QUARTERLY BULLETIN OF THE ROYAL COLLEGE OF OPHTHALMOLOGISTS

College NEWS

Autumn
2006

CVI Certificate of Vision Impairment

Introduction
The Certificate of Vision Impairment (CVI) was released by the Department of Health (DH) for certifying patients as visually impaired. The CVI replaced the BD8 certificate, which specifically asked the ophthalmologists to record the main cause of visual impairment.

Certification Update

- The Certificate of Vision Impairment has been in use since September 2005 in England and the CVI-W is to be launched in Wales later this year.
- For many years analysis of the data was neglected but we are pleased to announce the establishment of a Certifications Office.
- All CVI's and CVI-W's received at the office will be entered into our system to enable rapid inspection of how many people are newly sight impaired by cause.
- The Certifications Office operates under the auspices of the Royal College of Ophthalmologists and has received three years funding from The Guide Dogs for the Blind Association.

Project Update

- It is recognised that the form has its drawbacks but we encourage members to make use of the *'Diagnosis not covered in any of the above'* box where the cause of vision impairment is not listed.
- To facilitate comparison with previous data sets, we urge members to identify the main cause of vision impairment as instructed on the form.
- The DH has **not** changed policy with regards to payment for CVI's – there will be no payment for certifications via the old BD8 forms.
- Our certifications office may be in contact with you (or your secretaries) if there is data missing from the CVI form.

Next Stages

- We are exploring the use of an additional diagnostic form for paediatric ophthalmologists to complete, should they wish to record diagnoses in greater detail.
- An electronic version of the CVI is currently being piloted at Moorfields Eye Hospital – if you would like to take part, contact richard.seeberan@moorfields.nhs.uk

We will meet with the DH to give feedback on the new form and would appreciate comments from our members.

Please contact Catey Bunce or Anita Chauhan, Certifications Office, Empire House, 136-144 City Road, London EC1V 2QN
c.bunce@ucl.ac.uk

College Surgical Skills Tutor

After two successful years, John Brazier is stepping down from this role. The College skills centre is a fully equipped facility; we run courses for beginners to advanced level surgeons. With the new curriculum, the changes brought by PMETB and the pressure on 'live' training sessions, the skills centre is a crucial resource for the promotion of excellence in surgical techniques. The position is funded one day a week, normally through reimbursement of the ophthalmologist's employing Trust. Applicants should be members of the College and registered for continuing professional development. Please contact beth.barnes@rcophth.ac.uk for a detailed job description. Closing date: 16 October.

President Brenda Billington presents Honorary Fellowship to Tony Chignell. See page 9 for full report

Articles and information to be considered for publication should be sent to kathy.evans@rcophth.ac.uk and advertising queries should be directed to Robert Sloan 020 8882 7199 rsloan@rsa2.demon.co.uk

Copy deadlines

Winter	5 November 06
Spring	5 February 07
Summer	5 May 07
Autumn	5 August 07

Structured Clinical Attachments for Optometrists

Since 1968, optometrists have been allowed to supply a limited range of ophthalmic drugs to patients under an exemption to the Medicines Act by issuing a 'written order' (effectively a private prescription). Secondary legislation in 2005 introduced two new frameworks under which optometrists may prescribe ophthalmic drugs.

1. *'Additional Supply'*, which provides a modest extension to the range of ophthalmic drugs which an optometrist may supply on a written order.
2. *'Supplementary Prescribing'* where an optometrist may initiate or change ophthalmic medication within a management plan agreed in advance with a medically qualified principal prescriber (with the patient's consent). This implies a close working relationship between the principal and supplementary prescriber, and is most likely in clinical settings such as glaucoma clinics or ophthalmic primary care clinics where optometrists with additional training work alongside ophthalmologists.

Optometrists who wish to prescribe in either category must undergo a course of additional training accredited by the General Optical Council. The training consists of:

1. A course of academic study,
2. A clinical placement (10 half days re Additional Supply, 24 half days re Supplementary Prescribing)
3. A final examination.

The optometrist is expected to keep a training portfolio, detailing a log of patients seen during the clinical placement.

Eye departments or individual clinicians may be approached by optometrists who wish to arrange a clinical placement as part of a course of study towards a qualification in therapeutics in return for a fee. Departments with many commitments to trainee ophthalmologists, medical students, pre-registration optometrists and others may find it difficult to accommodate further requests for periods of clinical observership.

