Sir,

To assess the results of the clinical outcome of high volume cataract operations performed by a fellow and a consultant in Moorfields Eye Hospital

High volume cataract surgery is being performed by an increasing number of post-CCST (certificate of completion of specialist training) surgeons. Our study demonstrates that national complication rates may be more suited to trainee surgeons than to consultant surgeons.

Case report

Cataract surgery is the most common elective surgical procedure performed in the United Kingdom.[1] Guidelines have been created to safeguard practice by allowing surgeons to audit their surgical performance against national and international standards. Studies have shown that the more experienced surgeon has a lower complication rate.[2] Current national standards do not take into account the different rates of complications for trainees at different stages in their training, and all complication rates are grouped together as a single figure.

We look at the outcomes of cataract surgery performed by post-CCST ophthalmologists. Using quantitative analysis of data, we compare their outcomes and complication rates against the national and international standards.

A retrospective review of case notes was performed for all patients who underwent phacoemulsification surgery between 1 November 2007 and 31 October 2008 at Moorfields Eye Hospital. Surgery was performed by either a consultant ophthalmic surgeon or an experienced cataract fellow about to gain his CCST.

With the exception of two cases, the visual acuity improved or stayed the same postoperatively compared with preoperative readings (Figure 1).

A total of 119 (25.7%) difficult cases were identified from the 462 cases (difficult cases included myopia >5 D, hypermetropia >4 D, vitrectomised eyes, dense white/brunescent cataracts, pseudoexfoliation, small pupils, gross head movements intraoperatively, and patients on Tamsulosin (Table 1)). The complication rate was calculated as 2.60% based on 462 cases. These included zonular dehiscence, anterior vitrectomy, posterior capsular tear, and vitreous prolapse.

Surgical complications can be minimised by careful planning and identification of risk factors.[3] For post-CCST surgeons, we should expect a lower rate of posterior capsular tears and zonular dehiscence than

Table 1 Number of patients with high-risk ocular comorbidities

High-risk factors	*Number of patients*	*Percentage of patients*
White cataract	33	7.14
Brown cataract	17	3.67
Myopia >-5 D	68	14.7
Hypermetropia $>+4$ D	20	4.33
Pseudoexfoliation	7	1.52
Small pupil	16	3.46
On Tamsulosin	2	0.43
Head movement	2	0.43
Vitrectomised eye	80	17.31

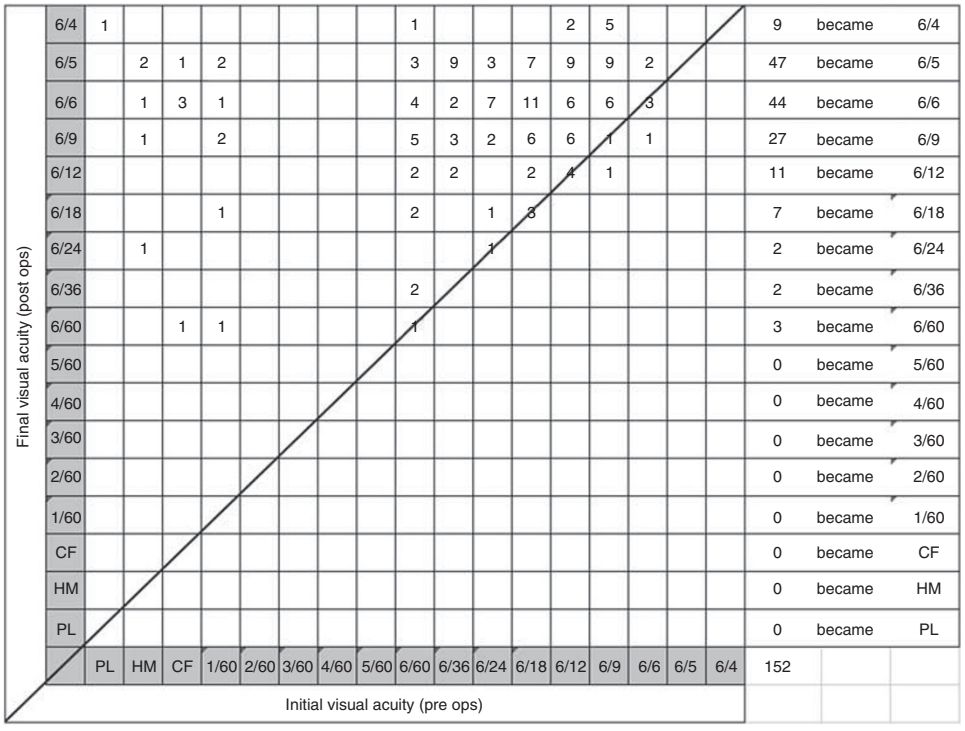

Figure 1 Comparison of the preoperative and postoperative visual acuities of 152 patients.

