

Sir,

Whilst applauding the excellent paper of Tong and Vernon,<sup>1</sup> I would like to point out a very common misconception of the Royal College of Ophthalmologists guidelines to the DVLA<sup>2</sup> regarding the standard for driving visual fields which was highlighted in the article. The guidelines state that 'the minimum visual field for safe driving is a field of vision of at least 120° on the horizontal meridian measured by the Goldmann perimeter on the III4e settings (or equivalent perimetry). In addition there should be no significant field defect in the binocular field which encroaches within 20° of fixation either above or below the horizontal meridian. By this means, homonymous or bitemporal defects which come within 20° of fixation, whether hemianopic or quadrantanopic, are not accepted as safe for driving. Isolated scotomata represented in the binocular field near to the central fixation area are also inconsistent with safe driving.' This is *not* represented by a 'letterbox' superimposed over the Estermann plot as drawn in Fig. 1 of the article. This would exclude many more patients from holding a driving licence than is appropriate.

It is difficult to represent the standard by means of a diagram, but it would include an infinitely narrow line extending 120° across the horizontal meridian. In addition it would include a circle of radius 20° from the central fixation.

It is essential to give every chance to our driving patients to maintain their independence through holding a driving licence. The medical advisers at the DVLA are very fair in their assessment of the visual field of individual patients but it is beholden to us as ophthalmologists to be aware of the guidelines and to advise our patients appropriately. Misconceptions regarding the guidelines are unfortunately all too common amongst us. I hope that this letter will go some way to correcting this.

#### References

1. Tong L, Vernon S. Passing the DVLA field regulations following bilateral macular photocoagulation in diabetics. *Eye* 2000;14:35–8.
2. Visual Standards for Driving. London: Royal College of Ophthalmologists, 1999.

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Sir,

We thank Mr Keightley for his interest in, and timely comments on, our paper. As stated in the manuscript, our use of the box shown in our figure was for the purposes of *our* study and was *our* definition of a pass. By using such a definition, we considered that there would be no doubt concerning the status of 'pass' in our patients (interestingly, it also indicates that patients requiring bilateral focal macular laser, in the absence of proliferative disease, do not have peripheral retinopathy sufficient to cause field defects in the zone outside 20° from fixation on a binocular test). If we had had patients who failed as a result of their retinopathy, we would have referred the fields to the Chairman of the Advisory Panel as in a previous study from our unit.<sup>1</sup>

The regulation for acuity sufficient to drive is a relatively simple one: the ability to read a standard UK number plate at a distance of 20.5 m. It is therefore unfortunate that the visual field regulation is not as simple to interpret. Until very recently, ophthalmologists were asked to give their opinion to the DVLA on whether a field passed the regulations. An interesting study designed to assess the agreement between consultant ophthalmologists and the Chairman of the Visual Standards sub-Committee (CVSC) indicated that, in diabetics who had had panretinal photocoagulation for proliferative retinopathy, 'substantial differences' occurred as to whether the Estermann fields were considered to pass or fail the DVLA's requirements.<sup>2</sup> It is of note that this study also mentions the 120° × 40° central field and states that up to 10 points may be missed within this zone and still be compatible with 'a pass' (at least by the CVSC). It would have been interesting to study the reproducibility of the CVSC's decisions, which, although based upon experience, are still subjective.

Patients who are required to take a binocular 'driving field test', not surprisingly, still want to know, from *their* ophthalmologist, whether they have passed or failed the test. Given the difficulty the Advisory Panel has in defining the limits of pass and fail in terms that may be easily and reproducibly determined by the test(s), we would advise all ophthalmologists not to pre-empt the DVLA's decision unless it is a clear pass as per our study's definition. (S.A.V. has had to appeal (successfully) on behalf of one of his patients who had his licence cancelled when S.A.V. had considered his field passed the regulations!)

In today's world of evidence-based decision-making, surely the time has come to insist that the DVLA develop a form of functional test which assesses the performance of an individual in the correct environment (such as a simulator). As many of our patients also have other factors which could reduce their ability to drive safely, such a test would allow cumulative deficiencies to have a bearing on the outcome of the test as, indeed, they do when one first takes the driving test.

#### References

1. Hulbert MFG, Vernon SA. Passing the DVLA field regulations following bilateral panretinal photocoagulation in diabetics. *Eye* 1992;6:456–60.
2. Pearson AR, Keightley SJ, Casswell AG. How good are we at assessing driving visual fields in diabetics? *Eye* 1998;12:938–42.

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Sir,

Tan *et al.*<sup>1</sup> report a commendably low need for intervention (2.2%) at the first day review after uncomplicated phacoemulsification. However, it depends on what one calls safe as to whether this review can indeed 'safely be withdrawn'. For the 2.2% it would not seem particularly safe.

In our own study of uncomplicated phacoemulsification, out of 392 patients<sup>2</sup> we found raised pressure in 6 (1.53%), 1 patient (0.26%) with iris prolapse and 7