real-world studies from countries other than the United States. We performed an audit of all patients who received intravitreal treatments as monotherapy (ranibizumab or dexamethasone) for newly diagnosed RVO attending one clinic in the UK during one year. This was in 2014, and findings reflect a surge of referrals then given recent licensing of ranibizumab for RVOs in the UK. Fifty-six patients were identified, mean age 74 years (range 30–89), with 50% having a branch retinal vein occlusion and 50% having a central retinal vein occlusion. Ranibizumab was given to 55% ($n=31$) and dexamethasone to 29% ($n=16$). There was no significant difference ($P=0.7$) in the follow-up periods for patients who received ranibizumab (mean 171.2 days, standard deviation (SD) 46.3) compared to dexamethasone (mean 177.9 days, SD 64.8). The number of injections was significantly different for the two drugs ($P<0.001$), with a mean of 3.1 (SD 0.9) for ranibizumab and 1.1 (SD 0.3) for dexamethasone. For example, for ranibizumab 55% received three injections and 29% received four injections, while for dexamethasone 88% ($n=14$) received one injection. There was no significant difference ($P=0.9$) in BCVA from the first injection to follow-up: mean +7.3 letters (SD 12.3) for ranibizumab and +7.8 letters (SD 8.6) for dexamethasone. Similarly, central retinal thickness changes were not significantly different ($P=0.95$): $-165.5\,\mu$m (SD 218.7) for ranibizumab, and $-169.1\,\mu$m (SD 152.3) for dexamethasone. Intraocular pressure-lowering topical treatment was needed in 5% following ranibizumab and 23% following dexamethasone.

The visual results obtained fall short of those achieved in clinical trials and treatment patterns in our clinic are now closer to the label recommendations.

Our practice was and remains to monitor patients on ranibizumab monthly, injecting if appropriate, and for dexamethasone to review patients 6 weeks following the implant, and then at least 3 months later depending on any prior clinical responses. Thus, similar outcomes are obtainable with ranibizumab and dexamethasone, but with far fewer treatment and non-treatment visits for the latter.

Conflict of interest

The authors declare no conflict of interest.

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Disclaimer

This material is original research, and has not been published elsewhere, nor is it under consideration for publication elsewhere.

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Sir,
Unmet needs of cataract blind children in special schools in Southeast Nigeria

The article 'Benchmarks for outcome indicators in pediatric cataract surgery', in which 96% of operated children had outcomes of best corrected visual acuity $\geq 20/40$,[1] is in stark contrast to what was obtained in some low and middle income countries settings. Herein, we describe the profile of the cataract blind children in special schools in Southeast Nigeria and their unmet needs. This study was done concurrently with research into trends in childhood blindness in which part of the methodology has been reported elsewhere.[2]

Data regarding onset of blindness, history of cataract surgery, ocular examination, refraction, and low vision assessment were recorded on the WHO/PBL form for childhood blindness and analysed with STATA 12.1 (Statcorp, TX, USA), from which frequency tables, odd-ratios, and *P*-values were generated. Tests of significance were set at the 95% level. Out of 127 children with childhood blindness in schools for the blind, 42 had lens-related pathologies.

Figure 1 shows the categorization of children with lens-related blindness and Table 1 shows the relevant relationship of correlates between operated and unoperated participants. There were several unmet needs in these cataract blind children. First, the presence of children in the school for the blind with unoperated cataracts is a cause for concern. In addition, the outcome of surgery was poor. Furthermore, none of the children who had undergone surgery had any evidence of intra-ocular lenses (IOLs) or any optical rehabilitation post surgery. One participant's vision improved from $<6/60$ to $6/60$ in one eye after refraction. There is suggestive evidence that the odds of having surgery in ≤ 15-year-olds was almost three and a half times greater than in those >15 years. This implies that the rate of cataract surgery in children may have increased over time. However, cataract surgery is not synonymous with good vision. Existing data suggest that many cataract blind or visually impaired children in low and middle income countries have undergone previous surgery, but that their vision has remained poor.[3] Several factors affect the outcome of paediatric cataract surgery—these include delay in surgery and inadequate postoperative rehabilitation.[4] In the absence of medical records on these blind children, there were limited data on the timing of surgery and follow-up period. This was a blind-school survey;

