

one tends to associate with the term aerosol. I understand that because of the problems that arose in his officers, their Chief Constable decided not to advocate the use of CS in his force. I have also seen many casualties, both in Inner London and in the West Country, following exposure to CS; I am not aware of any of these developing long-term sequelae although quite a few were 'lost to follow-up'. Many of these patients had non-ocular symptomatology, often of a respiratory nature, as well as ophthalmological involvement, and this may well reflect why such patients are not brought to a dedicated eye casualty department because of primary triage by the ambulance service. In addition the police surgeon would be the first person called to attend any individual with medical problems in police custody. I believe that the Poisons' Information Centre will be monitoring patients exposed to CS⁴ and one awaits their findings.

I would once again emphasise that CS is a safe agent when used for riot control purposes,⁵ where it is effective in producing intolerable symptoms at atmospheric concentrations of 0.0026%. However, the aerosols utilised by the police squirt a 5% solution of CS dissolved in methylisobutyl ketone, a solvent used in the organic chemical industry where safety regulations advise that protective clothing, gloves and eye/face protection are worn by all workers handling the chemical.⁶ Yet police officers are spraying CS dissolved in methylisobutyl ketone [4-methyl-2-pentanone] directly at members of the public – an action that may well lead to serious sequelae.

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References

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5. Himsworth H (chairman). Report of the enquiry into the medical and toxicological aspects of CS [ortho-chloro-benzylidene malononitrile]. Part II: Enquiry into toxicological aspects of CS and its use for civil purposes. Command Paper 4775. London: Her Majesty's Stationery Office, 1971.
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Sir,

I welcome Mr Gray's comments on his experience with CS gas injury, and apologise for incorrectly referencing his previous correspondence on the

subject. It is clear from the nature of both the agent itself and the vehicle used for its delivery that ocular injury is theoretically possible. My point is that we have not in practice seen any cases in this hospital since the adoption of CS gas by the Metropolitan Police.

I am not aware of any published data describing ocular injuries resulting from the CS aerosol available to the police. Such information would clearly be helpful in the management of any future casualties.

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Sir,

Congratulations to Bray *et al.* (*Eye* 1996;10:714–8) upon bringing the subject of amblyopia to general attention once again. After years of neglect in the morass of developmental trends and the shift of responsibility to parents, as advised by the Hall report and so much beloved by the cost-cutting administrators, this is a breath of fresh air.

My experience over 30 years of paediatric ophthalmology evolved along similar lines. It was satisfying initially to pick up amblyopes from whatever cause at 3 and 5 years of age and to carry out the treatments with the expense involved.

However, in due time, I found by organising screening clinics during the sensitive period of visual development, with orthoptists at post-natal and infant welfare clinics, it was possible to pick up younger children with early visual defect, before gross amblyopia had developed. This meant that there was early referral, with only slight visual suppression, which entailed only a short period of occlusion and treatment. This was cost-effective for hospital attendances and for the families; indeed, in my region of South West Thames, full-blown amblyopia was virtually eliminated at that time.

Perhaps the pendulum may once again turn towards really early assessment, and referral, and hence lead to prevention rather than cure. I would urge the authors and all concerned with paediatric management to direct their energies towards this goal and fulfil the aspirations of the giants of yesteryear such as Mary Sheridan and Ronnie MacKeith.

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