However, some eye departments may wish to set up a system of structured placements for optometrists who are enrolled in therapeutics courses. There may be advantages in having a dedicated training clinic using patients from the 'eye casualty' queue or another clinic where common eye conditions are likely to present. In a dedicated training clinic, one ophthalmologist would be able to supervise a number of optometrists simultaneously and also ensure that they are exposed to a reasonable range of clinical conditions. Moorfields Eye Hospital has entered into a training agreement of this type with one course provider.

Ophthalmologists who supervise optometrists during clinical placements will not be expected to make assessments of their competence but they will be asked to verify that the optometrists attended the required number of sessions. The final assessment involves a viva voce examination by a panel which includes optometrists and ophthalmologists.

If any ophthalmologists or departments are interested in becoming involved in this type of training, please contact Kathy Evans kathy.evans@rcophth.ac.uk

Richard Smith
Chair, Professional Standards Committee

Teaching material

The education committee of the College would like to produce a database of teaching materials used to educate medical students in the UK. There is particular interest in PowerPoint lectures and computer based learning software packages, whether generated in-house or from external sources.

We would be grateful if those who are in charge of undergraduate teaching at UK medical schools could in the first instance e-mail me at p.i.murray@bham.ac.uk and I will then be in contact to obtain further details.

Phil Murray
Education Committee

CLINICAL EXCELLENCE AWARDS

The Department of Health's Advisory Committee on Clinical Excellence Awards will be seeking nominations from the College later this year. Consultants who wish to be considered must complete the requisite forms, accessible from the College website www.rcophth.ac.uk Further advice for members will be posted to our website as it becomes available. Generic advice to applicants can be found at: www.rcophth.ac.uk/finance-membership/members/accea-tips

The relevant DH website is:
www.advisorybodies.doh.gov.uk/accea/index.htm

Completed forms should be emailed to the College's dedicated email address accea@rcophth.ac.uk by 20 October 2006.

Members' News

Mr Paul Bishop has been appointed to a chair in ophthalmology and matrix biology at the University of Manchester. He has been a consultant at Manchester Royal Eye Hospital since 1998, specialising in medical retina. He has held Wellcome Trust Clinical Fellowships for the past 15 years, culminating in being the first ophthalmologist to be awarded a highly prestigious Wellcome Trust senior research fellowship in clinical science. Much of his research is focused on studying the extracellular matrices of the eye and he is the only principal investigator who is also a clinician at the internationally renowned Wellcome Trust Centre for cell-matrix research.

Nikhil Kaushik of Wrexham Maelor has produced *'Bhavishya – the Future!'* featuring medical students from Manchester, qualified doctors and the Bollywood star Saeed Jaffrey. It follows a young Indian doctor at a Welsh Hospital over three months – a short period but one that has consequences for so many. The film, which has a strong message about medical migration, is in Hindi and English with a touch of Welsh. Subtitles help the audience keep track of the plot.

As one would expect of a Bollywood film, there is plenty of catchy music, songs and dances. The world premier will occur in Wrexham on 15 September, with further showings planned. www.bhavishya-thefuture.com

Obituaries

J.D.C. Anderson, OBE 1924-2006

Anderson, known to everyone as "Jock", died on 16th June 2006, aged 81. He had been forced to retire early from the Institute of Ophthalmology because of a spinal tumour. During their last few years in Salisbury, he and his wife Gwendy were both in wheel chairs but this did not deter them from a full social life in the local church and town. They welcomed many guests to their home and Jock successfully took on all comers at table tennis, which he played from his wheel chair with a bat in each hand!

Jock had studied medicine at Cambridge and the Middlesex Hospital. His deeply- held, uncomplicated Christian faith became the bedrock for an outstanding life of service in Asia. In 1955 he sailed for Pakistan to work first at Quetta, and then at the Christian Medical College, Ludhiana, India. In 1960 an ambition was achieved when a fully equipped mobile "Caravan Hospital" was shipped from the UK to enable thousands of people throughout Sindh Province, Pakistan, to receive medical and surgical eye treatments.

In 1967 he moved to Kabul, Afghanistan, to help establish the first eye hospital, train doctors and nurses, and pioneer eye camps. Here, as in earlier posts, he inspired a number of people to take up ophthalmology as a career, including, I understand, the current President of our College who was in Kabul at the time on a medical student elective! His groundbreaking work in Afghanistan was recognized in 1981 by the award of the OBE.

