

demonstrates identical measurements in ACD and LT in one patient on two separate scans. It would interest us to know the time between scans and whether or not vitrectomy had been done between measurements.

Whilst we agree that the ideal scenario would be to have AL measured by an experienced biometrist using a machine in which sound speeds can be varied, Mr Bolger has pointed out that even in the most experienced hands lens exchange may still be necessary. In addition, the speed of sound through silicone oil of viscosity 1300 centistokes is unknown (987 m/s is actually sound speed through silicone oil of viscosity 1000 centistokes<sup>3</sup>). In any event, not all units are equipped with biometry machines with which ACD, LT and VCD can be measured individually and in which sound speeds can be varied. Instead, many older machines give one measurement of AL which incorporates ACD, LT and VCD and/or have the velocities preset into the instrument.

The conversion factor of 0.71 used to estimate true AL allows estimation of desired intraocular lens power which may otherwise not be possible. Prospective evaluation of this conversion factor will be the subject of a future report.

#### References

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2. Gonvers M. Temporary silicone oil tamponade in the management of retinal detachment with proliferative vitreoretinopathy. *Am J Ophthalmol* 1985;100:239–45.
3. Hoffer KJ. Ultrasound velocities for axial eye length measurement. *J Cataract Refract Surg* 1994;20:554–62.

Desireé Murray ✉

Peter Good  
Graham Kirkby  
Mark Benson  
Birmingham and Midland Eye Centre  
City Hospital NHS Trust  
Dudley Road  
Birmingham B18 7QU, UK

Sir,

The propriety of a domiciliary nurse for first dressings after cataract surgery (Willins *et al.*, *Eye* 1999; 13: 336–8) is perhaps not so much in question, as the actual instructions given to a well-trained specialist nurse. The empirical use of 2-hourly steroid or acetazolamide for a hazy cornea, a florid uveitis, or undue pain is surely poor practice.

Should not *all* such patients be referred immediately to hospital for slit-lamp examination? How else can intense

anterior chamber activity with or without exudate possibly indicating early endophthalmitis, be excluded?

In the last four and a half years at Brecon, in a multi-purpose theatre without phaco facilities, 225 extra-capsular procedures have been carried out. All but a few (social reasons) have been day case procedures in this very rural area. There has been a zero incidence of intraocular infection. No antibiotics have been used in perfusion fluids.

A hypopyon incidence of more than 1 per 100 procedures as in the paper by Willins *et al.* poses the question, 'Why?'

Alec G. Karseras OBE, BSc, FRCP(Ed), FRCS (Eng), FRCOphth  
The Laurels  
27 Penlline Road  
Whitchurch  
Cardiff CF14 2AA, UK

Sir,

We thank Mr Karseras for his interest in our paper and his comments.

We believe that an experienced ophthalmic nurse is able to make a sensible determination as to whether the eye is more inflamed than normal, and we fully support them using their discretion in applying more intensive steroids for a few days. We believe that this has been normal practice for many years amongst ophthalmologists, and we are simply allowing our nursing colleagues to exercise the same discretion.

The signs and symptoms of endophthalmitis do not begin to manifest until day three or four post-operatively and therefore any such increased inflammation at day one cannot be taken as an indication of impending endophthalmitis.

We would agree entirely that the key to early detection and treatment of post-operative endophthalmitis is patient awareness of the condition and of the importance of reporting promptly. The close contact of our nurses with patients before, during and after surgery reinforces this.

The two hypopyons in our series were in cases of sterile uveitis which responded to intensive steroid treatment and were not cases of endophthalmitis.

Patrick P. Kearns  
Ophthalmology Department  
Fife Acute Hospitals NHS Trust  
Whitefield Road  
Dunfermline  
Fife KY12 OSU, UK

Sir,

In his excellent review of the management of monocular congenital cataracts<sup>1</sup> Scott Lambert refers to pupil

trap as a complication which can be avoided by careful attention to surgical technique and lens design.

Having seen a number of cases of pupil trap occurring 1 or 2 weeks after paediatric cataract surgery we hypothesised that eye rubbing could be the cause, particularly at night when pupil dilatation increases the possibility that the iris could be 'tyre-levered' behind the lenticulus when endocapsular placement has not been possible. During the last 4 years we have prescribed pilocarpine 1% morning and evening for 2 weeks post-operatively and have arranged for children to wear an eye shield, especially at night during this period. During this time, we have seen no cases of pupil trap.

The validation of our hypothesis would require a clinical trial; however, the combination of pupillary constriction and prevention of eye rubbing, particularly at night, appears, in our practice at least, to have eliminated the problem of pupil trap occurring during the weeks following cataract surgery in children.

#### Reference

1. Lambert SR. Management of monocular congenital cataracts. *Eye* 1999;13:474–9.

Gordon N. Dutton ✉

Badia Fahad  
Royal Hospital for Sick Children  
Yorkhill  
Glasgow G3 8SJ, UK

Sir,

I agree with Drs Dutton and Fahad that pupillary capture can be a problem in children if both haptics are not placed in the capsular bag. Careful attention to wound closure in a child is also critical because of the possibility of eye rubbing or ocular trauma.

I also recommend an eye shield be worn at night, but do not favour the use of miotics. In fact, I typically prescribe cyclopentolate 1% to be used once a day in an attempt to maintain the normal function of the pupil. I have not had a child develop pupillary capture over many years using this regimen.

Scott R. Lambert, MD ✉

Department of Ophthalmology  
Emory University School of Medicine  
1365B Clifton Road NE  
Atlanta  
GA 30322, USA

#### Erratum

*Eye* 1999;13:391–2

The name of Richard A Harrad, first author of the letter regarding the paper by Inkster *et al.*, was accidentally omitted.