



Figure 2 Composite illustration of case 1 (a–d) and case 2 (e–f). (a) *Fusarium* keratitis at the time of presentation, (b) corneal biopsy with periodic acid-schiff (PAS) stain showing septate hyphae in deep stroma (arrow) $\times 400$ (c) worsening clinical course, and (d) following therapeutic keratoplasty. *Fusarium* keratitis in an 18-year-old contact lens wearer (case 2) before (e) and after (f) treatment.

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CS Daniel¹, MS Rajan¹, VPJ Saw¹, I Claerhout², P Kestelyn² and JKG Dart¹

¹Moorfields Eye Hospital, London, UK

²Department of Ophthalmology, Ghent University Hospital, Ghent, Belgium

E-mail: claire.daniel@moorfields.nhs.uk

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Sir, Training problems in trabeculectomy

We read with interest the paper by Troutbeck *et al.*¹ There are not many articles published so far showing the outcome of the trainee and consultant's trabeculectomies. We recently carried out a study on this subject.

We agree that with the new antiglaucoma medications, the need for the trabeculectomy is reduced. The cases that require trabeculectomy are usually either not responding to maximum medical treatment or not suitable for it due to side effects, medical comorbidities, or poor compliance. Therefore, these cases are challenging. Troutbeck *et al.*¹ mentioned in their study that the trainee performed trabeculectomies as a sole operator with or without supervision. Direct supervision throughout the trabeculectomy should improve the technique as well as predict and reduce early postoperative complications.

We note in this study that the trainee commonly performed phacotrabeculectomies or trabeculectomy

with antimetabolites (5 fluorouracil: 36 cases, mitomycin C: 21 cases). It would be interesting to know the outcomes of the trabeculectomies without antimetabolites. In this paper, it seems trainee and consultants operated on almost equal number of cases who required mitomycin C (21 and 20, respectively) although it is mentioned that these cases were exclusively performed by consultants. Use of antimetabolites is more often associated with early and late postoperative complications (eg, hypotony, increased incidence of bleb interventions and corneal toxicity). This affects long-term intraocular pressure (IOP) control. Therefore, these cases are best managed by experienced surgeons.

In this study, the trainee performed only 1.6 trabeculectomies per year. Our departmental audit in Scotland showed that the trainee performed 6–12 trabeculectomies per year. We agree with Troutbeck *et al*¹ and Franks *et al*² that trabeculectomies are now more frequently carried out by specialized glaucoma surgeons.^{3,4} A multicentre audit presented in the Scottish Ophthalmological Club (SOC) in February 2005 showed significant reduction in the number of trabeculectomies performed by general ophthalmologists.

The success rate (30%) in this study by Troutbeck *et al*¹ seems low.^{3,4} We believe that careful case selection for trainee, intraoperative supervision and close postoperative monitoring can achieve good long-term IOP control and increase the success rate.

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A Vani¹, R Sanders² and H Devlin¹

¹Department of Ophthalmology, Princess Alexandra Eye Pavilion, Edinburgh, Lothian, UK

²Department of Ophthalmology, Queen Margaret Hospital, Dunfermline, Fife, UK
E-mail: archnavani@hotmail.com

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Sir, Response to Drs Vani and Delvin

Many thanks for your letter regarding our article on trabeculectomy training challenges. It is not surprising that our concerns are worldwide and will result in progressive deskilling of general trained ophthalmologists.

You raise a number of important points. We greatly believe in supervision of the trainees and nearly all

would be operating under supervision (although possibly the supervising consultant did not get recorded). Postoperative supervision of the management post trabeculectomy is also just as critical. The number of trabeculectomies with mitomycin C performed by trainees was actually one (not 21) and thus were mostly performed by consultants. The subsets of IOP ≤ 15 mmHg outcomes were trabeculectomy (41%), trabeculectomy with 5FU (39%) and phacotrabeculectomy (38%). We suspect the similar results depends on case selection—phacotrabeculectomies tend to have less severe glaucoma compared with the augmented trabeculectomies that tend to have the more difficult to control glaucoma.

The ‘success rate’ of 30% was set quite strictly, being defined as ≤ 15 mmHg on no medication following the traditional trabeculectomy technique. We agree with better techniques such as fornix-based conjunctival flaps, preplaced removable scleral trapdoor sutures, careful use of mitomycin C, and meticulous conjunctival edge closure outcomes can be improved. Unfortunately the trainees have limited number of cases and will probably require further glaucoma fellowship training to reach satisfactory surgical standard.

GA Lee and R Troubeck

City Eye Centre, Brisbane, Queensland, Australia
E-mail: eye@cityeye.com.au

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Sir, Awareness and the use of nutritional supplementation for age-related macular degeneration patients

We read with interest the article ‘Awareness and the use of nutritional supplementation for age-related macular degeneration (AMD) patients’ by Waisbourd *et al*.¹ The authors reported that their ‘AMD patients lack knowledge about their own ocular disease.’ The authors, however, erroneously stated that ‘other studies conducted internationally demonstrated lack of awareness for this blinding disease among the general population with 9.2–30% who were not familiar with the disease.’¹ In fact, only 9.2–30% were familiar with the condition as a cause for loss of vision.^{2–4}

Singapore has been organising an AMD Awareness Week annually since 2005 in conjunction with AMD Alliance International, a global non-profit coalition of vision, research, and senior organisations working to raise awareness of AMD, its treatment and rehabilitation options, and the importance of early detection. During the AMD Awareness Week, numerous educational talks on AMD, patient support group meetings and eye screenings are conducted at a number of participating hospitals, community centres, libraries, private ophthalmology clinics, and optometry outlets across the country. Amsler charts are also displayed in many public places, and have included trains of the mass rapid transit system (Figure 1) and possibly the largest Amsler chart in the world on a commercial building (Figure 2). There is