The Soviet intervention in Afghanistan made the work increasingly difficult. In 1981 he joined Professor Barrie Jones at the newly-formed International Centre for Eye Health at the Institute of Ophthalmology. His experience in the field made his teaching highly relevant to students from all over the world, who also found in Jock and Gwendy a couple who had a deep understanding of their cultural backgrounds and who offered them unstinting support and hospitality.

Gordon Johnson

We also note with regret the death of:

Mr Roger Ainley of Cheshire
Mr Derek Ainslie of Esher
Dr Khalid Anwar of Islamabad
Dr Andrew David Barr of Dunfermline
Dr Cecil C Ewing of Saskatoon, Canada.
Dr Govindappa Venkataswamy, FRCOphth (Hon), Aravind, India

FROM THE MEMBERSHIP DEPARTMENT

Collection of email addresses

The College would like to be able to email all members. As a first step, in July we wrote to all UK consultants asking them to email database@rcophth.ac.uk with one contact email address. The response so far has been good but we would like all UK consultants to participate. In due course we hope to collect email addresses for the entire membership.

DIRECT DEBITS There will be a £30 discount for those UK members who pay their 2007 subscriptions by direct debit. Members who do not currently pay by this method are invited to complete and return a direct debit form - available from the website www.rcophth.ac.uk/finance/membership

Jackie Trevena, Head of Finance and Membership

Carleton

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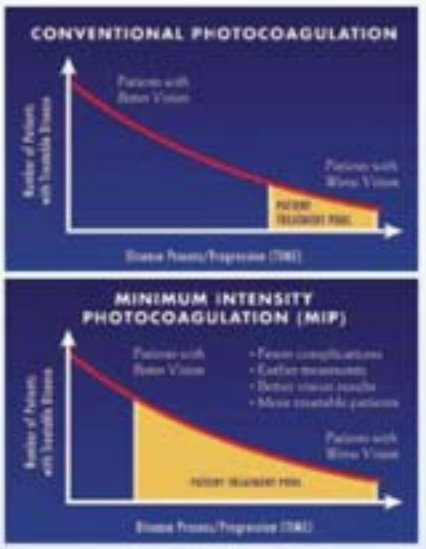
Minimum Intensity Photocoagulation
Technology for the Future



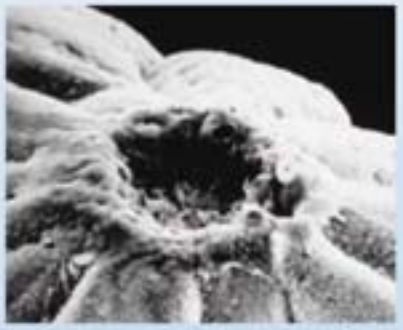
Minimum Intensity Photocoagulation ™:

A generalized dosing approach that generates an effective therapeutic response while maximizing tissue preservation

The benefits of minimum intensity photocoagulation over conventional photocoagulation include:

- Treating earlier in the disease process
- Allowing more patients to receive treatment
- Preserving more vision
- Fewer complications

C.W.(100% duty cycle) laser burn on human RPE cells



E = 16 mJ
P = 80 mW
t = 200 ms
Spot ∅ = 75 µm
Crater ∅ = 180 µm
(lateral thermal spread = 52.5 µm)

SEM x 120 - Marked thermal damage and tissue shrinkage

Courtesy of Doris Ruskovich, LMU München, Germany
ARVO 1997, Abstract # 3483/xx

MicroPulseTM burn on human RPE 10% duty cycle

E = 16 mJ
P = 80 mW
t = 200 ms
envelope with 100 micropulses at 10% duty cycle
(T = 2 ms : 200 µs "on" + 1800 µs "off")
Spot ∅ = 75 µm
Crater ∅ = 80 µm
(lateral thermal spread = 2.5 µm)

SEM x 240 - Mild and confined damage

Courtesy of Doris Ruskovich, LMU München, Germany
ARVO 1997, Abstract # 3483/xx

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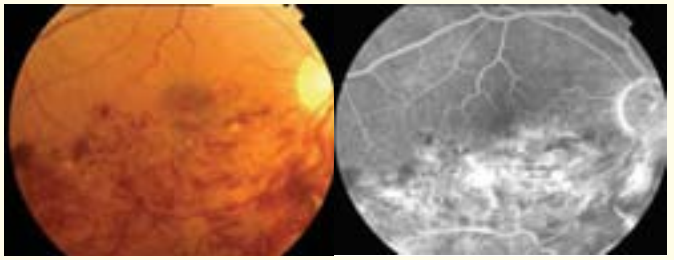
THE ROYAL COLLEGE OF OPHTHALMOLOGISTS

Focus

Autumn
2006

Retinal Vein Occlusion



Colour fundus photograph and fluorescein angiogram showing inferotemporal BRVO with macular edema.

