Sir,
Inaccuracy of ROP screening data in National Neonatal Audit Programme report

National audit programmes inform the commissioning of services and the development of guidelines by the National Institute of Clinical Excellence. Accurate data and reports are important to set local targets and evaluate service quality. The National Neonatal Audit Programme (NNAP), established in January 2006 and funded by the Healthcare Quality Improvement Partnership (HQIP), contains a data set evaluating the occurrence and timeliness of screening for retinopathy of prematurity (ROP).

Paediatric ophthalmologists have expressed concern about inaccurate NNAP reports, but to our knowledge these concerns have not been published. The NNAP 5-year trends of the proportion of eligible babies receiving ROP screening (2007: 38%, 2011: 82%) and first screening occurring on time (2009: 27%, 2011: 87%)[1] indicate that NNAP reports are likely to be inaccurate and may have a high proportion of missing data, although trends may be improving. There has been frustration about eye teams not being allowed to contribute to data upload, and about the impossibility of correcting uploaded data before the publication of the annual report. Neonatal unit (NNU) staff upload data via the UK National Neonatal System (UKNNS, previously Standardised Electronic Neonatal Data System, SEND). A 'dashboard' summarises data for each month of the calendar year (Figure 1). The Neonatal Data Analysis Unit (NDAU) at Imperial College London analyses the data and collates the NNAP report.

We recently carried out our annual ROP screening audit.[2] All babies whose first screening was due in our unit were assessed within the NNAP time window. However, the 'dashboard' showed one baby as not having been screened. We verified the screening status and updated the data on UKSNN, resulting in 100% compliance (Figure 1). However, the 2013 NNAP report shows two discrepancies with the dashboard: a greater number of babies eligible for ROP screening, and missing data for four infants. Our data update in August 2013 had occurred after NDAU had analysed the data for the annual report in February 2013.

In 2014, NDAU will feed data back to NNUs before analysis to allow an update before publication. Ophthalmologists involved in ROP screening may wish to carry out their local audit in January of each calendar year, so that NNU staff can upload correct data before the NDAU analysis in February.

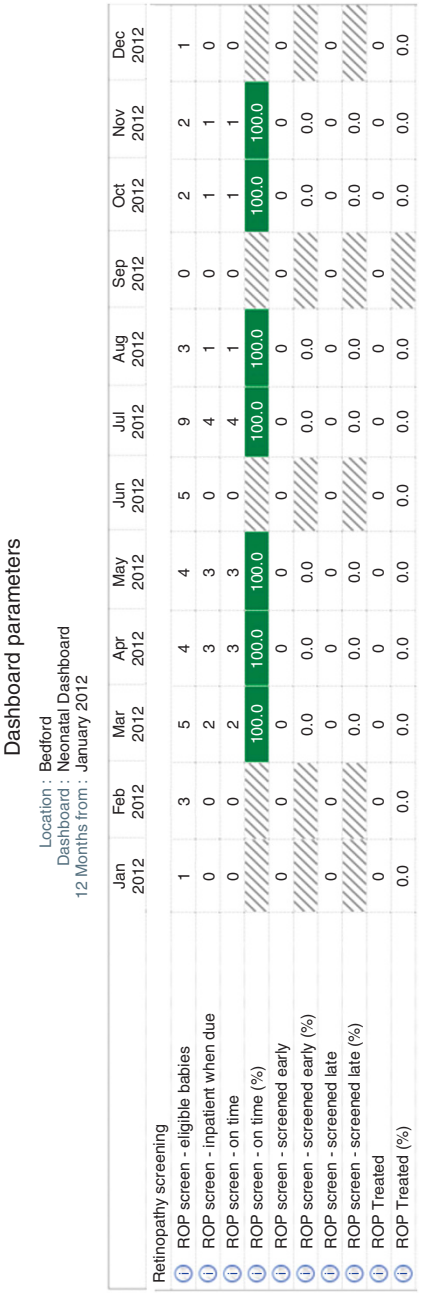

Figure 1 'Dashboard' summarising ROP screening data on a monthly basis.

Conflict of interest

The authors declare no conflict of interest.

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Sir,

Anterior vitreous displacement of the intravitreal dexamethasone implant (Ozurdex)

Ozurdex is a biocompatible implant licensed for the treatment of cystoid macular oedema (CMO) after retinal vein occlusions. We report a case of anterior vitreous displacement of Ozurdex, discussing the possible mechanism and outcomes of it.

Case report

A 76-year-old female patient with a right branch retinal vein occlusion (BRVO) and CMO underwent a routine intravitreal 0.7 mg dexamethasone implant injection (Ozurdex; Allergan Inc., Irvine, CA, USA). Approximately one hour after the procedure, slit lamp examination and intraocular pressure (IOP) were measured. The implant was seen floating in the vitreous with normal perfusion of the central retinal artery and an IOP of 16 mm Hg. After two weeks, slit lamp examination revealed the implant sitting in the anterior vitreous, just behind the natural lens (Figure 1a). Visual acuity (VA) was 6/12. There was no lens touch. Over the next 6 weeks, the implant dispersed and floated away from the central visual axis without any ocular complications. Final VA was 6/9 and optical coherence tomography confirmed the reduction of macular oedema (Figures 1b and c).

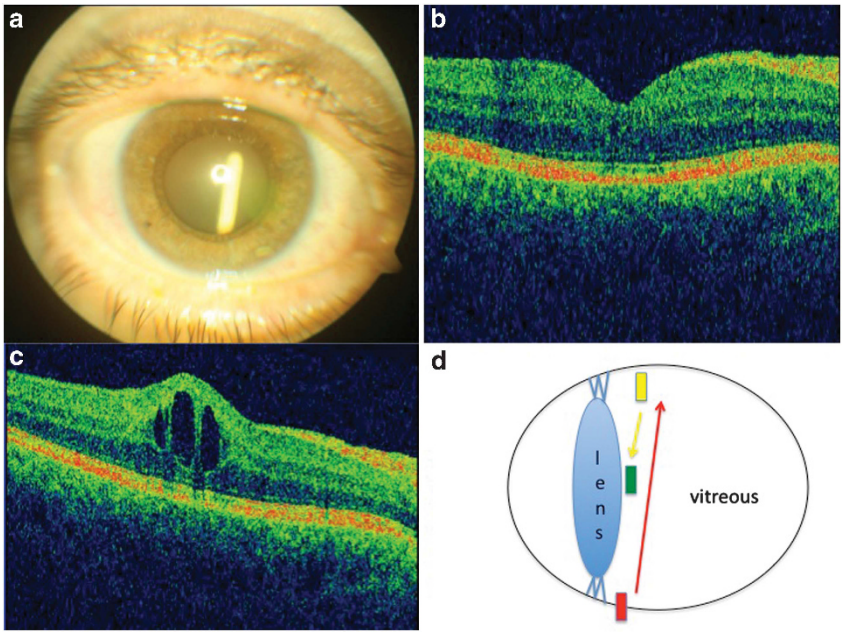

Figure 1 (a) Ozurdex implant in the anterior vitreous. (b) OCT after Ozurdex implant. (c) OCT before Ozurdex implant. (d) Schematic view of the eye explaining the final position of the Ozurdex implant. Implant was injected inferotemporal at the pars plana (red) and travelled superiorly to the vitreous (yellow) due to the high initial velocity. It then gradually migrated to the hyaloid fossa space (saucer-shaped depression between the lens and the anterior vitreous) due to drag force and gravity (green). OCT, optical coherence tomography.