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.

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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.

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Sir,
Effectiveness of the present ROP screening protocol

We were pleased to read the correspondence article by Kontos *et al*[1] on screening of premature babies for retinopathy of prematurity (ROP). Our experience concurs entirely with the suggestion put forward in this correspondence to change the UK guideline for screening[2] in this regard. This was presented in 2009 at the ROP seminar held by the Royal College of Ophthalmologists (Effectiveness of New Screening Protocol—K. Merchant, M. Nassar, A. Shafiq, D. Cottrell).

In that short study, we compared two groups of screened babies at the Royal Victoria Infirmary, Newcastle upon Tyne, UK. The study involved screening of babies born between gestational age (GA) 24–26 weeks. The first group included babies screened before implementation of the new protocol (March 2008–August 2008) and the second group included babies screened as per the new protocol (September 2008–February 2009).

In the second group, 13 babies were screened at 30 weeks GA as per the new protocol. Ten of these babies had a very hazy view of the fundus owing to corneal haze, vitreous haze or persistent tunica vasculosa lentis. Three of the 13 babies eventually required treatment but did not meet the treatment criteria until 33 weeks GA. All three had a poor fundus view at 30 weeks owing to the above-mentioned reasons. According to our study the second group had a 5.3% increase in screening visits as compared with the first group.

Data evaluation from the Swedish National Register for Retinopathy of Prematurity (SWEDROP)[3] indicates that screening at 31 weeks GA should always pick up babies at-risk who go on to be treated. In their national database treatment was never required earlier than 32 weeks GA. The Canadian Paediatric Society[4] has also revised the age of initial ROP screening examination for premature babies to 31 weeks.

In our opinion, we are subjecting these premature babies to an additional, unhelpful and distressing examination by screening at 30 weeks GA. We agree that delaying the start of screening these babies until 31 weeks GA is appropriate, safe and sensible.

Conflict of interest

The authors declare no conflict of interest.

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Sir,
Screening for retinopathy of prematurity can be started in postmenstrual week 31 in very premature babies!

We concur with Kontos *et al*,[1] stating that screening for retinopathy of prematurity (ROP) in extremely premature infants can be postponed. Further, and as indicated by the authors, we believe that a change in guidelines should preferably be on the basis of studies of the natural course of ROP in the population *per se*.

In Sweden, a national study of extremely preterm infants, born with a gestational age (GA) of <27 weeks during the years 2004–2007, showed that no infant developed ROP stage 3 before 31 weeks postmenstrual age (PMA) and no infant was treated before 32 weeks PMA.[2] On the basis of this study, and in alignment with American guidelines, the first ROP examination in infants below a GA of 27 weeks was postponed to PMA 31 weeks in Sweden, 2010.