The editorial and both papers highlight the need for training to minimise the risk of complications, in particular globe perforation. Significantly, this complication had not been encountered by those surveyed, although perforation during local block was known to have occurred in the region during the preceding year. This may represent a lack of communication between anaesthetic and ophthalmology colleagues.

In the United States the lack of formal ocular local anaesthetic training has been clearly identified[4] and anaesthetists have been previously implicated as having a higher complication rate.[5] Mr Boase suggests resisting 'the help offered by junior anaesthetists keen to fill their training log books'. In light of the joint report from the Royal College of Anaesthetists and College of Ophthalmologists,[6] surely these juniors are precisely those who would benefit from a structured teaching programme with responsibilities and input from both specialities.

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Sir,

We read with interest the correspondence and confine our response to answering comments made about our papers rather than the editorial.

The papers were presented with two main aims. The first was to demonstrate the serious morbidity which may follow local anaesthetic (LA)-associated ocular perforation. We welcome the confirmation from Gray's study. The second was to alert clinicians to the scale of the problem. Unfortunately, far from being a transient epidemic in 1994–5 LA-associated ocular perforation remains depressingly common. Fresh prospective data collected by the British and Eire Association of Vitreoretinal Surgeons found 39 perforations referred to members in the year to October 1996 (G. R. Kirkby, unpublished data).

We agree with Tighe and Bywater that there may be several explanations why 'anaesthetists are inflicting more ocular perforations than ophthalmologists' and this is the reason why on this issue our paper presented the result without conjecture. The importance of structured training in ophthalmic local anaesthesia is rightly stressed in this correspondence, although the key issue of whether all anaesthetists should be trained in the sub-speciality is not addressed.

We are pleased that the correspondents share our concerns. If these papers have stimulated debate and focused attention on the problems of ophthalmic local anaesthesia then they have achieved their aims. Ophthalmic anaesthesia can only benefit when the problems in current practice are widely recognised.

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Sir,

Considerable concern has been voiced[1,2] regarding the addition of CS gas spray to the equipment carried by police officers, with fears of severe and/or permanent ocular damage resulting from its use. CS gas was due to be introduced on a trial basis in July 1995, but was delayed until March 1996 by further investigation into its safety after a police officer suffered (temporary) ocular injury while in training. Subsequently, the spray has been in use nation-wide, including six centres in the London area, and provisional data report its use on 600 occasions during the 6 month trial period (personal communication, New Scotland Yard). It has been interesting, therefore, to review the records of the accident and emergency department at this hospital, a busy 'walk-in' 24-hour unit: since CS gas was introduced we have treated no cases of ocular injury resulting from either police or (illegal) personal use. The Metropolitan Police have no records of referral to eye units in London during the trial period (personal communication, New Scotland Yard).

Despite the potential dangers it appears that use of CS gas by the police, which was approved for long-