Retinal vein occlusion (RVO) is a frequent cause of visual loss in the elderly population. It is classified into; central retinal vein occlusion (CRVO), branch retinal vein occlusion (BRVO) and hemi-central retinal vein occlusion (HRVO), based on the site of obstruction. The prevalence of BRVO is 0.6% and of CRVO is 0.1%. While HRVO is a variant of CRVO, BRVO differs in pathophysiology, clinical course and management.

Pathogenesis

CRVO results from thrombosis of central retinal vein near lamina cribrosa, but BRVO is caused by venous thrombosis at an arteriovenous crossing where the artery and vein share a common adventitious sheath. Atherosclerosis of neighbouring artery, altered blood viscosity and raised IOP are implicated in the pathogenesis of RVO. Rare causes of CRVO include optic disc drusen and compressive or inflammatory diseases of the optic nerve/orbit. BRVO can rarely be associated with retinal vasculitis and Coats disease.

Risk factors for RVO: systemic risk factors include hypertension (64%), hyperlipidemia (50%), smoking (50%), diabetes mellitus, hyperhomocysteinemia, thrombophilic disorders and autoimmune diseases. Regular exercise, alcohol intake and higher high-density lipoprotein levels are associated with decreased risk of RVO. Local risk factors include glaucoma and retinal vasculitis.

Clinical characteristics

CRVO: non-ischemic CRVO presents with mild to moderate visual loss and carries a low risk (2%) of iris neovascularisation (NVI). 5-20% of these cases progress to ischemic type. Ischemic CRVO presents with poor vision and carries a high risk of NVI (>60%) and neovascular glaucoma (NVG). Final visual acuity is 3/60 or worse in 87% of the ischaemic group; whereas the non-ischaemic group retains 6/18 or better in 80%. The two types of CRVO can be differentiated using fundus fluorescein angiography (FFA), electroretinography (ERG) and colour Doppler imaging. Eyes with ≥ 10 disc areas of retinal non-perfusion on FFA are at risk of developing neovascularisation. Ultra-wide-field FFA using Optomap scanning laser ophthalmoscope (Optos PLC, Dunfermline) may be useful in quantifying the degree of retinal non-perfusion especially of the periphery. ERG and colour Doppler imaging are useful during the initial three months when FFA assessment is difficult.

BRVO: BRVO presents with variable degree of visual loss. Neovascularisation of retina (NVE) occurs in 20% of cases and NVI is rare. Risk of NVE is greater in eyes with retinal non-perfusion of ≥ 5 disc areas. 50–60% patients with BRVO retain a visual acuity of ≥ 6/12 after one year.

HRVO: In 20% of normal eyes, the central retinal vein enters the optic nerve as dual trunks before merging into single trunk. Obstruction in one of the trunks results in HRVO. Risk of neovascularisation is greater than in BRVO.

Investigations

The Royal College of Ophthalmologists guidelines recommend complete blood count, ESR, renal function tests, blood glucose, lipid profile, plasma protein electrophoresis, thyroid function test and ECG in all patients with RVO. Further tests such as lupus anticoagulant, anticardiolipin antibodies, fasting homocysteine and autoantibodies are indicated in young patients.

Treatment of CRVO:

1. *Control of risk factors:* Treat the underlying medical conditions and control glaucoma.
2. *Treatment of macular edema:* CRVO study found that macular grid laser reduces edema but has no effect on vision; hence not recommended.
   a. Steroids: intravitreal triamcinolone (IVTA) reduces macular oedema giving a two-line visual improvement in 62% of cases. However, the response is short lived and IOP raises in 50% of eyes.[1] Other risks include endophthalmitis, cataract and retinal detachment. Phase-2 trial of intravitreal dexamethasone in sustained-release form (Posurdex, Allergan) has demonstrated a three-line visual improvement in 20% of patients with macular edema. Increase in IOP was found in only 17% of cases.[1] Phase-3 trial is under way.
   b. Anti-VEGF treatment: intravitreal bevacizumab (Avastin, Genentech) is reported to reduce macular edema and improve visual acuity within one week. Further studies are required.

