

we found that mothers in the former group had a fatalistic attitude. It is well documented that fatalistic attitude is prevalent in less educated societies and is a barrier to positive health behaviour and adversely affects health outcomes.<sup>5</sup>

Results from this study show that the main barrier to access of eye care was the parents' inability to detect that the child had any eye problem. Hence it is important to develop awareness programs to educate the parents on various common eye diseases. Educating teachers and community workers in screening of eye diseases would also help in early detection.

### Conflict of interest

The authors declare no conflict of interest.

### Acknowledgements

We would like to sincerely thank Swami Japanandaji, Chairman and all the staff of Shree Sharada Devi Eye Hospital and Research Centre, Pavagada, Karnataka, India. This project was supported by the Indian Council of Medical Research (ICMR) vide Ref: 5/4/6/2/09—NCD-11 dated 22.03.2011. Pavagada Pediatric Eye Disease Study/Beyond Blindness.

### References

- 1 Fletcher AE, Donoghue M, Devavaram J, Thulasiraj RD, Scott S, Abdalla M *et al*. Low uptake of eye services in rural India: a challenge for programs of blindness prevention. *Arch Ophthalmol* 1999; **117**(10): 1393–1399.
- 2 Nirmalan PK, Sheeladevi S, Tamilselvi V, Victor AC, Vijayalakshmi P, Rahmathullah L. Perceptions of eye diseases and eye care needs of children among parents in rural south India: the Kariapatti Pediatric Eye Evaluation Project (KEEP). *Indian J Ophthalmol* 2004; **52**(2): 163–167.
- 3 Nirmalan PK, John RK, Gothwal VK, Baskaran S, Vijayalakshmi P, Rahmathullah L, Kariapatti Pediatric Eye Evaluation Project. The impact of visual impairment on functional vision of children in rural South India: the Kariapatti Pediatric Eye Evaluation Project. *Invest Ophthalmol Vis Sci* 2004; **45**(10): 3442–3445.
- 4 Gothwal VK, Lovie-Kitchin JE, Nutheti R. The development of the LV Prasad-Functional Vision Questionnaire: a measure of functional vision performance of visually impaired children. *Invest Ophthalmol Vis Sci* 2003; **44**(9): 4131–4139.
- 5 Drew EM, Schoenberg NE. Deconstructing fatalism: ethnographic perspectives on women's decision making about cancer prevention and treatment. *Med Anthropol Q* 2011; **25**(2): 164–182.

V Kemmanu<sup>1</sup>, SK Giliyar<sup>1</sup>, BK Shetty<sup>1</sup>, AK Singh<sup>2</sup>, G Kumaramanickavel<sup>1</sup> and CA McCarty<sup>3</sup>

<sup>1</sup>Narayana Nethralaya, Bangalore, India

<sup>2</sup>Government Medical College, Ambedkar Nagar, Uttar Pradesh, India

<sup>3</sup>University of Minnesota Medical School, Duluth, MN, USA

E-mail: vasudhakemmanu@gmail.com

*Eye* (2018) **32**, 467–468; doi:10.1038/eye.2017.170; published online 18 August 2017

### Sir, Comment on 'Licence to save: a UK survey of anti-VEGF use for the eye in 2015'

We read with great interest the article 'Licence to Save: a UK survey of anti-VEGF use for the eye in 2015'.<sup>1</sup> It is a particularly pertinent and well-timed article given the recently declared 'crisis' the NHS is experiencing. We are writing to highlight the potential influence this article may have now that the 'Getting It Right the First Time' (GIRFT; <http://www.gettingitrightfirsttime.com>) project will eventually extend to subspecialties such as ophthalmology. The GIRFT project was initially piloted in orthopaedics, financially supported by the NHS PCC (Primary Care Commissioning). The GIRFT project is a comprehensive review of service seeking improvement through the careful analysis of existing care pathways, patient experience, waiting times, service costs, cost commissioning, surgical targets, and outcomes, with the aim of developing a more standardized improved national service (<http://www.gettingitrightfirsttime.com/downloads/GIRFT-National-Report.pdf>). It will be interesting to see if this service review in ophthalmology will impact on drug licensing and our current anti-VEGF practices.

### Conflict of interest

The authors declare no conflict of interest.

### Reference

- 1 Shalaby AK, Lewis K, Bush K, Meredith PR, Di Simplicio S, Lockwood AJ. Licence to save: a UK survey of anti-VEGF use for the eye in 2015. *Eye* 2015; **30**(11): 1404–1406.

C MacGregor<sup>1</sup>, C Whaley<sup>2</sup> and N Maycock<sup>3</sup>

<sup>1</sup>St Mary's Hospital, Newport, Isle of Wight, UK

<sup>2</sup>Salisbury District General Hospital, Salisbury, UK

<sup>3</sup>Queen Alexandra Hospital, Portsmouth, UK

E-mail: macgregor.cheryl@doctors.org.uk

*Eye* (2018) **32**, 468; doi:10.1038/eye.2017.177; published online 25 August 2017

### Sir, Comments on 'Treatment patterns of ranibizumab intravitreal injection and dexamethasone intravitreal implant for retinal vein occlusion in the USA'

We commend a study comparing ophthalmology clinic visit frequency for patients receiving ranibizumab and dexamethasone for retinal vein occlusion (RVO).<sup>1</sup> The case is made that visit burden for both treatments may not be significantly different, but highlights the importance of

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 ( $P=0.95$ ):  $-165.5\ \mu\text{m}$  (SD 218.7) for ranibizumab, and  $-169.1\ \mu\text{m}$  (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.

#### Acknowledgements

Dr Williams has received support to attend meetings from Allergan, Novartis and Bayer.

#### Disclaimer

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

#### Reference

- 1 Nghiem-Buffet S, Baillif S, Regnier S, Skelly A, Yu N, Sodi A. Treatment patterns of ranibizumab intravitreal injection and dexamethasone intravitreal implant for retinal vein occlusion in the USA. *Eye* 2017; 31(4): 551–559.

MA Williams<sup>1</sup>, C Shute<sup>2</sup> and S Wright<sup>3</sup>

<sup>1</sup>Centre for Medical Education, Queen's University of Belfast, Belfast, UK

<sup>2</sup>Department of Ophthalmology, Belfast Health and Social Care Trust, Belfast, UK

<sup>3</sup>Optometry, Belfast Health and Social Care Trust, Belfast, UK

E-mail: m.williams@qub.ac.uk

*Eye* (2018) 32, 468–469; doi:10.1038/eye.2017.178; published online 25 August 2017

#### 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  $\geq 20/40$ ,<sup>1</sup> 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.<sup>2</sup>

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 intraocular 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  $\leq 15$ -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.<sup>3</sup> Several factors affect the outcome of paediatric cataract surgery—these include delay in surgery and inadequate postoperative rehabilitation.<sup>4</sup> 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;