine now tracks towards the patient's collar, which is protected by absorbent material. (d) With the axis of the microscope tilted back 60° from the vertical, and the foot pedals parallel to the long axis of the operating table, the surgeon is able to position himself comfortably.