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Sir,

We thank Sheard and Snead for their interest and comments on our paper. We note their observation that there have been previous studies on ocular involvement in Proteus Syndrome; we were genuinely unaware of these studies while preparing our manuscript. We apologise for the error. However, we would like to state that these previous publications only serve to substantiate our statement recommending a comprehensive examination of all patients with Proteus Syndrome, including a complete ophthalmic evaluation.

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Sir,

We read the article by King *et al.*[1] with interest. We have recently undertaken a review of blindness and partial sight registrations in the Bristol area. Data on age and cause of loss of sight from registrations for the period 1 August 1990 to 31 July 1993 were examined by retrieving all BD8 forms for individuals living in the Bristol area and registered at the Bristol Eye Hospital (population served approximately 850 000). During this 3 year period, 1468 individuals were registered. Of these, 890 forms (61%) were examined. Of those not examined 102 (7%) had died, 213 (14.5%) had not been seen for over 6 years and their files had been destroyed, 183 (14.3%) were being seen in other hospitals (e.g. Weston-Super-Mare) and 56 (3.8%) were being seen privately. Age-specific rates were calculated using the 1991 population census figures for Avon available from the Office of National Statistics. Results were compared with a similar review of registrations undertaken in Avon for the period 1984–1986.[2]

Analysis of the causes of registration for the 890 available forms demonstrated that age-related macular degeneration is by far the most common primary cause of sight loss, increasing since 1984–1986 in terms of the total proportion of blindness/partial sight. However, glaucoma remains the second most common single cause, and the overall proportion of sight loss from this cause has not declined. This reflects the experience of King *et al.*,[1] who have demonstrated that despite ongoing care and surveillance within the hospital eye service 35% of the 258 patients followed up from 1982 achieved eligibility for registration as blind or partially sighted, although only 18% were actually registered.

The proportion of cases registered blind or partially sighted due to glaucoma appears to have changed little since 1984–1986, when Grey *et al.*[2] demonstrated that glaucoma was responsible for 13% of registrations in Avon. These findings are consistent with a comprehensive study of blindness in the UK[3] from 1950 to 1990 which found that registrations due to age-related macular degeneration were increasing whilst those for all causes, cataract, glaucoma and optic atrophy have decreased. From these national data, it was notable that no appreciable decline in standardised registration rates for blindness was observed between 1980 and 1990 for men and women for glaucoma, which is consistent with the results from our study.

Despite advances in therapy, glaucoma remains a significant cause of blindness within the community. The Office of National Statistics is due shortly to publish the registration data for the previous 3 years, which we await with interest to see whether shifts have occurred.

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Table 1. *Causes of registration of partial sight and blindness in Avon 1984–1986 and 1990–1993 (number and %)*

	1984–1986 (n = 890)			1990–1993 (n = 1692 eyes)[a]		
Cause	*Partial sight*	*Blind*	*Total*	*Partial sight*	*Blind*	*Total*
ARMD	285 (51.9)	187 (55.0)	472 (53.0)	565 (49.0)	234 (43.0)	799 (47.0)
Glaucoma	93 (16.9)	28 (8.2)	121 (13.6)	176 (15.0)	40 (7.0)	216 (13.0)
Diabetic retinopathy	33 (6)	32 (9.4)	65 (7.3)	71 (6.0)	51 (9.0)	122 (7.0)
Cataract	12 (2.2)	5 (1.5)	17 (1.9)	24 (2.0)	30 (5.0)	54 (3.0)
Other	127 (23.1)	88 (25.9)	215 (24.2)	310 (27.0)	191 (35.0)	501 (30.0)
Total	550 (100.0)	340 (100.0)	890 (100.0)	1146 (100.0)	546 (100.0)	1692 (100.0)

[a]Of the total of 1468 BD8 forms analysed.
ARMD, age-related macular degeneration.