the current rate given by the Royal College of Ophthalmologists (RCO).[4] The American Academy of Ophthalmology (AAO) rate of zonular dehiscence and/or posterior capsular rupture is 2.6%:[5] exactly the same as our results. We feel that the lower AAO (2.6%) complication rate is a better target for post-CCST surgeons, and the higher RCO rate (4.4%) is more suitable for a trainee ophthalmologist.

Conflict of interest
The authors declare no conflict of interest.

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This data was presented as a poster at the Royal College of Ophthalmologists Annual Congress 2009.

Eye (2012) **26,** 756–757; doi:10.1038/eye.2011.357; published online 3 February 2012

Sir,

Acquired Brown's syndrome following cosmetic blepharoplasty

Brown's syndrome is a rare but serious complication of cosmetic blepharoplasty.

Case report

A 56-year-old male presented in 2006 with vertical diplopia, which had developed immediately after routine bilateral, upper-lid blepharoplasties performed as part of a 'medical tourism' package. The patient had a best-corrected visual acuity of 6/5 OD and 6/6 OS, with no previous ophthalmic history. Clinically, there was marked limitation of both dextroelevation and elevation of the left eye. Orthoptic measurements showed orthophoria in the primary position, but a manifest left hypotropia measuring 10 Prism Diopters in dextroelevation. Orbital palpation revealed no tenderness in the trochlea region. The patient had symptomatic diplopia in right gaze, which extended close to the primary position. Lees screen testing showed a mechanical limitation of ocular motility typical of an acquired Brown's syndrome (Figure 1). MRI imaging indicated normal and symmetrical extraocular muscles.

The clinical situation remained unchanged over a 4-year follow-up period. Peri-trochlear steroid injection was performed, to no effect. The patient was unwilling to have surgery on the contralateral eye to match the motility defect. The patient copes with the diplopia by using occlusion and has been discharged from clinical care.

Comment

Complications of blepharoplasty are generally mild, but acquired strabismus is a rare, serious complication. Both horizontal[1] and vertical strabismus[2–4] have been described. Previous case reports of acquired Brown's syndrome following blepharoplasty are scarce. Bhola *et al*[2] reported on one case where MRI revealed scarring of the reflected superior oblique tendon. Kushner and Jethani[3] reported one case where the superior oblique tendon could not be identified as a distinct structure following blepharoplasty. Syniuta *et al*[4] reported on one case with concurrent superior oblique weakness and Brown's syndrome.

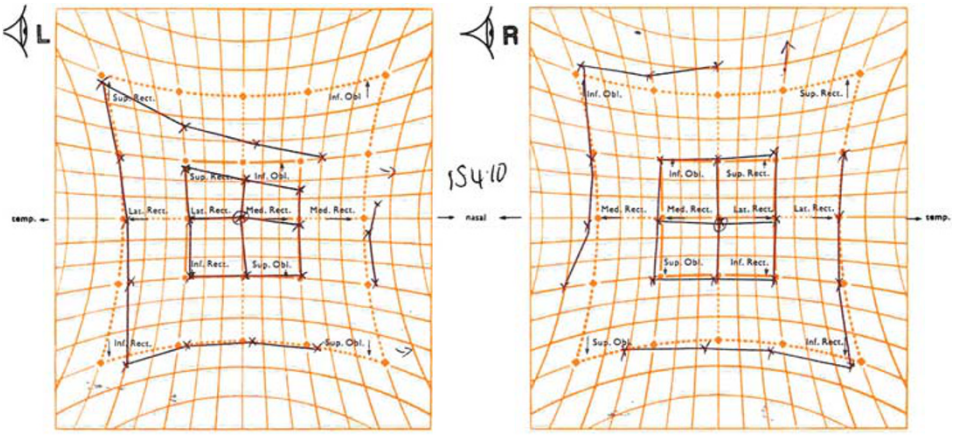

Figure 1 Hess chart showing left Brown's syndrome.