3. *Treatment of neovascularisation*
   a. Laser: untreated NVI leads to blindness in 76%. In ischemic CRVO, panretinal photocoagulation (PRP) reduces the risk of NVG. The CRVO study group recommends PRP only in presence of NVI; however, some advise prophylactic PRP when regular follow-up is impossible.
4. *Treatment of underlying pathology:* Several therapeutic methods target the underlying pathophysiology.
   a. Haemodilution: isovolemic haemodilution reduces haematocrit and blood viscosity improving retinal blood flow. Studies show that 41% of patients achieve a final visual acuity of ≥ 6/12, if treated within first two weeks.[2] Haemodilution reduces the risk of conversion from non-ischaemic to ischaemic type. It is ineffective in long-standing CRVO and is not suitable for patients with cardiac failure, renal insufficiency and anaemia.
   b. Radial optic neurotomy (RON): RON releases pressure in the scleral outlet compartment improving retinal blood flow. The RON study observed rapid clearing of retinal haemorrhages and visual improvement in 73% of patients with ischemic CRVO. A recent study reports an anatomical resolution of CRVO in 95% patients and >two-line visual improvement in 53%.[3] Potential complications include globe perforation and retinal detachment. The anatomical success does not correlate with functional success and the rationale for this procedure is controversial. Prospective randomised studies are warranted.
   c. Chorioretinal venous anastomosis: chorioretinal anastomosis (surgical or laser induced) allows blood to bypass the blocked vein into choroidal circulation. Visual results are poor although functional anastomosis is achieved in 50%.[4] Complications include vitreous haemorrhage and choroidal neovascularisation. Timing of intervention is yet to be determined.

Follow-up

Follow-up is advised monthly for ischemic CRVO and three monthly for non-ischemic cases. After six months, patients with ischemic CRVO should be followed up three monthly for a year. Follow-up is not necessary after two years in uncomplicated cases.

Treatment of BRVO:

1. *Control of risk factors:* Treat underlying medical conditions and control glaucoma.
2. *Treatment of macular edema:*
   a. Laser: If visual impairment (<6/12) is due to macular edema, with no improvement by three months, grid laser is advised. It improves vision in 65% of patients (as against 37% in untreated group). Laser is not advised in presence of macular ischemia.
   b. Steroids: intravitreal steroids are used in patients not eligible for or those resistant to laser photocoagulation. Visual improvement by 2-6 lines is reported in 54%. Raised IOP (up to 62%), infection, cataract and retinal detachment are some of the associated risks.

   Safety and efficacy of intravitreal dexamethasone (Posurdex) is being assessed in phase-3 clinical trial, with initial promising results.[1]
3. *Treatment of neovascularisation*
   a. Laser: scatter laser photocoagulation of retina is advocated in patients with NVE to prevent vitreous haemorrhage. 61% of untreated eyes develop vitreous haemorrhage (29% of treated eyes).
4. *Treatment of underlying pathology*
   a. Isovolaemic haemodilution: haemodilution is effective during the first three months of onset of BRVO. 76% of haemodiluted patients achieve a final vision of 6/12 (43% in control). However it is not suitable for patients with cardiac failure and renal insufficiency.
   b. Arteriovenous sheathotomy (AVS): AVS relieves compression of the retinal vein improving retinal perfusion and reducing macular edema. Visual improvement by ≥ 2 lines is reported in 60%.[5] However, AVS is associated with complications such as cataract and retinal tear/detachment, and the optimal timing of intervention is unknown.

Follow-up

In presence of retinal ischemia, three monthly follow-up is advised to watch for NVE. Follow-up is not necessary after two years.

Conclusion

Retinal vein occlusions are a common retinal vascular disorder with multifactorial pathogenesis. Effective therapeutic options are very limited. Currently available treatments deal with complications of the disease, such as macular edema and neovascularisation, rather than the disease itself. Intravitreal steroids may be beneficial in selected cases of macular edema. Anti-VEGF agents such as bevacizumab appear to be promising, but their role is yet to be established.

Among interventions targeting the underlying pathology, haemodilution seems to be effective, but requires careful patient selection. The real therapeutic benefit of radial optic neurotomy, chorioretinal anastomosis and arteriovenous sheathotomy is unknown. Randomised controlled trials are warranted to confirm the efficacy and optimal timing of these interventions.

