twentieth century should be considered with regard to this problem.

Firstly, paradoxically, in spite of the explosion of cigarette smoking during the twentieth century, the number of tobacco amblyopia cases significantly decreased. The discussion related to this phenomenon can be found elsewhere.²

Secondly, it was shown that optic neuropathy in excessive alcohol consumers—called ‘alcohol amblyopia’ previously or often ‘tobacco-alcohol amblyopia’—is in fact just ‘nutritional optic neuropathy’ related to deficiencies of vitamin B and folate acid.³ In different studies, it was shown that a supplementation diet improves the prognosis even without tobacco abstinence.⁴

Thirdly, it was proposed and documented that some cases of ‘tobacco amblyopia’ were in fact Leber’s hereditary optic neuropathies (LHON) and, possibly, which is less understood, epidemic optic neuropathies in Tanzania, Cuba, or Nigeria.⁵

The patient presented in the article had probably some major nutritional deficiencies, although there was no description of tests for vitamin B12 or folate acid in serum, etc, which could confirm this diagnosis. The LHON and other epidemic causes of optic neuropathy are probably very unlikely in this case. Thus, in my opinion, the patient should be diagnosed as having nutritional optic neuropathy.

I believe that the term ‘tobacco optic neuropathy’ should be reserved only for such cases, where the other—that is nutritional, genetic, as well as toxic or infectious—causes can be excluded. There is also one more argument against using the name ‘tobacco amblyopia’, neither is it caused by tobacco itself (it might be an additional or accompanying factor), nor is it real amblyopia.

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Eye (2007) **21**, 1448–1449; doi:10.1038/sj.eye.6702950;
published online 10 August 2007

Sir,

An unusual ocular manifestation in fanconi anaemia: anterior ischaemic syndrome

Fanconi’s anaemia (FA) is a rare autosomal recessive disorder.^{1,2} We report this case, hitherto unreported, to emphasize that anterior segment ischaemia may develop as a complication of uncontrolled anaemia.

Case report

A 23-year-old male, a known case of FA, presented with decreasing left eye vision of 15 days duration. On examination, the best-corrected visual acuity (BCVA) was 6/6 and light perception in the right and left eye respectively. Intraocular pressure was 20 and 6 mmHg in the right and the left eye respectively. Right eye examination was unremarkable. Left eye showed sub-conjunctival haemorrhage, diffuse corneal oedema with Descemet’s folds, pigmented keratic precipitates, distorted pupil, and a complicated cataract (Figure 1). The fundus could not be visualized. Ultrasound B-Scan of the left eye revealed an echo-free vitreous cavity with attached retina. Integrity of the visual pathway was confirmed with ERG and VEP.

Haematological evaluation revealed haemoglobin of 7.2 g%, haematocrit 13.30%, total leukocyte count 2100 and low platelet count. Blasts were absent. Systemic vasculitic disorders were ruled out. Doppler scan of the carotids was normal.

The patient received alternate day blood transfusions and oral steroid therapy, for a period of 10 days, monitored by a haematologist. Topically prednisolone acetate 1% eye drops 6 times/day, in weekly tapering doses, and atropine sulphate 1% eye drops 3 times/day was administered. On follow-up, 1 month later, BCVA was 20/600, intraocular pressure was 9 mmHg, corneal oedema had reduced, and iris showed generalized atrophy. There was no evidence of iris neovascularization. The patient was subsequently lost to follow-up.

Figure 1 Clinical photograph of the left eye showing dispersed sub-conjunctival haemorrhage, diffuse corneal oedema with Descemet’s folds, pigmented keratic precipitates, distorted pupil, and a complicated cataract.

Comment

Severe anaemia, with decreased haemoglobin content, lowers the 'oxygen availability', to various parts of the body.³ Ocular findings reported include sub-conjunctival haemorrhage, orbital or eyelid haematoma, hyphema, and fundus findings.^{4,5}

In this patient, severe anaemia probably led to ischaemic damage of the small vessel wall. This led to bleeding (sub-conjunctival haemorrhage). Besides this, generalized reduction in ocular 'oxygen availability' probably led to ischaemia of the ciliary body. This resulted in diminished aqueous production, anterior segment inflammation, and complicated cataract. These features were suggestive of anterior segment ischaemia.

In haematological disorders as FA, blood parameters should be monitored and strictly controlled, to prevent ocular complications, arising from decreased oxygen yield.

Acknowledgements

This study was financially supported by Aditya Jyot Research Foundation, Dadar, Mumbai, India.

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The authors do not have any financial interest in the materials and methods used in the study.

Eye (2007) **21**, 1449–1450; doi:10.1038/sj.eye.6702960; published online 24 August 2007

Sir,

The relevance of blood pressure measurements in patients attending a diabetic eye clinic: the use of an electronic patient record

We read with interest Sivaprasad and Jackson's¹ finding that 65% of diabetic macular laser was performed on patients whose blood pressure (BP) was not adequately controlled as measured in the clinic. The Scottish Care Information-Diabetes Collaboration (SCI-DC) database provides an electronic patient record on all patients with diabetes in Scotland. Data are recorded from any clinic visit whether it is to the general practitioner, practice nurse, or hospital. We used these data to determine whether the BP measurement on a stressed patient, at the eye clinic preparing to receive bad news about their sight, is accurate.

Of the 86 new patients with diabetic retinopathy attending our Diabetic Eye Clinic over a 5-month period, 97% had a BP measurement found on the SCI-DC database.

We found that clinic BPs were significantly higher than those on the SCI-DC database. The systolic BP was 18.0 ± 18.8 mmHg (mean $\pm$ SD) higher in the eye clinic ($P < 0.01$) and the diastolic was 10.1 ± 12.5 mmHg (mean $\pm$ SD) higher ($P < 0.01$).

Only 20% had a systolic BP ≤ 140 and 22.2% had a diastolic BP ≤ 80 when BP was measured at the eye clinic. However, the SCI-DC measurements showed that 67 and 70% were reaching these targets respectively.

We feel that the BP measurements taken at the diabetic eye clinic may not be accurate. However, only 65% of patients had a BP recorded on SCI-DC within the last 6 months. Although NHS Quality Improvement Scotland standard 4² suggests that the BP review is only carried out 'on an annual basis', we know that our patients are at high-risk of worsening retinopathy if BP is not controlled.³ We, therefore, now only check the BP if there is no measurement available on SCI-DC during the last 6 months, especially if there is significant retinopathy. The information from this database helps us to target patients more effectively and use our resources more efficiently.

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Eye (2007) **21**, 1450; doi:10.1038/sj.eye.6702968; published online 31 August 2007