

Conflict of interest

The author declares no conflict of interest.

References

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Eye (2016) **30**, 326–327; doi:10.1038/eye.2015.225;
published online 27 November 2015

Sir,
Comment on: 'Direct ophthalmoscopy should be taught to undergraduate medical students'

We read with interest the controversy surrounding direct ophthalmoscopy.^{1,2} Purbrick and Chong suggests substituting direct ophthalmoscopy with fundus photography.¹ Non-mydriatic fundus photography remains expensive and therefore difficult to disseminate internationally and smartphone applications such as PEEK require more detailed assessment. Although these technologies may hold promise for the future, they do not replace the need for clinical ophthalmic assessment. Perhaps rather than replacing direct ophthalmoscopy, fundal photographs could be used to supplement and aid the teaching of this important clinical skill.

We have shown by using a simple patient assessment tool that in-patients referred to neurology were not appropriately examined—in particular, omission of ophthalmoscopy—before referral.³ We feel this data should not be used as an excuse to stop examining patients. Instead we agree with Yusuf *et al*² that despite advances in non-mydriatic fundus photography, basic skills in ophthalmic assessment are essential and advocate that there is no substitute for appropriate clinical examination.^{4,5}

It is unrealistic to expect undergraduates to be competent at direct ophthalmoscopy at the end of their short ophthalmology attachment. Instead, these skills should be taught early in the clinical curriculum so that they can be practised, reinforced, honed, and (most importantly) assessed during further attachments in neurology and general medicine. This requires the support and collaborative efforts of ophthalmologists, physicians, and educators at undergraduate and

postgraduate levels to ensure these important clinical skills are engrained for the benefit of our patients.

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Eye (2016) **30**, 327; doi:10.1038/eye.2015.226;
published online 27 November 2015

Sir,
Response to: 'Direct ophthalmoscopy should be taught to undergraduate medical students'

We would like to respond to the recent controversy regarding the relative merits of teaching direct ophthalmoscopy to undergraduate students.^{1,2}

At the University of Nottingham, direct ophthalmoscopy is considered to be a life-saving examination that all medical students must acquire competency in. It is a widely held view that, direct ophthalmoscopy is an essential skill in the undergraduate ophthalmology curriculum.³ This is reflected in the universal teaching of this skill at an undergraduate level in the UK.³ Indeed, ophthalmoscopy is considered a fundamental competency of the Foundation Programme.⁴

Although it is true that physicians lack confidence in performing direct ophthalmoscopy, the reasons for this are multifactorial. The brevity of undergraduate ophthalmology rotations combined with the lack of practice of ophthalmic examinations by peers (GPs, hospital doctors and so on) may discourage trainees from using an ophthalmoscope when the need arises. The scenario of GPs sending patients with eye complaints to the friendly high street optometrist for evaluation and guidance is also familiar. As ophthalmologists we must

strive to reverse the trend of self-reported low levels of confidence and address these concern head-on.

The suggestion that ophthalmic photography could negate the need to learn how to perform ophthalmoscopy fails to recognise the acute settings in which this skill is required. A junior doctor on-call overnight in the medical assessment unit assessing a patient with headache is not likely to have access to such photographic equipment, just as a junior doctor examining a patient with breathlessness would not have immediate access to a chest radiograph.

Implementation of simulation training and electronic resources in many medical schools has helped to deliver a more engaging and encompassing curriculum. Support for the validity of fundus simulators is gathering momentum. This is an under utilised teaching tool with the potential to maximise clinical confidence and competence when clinical opportunities may be scarce.⁵

As ophthalmic educators we need to tackle this ongoing educational need at a postgraduate level in addition to undergraduate training so that the next generation of students and physicians are equipped with the skills they need to improve patient outcomes.

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Eye (2016) **30**, 327–328; doi:10.1038/eye.2015.227;
published online 27 November 2015

Sir, Myopic foveoschisis: an ectatic retinopathy, not a schisis

In their recent article, Gohil *et al* thoroughly review a condition referred to as 'myopic foveoschisis' that is diagnosed in highly myopic eyes.¹ Our letter aims to support the argument that the use of the term 'schisis' for this particular condition, originally coined by Tacano and Kishi in 1999,² is inaccurate and misleading and should be abandoned in favor of a more representative term.

According to Merriam Websters the term 'schisis' refers to 'breaking up of attachments or adhesions'.³ The root of the term is the Greek verb 'σχίζω', which means to cleave, to part, to separate, or to divide.⁴

As stated by the authors, imaging of this condition with spectral domain OCT clearly and consistently demonstrates that the retinal tissues are not cleaved but rather stretched with 'bridges' of neural structural elements spanning between the retinal layers. When the stretching forces are relieved after removal of epiretinal membranes and the internal limiting membrane, the retinal tissue can return to its normal anatomy and function (Figure 1). This is in contrast to other entities defined as schisis, such as juvenile X-linked retinoschisis and long-standing age-related degenerative retinoschisis, in which anatomical restoration is usually not possible.

For reasons probably related to habit, convention, mutual understanding and convenient literature citing, the term 'schisis' continues to be used. However, the use of this term for this specific clinical entity is inaccurate and misleading since it groups this situation together with juvenile and degenerative retinal schisis, diseases with different morphological characteristics and prognosis.

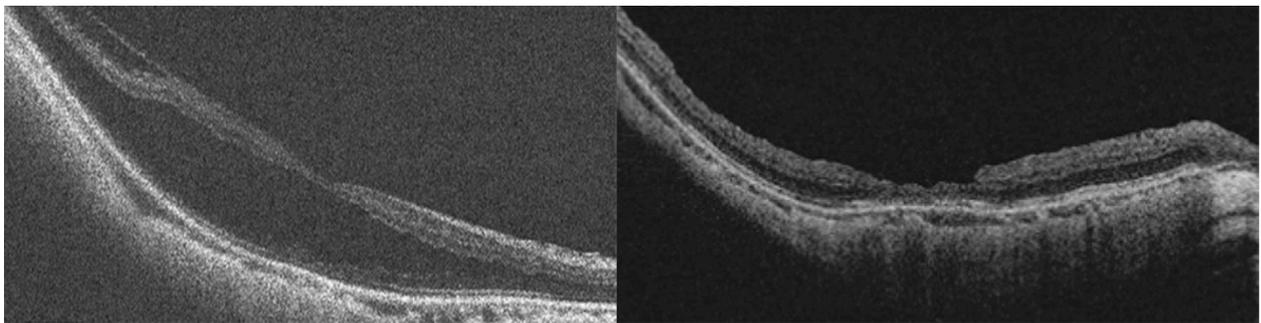


Figure 1 Case of a patient with 'myopic ectatic retinopathy'. The favorable functional outcome of such cases after vitrectomy supports our argument that the term foveoschisis is not appropriate for the description of this clinical entity. Left: At presentation BCVA was 20/40 and OCT revealed the typical appearance of outer retinal layers stretching. Right: After vitrectomy, OCT revealed normalization of the retinal anatomy with attenuation of stretching. BCVA improved to 20/25.