Author: Mr KC Madhusudhana MD, FRCS, MRCOphth
Southampton Eye Unit, Southampton

References

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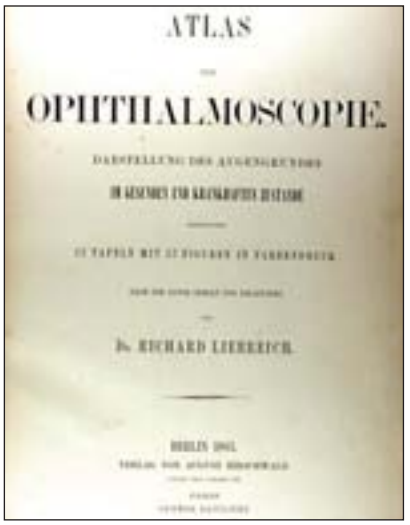
2. Glacet-Bernard A, Zourdani A, et al. Effect of isovoemic hemodilution in central retinal vein occlusion. Graefes Arch Clin Exp Ophthalmol 2001; 239: 909-914.
3. Opremcak EM, Rehmar AJ, et al. Radial optic neurotomy for central retinal vein occlusion: 117 consecutive cases. Retina 2006; 26(3): 297-305.
4. McAllister IL, Douglas JP, Constable IJ, et al. Laser-induced chorioretinal venous anastomosis for nonischemic central retinal vein occlusion: evaluation of the complications and their risk factors. Am J Ophthalmol 1998; 126: 219-229.
5. Mester U, Dillinger P. Vitrectomy with arteriovenous decompression and internal limiting membrane dissection in branch retinal vein occlusion. Retina 2002; 22: 740-746.

Museum Piece
Fundus Oculi Artists

In the middle of the 19th century ophthalmologists suddenly had a new tool for examining the eye… the ophthalmoscope.


ATLAS

OPHTHALMOSCOPIE.

Richard Liebreich Atlas 1863


Fundus paintings


Eduard von Jaeger


Fundus paintings from 1869 atlas


Bird fundi by Arthur Head


Theodore Hamblin's illustration department

Those who obtained one of these instruments had little idea either of how to use it, or of how to recognise retinal disease. The first published fundal painting was by Adrian van Trigt in his dissertation, *Speculo Oculi* (1853); but coloured illustrations were not widely available until the appearance, in 1863, of Richard Liebreich's Atlas. This contained 12 lithographic plates and a monochrome drawing of a normal fundus overlaid with a one-millimetre-square grid. Liebreich, an accomplished artist, painted these while with von Helmholtz in Berlin; he achieved great accuracy and speed by using a camera lucida attached to his own table-mounted ophthalmoscope.

Eduard von Jaeger, descended from a well-connected family of ophthalmologists, was also an artist but his method was much slower. He required 20 or more two-hour sessions just to complete the sketch; one painting reputedly took 100 hours.

From the late 1800s until the 1920s Arthur Head FZS had a major impact on fundus illustration, providing all the images for Adam Frost's *'The Fundus Oculi Atlas'*, Casey Wood's *'Atlas of Bird Fundi'* and Lindsay Johnson's *'Animal Fundi'*. He established the illustration department of Theodore Hamblin (dispensing opticians) which served ophthalmologists until the Second World War: patients' eyes were painted in duplicate, one copy for the referring ophthalmologist and the other kept as a record.

Even colour fundus photography, introduced by Nordensen (Zeiss) in 1925, did not spell the demise of the fundus artist. More recently the incomparable Terry Tarrant (honorary fellow) worked at the Institute of Ophthalmology and created hundreds of illustrations, including many of those in Duke-Elder's *'System of Ophthalmology'*.

Richard Keeler
Museum Curator

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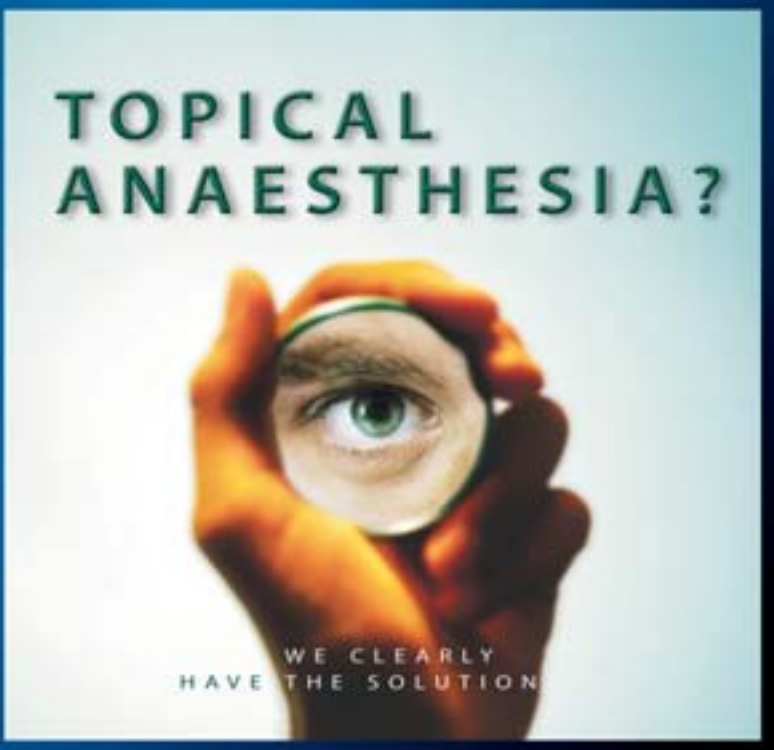

