

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.¹ 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

performed by those who are able to provide long-term systemic care.

Although abnormal results among pre-operative investigations were common, the majority of these were to be expected from the history and examination. Only 11 abnormal results from the 318 investigations performed were unexpected. None of these required subsequent treatment. Pre-operative investigations may be of benefit if they help to avoid the complications of surgery or if they help to identify disease which needs and is amenable to treatment. For the asymptomatic patients in this study undergoing local anaesthetic surgery, these criteria were not met. In these cases, pre-operative investigations are a financial drain and an unnecessary burden for the patient.

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Sir,

I was interested to read Mr McKibbin's study on pre-operative investigation of ophthalmic patients.¹ Following the original study performed in the same hospital a prospective study was started to see whether the management of patients undergoing cataract surgery was affected by pre-operative investigations. One hundred patients listed for cataract surgery were assessed and investigated in accordance with the guidelines of the Joint Working Party on Anaesthesia in Ophthalmic Surgery.² Eighty-four patients had local anaesthetic (11 having been listed for general anaesthetic but deemed medically unfit). Twenty per cent of the results of investigations were abnormal (74% as predicted by history and/or examination). No patients undergoing local anaesthetic surgery had their operations cancelled because of abnormal results and none subsequently had problems related to the local anaesthetic. Subsequent to this study the unit policy on pre-operative investigations was changed to that of only investigating patients undergoing local anaesthetic surgery in circumstances that may affect surgical management (e.g. INR in patients on warfarin). Following this policy no adverse consequences have been reported from the anaesthetic department. The department will save approximately £14 000 per year with no apparent deleterious effect on the patients.

I agree that the purpose of a pre-operative clinic is to assess the patient's suitability for a particular procedure.¹ Peribulbar local anaesthesia is an extremely safe procedure³ and it appears that pre-

operative investigations do not alter the management of a patient undergoing local anaesthesia. Performing pre-operative investigations on these patients is both costly and time consuming with no obvious benefit other than screening, which is not the role of a pre-operative clinic.

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References

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2. Royal College of Anaesthetists and Royal College of Ophthalmologists. Report of the Joint Working Party on Anaesthesia in Ophthalmic Surgery, March 1993.
3. Davis BD, Mandel MR. Efficacy and complication rate of 16 224 consecutive peribulbar blocks. *J Cataract Refract Surg* 1994;20:327-36.

Sir,

I am grateful for Mr Walters' comments on my paper, and am pleased he agrees that routine pre-operative investigations are not necessary for patients having local anaesthetic ophthalmic surgery. Pre-operative investigations are expensive and unexpectedly abnormal results from the investigations are rare. Furthermore, in my experience, and also that of others, the results are rarely recorded, other than in the laboratory report, or consulted.¹ Not even the unexpected results alter the management of patients having local anaesthetic surgery. Systemic complications can result from local anaesthetic surgery but tend to be unexpected and cannot be predicted from the history, examination or pre-operative investigation. Peri-operative monitoring is, however, vital to provide an early warning of significant complications so that appropriate action can be taken.²

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References

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2. Jayamanne DGR, Gillie RF. The effectiveness of peri-operative cardiac monitoring and pulse oximetry. *Eye* 1996;10:130-2.