

Sir,

We were surprised to see a letter<sup>1</sup> referring to the National Survey of Local Anaesthesia for Ocular Surgery, as peer-reviewed papers from the Survey have yet to be published.

We cannot agree with Kamath *et al.*'s assertion that 'the survey has been able to show . . . that 'routine' pre-operative investigations before local anaesthesia are unnecessary . . .'. Our observational study showed that many patients who had local anaesthesia did not have any pre-operative investigations, and that the incidence of serious adverse events was low. A study of this kind cannot attempt to address the question of whether or not pre-operative investigations are actually necessary.

As regards Kamath *et al.*'s criticisms of the limitations of the Survey methodology, we took these and other factors into account when designing the Survey. Any large audit of this type is by necessity a compromise between pure scientific method and what is acceptable to the clinicians who are asked to complete the survey forms. The limitations of the Survey are discussed at length in our forthcoming papers, as is the significance of the results. The Early Report cited by Kamath has not been formally published, and was never intended to be anything more than a brief overview, and should be considered as such.

We are concerned that some readers may be tempted to discontinue pre-operative investigations on the basis of Kamath *et al.*'s erroneous interpretation of the Early Report. It is our personal opinion that the 1993 Guidelines<sup>2</sup> are in general an appropriate 'gold standard', though in certain circumstances modifications could be made without compromising safety.

We wish to reassure Kamath *et al.* that the Colleges will be considering evidence from all sources when the safety Guidelines are reviewed, and thank them for their interest in the Survey.

#### References

1. Kamath G, Prasad S, Clearkin L. [The National Survey of Local Anaesthesia for Ocular Surgery.] (letter) *Eye* 1998;12:489.
2. Report of the joint working party on anaesthesia in ophthalmic surgery. London: Royal College of Anaesthetists and College of Ophthalmologists, 1993.

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Sir,

As the Royal College of Ophthalmologists launches its national audit of the results of retinal reattachment repair, the recent article by Sullivan and colleagues<sup>1</sup> examining the results of primary retinal reattachment surgery is timely, and attracted our attention. Although the figures for final reattachment have been improved it is perhaps disappointing that this is not reflected in the primary repairs. The increased final success rate after subsequent procedures is largely attributed to recent technical improvements. The question arises as to why, over the 23 year interval between the two studies, the primary repair rate has not also improved in the light of these advances and remains static at 75–80%.

The data presented do not show any significant pre-operative risk factors other than highly elevated breaks. Although the grade of surgeon did not significantly affect the primary outcome, since the majority of primary failures were found to be due to avoidable factors (missed breaks/inadequate buckle) it would be surprising if they were not influenced by the presence or otherwise of a consultant assistant. It would also be interesting to compare the success rates of conventional and vitrectomy procedures and likewise the influence of risk factors thought to affect the incidence of proliferative vitreoretinopathy (PVR).

Two recent independent multicentre audits within our own region<sup>1,2</sup> (195 eyes, 193 patients (1989–90) and 245 eyes, 237 patients (1995–7) respectively) clearly showed the grade of surgeon and, in the case of trainees, grade of assistant, to be significant factors in the outcome of primary surgery. In the more recent analysis, juniors were able to improve their results for a consecutive series of primary repairs from 78% operating alone to 94% with consultant supervision.<sup>2</sup> As a result of these findings no patient in our unit now

undergoes any form of retinal surgery without the supervision of a consultant specialising in vitreo-retinal surgery.

We would not support the final conclusion that a 75% primary success rate is either a reasonable goal or a suitable standard for future audit. The results of several independent studies<sup>2,4</sup> would suggest that a reasonable primary repair success rate for present day standards ought to approach 90% for both conventional and 'non-conventional' retinal detachment repairs. The goal should always be a 100% success rate and we should continue to ask ourselves why we have yet to achieve it.

#### References

1. Sullivan PM, Luff AJ, Aylward GW. Results of primary retinal detachment surgery: a prospective audit. *Eye* 1997;11:869–71.
2. George ND, Callar AB, Halkias A, Ruigrok A, Moore AT. Should all primary retinal detachments be referred to a vitreoretinal unit? Free paper presentation, Annual Congress of the Royal College of Ophthalmologists, 1993.
3. Comer MB, George ND, Callar AB, Martin K, Halkias A, Ruigrok A, Moore AT. Who should manage primary retinal detachments? Resource implications of closing the audit loop. Free paper presentation, Annual Congress of the Royal College of Ophthalmologists, 1998.
4. Wong D, McGalliard J. Are we getting better at treating retinal detachment? Technology, referral pattern or primary care? [editorial]. *Eye* 1997;11:763–70.

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Sir,

We are grateful to Snead and Scott for their comments. Firstly may we be the first to congratulate them on their remarkable results. A primary success rate of 94% in a large unselected group of patients with rhegmatogenous retinal