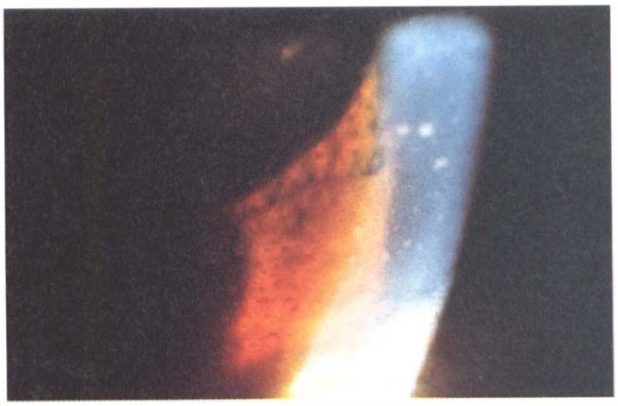

Fig. 1. *Anterior segment photograph showing blood-stained keratic precipitates, best seen inferiorly.*

Within a further 4 weeks her vision was 6/6 bilaterally with quiet eyes and her inflammatory markers were settling.

Comment

Some degree of thrombocytopenia in sarcoidosis is well recognised. However, severe thrombocytopenia (platelet count of less than 20×10^9/l) is much rarer, with fewer than 30 cases reported in the literature.[1,2] Thrombocytopenia may occur in sarcoidosis secondary to bone marrow involvement, hypersplenism or antibody-mediated destruction of platelets. There have been only four reports of the use of intravenous immunoglobulin in thrombocytopenia associated with sarcoidosis, in all of which it was used when systemic steroids with or without vincristine had failed to increase the platelet count.[3–6] In our case steroids were avoided initially due to the fact that uveitis and severe thrombocytopenia were the presenting features of the disease, and infectious causes had not been excluded at that stage. The severity of the thrombocytopenia meant that delay in its treatment pending further results was not advisable.

To our knowledge this is not only the first description of blood-stained keratic precipitates but also the first report of the use of intravenous immunoglobulin to increase the platelet count as a first-line treatment in sarcoidosis with thrombocytopenia.

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Sir,

The use of supplementary blue light during Perkins applanation tonometry in theatre

Accurate intraocular pressure measurement is an important part of a paediatric ophthalmologist's examination of a child. Goldmann applanation tonometry is regarded as the 'gold standard' for intraocular pressure measurement as it has been shown to be consistently reliable and accurate. It is the standard against which all other tonometers are measured.[1] However, Goldmann applanation tonometry is not a portable technique, which makes it impractical in the paediatric setting where pressure measurements are performed in the spine position under general anaesthesia.

The Perkins tonometer (Clement Clarke) is a portable applanation tonometer which is used frequently during examination under anaesthesia. It is based on the Goldmann tonometer but is counterbalanced so that tonometry can be performed in any position. Its accuracy is comparable with the Goldmann applanation tonometer and this has been confirmed by a number of research groups.[2,3]

One disadvantage of the Perkins tonometer is that the illumination of the tonometer prism by two cobalt blue filtered light sources within the instrument is very dim (5.4 volts total). This makes visualisation of the excited fluorescein within the tear film difficult, even when the room lighting is reduced. This may increase the time required for examination, and can lead to an underestimation of intraocular pressure.[4] Modifications have been suggested to the tonometer to increase the internal illumination[5] but these are not easily achievable. Simple pen torches with blue filter caps are widely available and used in the examination of the anterior segment with fluorescein. The average bulb voltage from a pen torch is 2.2 volts. We wished to establish whether the use of external supplementary blue light from a pen torch facilitates measurement of intraocular pressure in theatre using the Perkins tonometer.

There are other methods of intraocular pressure measurement in children examined under anaesthesia. The Tono-pen and non-contact tonometry are probably the other techniques most commonly used. In our experience the Perkins tonometer is a more accurate technique. The Tono-pen has been reported to overestimate intraocular pressure in the low ranges and to underestimate it in the high ranges.[6,7] The accuracy of the non-contact tonometry has been suggested to be diminished with higher pressures and in eyes with abnormal corneas or poor fixation.[8–10]

Report

During examination under anaesthesia by an experienced ophthalmologist (P.H.) the intraocular pressure of both eyes of 10 patients was measured using the Perkins tonometer. Fluorescein and proxymetacaine were instilled into the conjunctival fornix. For each patient the pressure measurement for one eye was carried out using light supplementation provided by a pen torch with a blue filter cap, held 5 cm from the eye pointing towards the tonometer prism. In order to avoid any bias from any difference in difficulty between measuring left and right eyes, or from a learning effect, it was randomly assigned for each patient which eye was measured first and which eye had external supplementary blue light. The time taken to achieve a confident measurement of intraocular pressure was recorded.

In one eye (without supplementary light) no reading was possible so 19 eyes of 10 patients were included in the analysis. There was a significant difference ($p < 0.01$) between the time taken to measure the intraocular pressure without light supplementation (mean 38.7 s, range 24–72 s) and with supplementary blue light (mean 8.9 s, range 3–15 s).

Comment

The use of supplementary blue light from a pen torch in theatre significantly reduced the time taken for a reliable reading of the intraocular pressure using the Perkins tonometer. This simple technique also has the advantage in reducing the amount of time that the anaesthetist has to monitor the child in conditions of dim illumination. Many paediatric anaesthetists use ketamine sedation for intraocular pressure measurement during examination under anaesthesia; however, if inhalational anaesthesia[3] is used it is even more important to check intraocular pressure rapidly as many anaesthetic agents will alter it. Use of supplementary blue light should also reduce the artificially low readings associated with hypofluorescence of the tear film,[1] although our study was not designed to address this point.

In summary, we strongly recommend the routine use of supplementary blue light to improve the ease of intraocular pressure measurement with the Perkins tonometer in theatre.

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Sir,

The use of the phacoemulisification keratome in dacryocystorhinostomy

Dacryocystorhinostomy is an effective treatment for complete nasolacrimal duct obstruction. The operation creates an anastomosis between the lacrimal sac and the nasal cavity through a bony ostium. A large osteotomy facilitates the formation of the anterior and posterior mucosal flaps from the lacrimal sac and the nasal mucosa. Most techniques employ the use of a Bard-Parker blade in the creation of the mucosal flaps. We describe a technique where the phacoemulsification keratome is employed for this purpose. The technique is effective and easier to perform.

Technique

Dacryocystorhinostomy involves making an incision in the lacrimal sac and nasal mucosa to create the anterior and posterior flaps that will be sutured together to create an anastomosis between the lacrimal sac and the nasal cavity. Most techniques employ the no. 12 Bard-Parker