



Figure 2 Kaplan–Meier plot. The plot shows the estimation of rejection-free survival after DSAEK determined with the Kaplan–Meier method ($n=35$). All six rejections occurred within 1 year after transplantation.

Table 2 Cox regression model with the end point graft rejection

	Hazard ratio (HR)	Standard error of the coefficient	P
Decentering	1.067	0.0245	0.007
Peripheral graft thickness	1.216	0.1002	0.051
Central graft thickness	0.498	0.3143	0.027
Age	1.018	0.0553	0.75
Graft diameter	0.273	1.3986	0.35

Conclusions

Our data suggest that the DSAEK stroma may have a causative role in generating immune responses, that is, rejections seem to be favored by graft proximity to the AC angle. It may contribute to the migration of donor-derived antigen presenting cells (APCs) into the recipient's lymphatics (direct pathway). Alternatively, access to the graft of recipient APCs may be promoted by decentered graft positioning (indirect pathway).

Interestingly, cells infiltrating the anterior chamber (AC) belong to the innate immune system: the cellular infiltrate contains mainly monocytes and cells differentiating into APCs, that is, mainly macrophages.⁶ These cells can also be found in the cornea—but as an intact Descemet membrane does not allow any cellular transmigration, it is widely believed, that cells in AC are recruited through iris vessels and ciliary body in the context of a breakdown of the immune privilege. Cells in the corneal stroma (eg, after DSAEK) or the exchange of allo-antigens through APCs coming from the AC and/or the AC angle (especially after DMEK, where there are no donor stromal APCs present) consequently must be crucial for the generation of an immune response.

In summary, the data may indicate an active role of donor-derived immune cells in the rejection process. Major limitation of our work is the size of the cohort; the importance of graft centration in DSAEK to minimize the

risk for graft rejection therefore needs to be confirmed in a larger clinical setting.

Conflict of interest

The authors declare no conflict of interest.

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Sir, Patient satisfaction in the Peterborough community specialist optometrist in glaucoma shared-care scheme

We note with interest the results published by Levy and Booth¹ on 'Patient satisfaction with Peninsula Optometry Community Glaucoma Scheme'. We have significant experience with our own community optometrist glaucoma scheme² and have recently collected satisfaction data.

Questionnaires were sent to 120 patients attending the community scheme and 120 patients in the hospital glaucoma service. Patients were questioned about the clinician they saw, and their satisfaction with the service overall (Table 1). Response rate was 57%.

Patients in the community scheme were asked whether they would like to continue with the scheme, whereas

Table 1 Rates of patient satisfaction with the glaucoma services and their health professionals

	Dissatisfied (%)	Neither satisfied nor dissatisfied (%)	Satisfied (%)
Community optometrist	0	5	95
Hospital doctor	2	16	82
Community scheme overall	1	24	75
Hospital service overall	1	26	73

patients in the hospital service were asked if they would be happy to be transferred to the community scheme. Sixty-two out of 66 patients in the community scheme were happy to remain, whereas only 33/65 of hospital patients would be happy to be transferred to the community optometrist scheme.

The difference in satisfaction between the optometrist and doctor may reflect differences in training (with a more client-oriented approach in optometry) or differences in perceived time pressures. Satisfaction rates were equivalent between the schemes overall.

Both previous publications on satisfaction in community schemes found higher satisfaction with the community service, whereas we have found them equivalent. In comparison with the Bristol scheme,³ we did not randomise our patients to each group, and therefore some of the hospital patients may have been ineligible for the community scheme. In contrast to Levy and Booth's¹ series, we asked patients to comment on satisfaction with their current scheme, rather than making a comparison.

Patients in the scheme were happy to remain there, whereas of those in the hospital only half would be happy to be transferred. This may be due to more complicated requirements (whether perceived or real) of the hospital patients' glaucoma. Without adequate explanation, the patient may feel that they are being 'downgraded' or outsourced. We would like to highlight the importance of adequate information given to patients when they are transferred to a community scheme.

Conflict of interest

The authors declare no conflict of interest.

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Sir, Comment on 'Cost effectiveness of collagen crosslinking for progressive keratoconus in the UK NHS'

It is difficult to overestimate the importance of the UK National Health Service (NHS) policy to structurally assess the cost effectiveness of novel treatments. This policy serves as an example for policy makers in many developed countries, and the outcomes of the analyses are made available to fellow researchers in the field. The recent publication by Salmon *et al*¹ regarding the cost effectiveness of crosslinking for progressive keratoconus is an excellent example of this. The authors concluded that crosslinking is likely to be cost effective, with an incremental cost of £3174 per quality-adjusted life year (QALY), supporting the NHS' decision to reimburse this treatment.

We would like to address the methods used in this study, specifically the authors' calculation of QALYs in keratoconus. QALYs represent the value of the impact of disease on quality of life measured over a lifetime. The concept is based on the measurement of utilities. A utility is represented on a scale anchored at 0 (representing death) and 1 (representing full health) and can be assessed using specific questionnaires (eg, the Euroqol EQ-5D (Euroqol group <http://www.euroqol.org/about-eq-5d.html>) or calculated from patient-reported health surveys (eg, SF-6D² derived from Short Form 36 Health (SF-36) survey questionnaires³). QALYs and utilities are the preferred outcome measures used when performing a cost effectiveness analysis. The authors state that direct measures of utilities in keratoconus are not available and therefore estimated utilities based on expected visual acuity (VA) in various stages of keratoconus, leading to decreased utilities in advanced keratoconus.

However, the Collaborative Longitudinal Evaluation of Keratoconus (CLEK) study measured SF-36 in more than 1200 keratoconus patients, including appropriate descriptions of the patients' VA, keratometry, and subsequent staging using the Amsler–Krumeich classification.⁴ Using the CLEK database, we classified all of the included subjects according to their keratometry readings, and we linked these results to SF-6D-derived utilities, following the method developed by Brazier *et al*.²