received responses from Stanga and Muqit,¹ and YiJun Hu.² It became apparent during our 2006 survey of ophthalmic units across the United Kingdom that a small number of units had started using Pascal laser photocoagulation, and we reported that the respondents considered that this was improving the situation with regard to pain and compliance during the procedure. These comments were anecdotal and were reported in the paper. We noted in the conclusion that the results should be viewed with caution because of the nature of the surveys and that newer lasers were being introduced at the time of the survey.

In terms of analgesia, we reported that 9% of units routinely use sub-tenons anaesthesia. We stated that there may be a case to support the use of sub-tenons based on the laser being used at the time, but suggested caution because of the potential side effects that Stanga *et al* allude to in their letter and also that new lasers that may cause less pain were emerging.

YiJun Hu makes an excellent point about pain assessment. As this was a survey of practitioners, we only have their viewpoint and we did not therefore attempt to offer any results from the patient's perspective. What was clear from many responses was that the responders often considered that their own patients were not in pain but that they knew colleagues for whom pain was an issue when they performed this therapy, which seems to suggest that different practitioners do identify pain differently.

Regarding the 'strength of burns per session' identified by Stanga and Muqit as requiring clarification, this was a term proposed during our questionnaire pilot. It was apparent that laser 'settings' were variable and that therapists identified different aspects of 'strength', such as 'intensity' and 'fluence', mentioned by Stanga and Muqit. The decision to go with 'strength' was taken to try to cover all of these aspects and also to assist with questionnaire brevity, that is, to have one question to cover them all. Few respondents had difficulty with this term, but a small number of them clarified their understanding of the term in their response.

Conflict of interest

The authors declare no conflict of interest.

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Sir, Subjective visual perceptions during vitreoretinal surgery under local anaesthesia

I read with interest the article by Vohra *et al*¹ describing subjective visual perceptions during vitreoretinal surgery under local anaesthesia, and would like to comment on a point raised by the authors—that patients 'can be reassured that they [visual perceptions] are not normally frightening'. Although in this cohort only 2 (2.7%) patients were frightened by their visual perceptions, it is important to note that there is considerable variation in the proportion of patients who are frightened by their intraoperative visual sensations, ranging from 5.9 to 13.8%.^{2,3} The variation in the proportion of patients frightened is similar to that described during cataract surgery, which ranges from 3 to 19.4%.⁴

There are many possible reasons for this variation between studies, including cultural differences, as well as the previous operative experience of the patients. In the cohort of 65 patients described by Tan *et al*,² 61 (93.8%) were undergoing vitreoretinal surgery for the first time. It would be interesting to know what proportion of patients in this series had undergone previous vitreoretinal surgery. It has been suggested that previous ocular surgery may serve as a 'practical' form of counselling on the range of possible intraoperative visual experiences.⁴ A study on patients undergoing cataract surgery⁵ reported that 15.8% of patients undergoing surgery for the first time were frightened by their intraoperative visual sensations, compared with only 6% for those having surgery to the second eye.

Besides the proportion of patients who experience fear, it is also important to consider the severity of fear experienced by the individual. In an earlier multicentre study,² 12.8% of patients indicated that they would have preferred general anaesthesia in order to avoid experiencing these sensations, and 7.7% would still have wanted this even after being counselled on the higher risks associated with this form of anaesthesia. Of those who were frightened, 33.3% indicated that they would have wanted GA, compared with 8.9% of those who were not frightened.

In summary, I agree with Vohra *et al* that healthcare providers should explain to patients what they may encounter during vitreoretinal surgery, but urge caution about stating that they are not normally frightening.

Conflict of interest

The author declares no conflict of interest.

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Sir, Reply to Dr Tan

We thank Dr Tan¹ for taking interest in our paper and note his comments on the issue of fright resulting from subjective visual perceptions (VPs). We agree that there is a variation in the number of patients who are frightened by intra-operative VPs, but overall the percentage of such patients is small. It is appropriate to state that the majority of patients find VPs during intra-ocular surgery bearable; some find them even pleasant^{2–4} and one has found them good enough to write a poem about them.⁵

In our study, 52/72 (72.22%) of patients described their VPs as 'bearable', and only two patients (2.7%) thought that they were 'frightening'. Interestingly, one of the patients who was initially frightened found the experience to be pleasant as the surgery progressed. Dr Tan has suggested that previous surgery may be a contributory factor in reducing the fright associated with the VPs. In our study, 38 patients had previous intra-ocular surgery, 39 had none, and in 3 this was not recorded. Although neither of the patients who were initially frightened had undergone previous surgery, there were 16 patients in our study who thought the VPs were 'pleasant', of whom 9 had undergone previous surgery but for 7 it was their first experience.

Contrary to the view expressed in the letter, previous surgery does not always work as a 'practical' form of counselling. Some patients find the second surgery to be more frightening. In a study by Ang *et al*,⁶ patients who had had previous cataract surgery were more likely to be frightened compared with those undergoing surgery for the first time ($P = 0.018$).

Tranos *et al*⁷ examined if fright was related to whether it was the first eye surgery or the second one. The second eye surgery was less frightening, although this was not statistically significant ($P = 0.06$). Similar observations have been published by other authors.^{8,9} Although fear did appear to be associated with the first eye surgery in these studies, once again it failed to reach statistical significance.

As far as the issue of forewarning is concerned, it is noteworthy that in our study only 4 patients wished to be forewarned about the VPs. More interestingly, of

the two patients who were frightened, only one would have liked to be pre-warned. One patient who found the VPs to be pleasant thought that warning patients about them would result in unnecessary worry.

Based on the literature and our experience, it would appear that it might be beneficial to inform people should they wish to know. As far as the issue of fright is concerned, we are still of the opinion that VPs are not normally frightening.

Conflict of interest

The authors declare no conflict of interest.

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