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College Events

THE ADMISSIONS CEREMONY was held in June at the magnificent Plaisterers Hall in the City of London. The highest number ever of successful examination candidates received their diplomas and Anthony Chignell, David Taylor and Keith Waddell were presented with honorary fellowships. An edited version of citation given for Mr Chignell is produced below, and future editions of *College News* will précis the other citations.

A stirring address was given by Dr Fiona Adshead, a deputy chief medical officer and the afternoon finished with a splendid tea.

Matthew Simunovic	**Duke-Elder Undergraduate Prize**
Anandshil Chawla	**Crombie Medal**
Timothy Cochrane	**Elizabeth Hunt Medal**
Monika Pradhan	**Harcourt Medal**
Philip Alexander	**McCartney Prize**

Mr Anthony Chignell

Madam president, members of council, ladies and gentlemen – it is a great personal pleasure to introduce Mr Anthony Chignell to you.

Actually never known as anything other than Tony, he was, in effect, born and bred at St. Thomas' Hospital. He qualified in 1962 and, within four years, was a Resident at Moorfields Eye Hospital and then senior registrar at Moorfields and St. Thomas' Hospitals and Lecturer at the Institute of Ophthalmology. He tells many stories – mostly unrepeatable – of the glory days of the pioneers of retinal detachment surgery at the Highgate Annex of Moorfields, and of the rivalries between those pioneers.

He was appointed consultant at St. Thomas' in 1973 and three of the current officers of this College plus the present president and the immediate past president, trained with him.

He always took care to promote training of UK retinal surgeons and he set an outstanding example – he always drew the retina himself – how many retinal surgeons can say they do this nowadays? He examined the patient better and in more detail than his junior colleagues. His standards were exacting but exerted with good, if somewhat caustic, humour. He was, and is, famously loyal and generous to his trainees, past and present.

He has published over 100 papers, having set up from the outset prospective studies in retinal surgery with a primitive punch card database that needed dexterity with a knitting needle to extract the data, until the advent of computers. He published right up until his retirement, latterly with many papers in the field of cell biology related to vitreoretinal surgery. He has written two well known textbooks, one of them with an ex-fellow, now senior vice-president of this College. He had a large vitreoretinal practice and an international reputation.

He has always had a commitment to charitable work; he became master of the Worshipful Company of Spectacle Makers in 2000 and was a governor of the Royal National School for the Blind. He worked with many charities in the interest of funding research in ophthalmology and has been notably successful as a trustee of Fight for Sight and the Ridley Foundation. He had a long association with the Guide Dogs for the Blind Association, serving on its Council for thirteen years, and as chairman of its scientific committee, ensuring that, at a difficult time for that charity, research in ophthalmology continued to benefit from its donations.

Finally, in 2002 he was appointed Hospitaller to the Order of St John, effectively the executive chief of the St John Eye Hospital in Jerusalem. The hospital had been going through some dangerously difficult times but in his hands, the organisation has turned around. He has raised its profile in the Palestinian community and within the Order, the finances are more secure and the hospital is providing desperately needed ophthalmic care to an increasing number of patients, despite very difficult political circumstances. This has required huge personal effort and commitment and for all his work we honour him today.

John Talbot

THE ANNUAL CONGRESS 2006

Congress 2006 was held at the Manchester International Convention Centre/G Mex in May 2006. It was organised by the winning team of Professor David Wong and Winfried Amoaku who were ably supported by Heidi Booth-Adams and Nicky Briggs.

