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.escrs.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

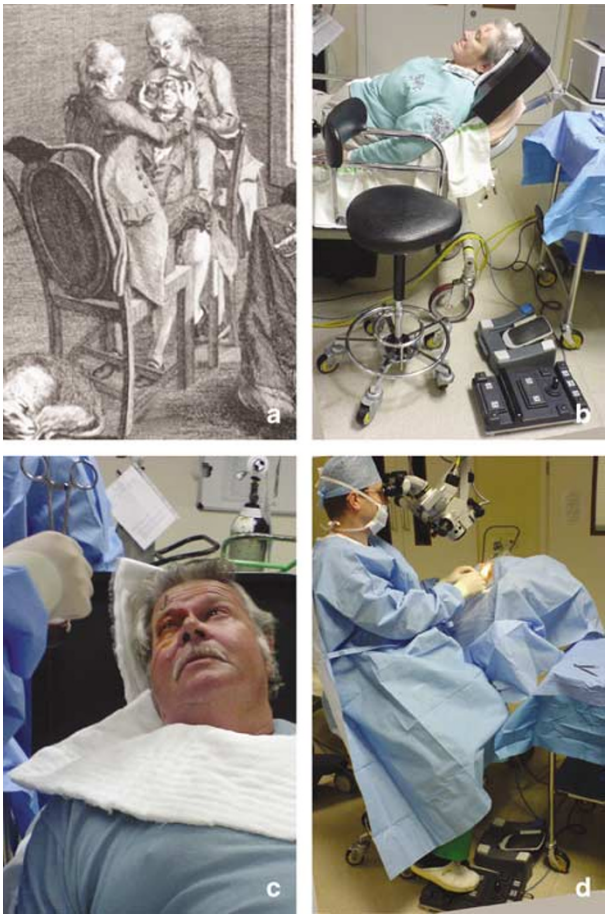

Figure 1 (a) Posture used by Daviel in 1753. (b) A patient unable to lie flat is positioned for cataract surgery. (c) The povidone iodine now tracks towards the patient's collar, which is protected by absorbent material. (d) With the axis of the microscope tilted back 60° from the vertical, and the foot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

approach, but sits *side saddle*, with his thighs parallel to the long axis of the operating table and facing the head end (Figure 1d). The optical axis of the microscope is inclined about 60° towards the horizontal, and the globe is tilted a little more superotemporally than usual to optimize the red reflex if present.

We have used this positioning for about 10 patients now. All patients had intracameral anaesthesia and some required capsular staining and pupil stretching. All but one had uneventful surgery. One patient needed anterior vitrectomy, which was not significantly more difficult than usual. We would not expect the risk of endophthalmitis to be any different from that of a temporal section. Although the surgeon had to take the weight of his arms a little more than usual, he found this posture to be far superior to the alternative of standing.

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Sir,

Infective crystalline keratopathy secondary to non-tuberculous mycobacterium (*Mycobacterium abscessus*) in a non-traumatized eye

We report a rare case of infective crystalline keratopathy (ICK) secondary to non-tuberculous mycobacterium.

Case report

A 55-year-old Pakistani myopic gentleman with primary open-angle glaucoma was taking three ocular hypotensive drops in his right eye. He complained of discomfort in his right eye. Examination revealed pseudoproptosis, inferior punctate staining, and filamentary keratitis more in the right eye. Lubricants and punctal plugs were applied. As symptoms deteriorated, he was changed to preservative-free (PF) drops and started doxycycline 100 mg o.d. with lid hygiene for posterior blepharitis.

Two weeks later, while in Pakistan, a dendritic ulcer in the right eye was treated with occ-acyclovir 3%. On returning the following week, disciform keratitis developed with no epithelial defect. Mild inflammation was present, and therefore, g-Predsol 0.5% PF t.d.s., g-chloramphenicol, and oral acyclovir 400 mg (5 × /day) were started.

There was a marked improvement in his condition. However, after 5 weeks of reducing g-Predsol, he developed bacterial keratitis. Steroids were stopped and hourly g-ofloxacin 0.3% was commenced. Cultures showed fast-growing non-tuberculous mycobacterium (*Mycobacterium abscessus*) sensitive to amikacin and clarithromycin, but resistant to ciprofloxacin/chloramphenicol/vancomycin/erythromycin/cefotaxime/penicillin/rifampicin/imipenem/gentamicin. Despite intensive topical g-amikacin 1.25% monotherapy, the ulcer grew with stromal crystalline keratopathy at the edges (Figure 1a and b). Clarithromycin 500 mg b.d. and g-clarithromycin 1% were added. g-Clarithromycin was poorly tolerated and g-amikacin was recommenced.

Gradual deterioration with eventual perforation occurred. Therapeutic penetrating keratoplasty was performed. Crystalline keratopathy due to *M. abscessus* recurred while on topical g-dexamethasone 0.1%, g-chloramphenicol, and oral clarithromycin and acyclovir. The patient obtained g-gatifloxacin 0.3% from the United States, which was effective with resolution at 4 weeks.

Comment

Less than 30 cases of non-tuberculous mycobacterial ICK have been described.[1,2] Previous surgery or trauma is

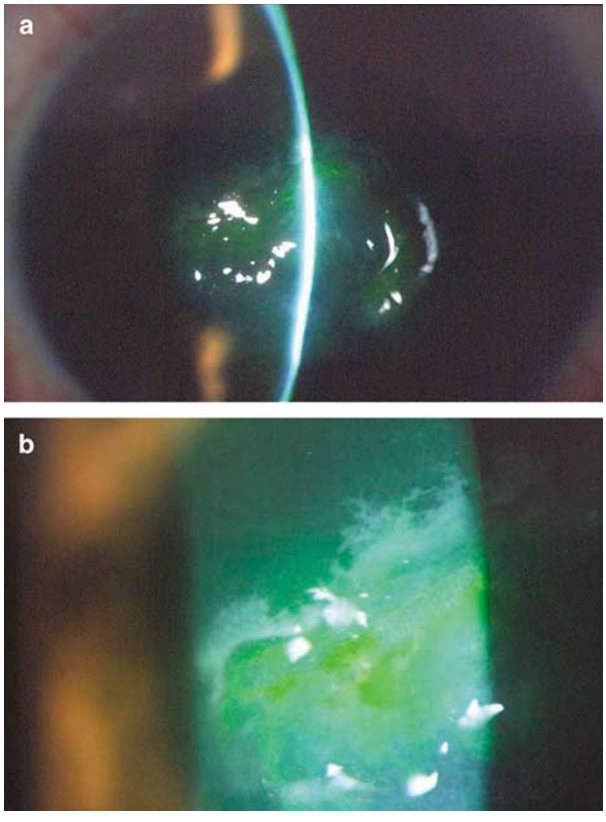

Figure 1 (a) Right cornea. (b) Magnified right cornea: mid-stromal crystalline keratopathy at the edges of the epithelial defect.