

was related to the birth weight and gestational age in the multiple gestation group. Interestingly the percentage of neonates reaching threshold was smaller in the multiple gestation group than the single gestation group. Using risk-adjusted outcomes for very low birth weight (VLBW = between 401 and 1500 g) neonates it has been shown that twins and singletons have similar morbidity and mortality outcomes.<sup>7</sup> In addition it has been reported that the more severe ROP may be observed in the higher birth weight twin.<sup>8</sup> We therefore do not accept that the only reason for these children reaching threshold disease is age and birth weight.

Excellent obstetric and neonatal care is indeed having an impact on ROP screening, with the evidence suggesting a reduction in severe retinopathy except in the extremely premature neonates of less than 25 weeks gestation.<sup>10-12</sup> The increasing survival of VLBW infants is possibly a direct result of good obstetric and neonatal care,<sup>9</sup> with the mothers of twins more likely to receive prenatal care, have caesarian delivery and receive antenatal glucocorticoids than those with singleton pregnancies.<sup>7</sup> Hence assisted conceptions are likely to receive 'good' obstetric care and the development of ROP would appear not to be a direct result of their plural gestation or solely a function of their gestational age and birth weight. Our study suggests that the method of conception is an important risk factor for the development of severe ROP.

We continue to exercise and advise extreme caution in all assisted conceptions reaching stage 3 disease, as the experience in our cohort demonstrates that they are likely to progress to threshold disease.

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Sir,

I read with interest the report concerning first day discharge to the optometrist with subsequent communication to the hospital in 77% of cases.<sup>1</sup>

Before we are all swept into a whirlwind of fast track cataract surgery (others, notably in Gloucestershire, have recommended but one post-operative visit<sup>2</sup>), may I make a plea for documentation of visual outcomes.

The national benchmark is for 6/9 with correction after phacoemulsification in 76%.<sup>3</sup> However, this leaves much to be desired: the aim should be for at least 80% seeing 6/12 unaided and with 99%

achieving 6/9 with correction when comorbidity is excluded. How are we therefore to improve standards without careful follow-up and self-audit? It seems that the rush into higher turnover with optometrist communication at best in only 77%, will inevitably lower the standard of patient care.

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Sir,

Percival is concerned that post-operative arrangements outlined in our paper are inadequate for audit. Concerns of such a leading figure in modern British cataract surgery must be taken very seriously indeed. We all want the highest standard of surgery delivered to as many patients as possible within the confines of available resources.

Despite the absence of feedback in 23%, only 6 eyes were unaccounted for out of 318 cataract operations because of ongoing follow-up for other conditions. Those few patients were probably satisfied because it is inconceivable that a British general practitioner would refer a dissatisfied patient to another eye surgeon without informing the operating surgeon. Thus no patients suffered as a result of the shared care.

High standards of surgery could be ensured without exhaustive post-operative details of every single patient. A successful cataract operation depends on a highly skilled surgeon and an accurate biometrist. A surgeon could be preoperatively assessed as part of the College inspection, in part analogous to the monitoring of airline pilots. This would reveal more of the surgeon's respect for the endothelium than could be detected in clinics, not to mention bedside manner, which is important for an overall success of local anaesthetic cataract surgery as perceived by the patient. In due course artificial, calibrated eyes may be available against which biometrists could be measured.