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Sir,

I thoroughly enjoyed reading the article by Comer *et al.*, 'Who should manage primary retinal detachments?'[1] This regional study was conducted in the early 1990s, and it documents the shift away from 'general' ophthalmologists treating retinal detachments towards greater success by a 'dedicated vitreoretinal (VR) unit'. I believe the debate has moved on since then and there are increasing numbers of vitreoretinal-trained DGH ophthalmologists who fall into neither of the above categories and who provide a comprehensive retinal detachment service locally. The audit for 1999/2000 in Ipswich demonstrated a primary success rate of 86.1% (31/36), falling within the high standards (85–90%) called for by Comer *et al*. Clinical governance will show which surgeons in which hospitals are falling significantly and consistently below standard. The 1997 national audit for primary retinal detachment surgery did not demonstrate any significant correlation between surgical success and annual case load amongst surgeons with a VR interest.[2] Is it necessary for VR surgeons to centralise in teaching hospitals in order to perform retinal detachment surgery? I believe the answer to be 'no'. There may be certain procedures which ought to be performed exclusively in such centres, but that is a different debate.

References

1. Comer MB, Newman DK, George ND, *et al*. Who should manage primary retinal detachments? Eye 2000;14:572–8.
2. Personal communication from Mr Barny Foot, Audit Department, Royal College of Ophthalmologists, Nov 2000.

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Sir,

We read with interest the article by Comer *et al.*, 'Who should manage primary retinal detachments?'[1] We congratulate them for closing their audit cycle. The authors have shown a significant improvement in success rate for primary retinal reattachment surgery since such procedures were mainly done in a specialist vitreoretinal unit (VRU). We would like to share our results of primary retinal detachment (RD) surgery from a general ophthalmic unit with no VR facilities.

A retrospective audit was done between 1 March 1995 and 1 March 1998 on 52 consecutive patients who had conventional RD repairs (i.e. external approach only). This yielded a primary success rate of 88.5% (46/52). Overall, vision improved in 26 cases (50%). For macula-off RDs, vision improved in 20 of 24 cases (83%) with 7 achieving 6/12 or better. Of the 6 failures, 5 had subsequent successful reattachment at the local VRU.

In all these cases pre-operative assessment and surgery were performed by a single consultant surgeon with strict adherence to exclusion criteria which included: limited fundal view due to media opacity, vitreous haemorrhage or miosed pupils, moderate to severe vitreoretinopathy, unidentifiable or very posterior breaks and giant tears. Our success rate is within the standard of 85–90% suggested by the authors and better than the 76% quoted by Laidlaw *et al*.[2] where conventional surgery alone was used. Another factor that will no doubt affect success rate is the number of procedures performed by a particular surgeon. We felt that even after patient selection there were still sufficient procedures done to keep the surgeon adept. If this was not the case, then we agree that all cases should be referred to a VRU. However, as the authors showed, this would have a significant effect on the workload in that VRU and there will be cost implications to both patient and doctor.

It is important to have a good primary reattachment rate as single surgery is associated with better visual outcome and reduced patient co-morbidity.[3] We advocate that all units that perform primary RD repairs constantly audit their own results to ensure that a good standard of care is being provided.

References

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2. Laidlaw DAH, Clark B, Grey RHB, Markham RHC. Correspondence. Eye 1998;12:751.
3. Wilkinson CP, Rice TA. Michel's retinal detachment. 2nd ed. St Louis: Mosby, 1997.

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Sir,

We read with great interest the article by Comer *et al*. 'Who should manage primary retinal detachments?'[1] There did indeed seem to be an important improvement in the success rate for primary retinal reattachment procedures when the majority of the surgery was performed by the 'specialist vitreoretinal unit (VRU)'.

However, what the authors are really saying is that patients with retinal detachments have better outcomes when managed by specialists. It does not follow that these specialists can only exist in a teaching hospital environment where a number of them can get together as a VRU, and to which patients from district general hospitals should be referred. A number of smaller units are now appointing properly trained VR surgeons who, if referred all VR cases from their colleagues in a DGH environment, will have a significant throughput of cases so that their expertise is maintained. The fact that there would frequently be fewer trainees at a DGH might arguably make it easier to obtain good results in comparison with a teaching hospital. One might argue that such superspecialisation in smaller units has a negative effect on training and on-call arrangements and is not cost-effective, but another audit comparing teaching hospital VRU versus specialist DGH success rates would be needed to prove the superiority of the centralised units suggested in this paper.

Reference

1. Comer MB, Newman DK, George ND, Martin KR, Tom BDM, Moore AT. Who should manage primary retinal detachments? Eye 2000;14:572–8.

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