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Sir,

We thank Mr Diaper for his comments and are pleased to see that his study reached similar conclusions to ours. Alternative methods of drug delivery are without doubt going to be developed in the future and it is important that relevant clinical studies are performed to determine their clinical usefulness and their potential application to any of the groups of patients under our care.

In response to Mr Diaper's specific point, we had 17 blue, 11 brown and 2 green eyes. In the blue eye group the mean increase in pupil size was 4.15 mm for the drops and 3.61 mm for the NODS ($p = 0.0063$). In the brown eye group the mean increase was 3.75 mm and 3.28 mm respectively ($p = 0.235$).

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Sir,

I would like to make a few remarks relating to the article by T. Potamitis *et al.* entitled 'Phacoemulsification versus endocapsular cataract extraction in a unique cohort of patients' (*Eye* 1996;10:551–4).

1. Phacoemulsification is essentially an extracapsular cataract extraction (ECCE) technique. The term phacoemulsification is related to the phacoemulsification of the nucleus, which takes 10–20% of the time of the whole surgery. The operation is basically an ECCE.

2. By ECCE in your article you mean a manual ECCE. Conventional ECCE is an old system for manual ECCE, which needs a limbal incision of 8–10 mm. The modern approach to manual ECCE is characterised by a 5 mm incision sclero-corneal pocket tunnel, no sutures, quick rehabilitation, is safe and induces 0.25 D astigmatism after 3 months on average. It is essential not to consider ECCE as a specific type of cataract surgery. It is a name given to compare the technique with intracapsular cataract

extraction and not with phacoemulsification. ECCE was used before phacoemulsification came into being. Phacoemulsification is part of the ECCE surgery, comprising 10–20% of the total surgery time. *Manual ECCE* should be specified too – the modern approach and the old approach.

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Sir,

We thank Professor Blumenthal for his comments. Our paper, however, was a comparison between two specific types of cataract extraction. It was not intended as an overview of all the types of cataract surgery available.

We do not disagree that phacoemulsification is an extracapsular method of cataract extraction. For this reason we use the term 'conventional extracapsular cataract extraction' and described in detail our two surgical techniques.¹ Whether phacoemulsification 'comprises 10–20% of the total surgery time' depends largely on the hardness of the nucleus. Furthermore, how much time is spent on phacoemulsification is not the issue. Modern technology and foldable lenses allow the removal of a cataract to be performed through an incision far smaller than any manual technique. It does on average take a little longer than 3 minutes to perform but we feel it is an advantageous technique.

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Reference

1. Potamitis, Perreira AM, Pearce JL. Phacoemulsification versus endocapsular cataract extraction in a unique cohort of patients. *Eye* 1996;10:551.

Sir,

We congratulate Miss Dayan and co-authors of 'Flashes and floaters as predictors of vitreoretinal pathology. Is follow-up necessary for posterior vitreous detachment?' on their audit of patients presenting with flashes and floaters.¹ However, we believe that their conclusion is not supported by their data. Of 169 patients given follow-up examinations,

only 1 patient (0.59%) may have benefited from that follow-up visit. The authors rightly do not draw the conclusion that the retinal tear developed between the first and second examination. Although this is a possibility, the second examination was carried out by more experienced personnel and it is equally likely that the tear was present at the first examination. Therefore an alternative approach would be to ensure that patients with flashes and floaters are examined by an experienced funduscopist at the first visit. Patients should be educated about the symptoms of retinal detachment, and encouraged to re-attend promptly. Even if we do accept that tears can develop subsequently, the data in this study does not form a basis on which to formulate a rational follow-up policy.

The diagnosis of posterior vitreous detachment was made if the 'posterior face was seen to be separate from the retina'. We consider that the presence of a Weiss ring is essential for the diagnosis of posterior vitreous detachment, and this is not commented on.² Thus, it would seem reasonable to include all cases presenting with 'flashes and/or floaters'. This would give a diagnostic yield of 1/295 (0.34%).

When an audit is performed, completing the audit cycle and implementing change in procedures if indicated by the evidence provided is essential.³ Medical practitioners have an increasingly active role in distributing precious health care resources within the NHS. The evidence from this study does not justify the large volume of out-patient resources for follow-up examinations that the authors recommend.

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References

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Sir,
We thank Kirwan and colleagues for their interesting comments and for the chance to reply to some of the points that they raise.

We do not conclude that all patients who present with a symptomatic posterior vitreous detachment require follow-up but simply state that, given the potentially serious consequences of a missed retinal break, we feel justified in continuing to review these patients in our department on the basis of finding retinal breaks in 3 (1.9%) of the 157 patients who attended for follow-up. We agree that it cannot be shown whether the only tear which definitely required treatment (a horseshoe tear) occurred after the initial visit. In our large department the eye casualty is staffed by senior house officers and, although ideal, examination at presentation by senior staff of all patients presenting with flashes and floaters would be difficult to accommodate. The decision whether to carry out a 6 week review is for each individual department to make, and if the initial examination is made by a senior ophthalmologist we concur that a decision to abandon follow-up can arguably also be justified on the basis of our findings.

It is worth noting, however, that of the 55 patients (35%) who returned prior to their appointment due to a recurrence of symptoms, only 1 (1.8%) had any new pathology (a round hole which was lasered) - a percentage yield of pathology per number of patients examined similar to that identified at the 6 week appointment. Three breaks were identified in the remaining 102 (65%) asymptomatic patients at follow-up suggesting that, at least in our department, routine follow-up detects a larger number of patients with retinal breaks than giving a retinal detachment warning alone.

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Sir,
In their article 'Retinopathy in haemoglobin C trait' Hingorani *et al.*¹ report three cases in which haemoglobin C trait was associated with significant peripheral vascular occlusion and sea fan formation-retinal changes similar to those seen in patients with