Sir,

Regarding the UK guidelines for screening for Retinopathy of Prematurity (ROP),[1] Fleck *et al.*[2] stated 'The need to include infants of birthweight >1250 grams should be reviewed at a future date'. This followed their finding that no babies heavier than this developed threshold ROP in their 4-year study. Also, Goble *et al.*[3] have recently questioned the need to screen larger/older neonates for ROP. On the basis of a large population study they suggest reducing the upper limits for screening to 1250 g weight and 29 weeks gestational age at birth, with the possible inclusion of older babies in screening programmes if certain sickness criteria are met (e.g. severe neurological insult or severe blood loss). We should like to present a case of severe ROP in a baby considerably outwith these birthweight and gestational age criteria who did not meet either of these sickness criteria.

A 1440 g Caucasian baby girl was born in the UK in 1996, at 30 weeks and 4 days gestation. Respiratory distress developed 7 h post-partum, requiring ventilation for 2 weeks. During this she developed a left pneumothorax which was drained. For the first 4 days she was monitored with a transcutaneous pO_2 monitor with readings about a mode of approximately 9.4 kPa with a maximum of 11.6 kPa. Subsequently a saturation monitor was used with measurements between 94% and 99%; some supplemental oxygen was given but whenever saturations went above 96% room air was used.

Routine ophthalmic screening at 6 weeks of age found 5–6 clock-hours of stage II ROP at the zone 2/3 junction bilaterally, which progressed over 2 weeks to stage III plus in the left eye and stage IVa in the right. The staging was agreed by a second consultant to meet the accepted definition of 'threshold disease'.[4] Peripheral retinal cryotherapy was administered to both eyes with good regression of the ROP. There was no family history to suggest any inherited cause for retinopathy, and ophthalmic examination of the parents revealed that they had normal optic fundi with no evidence of familial vitreoretinopathy.

Goble *et al.* advise caution in the tightening of screening criteria and suggest inclusion of larger babies with a turbulent clinical course. The occurrence of threshold ROP in our case emphasises the importance of this. We suggest that the definition of 'sickness criteria' requires further study as our baby did not meet those criteria suggested by Goble *et al.*

Bagdoniene and Surtautiene[5] have recently presented data showing that ROP remains a significant problem in babies weighing considerably over 1500 g in Lithuania, indicating that ROP incidence has significant geographical variations. Even within the UK such variations are seen; Goble *et al.* compare their data with earlier studies including one by the same observer in a different part of the UK[6] where the incidence of severe disease was higher. They suggest that this variation may relate not only to neonatal survival but also to standard of care and ethnic mix. Published data for the Northern Region of the UK[7] indicate an incidence of threshold ROP of at least 3.6% in infants born at less than 32 weeks' gestation, compared with 2.2% found by Goble *et al.* A study of sickness criteria would therefore have to be conducted within a geographically defined population, and its findings would be applicable only to that population. The British Ophthalmic Surveillance Unit (BOSU) is currently acquiring data on all UK babies developing stage III ROP; it is hoped this will help to define screening criteria appropriate to the UK.

Until sickness criteria are clearly established we believe it would be dangerous to alter the current Royal College of Ophthalmologists screening guidelines.

References

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Sir,

I read with interest the article 'The association between the oculocardiac reflex and post-operative vomiting in children undergoing strabismus surgery' by Allen *et al.*[1] We have used a sub-Tenon's local anaesthetic block with 2 ml 0.5% plain bupivacaine, after surgery but prior to awakening, in all our patients for squint surgery for the past 2 years. Forty-five of these patients were prospectively audited for a 24 h period. A zero incidence of vomiting was achieved.[2] All patients received a standardised anaesthetic avoiding opioids, relaxants and reversal agents, and spontaneously breathing gas, oxygen, isoflurane or sevoflurane on a laryngeal mask. In addition all received non-steroidal pain relief, paracetamol and topical amethocaine intraoperatively, plus two anti-emetics (ondansetron and either metoclopramide or perchlorperazine). We have also assumed that the marked reduction in vomiting is the result of a blockade of the oculocardiac/