harm the eye. However, this opalescence had made YAG capsulotomy more difficult for some investigators.[5] Mehta *et al.*[2] observed discoloration of hydrogel IOLs following the use of fluorescein for corneal staining, although Epstein *et al.*[2] have not noticed any discoloration in their series of hydrogel IOLs. Soft acrylic IOLs can show glistening, probably because of microvacuole formation and warming before folding the IOL.[6]

Many of the polymers used nowadays are made by minor alteration of the side-chain component of the acrylate/methacrylate polymer backbone, resulting in materials with differing physical and biological properties. The IOL used in the present case was a hydrogel IOL, which is composed of ultrapure Poly-HEMA, methylmethacrylate (MMA) and an ultraviolet absorber.[4] At present we are unable to relate the opalescence to any clinical event. It seems that the physical properties of the polymer are responsible for it. A large number of patients in our series have this opalescence and might ultimately present with a decrease in visual acuity and require explanation. We have taken up an audit of all patients in whom this particular type of hydrogel IOL has been implanted. The present case may be an isolated example of an adverse event in hydrogel's material history (which is very short) but long-term follow-up clinical studies are lacking. This case emphasises the need for careful long-term follow-up of all the patients receiving this particular IOL material.

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Tarun K. Sharma
S.Chawdhary
Queen's Hospital
Burton on Trent, UK

S. Chawdhary ✉
Department of Ophthalmology
Queen's Hospital
Burton on Trent DE13 0RB, UK

Sir,

Are elderly people being screened for visual impairment in general practice?

Visual impairment is common among elderly people and is associated with falls, hip fracture and reductions in functional ability and quality of life.[1] A recent survey in London found 30% of people aged 65 years and over to have a visual acuity of less than 6/12, which in 72% of cases could potentially be improved.[2]

Since 1990, general practitioners have been required to offer annual screening to all patients aged 75 years or over, including an assessment of vision. A recent report for the Department of Health recommended that further research was needed to clarify the use of 'over-75 checks' as an outcome measure for the quality of cataract services.[3]

The aim of this study was to determine current practice with regard to systematic screening for visual impairment as part of the over-75 checks.

Participants, method and results

In August 1999 an anonymous postal questionnaire was sent to the practice nurse (or to the general practitioner if the practice had no nurse) in all 122 practices in Brent and Harrow and all 117 practices in Berkshire Health Authorities (Fig. 1).

The overall response rate was 72% (172/240). There were no significant differences between the replies of practices in Brent and Harrow or Berkshire. Eighty per cent (139/172) of practices carry out annual systematic screening for patients aged 75 years and over. Only 52% (90/172) of practices specifically screen for visual impairment. Of these 52%, 80% (72/90) screen for visual impairment by asking questions relating to vision, such as 'Do you have any problems with your eyes?', 'Have you seen an optometrist recently?' The remaining 20%

	Yes	No
1. Does your practice carry out over 75 checks? (i.e. a systematic screening programme of the over 75 elderly population)	☐	☐
Any additional comments:		
	Yes	**No**
If ***you*** do not do over 75 checks, do you think the patients in your practice receive over 75 checks from anyone else?	☐	☐
If so, who (health visitor, district nurse etc)?		
If you do undertake over 75 checks:	**Yes**	**No**
2. Do you screen for problems with vision?	☐	☐
Any additional comments:		
3. If yes:	**Yes**	**No**
a) Do you ask a question or questions about vision?	☐	☐
If so, what question or questions do you use?		
	Yes	**No**
b) Do you use a chart?	☐	☐
If so, do you know what sort of chart it is?		
4. What do you do if you find someone has problems with their vision?		
Any other comments:		

Please complete this questionnaire and return it in the envelope provided: You do not need to attach a stamp.

Thank you for your help.

Fig. 1. *Over-75 checks: postal questionnaire.*

(18/90) that screen for visual impairment use an acuity chart, specified as a Snellen chart in 12 practices and as 'the usual eye chart' in 6 practices.

Practices were asked what happened if someone was found to have a visual problem. Twenty-four per cent (42/172) said they refer the patient to a community optometrist, with 29 of these 42 (17%) stating the patient is also advised to see the general practitioner. Forty-five per cent (77/172) gave no answer to this question.

Comment

Only 52% of practices in our survey are screening for visual impairment, the majority of which are using questions about visual problems as a screening tool. The sensitivity of such questions compared with formal visual acuity testing in the general population has been found to be around 30%.[1] Of those practices giving an answer, referral to an optometrist is the single most likely action to be taken if a patient is found to have a visual problem. Despite the re-introduction of free sight tests, the cost of spectacles may still deter people from attending the optometrist or from obtaining glasses.[1] What happens to those people who do attend (particularly those people with ophthalmological disease rather than uncorrected refractive error) is unclear.

Twenty per cent of general practices are not offering regular screening assessments to patients aged 75 years and over – a similar proportion to the 15% found in 1992.[4]

The use of questions about visual problems as a screening tool and the lack of clear plans of intervention for those people found to have a visual problem were proposed as explanations for the lack of effectiveness of screening for visual impairment found in a systematic review of randomised controlled trials.[5] These two factors, along with the low proportion of practices carrying out screening, suggest that elderly people are not being adequately screened for visual impairment. The over-75 checks policy is currently under review. Visual impairment in elderly people is common, disabling and frequently treatable. If general practice is to continue to be given responsibility for screening then adequate resources, training in visual acuity testing, and clear plans of intervention which acknowledge the role of optometrists will be needed.

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Raman Malhotra
Department of Ophthalmology
Royal Berkshire Hospital
Reading RG1 5AN, UK

Jignesh Patel
Central Middlesex Hospital
London NW10 7NN, UK

Liam Smeeth
Epidemiology Unit
London School of Hygiene and Tropical Medicine
London WC1E 7HT, UK

Mr R. Malhotra, FRCOphth ✉
Department of Ophthalmology
Royal Berkshire Hospital
London Road
Reading RG1 5AN, UK

Tel: +44 (0)118 9877161
e-mail: malhotraraman@hotmail.com

Sir,

Chorioretinal alterations in mucormycosis

Mucormycosis is an acute infection caused by several fungi of the order Mucorales.[1] These fungi are normally saprophytic and non-pathogenic.[2] In mucormycosis several clinical syndromes are defined, rhino-orbito-cerebral being the most common.[2] Signs and symptoms of orbital mucormycosis include chemosis, periorbital cellulitis, ophthalmoplegia, proptosis, ptosis, abrupt visual loss, orbital pain and facial hypoesthesia. The fungi invade blood vessels, and cause necrotising vasculitis resulting in thrombosis of the vessel lumen.[3] Unless diagnosed and treated early, mucormycosis is often fatal, due to cerebral involvement.[2] We report a patient with rhino-orbital mucormycosis in whom choroidal ischaemia resulted in extensive chorioretinal pigmentary changes.

Case report

A 46-year-old woman reported that she had experienced left facial pain and had developed left proptosis and complete ophthalmoplegia with abrupt loss of vision. Coronal paranasal tomography had revealed left frontal, ethmoid and maxillary sinusitis with retro-orbital involvement on the left. Broad spectrum antibiotic therapy had not changed the condition. The patient was said by her ophthalmologist to have left optic atrophy. Medical history was negative for systemic diseases; however, fasting blood sugar was found to be 240 mg/dl. Biopsy taken by a local otorhinolaryngologist revealed necrotic material. The patient was then referred to our centre for further investigation.