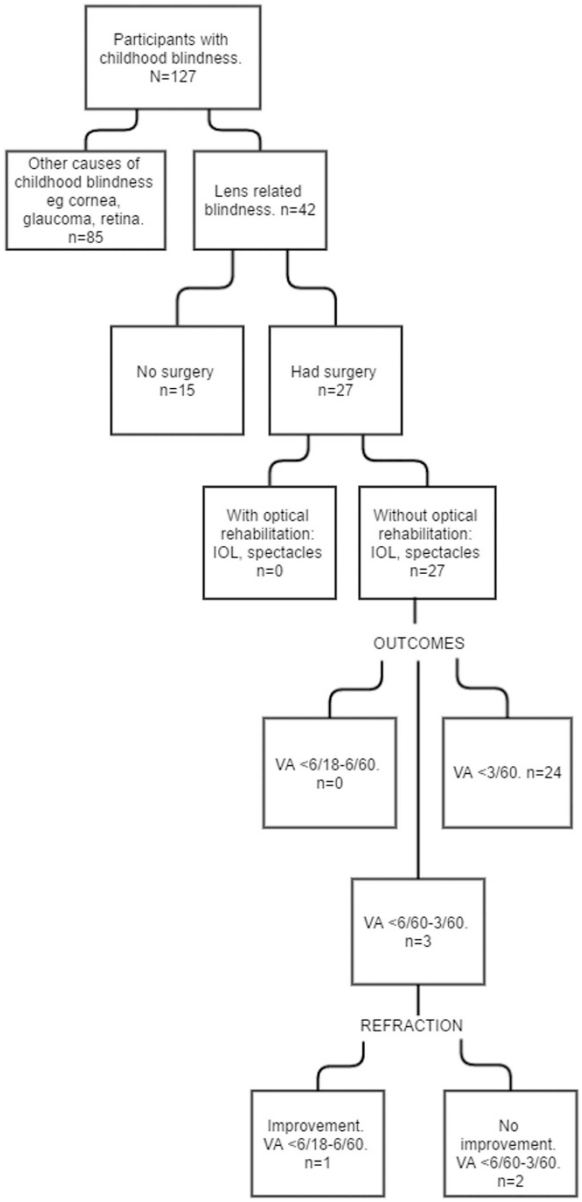

Figure 1 Categorization of children with lens-related blindness.

therefore, it is likely that the cataract outcomes from this study may not be a true reflection of the outcomes of all paediatric cataract surgeries in the region as only those with poor outcomes will be registered in the schools for the blind. Better outcomes have been reported from a similar east African blind-school study; IOLs were inserted in 65% of the children who underwent surgery and 41% of them had a visual acuity of $\geq 6/60$.[5] Cataract is an increasingly important cause of childhood blindness in Africa. To help improve the capacity for paediatric cataract surgery, there is need to develop the WHO-recommended Child Eye Health Tertiary Facilities in Southeast Nigeria. In addition, it is important for local stakeholders to aggressively pursue strategies to overcome the other barriers that influence poor outcomes.[4]

Table 1 Relevant relationship of correlates between operated and unoperated participants

	Number operated (%)	*Number unoperated (%)*	*Odds ratio*	*95% CI*	*P value*
Male	14 (63.6)	8 (36.4)	0.94	0.22–3.9	0.9
Female	13 (65)	7 (35)			
Age					
≤15 years	15 (78.9)	4 (21.1)	3.4	0.74–18	0.07
>15 years	12 (52.2)	11 (47.8)			
Family history					
Positive	2 (50)	2 (50)	0.52	0.03–8.0	0.5
Presumed negative	25 (65.8)	13 (34.2)			
Visual acuity					
VI					
SVI	3 (42.9)	4 (57.1)	0.34	0.04–2.5	0.2
BL	24 (68.6)	11 (31.4)			

Conflict of interest

The authors declare no conflict of interest.

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