The incidence of postoperative day 1 IOP >23 mm Hg was 22.0% (244/1111) in our study.[2] As we described in the discussion, comparison among studies was limited because the definitions of 'IOP increase' and surgeon's experience such as resident *vs* non-resident were different.[2] Jaycock *et al*[3] reported that the incidence of raised postoperative IOP >21 mm Hg was 2.57% (430/16731) with a median time to postoperative review of 31 days. However, the exact time when they measured postoperative IOP was not described and trainees performed only 33.9% of operations. Browning *et al*[4] showed that the incidence of IOP >26 mm Hg at 24 h after surgery was estimated to be 11.8% by three training surgeons. We similarly found our incidence to be 14.9% (165/1111; $P = 0.56$, Fisher's exact test).

We agree that the aetiology of postoperative day 1 IOP rise after cataract surgery can result from relatively more manipulations, residual OVD, and subsequent increased inflammation. A prospective study to evaluate the factors would be useful.

Conflict of interest

The authors declare no conflict of interest.

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Sir,

Workload, referral characteristics and consultation outcomes of out-of-hours ophthalmology services

Ophthalmology is mostly an outpatient, office hours specialty, and no studies have yet examined the necessity, cost, workload, or outcomes of out-of-hours ophthalmic (OOHO) services in the UK. Knowledge of these parameters could allow more efficient service planning, especially in a possible climate of increasing UK healthcare privatisation.[1]

Consequently, we prospectively examined all out-of-hours (OOH; outside Monday–Friday 9 am–5 pm) consultations by two ophthalmologists working on-call shifts at two different hospitals in south-east England (one urban teaching hospital, and one provincial district general hospital) over three months. Each doctor performed an average of 58 OOH consultations over 18 on-call shifts in the three-month study period (average 2.6 patients per weeknight, and 8.6 patients per weekend). The main sources of referral were emergency department (ED) doctors (33%) or nurse practitioners (26%), and general practitioners (17%). Fewer OOH referrals were received from hospital wards (6%), other ophthalmologists (4%) and optometrists (6%), the latter presumably reflecting their daytime office hours. Some 50% of patients referred had not had their visual acuity (VA) checked, corroborating earlier studies in which ED staff did not correctly record VA in 33%[2] and 44%[3] of cases. Only 29% of patients were referred with a correct working diagnosis. This suggests that OOH ophthalmologists are a valuable adjunct to the hospital's ED service after hours, and it may also reflect the inconsistent training and low confidence of junior ED doctors when faced with eye emergencies.[4,5] Following OOHO consultation, 36% of patients were discharged, 6% were referred to another medical team or hospital, and 57% were booked a follow-up appointment in the same eye department. Extrapolating our data, each hospital's OOHO service would see approximately 1200 patients per year, necessitating 600–700 eye clinic review slots for patients seen OOH.

We have generated a small dataset on OOHO consultations across two hospitals. However, as the only such published data, it may provide initial guidance in planning, commissioning or pricing future OOHO services in the UK. It also underlines the need for future commissioners of OOH services to organise enough clinic capacity for follow-up arising from OOHO consultations. Larger, multi-centre studies will provide more accurate and region-specific datasets, but will only be practical to conduct after the more widespread

provision of electronic medical record systems to ophthalmologists working outside office hours.

Conflict of interest

The authors declare no conflict of interest.

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