Sir,

Representative data remains the key for national benchmarks

We congratulate the authors Johnston *et al* for their very informative paper on the risk of posterior capsular rupture among grades of surgeons with varying levels of experience.[1] We are in full agreement about the benefits of electronic medical record (EMR) in a cataract service and we routinely use the software application used in the study, in our own practice. However, EMR is yet to be widely taken up across the country and we do observe differences in their uptake even within the same region as ours.

We are concerned about the selection bias in these studies as adoption of EMR and regular data input in the UK tends to currently favour highly geared and well-resourced departments alone. Many units where high-volume surgery happens, demographically higher risk (eg, ethnicity,[2] increased age[3]) patient groups and late presentation exist, have not contributed to the dataset owing to the non-availability of EMR. The headline figure of posterior capsular rupture rate of less than 2%, therefore, might be less rosy in reality when compared with the data generated from the contributors to the dataset.

It, nevertheless, is a very good effort and largely in concordance with results available from centres with comparable populations,[4] and we would recommend more wider uptake of the EMR, preferably, in a standardised software platform which when linked to a national body as the Royal College of Ophthalmologists could then act as a data guardian and provide a more realistic and accurate benchmark for everyone to compare their standards against.

Conflict of interest

The authors declare no conflict of interest.

References

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PT Ashwin and SR Mohamed

Department of Ophthalmology, University Hospitals Birmingham, Birmingham, UK
E-mail: ashwin4you@hotmail.com

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Sir,

Responding letter

I would like to thank PT Ashwin and SR Mohamed for their interest in our article on variance in posterior capsular rupture rates between surgeons and grades of surgeons. As described in the first paper in this series[1]: 'The majority of the data (86%) from the 12 participating trusts were collected between January 2004 and July 2006, with no individual surgeon having performed more than 4.6% of the operations and no unit having contributed more than 20% of all operations'. The basic demographic details in this large sample of 55 567 operations and 406 surgeons were also nearly identical to the National Hospital Episode Statistics for this period. This reassures us that despite the contributing centres being at the forefront of the electronic medical record (EMR) use, their casemix is probably representative of the UK.

The same EMR system used in this study has now been adopted at more than 50 Trusts in the UK performing close to 100 000 cataract operations per annum. A National Ophthalmology Database capable of accepting pseudoanonymised data from all centres that use EMR systems is being built under the auspices of the Royal College of Ophthalmologists for the purposes of audit, revalidation and epidemiological research. If all centres agree to contribute data, we will soon be able to establish unequivocally accurate benchmark standards for the UK population.

Conflict of interest

The author declares no conflict of interest.

Reference

1 Jaycock P, Johnston RL, Taylor H, Adams M, Tole DM, Galloway P *et al*., UK EPR user group. The Cataract National Dataset electronic multicentre audit of 55 567 operations: updating benchmark standards of care in the United Kingdom and internationally. *Eye* 2007; **23**: 38–49.

RL Johnston

Cheltenham General Hospital, Cheltenham, UK
E-mail: rob.johnston@glos.nhs.uk

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Sir,

Re: The report 'irrigation of the capsular bag using a sealed-capsule irrigation device and 5-fluorouracil' by Milverton

Although posterior capsule opacification has been much reduced by changes in intraocular lens design, it still remains a problem and, therefore, the report 'Irrigation of

the capsular bag using a sealed-capsule irrigation device and 5-fluorouracil' by Milverton is of great interest, as irrigation of the capsular bag using the Milvella-sealed capsule irrigation device has the potential to destroy all lens epithelial cells without bystander damage in the rest of the eye. Previous attempts to hydrolyse lens epithelial cells in the bag using this device by irrigating with distilled water have failed, as residual cortical material appears to protect the equatorial cells. The author claims that irrigation with 5-fluorouracil prevented posterior capsule opacification in this case up to 1 year after surgery.

However, a careful perusal of the 12-month image shows that there is clearly fusion of the capsular bag around the intraocular lens haptics, which would suggest that viable lens epithelial cells are still present and that PCO may be delayed rather than prevented by irrigation with 5-fluorouracil.

Conflict of interest
The author declares no conflict of interest.

Reference
1 Milverton EJ. Irrigation of the capsular bag using a sealed-capsule irrigation device and 5-fluorouracil. *Eye* 2009; **23**: 1746–1747.

DJ Spalton

Department of Ophthalmology, St Thomas' Hospital, Ground Floor South Wing, London, UK
E-mail: spalton@eyepractice.fsnet.co.uk

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Sir,
Reply to Mr Spalton

The opinions expressed by Mr David Spalton[1] are absolutely correct.

There is apparent fusion of the anterior and posterior capsules, as stated. 5-Fluorouracil may well only delay the onset of PCO, however clinical trials need to be carried out to determine its long-term effectiveness in preventing PCO. Sealed irrigation of the capsular bag, under positive pressure to inflate the bag fully, using Perfect Capsule, should enable an irrigating solution to reach the equatorial cells, eliminating them and so hopefully ensuring a clear and supple capsule.

Conflict of interest
The author declares no conflict of interest.

Reference
1 Spalton DJ. Re: The report 'irrigation of the capsular bag using a sealed-capsule irrigation device and 5-fluorouracil' by Milverton. *Eye* 2010; **24**: 1298–1299 (this issue).

EJ Milverton

Intraocular Implant Unit, Sydney Eye Hospital, Sydney New South Wales, Australia.
E-mail: John.Milverton@SESIAHS.HEALTH.NSW.GOV.AU

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Sir,
Medial and lateral rectus recession: a novel and rapid stepped technique

The principle of muscle recession in squint surgery is to detach the muscle from the globe, then to reattach it at the pre-determined distance from the limbus with or without postoperative manipulation. In order to avoid excessive fibrosis and contracture of the muscle and adjacent tissues, this should be achieved with minimal trauma to the muscle and surrounding tissues. We describe a novel method of primary muscle recession that is used in our routine clinical practice.

Method
The conjunctiva and Tenon's capsule are raised as a flap and the muscle tendon is exposed at its insertion (Figure 1a). Light cautery is applied to the blood vessels at the insertion of the muscle tendon (Figure 1b). At 1 mm behind the insertion, one-third of the muscle tendon is secured (Vicryl 7-0, Ethicon, Spreintenbach, Switzerland) using a locking suture (clove hitch knot, which consists of two half hitches made in opposite directions) (Figures 1c and 2a). Two-thirds of the width of the tendon is then detached from the globe, while the other third remains untouched (Figure 1d). Calipers are using to mark the desired amount of recession and the cut part of the tendon is reattached to the sclera. A spatulated quarter circle 6.O needle is used to reattach the muscle by spreading the tendon through a 1.5–2-mm scleral passage (Figure 2b). The second part of the muscle is then recessed in a like manner (Figure 1e and f). The conjunctiva is then sutured with the 8-0 vicryl.

Discussion
Today, the most common technique of squint surgery is based on that of Helveston.[1] The squint hook is used to help recognise and stabilise the muscle, before it is detached from the globe. In our experience, during primary muscle surgery, fine-toothed forceps are all that is necessary to identify and secure the muscle tendon, without the need for a squint hook.

Our method has been used successfully for over 10 years. The maximum recession from this method is 6 mm. The main advantage is it minimises manipulation of the tissues and thus minimises fibrosis and scarring. In addition, it has fewer steps, is rapid to perform, and is easy to learn. The use of cautery, prior to any manipulation of the muscle, prevents bleeding and ensures good visibility throughout the procedure. The