and in Singapore[4] 7.5% had severe vision loss, most commonly from cataract and glaucoma.

The current CVI registration form contains only 'chorioretinitis (unspecified), H30.9' as a specific uveitis category. However, a recent large study from this tertiary centre[5] permits only 671 of 3000 uveitis patients (21%) to be so labelled if severely affected. Uveitis causes visual loss from direct inflammation, but also substantially from macular oedema, epiretinal membrane, cataract, glaucoma, choroidal neovascular membrane and retinal detachment. One might suspect that in addition to the 0.43% of patients with chorioretinitis recorded by the authors,[1] many of the patients with uveitis in this study are 'hiding in plain sight' within 'secondary glaucoma', 'cataract', 'other retinal disorders' and so on. At a time when great advances in the control of uveitis by immunosuppression and biologic therapy are being thwarted by funding restrictions, it would mean a disservice to affected patients if their disease cannot be adequately represented in vision impairment statistics. For those attempting to record accurately and to raise the profile of uveitis in the registration process, the most useful codes for the few open-field boxes on the CVI form include the following:

H20.1 Chronic iridocyclitis

H26.2 Complicated cataract (includes chronic iridocyclitis)

H30.1 Disseminated chorioretinal inflammation

H31.0 Chorioretinal scars (there is no ICD10 code for macular oedema or epiretinal membrane)

H35.0 Includes retinal vasculitis

H40.4 Glaucoma secondary to eye inflammation

H44.4 Hypotony of eye

Conflict of interest

The author declares no conflict of interest.

References

1 Quartilho A, Simkiss P, Zekite A, Xing W, Wormald R, Bunce C. Leading causes of certifiable visual loss in England and Wales during the year ending March 2013. *Eye* 2016; **30**: 602–607.
2 Durrani OM, Tehrani NN, Marr JE, Moradi P, Stavrou P, Murray PI. Degree, duration and causes of visual loss in uveitis. *Br J Ophthalmol* 2004; **88**: 1159–1162.
3 Silva LM, Muccioli C, Oliveira FD, Arantes TE, Gonzaga LR, Nakanami CR. Visual impairment from uveitis in a reference hospital of Southeast Brazil: a retrospective review over a twenty years period. *Arq Bras Oftalmol* 2013; **76**: 366–369.
4 Yeo TK, Ho SL, Lim WK, Teoh SC. Causes of visual loss associated with uveitis in a Singapore tertiary eye center. *Ocul Immunol Inflamm* 2013; **21**: 264–269.
5 Jones NP. Manchester Uveitis Clinic: the first 3000 patients: 1. Epidemiology and casemix. *Ocul Immunol Inflamm* 2015; **23**: 118–126.

NP Jones

The Royal Eye Hospital, Manchester, UK
E-mail: nicholas.jones@cmft.nhs.uk

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Sir,
Uveitis certifications

We thank Mr Jones[1] for his interest in our paper reporting on the leading causes of certifiable vision impairment in England and Wales in the year ending 31 March 2013.[2] The cause of certifiable loss is determined by the examining consultant ophthalmologist and there is a field on the form for recording any diagnosis not presented in the picking list. It is a challenge to present this rich data source within a single report, and since this is an analysis on all ages clearly conditions that affect younger groups are likely not to feature. In answer to the question raised, we can report that there were 24 certifications with a main cause of visual loss being uveitis. We would point out, however, that this is the number of certifications rather than the numbers visually impaired—for an accurate estimate of incidence, clearly an epidemiological research study would be advised. The CVI data might, however, well serve as a useful guide for development of such valuable research.

Conflict of interest

The authors declare no conflict of interest.

References

1 Jones NP. Visual loss in uveitis. *Eye* 2016; **30**: 1521–1522.
2 Quartilho A, Simkiss P, Zekite A, Xing W, Wormald R, Bunce C. Leading causes of certifiable visual loss in England and Wales during the year ending March 2013. *Eye* 2016; **30**: 602–607.

A Quartilho[1], P Simkiss[2], A Zekite[1], W Xing[1], R Wormald[1,3] and C Bunce[1,3]

[1]NIHR BRC for Ophthalmology at Moorfields and UCL Institute of Ophthalmology, London, UK
[2]RNIB, London, UK
[3]London School of Hygiene & Tropical Medicine, London, UK
E-mail: c.bunce@ucl.ac.uk

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Sir,
Surgery for sight: outcomes of congenital and developmental cataracts operated in Durban, South Africa

