Sir,

We read with interest the case report by Gallagher *et al.*[1] where a patient with accelerated hypertension and anterior ischaemic optic neuropathy was treated using sublingual nifedipine 10 mg, reducing the blood pressure from 220/150 mmHg to 160/110 mmHg in a short period.

We are concerned at the continuing use of sublingual nifedipine for the urgent treatment of hypertension, especially when it is not even absorbed by the oral or oesophageal mucosa.[2] The liquid released from the crushed nifedipine capsule is erratically absorbed later from the gastric mucosa, resulting in fluctuating effects, including a sudden rapid fall in blood pressure. The latter is undesirable, especially when cerebral autoregulation is disordered in accelerated hypertension, and excessive blood pressure falls are potentially dangerous, resulting in cerebral and optic nerve head ischaemia or infarction.[3–5] Several cases of (sublingual) nifedipine-induced myocardial ischaemia or infarction in patients with or without ischaemic heart disease have also been published.[6,7] In patients with known cardiac ischaemia, such a precipitous fall in blood pressure accompanied by reflex acceleration of the heart rate and increase of myocardial oxygen demand is undesirable.[7] In addition, the nifedipine-induced preferential vasodilation in non-ischaemic myocardium at lower pressures may cause diversion of blood flow away from ischaemic areas, commonly referred to as a 'steal phenomenon'.

The acute hypotensive effect of nifedipine is therefore unpredictable and, in some cases, hazardous. This adverse haemodynamic profile renders sublingual nifedipine an inappropriate choice for hypertensive emergencies, especially when treating patients with cerebral, optic or coronary ischaemia, and may even be dangerous. Its continued use in clinical practice for the urgent reduction of high blood pressure should therefore be discouraged.

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Sir,

We thank Drs Lip and Lip for their interest in our publication[1] concerning the use of sublingual nifedipine in the treatment of accelerated hypertension. We believe that the use of this drug in clinical practice is substantiated, but is dependent on the clinical situation.

Hypertensive crises have been classified as: (a) true emergencies requiring immediate reduction of blood pressure using antihypertensive agents parenterally, and (b) hypertensive urgencies that can usually be treated with orally administered drugs to reduce blood pressure within 24 h.[2] Accelerated hypertension is a hypertensive emergency if target organ disease is present (e.g. encephalopathy, left ventricular failure, or ischaemic heart disease), but is an urgency in the absence of these conditions.[3]

Therapeutic evaluation in our case was dependent on the age of the patient, duration and history of onset of present symptoms, lack of pre-existing cardiac or cerebral vascular disease, and absence of extensive progressive target disease. Clearly our patient represents an atypical urgent case and sublingual nifedipine proved a successful therapeutic choice in this clinical situation.

It must be stated that in these clinical situations, precipitous reduction of the patient's blood pressure must be avoided, and the advice of a physician should be sought without undue delay.

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Sir,

Inkster *et al.*[1] present interesting data suggesting that as well as a higher cure rate, Mohs surgery can allow conservation of tissue including important structures such as the lacrimal canaliculi, leading to smaller than anticipated reconstruction in 37% of cases. They claim that in the 20% of cases where the reconstruction was larger than expected this was because of the presence of occult tumour which would have led to tumour recurrence if the traditional approach had been employed.

We routinely carry out surgical excision with a 2 mm margin of healthy tissue instead of the traditional 3–4 mm margin[2] for well-defined basal cell carcinomas in the peri-ocular region. We delay surgical repair until the tissue has been examined histologically and the margins pronounced free of tumour. Unlike Mohs technique 100% of the tumour surface is not examined. So far we have no tumour recurrences after 3 years' follow up. We feel that 2 mm margin excision with delayed repair following confirmation of histological clearance is appropriate treatment for

well-localised basal cell carcinomas. Like Mohs technique our approach facilitates reconstruction without increasing the risk of tumour recurrence. Multifocal, morphoeic or recurrent tumours, however, deserve either a wider excision margin or Mohs technique as advocated by Inkster *et al.*

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Sir,

We thank Harrad *et al.* for their comments on our paper.[1] We appreciate that this country is currently underserved for Mohs surgery, and in its absence welcome any treatment modality which improves outcome. However, we would like to add a word of caution with respect to any surgical technique which reduces the size of excision margin without the benefit of total margin control. Although Harrad *et al.* are to be congratulated on their lack of recurrences to date, basal cell carcinoma may recur many years after the original treatment. In fact in our series, the recurrent tumours we treated had occurred up to eleven years after the initial treatment. Patients should be carefully counselled about the potential risks of undergoing a surgical procedure which may increase their chance of tumour recurrence.

We continue to recommend Mohs surgery for all tumours which are large, recurrent, morphoeic, at the medial canthus or present in younger patients.

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Sir,

The paper by Gonglore and Smith (*Eye* 1998;12:976) made fascinating reading to a 'dinosaur' in his sixty-fourth year who converted to 'phaco' after 60+.

The history of the conversion was:

(i) Phaco course 1974 under the auspices of Mr Arnott *et al.*, Charing Cross Hospital.

(ii) 1975 (during the intracapsular era and iris-supported lenses), asking Mr Binkhorst whether he felt phacoemulsification was of benefit to his then novel technique of adhering his implant to the posterior capsule. (Audience in Cardiff and speaker somewhat bemused.)

(iii) The discarding of phaco technique for twenty years, when the advent of sutureless, bloodless, clear corneal implantation of foldable lenses was added to: (a) viscoelastic protection of endothelium and posterior capsule, (b) the established benefit of rhexis, (c) the evolution of in-the-bag nucleofractis techniques, (d) the perfection of posterior segment in-the-bag implantation. (I remember a paper by Mr Kelman listing reasons why implants should be in the anterior chamber!)

I do not regret missing out on phaco in the 1980s. Sutures were still in use and corneal decompensation apparently became the most common cause of a graft in the USA.

I *do* regret having missed a few years of scleral sutureless surgery with 5 mm rigid lenses, and had I known that the laterally placed 5 mm clear corneal, uniplanar valve was stable without sutures (Khatib and Karseras, unpublished 1998) I would certainly have converted before foldables.

I do hope this 'dinosaur' has been of some ophthalmological archaeological interest.

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Sir,

The dubious accolade of 'dinosaur' is usually awarded to those who, by being unable or unwilling to adapt to change, are at risk of failing to meet current standards of best practice. Mr Karseras has rightly pointed out that the change from extracapsular cataract extraction to phacoemulsification is only one of a number of advances in cataract surgical technique which have come about during the last 25 years. He also makes the very important point that, although it would have been possible to convert directly from intracapsular cataract extraction to phacoemulsification in the early 1970s, the results would probably have compared unfavourably with the best practice of the time. It was therefore right to regard phacoemulsification as an experimental technique until the many advances in equipment, lens implant materials and surgical technique of the 1970s and 1980s had ensured reliable results.

Mr Karseras has successfully managed the transitions from simple intracapsular extraction through intracapsular extraction with iris-supported implant, through extracapsular extraction with posterior chamber implant to phacoemulsification with foldable implant during his professional career. The fact that the last transition has taken place after the age of 60 is proof in itself that he is no 'dinosaur'.

Personal observation suggests that adaptability amongst ophthalmologists correlates poorly with chronological age and has more to do with quality of training and personality. We are living in an era where there is intense competition for training places in ophthalmology and strong encouragement to train towards excellence in sub-specialty areas. Are we selecting and training the innovators of the future, or are we breeding tomorrow's 'dinosaurs'? More research is needed.

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