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References

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Sir,

We thank Buckley *et al.* for their comments regarding our paper entitled 'How much blame can be placed on laser photocoagulation for failure to attain driving standards?'[1]

We agree that pre-existing visual field loss can occur prior to laser treatment in patients with diabetes; however, the degree of any loss will depend on the degree of binocular enhancement and the sensitivity of the test employed.

Absolute or relative scotomas in one eye[2] can be cancelled by areas of normal sensitivity in the other eye. In addition, the binocular visual field is often enhanced such that the score is greater than that of both monocular visual fields when merged.[3]

Trick *et al.*[4] employed a visual field program which has a standard stimulus size parameter III, which at a stimulus-to-background ratio of 20 dB converts to Goldmann III 2e equivalent. The Esterman test which we employed uses a Goldmann III 4e equivalent which corresponds to 10 dB – a target of twice the contrast. If the Esterman test was performed pre-operatively, we would suggest that any field losses recorded would most likely be minimal.

With regard to intensity of burns, the first 25 consecutive patients had fully documented records of laser treatment. Intensity was individually applied to produce a greyish/white 200 μm burn and averaged 350 mW. This initial treatment protocol for panretinal photocoagulation was adopted for all subsequent patients and is similar to burns of moderate intensity used in the Seiberth study.[5]

We agree with Buckley *et al.* that deducing the optimum strategies which combine effective treatment with a wide functional visual field are complex and have yet to be established. However, we feel we have achieved the aims of our study to determine the prevalence of failure to attain driving standards and to determine the contribution of field loss solely attributable to treatment. We utilised a newly approved Esterman visual field test and gave guidelines relating to its score output.

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Sir,

In their paper entitled 'A novel conjunctival incision for horizontal strabismus surgery' (*Eye* 1995;9:282–4), Callear and Eagling recommended routinely performing conjunctival peritomy in standard strabismus procedures from 2 o'clock to 10 o'clock inferiorly, to allow access to the horizontal rectus muscles from below, the main advantages of this procedure over conventional surgery being a reduction in time taken to perform surgery and decreased discomfort in the post-operative period, with apparently no alteration in the long-term cosmetic effect. This technique, however, abandons the use of limbal stay sutures during the procedure. We would, there-