We read with interest the recent paper by Gogate *et al*[1] studying the visual outcomes of congenital and developmental cataract surgery, and determining the

variables for presentation for pediatric cataract surgery in KwaZulu Natal province of South Africa. Although the study is indeed interesting, there are certain points we wish to highlight. First, what was the incidence of glaucoma postoperatively in the pseudophakic group and in the aphakic group, especially in patients with microphthalmos? No mention of a peripheral iridectomy has been made by the authors, as peripheral iridectomy done intraoperatively in patients with microphthalmos undergoing cataract surgery decreases incidence of glaucoma as seen in the study by Shrikanth *et al.*[2] Second, how many patients had strabismus or nystagmus at presentation? Third, which type of hydrophobic acrylic intraocular lens (IOL) was used in the surgery, single piece or multipiece? What was the site of placement of IOL, in the bag, ciliary sulcus or was the optic captured? Fourth, the authors need to clarify the measures taken to visually rehabilitate the unilateral aphakes post-operatively since that would affect the final visual outcome tremendously. In addition, information such as strategies of amblyopia therapy, adherence to patching and optical correction compliance are lacking. Lastly, the follow-up period of 3-months was very short, leaving many young infants not eligible for reliable visual acuity testing. A longer follow-up of patients is needed to further discuss the surgical outcomes of congenital/developmental cataracts in South Africa.

Conflict of interest

The authors declare no conflict of interest.

References

1 Gogate P, Parbhoo D, Ramson P, Budhoo R, Øverland L, Mkhize N *et al.* Surgery for sight: outcomes of congenital and developmental cataracts operated in Durban, South Africa. *Eye* 2016; **30**: 406–412.
2 Prasad S, Ram J, Sukhija J, Pandav SS, Gupta PC. Cataract surgery in infants with microphthalmos. *Graefes Arch Clin Exp Ophthalmol* 2015; **253**(5): 739–743.

PC Gupta and J Ram

Department of Ophthalmology, Post Graduate Institute of Medical Education and Research, Chandigarh, India
E-mail: drjagatram@gmail.com

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Sir,
Surgery for sight: outcomes of congenital and developmental cataracts operated in Durban, South Africa

We thank Prof. Jagat Ram for his interest in our study of the outcomes of pediatric cataract surgery in Durban, South Africa.[1] We agree that a 3-month follow-up is not the best time to report the outcomes of developmental and congenital cataract surgeries as the visual outcome would improve over time. This has been mentioned as a limitation in the Discussion section. However, this is the first such report from the southern part of the African continent.

There was only one child with Rubinstein Taybi Syndrome whose intra-ocular pressure was >20 mm of Hg (it was 24 and 38 mm of Hg in each eye). She had congenital glaucoma and needed bilateral Ahmed valve surgery. With such a small sample we cannot say that there was a difference between aphakic and pseudophakic children's eyes for glaucoma. There were 7 micophthalmic eyes in our series. A peripheral iridectomy was done in those eyes. An Alcon Acrysof IQ hydrophobic acrylic single piece intra-ocular lens was placed in the bag for all the pseudophakic eyes, all congenital and developmental cataracts in children >4 months of age. The aphakic eyes were prescribed spectacles at the first week follow-up. Amblyopia treatment in form of patching the good eye and spectacle dispensing was done at the 1-week follow-up as mentioned in the Materials and methods section.

The Inkosi Albert Luthuli Central Hospital, Durban is a quaternary care centre for the Kwa-Zulu Natal province of the Republic of South Africa. It is staffed with optometrists trained in pediatric optometry who are well versed in refraction, spectacle dispensing and amblyopia treatment of children. It aspires to follow the Royal College of Ophthalmologists norms. As the children were very young, with poor vision, their pre-operative strabismus could not be accurately measured. Many had nystagmoid movements. Our data collection may not have been very accurate about these two parameters, hence they were not included in the Results and Discussion.

But the series shows that it is possible to have a relatively good outcome even in very young children who undergo pediatric cataract surgery in Africa. The challenge is getting the children, as early as possible, to the pediatric ophthalmology centre to undergo the 'surgery for sight'. And then to follow those up diligently and regularly ensure proper amblyopia treatment to ensure a good visual outcome.[2–4]

Conflict of interest

The authors declare no conflict of interest.

References

1 Gogate P, Parbhoo D, Ramson P, Budhoo R, Øverland L, Mkhize N *et al.* Surgery for sight: outcomes of congenital and developmental cataracts operated in Durban, South Africa. *Eye* 2015; **30**: 406–412.
2 Gogate P, Patil S, Kulkarni A, Mahadik A, Tamboli R, Mane R *et al.* Barriers to follow-up for pediatric cataract surgery in Maharashtra, India. How regular follow-up is important for good outcome. The Miraj Pediatric Cataract study II. *Indian J Ophthalmol* 2014; **62**(3): 327–332.
3 Mboni C, Gogate P, Phiri A, Seneadza A, Ramson P, Manolakos-Tsehisi H *et al.* Outcome of pediatric cataract surgery in Copper belt province of Zambia. *J Pediatric*