

**Sir,  
Reply to: 'Comment on Evaluation of choroidal thickness in patients with scleroderma'**

Dr Uzun<sup>1</sup> expressed concerns with our paper published in *Eye*.<sup>2</sup> We appreciate the readers' interest, and we are pleased to respond to the comments.

First, Uzun questions that whether the patients were analysed for possible NTG and/or POAG. In fact, we measured IOP of all the patients, and found that all IOP measurements were <22 mm Hg. We did not observe any glaucomatous optic disc changes including increased cup/disc ratio (>0.3). There were no significant differences between patients with scleroderma and control subjects in terms of mean IOP values. Some studies reported that IOP has a significant effect on choroidal thickness (CT), but these studies included patients with glaucoma, not healthy control subjects.<sup>3</sup> Wei *et al*<sup>4</sup> examined 3468 individuals and found that CT was not significantly associated with IOP.

Second, Uzun is concerned about the presence of any systemic diseases, history of the medications, use of alcohol or caffeinated or non-caffeinated beverages or smoking before OCT, and the systemic blood pressure measurements. None of the patients with scleroderma and control subjects did use alcohol. All participants did not have any other systemic disease except scleroderma. If any participants consumed caffeinated beverages or smoked during the examination day, we instructed not to take caffeinated beverages or smoke until next day, and we performed OCT examination on the following day. Although it has been reported that drinking of caffeinated beverages causes temporary changes in CT,<sup>5</sup> there is no evidence that drinking of these beverages causes permanent alterations in CT. Moreover, smoking can cause temporary changes in CT, but it has been also demonstrated that CT was not significantly associated with smoking.<sup>4,6</sup> There were no significant differences in mean systolic and diastolic blood pressures in patients with scleroderma when compared with control subjects. Thus, we are confident that we have eliminated all confounding factors, which may have effects on CT measurements. Additionally, there is also evidence that CT was not significantly associated with blood pressure.<sup>4,7</sup>

Finally, the patients with scleroderma have been using immunomodulator drugs. However, there is no evidence that these drugs affect CT.

**Conflict of interest**

The authors declare no conflict of interest.

**References**

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**Sir,  
Can general A&E doctors manage common eye emergencies?**

We read with interest the correspondence highlighting junior doctors being unable to deal with ophthalmic emergencies and agree completely with the authors.<sup>1</sup> In the past it was not uncommon for Eye Units to provide a 24-hour emergency service, but this is now no longer the case. It is essential that patients receive appropriate emergency eye care outside of a dedicated eye A&E Department.

We recently undertook a questionnaire survey of Accident and Emergency doctors in six NHS Trusts in the West Midlands. The questionnaire was aimed at assessing the confidence and perceived competence of Emergency doctors in general A&E Departments. There were 65 responses: F1/F2 doctors = 12; CT1/ST2 = 19; ST3-6+ = 12; SAS = 13; Consultant = 9. A total of 37/65 (57%) of doctors felt their undergraduate ophthalmology teaching was inadequate, and 41/65 (63%) stated they had not received any formal ophthalmology training within the general A&E Department. The majority of doctors did not feel competent in using standard ophthalmological equipment, including the direct ophthalmoscope (46/65, 71%) and a slit-lamp (44/65, 68%). The number (%) of doctors who were confident or very confident in

formulating a differential diagnosis and management plan for the red eye was 26/65 (40%); acute loss of vision 22/65 (34%); ocular trauma 21/65 (32%); and chemical injury 28/65 (43%).

Our results imply that many doctors working in general A&E Departments do not feel competent in using standard ophthalmological equipment or confident in managing common eye emergencies. Little seems to have changed since the surveys published in 1997<sup>2</sup> and 2008.<sup>3</sup>

Only 1/12 (8%) Foundation doctors believed they were competent in performing direct ophthalmoscopy, and this skill is a Foundation Year 1/2 Examination Outcome "Demonstrates accomplished and targeted examination skills and appropriate use of equipment, including an ophthalmoscope." (Foundation Programme Curriculum 2012 updated for August 2015).

This highlights the importance of adequate undergraduate ophthalmology teaching and formal postgraduate teaching in a general A&E Department. We also welcome a National Survey to see if our findings can be extrapolated to the rest of the country.

#### Conflict of interest

The authors declare no conflict of interest.

#### References

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