

Table 1 Pressure levels from untreated 24-h curve studies and various time intervals

Time interval (hours)	Reference number					
	4	5	6	7	8	9
1730–1800	26.3	26.7	28.1	21.4	20.5	20.2
2130–2200	24.8	24.9	26.4	20.7	18.0	19.5
0130–0200	24.8	24.3	25.3	21.2	24.2	21.0
0530–0600	27.1	27.7	28.8	25.1	25.0	22.5
0930–1000	27.7	28.9	29.5	26.4	19.8	20.5
1330–1400	27.2	26.9	28.3	22.3	20.0	20.5

pressure, it is obviously not perfect, and new and better tonometers, which provide more accurate and consistent readings, are needed for routine clinical practice. Further, what method should be used to most accurately measure nighttime pressures in a time period when the patient is asleep and recumbent?

2. *Are nighttime pressures important in evaluating glaucoma?* The literature differs with regard to the importance of pressures measured outside normal office hours, both with regard to peak pressure and long-term progression associated with pressure fluctuations.
3. *How could nighttime pressures be assessed in routine clinical practice?* It is difficult for clinicians to measure nighttime pressures to assess a patient's glaucoma. A recent study by Konstas *et al*¹ showed that if 2 mmHg was added to the peak daytime pressure (measured at 1000, 1400, or 1800 hours), the value captured 98% of the 24-h peak pressures (Internal data, PRN). Consequently, it may be possible in routine practice in the future that most nighttime pressures could be assessed by assessing an appropriate series of daytime pressure points.

Again, we thank Drs Weinreb, Luis, and Medeiros for their comments about our paper. Their letter nicely highlights the need for further research regarding the best way to measure nighttime pressures, its influence on primary open-angle glaucoma, and the best way to assess these pressures in routine clinical practice.

Conflict of interest

The authors declare no conflict of interest.

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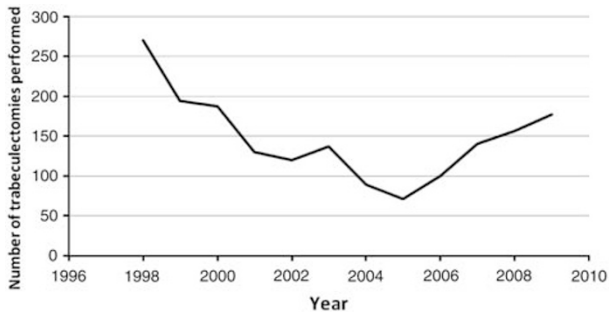
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Sir,
Trends in the rate of trabeculectomy

In the late 1990s and early 2000s a dramatic decline in the rate of trabeculectomy was observed; for example, a UK study reported a reduction in admissions for trabeculectomy from a peak of 38.7 per 100 000 population in 1995 to 10.6 per 100 000 in 2004.^{1–3} The decrease in surgery was attributed primarily to the introduction of new ocular hypotensive medications.

Table 1 Number of trabeculectomies and trabeculectomy rate for Leicester, Leicestershire and Rutland from 1998–2009

Year	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Number of trabeculectomies	270	194	187	130	120	137	89	71	100	140	156	177
Trabeculectomy Rate (per 100 000 population)	28.78	20.68	19.94	13.86	12.79	14.61	9.49	7.57	10.66	14.93	16.63	18.87

**Figure 1** Trends in trabeculectomies from 1998 to 2009.

We recently examined the trabeculectomy rates in our area. Patients who had undergone trabeculectomy at Leicester Royal Infirmary between 1 January 1998 and 31 December 2009 were identified from two sources; clinical coding records (searching for OPCS code C60.1) and the surgical logbook.

In common with the experience elsewhere the number of trabeculectomies performed in our unit declined by 73.7% between 1998 and 2005; however, from 2005 to 2009 there was a 149.3% increase in trabeculectomies (Figure 1). We calculated the trabeculectomy rate based on the Office of National Statistics 2003 mid-year population estimate for Leicestershire and Rutland of 938 013 (Table 1). The trabeculectomy rate declined from 28.78 per 100 000 in 1998 to 7.57 in 2005 but increased to 18.87 per 100 000 in 2009.

Our observations are the first to suggest that the decline in trabeculectomy has now stopped and may have begun to reverse. Reasons for an increase in trabeculectomy are likely to include recent improvements in surgical techniques, which have led to a reduction in perioperative complications and better outcome.⁴ Some patients may have avoided surgery a few years ago, as new medications were tried, only to later develop disease progression or medication intolerance. New medications may have delayed the

patient's journey to surgery but not prevented it. There may now also be increased recognition of the need for low target intraocular pressures not always achievable with medication.

We acknowledge that this study is limited to one unit and so may not reflect national or international trends; however, the trabeculectomy rates calculated for Leicestershire and Rutland between 1998 and 2004 closely mirror previously reported national figures.¹ An increase in trabeculectomy rate would have important implications for future health-care planning and resource allocation.

Conflict of interest

The authors declare no conflict of interest.

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