Comment

Ozurdex release sustained levels of dexamethasone and biological activity for 6 months and very few implants are seen after 270 days.[1] Case reports of migration of the Ozurdex implant into the anterior chamber of pseudophakic patients exist.[2,3] Patients in whom the posterior capsule of the lens is absent or has a tear are at risk of implant migration into the anterior chamber. The muzzle velocity of the Ozurdex implant is known to have a high initial velocity at 0.8 m/s that decreases exponentially over distance especially in vitreous.[4,5] In our case, the implant was not immediately seen on the slit lamp examination after injection because the high velocity of the implant caused the implant to be lodged superiorly. However, as the patient did not have a posterior vitreous detachment, the implant gradually migrated into the hyaloid fossa (saucer-shaped depression between the lens and the anterior vitreous) and the implant came into view (Figure 1d). As it had not migrated into the anterior chamber, there was no risk of ocular complications such as corneal oedema. Therefore, the implant was not removed and it eventually dispersed away without causing any complications.

Conflict of interest

The authors declare no conflict of interest.

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Sir,

Re: Adherence to NICE guidelines for new glaucoma referrals

We read with interest the correspondence by Chaudhary *et al*.[1]

The letter reviews the assessment of new glaucoma referrals and then compares this with NICE guidelines. It was noted that adherence to guidelines is varied and standards identified as requiring improvement included disc assessment with pupillary dilatation, central corneal thickness measurement (CCT), and gonioscopy among others. It was felt that the data may reflect areas of weakness in other centres and highlights areas for future training.

We have collected data over 4 years through audit of our practice compared with NICE guidelines and noted similar weakness to adherence in areas identified by Chaudhary *et al*.[1] To improve practice, we implemented written guidance to junior ophthalmologists before the commencement of their placement and ensured all necessary equipments were made available in the clinics by directives to the nursing staff.

This had a strong impact when we re-audited practice, with the following overall improvements noted: we found documentation of CCT at 27% (2009) *vs* 100% (2013), gonioscopy 39.4% (2010) *vs* 100% (2013), and optic disc assessment with dilatation 15.2% (2009) *vs* 97.2% (2013). Goldmann applanation tonometry was recorded 100% of the time in all audits and visual fields were performed 100% of the time conducted between 2010 and 2013 *vs* 75.8% in 2009.

Moreover, we identified poor practice in provision of information to patients and/or caregivers. An improvement from 5% (2011) *vs* 97% in 2013 was noted by initiating regular reordering of patient information leaflets.

In conclusion, our experience showed that regular written guidance to new junior ophthalmologists and better availability of equipments in clinics greatly improved the standard of glaucoma assessment. These measures may address poor adherence to NICE guidelines in other centres.

Conflict of interest

The authors declare no conflict of interest.

Reference

1 Chaudhary R, Dhillon N, Jones L. Adherence to NICE guidelines for new glaucoma referrals. *Eye* 2013; **27**: 571–572.

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