may do so by altering the nature of dynamic vitreoretinal traction when posterior vitreous detachment occurs making break formation more likely. Thus the prevention of gel incarceration into the section at the time of cataract surgery, which can be achieved by anterior vitrectomy, may discourage RRD and of course some of the other complications mentioned by the authors.

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1. Claoué C, Steel ADMcG. Visual prognosis following accidental vitreous loss during cataract surgery. Eye 1993;7:735–9.
2. McHugh D, Wong D, Chignell A, Leaver P, Cooling R. Pseudophakic retinal detachment. Graefes Arch Clin Exp Ophthalmol 1991;229:521–5.

Sir,

We are grateful to Mr Anthony Chignell for his comments on our recent paper.[1] We are well aware of his expertise in the field of pseudophakic retinal detachments and have not commented on this particular aspect in our paper since none of our patients had developed a retinal detachment at the time of data analysis. Clearly, it would be ideal to study patients until they are lost to follow-up or until their death in order to ascertain the long-term benefit of cataract extraction when complicated by vitreous loss. Unfortunately, the establishment of the internal market in the National Health Service encourages discharge of patients at the earliest opportunity commensurate with acceptable clinical practice. This means that the long-term follow-up of patients in order to monitor for eventual complication is likely to become increasingly difficult to justify and will have inevitable repercussions in terms of data generation.

We agree entirely with Mr Chignell's final sentence regarding the importance of preventing gel incarceration into the wound at the time of cataract surgery and likewise believe that adequate vitreous toilet following accidental vitreous loss should have a significant beneficial effect on the incidence of subsequent rhegmatogenous retinal detachment.

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References

1. Claoué C, Steele, ADMcG. Visual prognosis following accidental vitreous loss during cataract surgery. Eye 1993;7:735–9.

Sir,

Further to McElvanney and Sherriff's Letter to the Journal on 'Uveitis and Skin Tattoos',[1] I feel that emphasis should be placed on the more likely differential diagnoses.

The Koebner phenomenon (isomorphic reaction) describes the tendency for lesions characteristic of a particular disease to develop at sites of skin trauma such as surgical or mechanical trauma.[2] This phenomenon is well recognised in sarcoidosis and psoriasis, as well as the more common associations of lichen planus and viral warts. Additionally, the granulomata formed in cutaneous sarcoidosis are often indistinguishable from inclusion granulomata varying from cactus spine to zirconium, and this is the reason against tattooing with ink over the site of Kveim testing.[3]

Therefore in a patient who has uveitis plus a reaction in a coexisting scar, the diagnosis of sarcoidosis must be actively pursued (unless there are psoriatic lesions) because of the possible multisystem ramifications. The designation of 'sensitivity to metallic dye' can be made only by exclusion.

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1. McElvanney AM, Sherriff SMM. Uveitis and skin tattoos. Eye 1994;8:602–3.
2. Marks R, editor. Roxburgh's common skin diseases, 16th ed. Oxford: Oxford Medical, 1993.
3. Mckee PH. Pathology of the skin. London: Gower Medical, 1989;6.22–6.28.

Sir,

The occurrence of uveitis preceded by swelling of skin tattoos is a recently described association.[1,2] We would agree with Mr Harvey that patients who present in this manner should be appropriately investigated to exclude an underlying pathological cause for their uveitis; however, it is important to ensure that patients are not over-investigated.

The Koebner phenomenon, a term used to describe skin lesions which develop in recently traumatised skin, was originally described in psor-