Sir,

Whilst applauding the excellent paper of Tong and Vernon,[1] I would like to point out a very common misconception of the Royal College of Ophthalmologists guidelines to the DVLA[2] 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.

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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.[1]

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.[2] 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.
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Sir,

Tan *et al.*[1] 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[2] we found raised pressure in 6 (1.53%), 1 patient (0.26%) with iris prolapse and 7

patients (1.78%) who received a more intensive steroid regime. We felt this pick-up rate justified continuing the review, unless alternative safeguards were introduced. To simply dispense with it would risk avoidable poor outcomes.

As Tan *et al.* suggest, early review, 4–6 hours after surgery, would allow detection of significant pressure spikes, and treatment at this stage would make more sense. Truly 'day case' surgery may improve uptake and make a national rate of 85% more attainable. Selection of 'low-risk' patients, e.g. excluding those with diabetes and glaucoma, for no early review could be an alternative.

Apart from detecting complications the first review also serves a number of other roles. It provides valuable feedback to the surgeon, especially trainees, allowing continued development of technique.

It also serves to reassure patients who in spite of our best efforts at pre-operative education and counselling are often unsure whether their first day symptoms are normal or a portent of impending disaster. For patients with complicated surgery an unexpected extra first day visit may add to dissatisfaction and anxiety.

Advances in surgical technique should certainly be seen as opportunities to re-evaluate traditional practices. However, enthusiasm for change should be tempered with caution to avoid compromising patient care.

References

1. Tan JHY, Newman DK, Klunker C, Watts SE, Burton RL. Phacoemulsification cataract surgery: is routine review necessary on the first post-operative day? Eye 2000;14:53–5.
2. Herbert EN, Gibbons H, Bell J, Hughes DS, Flanagan DW. Complications of phacoemulsification on the first post-operative day. Can follow-up be safely changed? J Cataract Refract Surg 1999;25:985–8.

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Sir,

We would like to thank Herbert for his comments on the need for review on the first post-operative day after uncomplicated phacoemulsification cataract surgery.

The incidence of post-operative complications detected on the first day after uncomplicated phacoemulsification cataract surgery was low (2.2%) in our study.[1] Raised intraocular pressure (IOP) was the most common complication. This is a self-limiting complication that does not produce adverse sequelae in most eyes. However, transient elevation of IOP could be harmful in a small proportion of eyes with a susceptible optic nerve head (e.g. glaucoma). There may therefore be a role for reviewing such eyes on the first post-operative day. However, a more rational approach would involve reviewing patients on the day of surgery (after an interval of several hours) to enable early detection of raised IOP and prompt treatment.

A telephone-based post-operative review service would be a valuable supplement to pre-operative counselling. This would enable rapid access to the ophthalmic department for any patients who have worrying symptoms during the post-operative period. Post-operative uveitis requiring a more intensive steroid regime is likely to be symptomatic. No cases of iris prolapse occurred in our series.[1] Uncertain wound integrity is likely to be detected at surgery in such patients. These patients should be reviewed on the first post-operative day if wound suturing does not restore confidence in their wound integrity.

While feedback to trainees is important, this need not occur on the first post-operative day. This does not occur anyway for many day case procedures, such as squint surgery and oculoplastic surgery. It should be possible to create a system that allows trainees to review their post-operative phacoemulsification patients at a time determined by the patient's clinical need rather than trainee's convenience.

We maintain that the first day post-operative review after uncomplicated phacoemulsification cataract surgery can be withdrawn. However, steps should be taken to ensure that this is done safely and no patients are at risk of a poor visual outcome.

Reference

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Sir,

We read with interest the case report on 'Scleral dellen complicating primary pterygium excision' by Chen and Noonan.[1] We would like to recount our recent experience with a patient who developed a scleral dellen following primary pterygium excision and local steroid administration.

A 30-year-old Omani labourer presented with a 1 year history of recurrent irritation and watering in his left eye. But for the presence of a nasal pterygium in the left eye, ocular examination revealed no other abnormality. There was no evidence of dry eye. The pterygium was excised under local anaesthesia (benoxinate hydrochloride 0.4%) using the bare sclera technique and the patient was discharged on ointment Terra-Cortril (Pfizer: oxytetracycline hydrochloride 5.7 mg, hydrocortisone acetate 17 mg, polymyxin B 11 400 IU) q.i.d. One week later he presented with pain, redness and watering in the operated eye. Slit-lamp examination revealed a deep dellen on the bare sclera and surrounding conjunctival congestion; the ciliary body was visible through the thin sclera (Fig. 1).

Ointment Terra-Cortril was discontinued, ointment chloramphenicol was applied and the eye was patched for

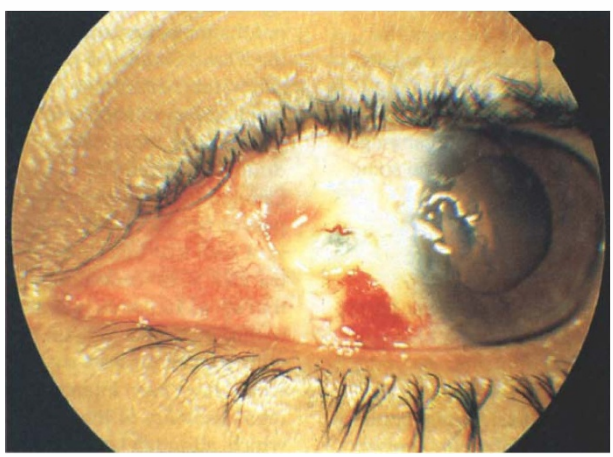

Fig. 1. *Scleral dellen as a complication of bare sclera excision of pterygium.*