

**Table I.** Suture removal with or without adjustment and according to diagnosis

Diagnosis	Intact sutures ( <i>n</i> = 14)		Sutures removed ( <i>n</i> = 16)	
	Adjusted	Not adjusted	Adjusted	Not adjusted
Scar ( <i>n</i> = 2)	0	0	0	2 (B)
PBK ( <i>n</i> = 8)	5	1	1 (B)	1 (B)
Keratoconus ( <i>n</i> = 15)	2	3	5 (B)	3 (B), 2 (L)
HSV ( <i>n</i> = 1)	0	0	1 (B)	0
FED ( <i>n</i> = 4)	1	2	1 (B)	0

PBK, pseudophakic bullous keratopathy; HSV, herpes simplex keratitis; FED, Fuchs' endothelial dystrophy; (B), broken suture; (C), loose suture.

interest to our earlier suture removal within the non-adjusted group compared with the adjusted group: no statistical difference was reported and a value of  $p = 0.43$  was clearly given to validate this statement.

Whilst our only patients with loose sutures were patients with keratoconus we do not feel that this necessitates a change in our practice as they are not statistically significant. We agree that differences in absolute levels of astigmatism will differ between the refractive values used in our study and topographic simk readings used by Karabatsas and Cook. We used refraction as the definitive assessment of astigmatism, as this is the most relevant test in terms of the patient's visual rehabilitation.

In conclusion, we do not concur with the problems reported by Karabatsas and Cook, and find the use of single continuous adjustable suture a safe, effective and eminently reversible technique for patients with all these preoperative conditions in non-vascularised corneae, including keratoconus.

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Sir,

I read with interest Mr McKibbin's article on the prevalence of medical disease amongst patients attending pre-operative clinics prior to ophthalmic surgery.<sup>1</sup> The article implies that pre-operative clinics are simply to decide on the fitness for surgery/anaesthetic, the identification of non-ophthalmological disease not being part of their remit.

Most of the studied patients were elderly, only 11 being under 60 years old. The study found 71% had significant medical conditions and almost half of these 'had neither a history nor signs of pre-existing disease'. Although only 1 of the 105 patients had their surgery postponed, abnormal results were

found in 77 of 318 investigations performed. The finding of: uraemia (10 patients), poor glycaemic control (10 patients), uncontrolled hypertension (6 patients), iron deficiency anaemia (2 patients), unexpected electrocardiographic evidence of myocardial ischaemia (4 patients) and arrhythmias (25 patients) suggests that much disease and side effects of treatment among elderly patients could be better managed.

The paper illustrates that elderly patients often have unsuspected and/or poorly controlled medical conditions and pre-operative clinics provide an opportunity for a medical review. The abnormal results reported by this study may only rarely influence the timing and choice of surgery/anaesthetic but they are highly significant for the patient's wellbeing. As doctors, ophthalmologists have a responsibility for the general health of the patients under their care in addition to their surgical management and should use pre-operative clinics to review non-ophthalmic treatments and disease.

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#### Reference

1. McKibbin M. Pre-operative assessment and investigation of ophthalmic patients. *Eye* 1996;10:138-40.

Sir,

I thank Dr Paul Diggory for his interest in my article and for his comments.

The pre-operative assessment clinic exists to obtain a medical and social history relevant to the surgery, to educate and reduce anxiety and to obtain informed consent. Pre-operative investigations may be helpful in assessing chronic disease, but care should be taken not to place too much emphasis on isolated measurements. Although urinalysis and blood pressure estimation are necessary for all patients, detailed screening for medical disease should not be part of the remit. This is best