Sir,

Caution needed when examining certificate of vision impairment rates: the new public health indicator

We read with interest the paper by Rostron and McKibbin[1] suggesting a possible fall in certificate of vision impairment (CVI) due to age-related macular degeneration (ARMD) in Leeds. It demonstrates the potential value in exploring variation in CVI rates across the country. As readers are aware the CVI is a public health indicator for vision in the newly launched Public Health Outcomes Framework,[2] so there is added interest in these figures. We feel that it is important to highlight that while CVI figures accurately describe new registrations in social service departments, it is currently unclear how this relates to disease burden as not everyone eligible for certification is certified.[3] Bunce *et al*[4] found that patients who require treatment for their sight impairment are almost three times less likely to be certified than those in whom treatment is not indicated. The fact that there are now new treatments for wet ARMD may mean less certifications not because of less need for social care support, but because certification can be seen to be done when no further treatment is available. Caution is needed if comparing BD8 certifications with CVI certifications, which are why the recent report by the Chief Medical Officer included CVI figures for 2007/8 as baseline.[5] When the BD8 was replaced by the CVI between 2003 and 2006, new registrations for sight impairment fell by 4000 for reasons which remain unclear, but which pre-dated widespread use of anti-VEGF drugs. This makes temporal comparisons difficult, which is why we believe focus should be on data collected from 2007 and beyond. The data reported for the period 2008 and 2010 in the paper suggests a relatively stable number of CVI registrations due to ARMD with a rise in the numbers in 2010 at a time of widespread adoption of ranibizumab therapy in the NHS. Though the incidence is reported per million population per year in the paper, it may be better to report this as a rate per million population older than 65 years of age (i.e., the at-risk population rather than total population) as in the Public Health Outcome Framework.

Conflict of interest

The authors declare no conflict of interest.

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Sir,

Re: The portsmouth-based refinement scheme: a role for virtual clinics in the future?

We read with interest the Portsmouth Glaucoma Referral Refinement Scheme findings.[1] The scheme does highlight the potential benefits in the current burden of waiting times and costs on the NHS since the introduction of the NICE guidelines. Interestingly, there was no mention of angle closure suspects in this report.

A similar glaucoma referral refinement scheme in our hospital is run by a glaucoma-trained optometrist and has been in place for the last 14 months.

In this clinic, patients have a series of tests similar to the ones described by the authors, but we also document Van Herick test in all patients and the patients with peripheral limbal anterior chamber depth less than 25% corneal thickness are referred to consultant-led clinics for gonioscopy and further evaluation.

A recent audit of our referral refinement clinic over 3 months showed that out of 35 patients seen, 22 were referred to the consultant clinic. This included three cases (13.6%) with narrow angles with Van Herick less than 25% of corneal thickness. Primary angle closure was confirmed in all three of these cases, and they went on to have laser iridotomy.

We would be keen to know if the authors can share their data on angle closure suspects detected in their scheme.

Conflict of interest

The authors declare no conflict of interest.

Reference

1 Trikha S, Macgregor C, Jeffery M, Kirwan J. The Portsmouth-based refinement scheme: a role for virtual clinics in the future? *Eye* 2012; **26**: 1288–1294.

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Sir,

Response to Shah *et al*

We thank Shah *et al*[1] for their interest in the Portsmouth Glaucoma Refinement Scheme.[2] The scheme also uses Van Herick grading for anterior chamber depth—all patients with a Van Herick peripheral limbal anterior chamber depth of less than 25% of corneal thickness were referred to the virtual clinic for assessment by an ophthalmologist. Approximately 10% of all of those accepted from the Refinement Scheme virtual clinic to HES (from a total of 11 out of 100 referred to the virtual clinic, from our audit) were due to narrow angles suspected through Van Herick grading. Of these, 25% subsequently required laser peripheral iridotomy, slightly higher than the 17% positive predictive value, for the suggestion of occludable angles by an initial Van Herick test, outlined by Foster.[3]

Conflict of interest

The authors declare no conflict of interest.

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Sir,

Identification of Epstein–Barr virus in a case of aggressive retinochoroiditis

We describe isolation of Epstein-Barr virus by aqueous PCR in a case of fulminant retinochoroiditis with prominent choroidal effusions as an atypical feature.

Case report

A sixty-five-year-old woman with primary open-angle glaucoma and previous bilateral augmented trabeculectomies presented with a painful, red left eye with decreased vision. She had been diagnosed with aplastic anaemia 1 year previously and was undergoing systemic immunosuppression (mycophenolate mofetil) in preparation for an anti-thymocyte globulin transfusion, receiving long-term prophylactic ciprofloxacin, acyclovir, and itraconazole. At presentation she had neutropaenia (0.07×10^9/l), thrombocytopaenia (13×10^9/l), and low reticulocytes (3×10^9/l).

Visual acuity in the right eye was 6/6, while the left was light perception. A left afferent pupillary defect was present with anterior uveitis and hypotony (intraocular pressure right eye 11 mm Hg, left 7 mm Hg). There was no associated blebitis. Fundal examination revealed vitritis, focal retinitis (Figure 1) and localised choroidal effusions (Figure 2). A diagnosis of retinochoroiditis was made.

Empirical intravenous acyclovir 10 mg/kg tds was commenced along with topical dexamethazone 0.1% and

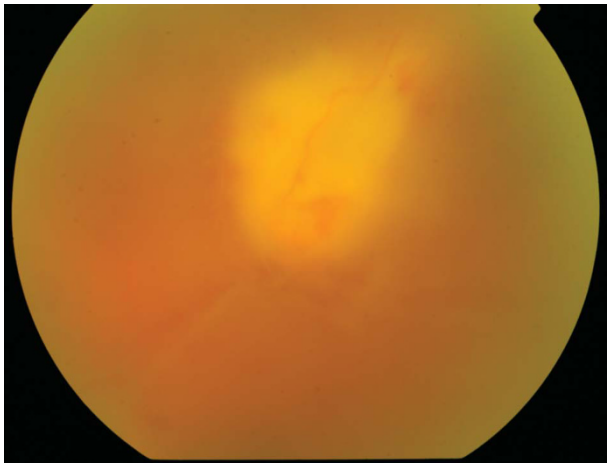

Figure 1 Focal retinitis with haemorrhagic arteriolitis in the region of the superotemporal vascular arcade. The view is partially obscured by marked vitiritis.

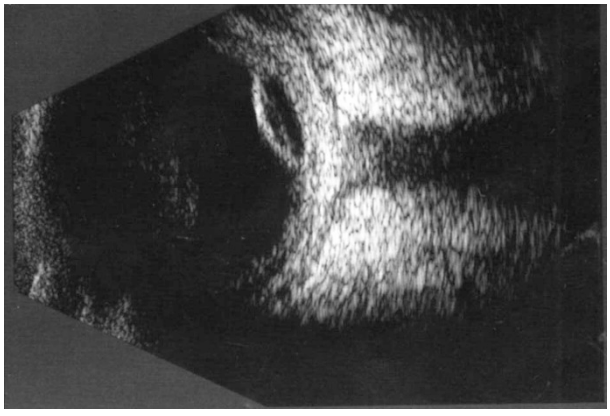

Figure 2 Localised choroidal effusion at presentation.