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Sir,
Virtual assessment and glaucoma shared care

We read with interest the report by Bourne *et al.*¹ Our attention was particularly drawn to the use of a virtual glaucoma assessment to support the community optometrists and provide quality assurance.

Many glaucoma management decisions are based on clinical findings, optic discs, visual fields, corneal thicknesses, and intraocular pressures (IOP) that are straightforward. Expert opinion is required however for a significant minority of cases. Unfortunately, deciding which patients require this additional input may be challenging. We also use a virtual clinic assessment to augment the triage of new patients who have been seen by 'in-house' ophthalmic nurse practitioners.² The decision-making remains the responsibility of the consultant, who reviews the clinical data, in the absence of the patient and oversees initial management. Our feasibility study has confirmed virtual assessment to be a reliable method of obtaining an accurate working diagnosis showing good agreement with experienced ophthalmologists.

In common with Bourne *et al.*¹ we found issues with disc image interpretation in some patients. For us this was largely due to disc size (for both small and large discs), extensive peripapillary atrophy, and abnormalities of shape (tilting). Such disc images may be difficult to interpret in isolation, but this need not mean they cannot be reviewed on a virtual basis through serial images over time. We too found subtle variations in IOP around 21 mm Hg between practitioners that would tend to suggest the allocation of patients to different parts of the glaucoma care pathway. However, we would argue that this variation reflects not the accuracy of the optometrists, but rather the need to base IOP-governed decisions on a series of values. Given the demands of the recent NICE guidelines for glaucoma and ocular hypertension,³ schemes for referral refinement and

review of patients deemed stable, which utilise resources in the professions allied to medicine, are timely and appropriate. The use of a virtual clinic environment to allow expert advice and quality assurance also has much to recommend it.

Conflict of interest

The authors declare no conflict of interest.

References

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Sir,
Immunohistochemical analysis of internal limiting membrane by confocal microscopy in a case of stage 4 idiopathic macular hole

There are only rare reports showing the presence of α -smooth muscle actin (α -SMA) staining-positive cells in internal limiting membrane (ILM) specimens removed during idiopathic macular hole surgery, and in these studies, specimens have been evaluated by means of light or scanning electron microscopy.^{1–3} To the best of the authors' knowledge, identification and localisation of α -SMA microfilaments by confocal microscopy in the ILM surrounding the borders of a macular hole have not been previously described.

Case report

A 68-year-old woman underwent vitrectomy for stage 4 idiopathic macular hole. Preoperative evaluation of the macular hole biomicroscopically and imaging with optical coherence tomography showed the absence of an epiretinal membrane (Figure 1b). Triamcinolone–acetone was used for visualising the posterior cortical