

- ⁴ Molteno ACB: The use of draining implants in resistant cases of glaucoma. Late results of 110 operations. *Trans Ophthalmol Soc NZ* 1983, **35**: 94-97.
- ⁵ Molteno ACB, Ancker E, Bartholomew RS: Surgical technique for advanced juvenile glaucoma. *Arch Ophthalmol* 1984, **102**: 51-57.
- ⁶ Molteno ACB: Use of Molteno implants to treat secondary glaucoma. Glaucoma ed. JE Cairns, pub. Grune and Stratton. 1986; Vol 1, Ch 10; 211-238.
- ⁷ Molteno ACB: Neovascular glaucoma—diagnosis and therapy. Glaucoma ed. JE Cairns, pub. Grune and Stratton. Vol 1, Ch 42; 883-915.

Sir, Dr Molteno has justly won international fame with his success in the management of 'Difficult Glaucomas'. Any contribution from him in this field is, therefore, to be welcomed. In his letter, he discussed a number of points made in our article.¹ He is concerned that his 'plate and tube' device is not seen as a 'surgical gimmick', but as a device that has 'stood the test of time'. His reported successes with his device and the length of his follow-up show that. When we reported the surgical results with the modified 'tube and gutter' device we had to compare the results with other silicone drainage objects and Dr Molteno's was clearly the one we should choose. We consider that the tube and gutter device was an alternative and perhaps cheaper method of treating these types of glaucoma. In making a comparison, we considered two aspects. The first of these was the question of Dr Molteno's antifibrosis regime and the second was the surface area required for aqueous absorption.

Concerning the first point, Dr Molteno states in his letter that he administers his antifibrosis regime according to 'the circumstances of the case'. In an independent report,² the authors noted that 'the antifibrosis regime gave an unacceptably high fre-

quency of side effects in a large number of patients, some of whom had to have their therapy terminated. The antifibrosis regime was eventually used only on fit young patients'. (It should be borne in mind that the development of antifibrotic agents given locally is one of the most exciting areas of glaucoma research today. It is to be hoped that an antifibrotic agent developed from 5-Flourouracil will be the treatment of choice in the management of this type of glaucoma in the future).

Concerning the second point, because of our concern with the systemic antifibrotic regime, especially in the young glaucoma patient, we looked at methods of increasing the area of the drainage bleb. By this increase we hoped to avoid the problem of fibrosis developing around the drainage site by increasing the area available for aqueous absorption. We consider that, even if the fibrosis reduced flow per unit area, a massive increase in the area of absorption would still allow normal intra-ocular pressures to be maintained. Our results demonstrate that this approach met with some success.

Dr Molteno has drawn our attention to the fact that we quoted him but failed to cite him. For pointing out this omission we are grateful and give the reference below.³

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References

- ¹ Hitchings RA and Lattimer J: How to Manage the Unresponsive patient. *Eye* 1987, **1**: 55-60.
- ² Brown RD and Cairns JE: Experience with the Molteno Long Tube Implant. *Trans Ophthalmol Soc UK* 1983, **103**: 297-313.
- ³ Molteno ACB: The Optimal Design of Drainage Implants for Glaucoma. *Trans Ophthalmol Soc NZ* 1981, **33**: 39-41.