Eponymous lecturers:

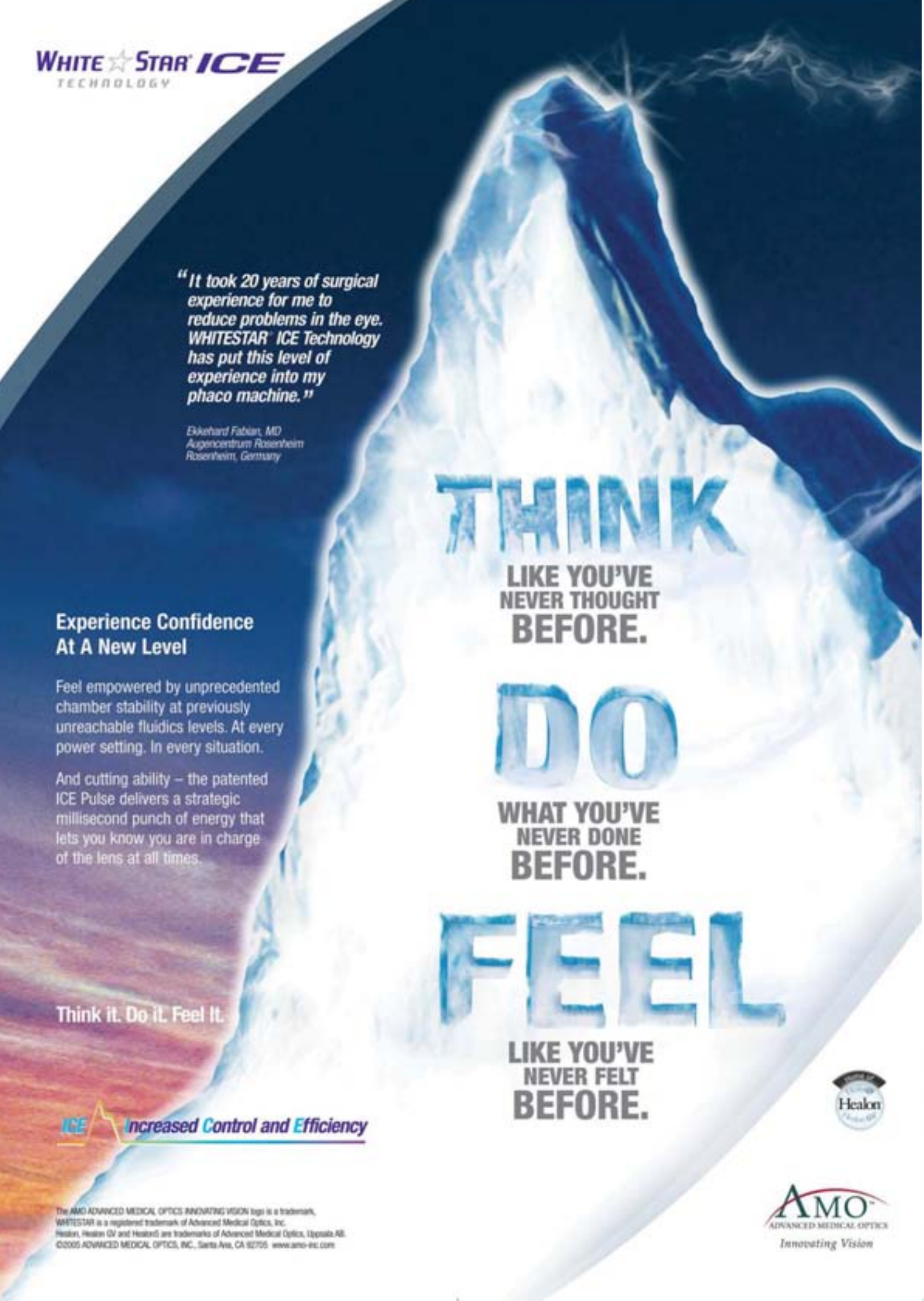
Bowman Lecture
Professor Alistair R. Fielder
London

Edridge Green Lecture
Professor Dean Bok
University of California
Los Angeles
USA

Duke Elder Oration
Professor Bradley R. Straatsma
Jules Stein Eye Institute
Los Angeles
California
USA

Alistair receiving the Bowman medal from Nick Astbury

WHITE STAR ICE
TECHNOLOGY



"It took 20 years of surgical experience for me to reduce problems in the eye. WHITESTAR® ICE Technology has put this level of experience into my phaco machine."

Ekkehard Fabian, MD
Augencentrum Rosenheim
Rosenheim, Germany

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Innovating Vision

International Centre for Eye Health

The International Centre for Eye Health (ICEH) was established in 1980 to address the need of low income countries for expertise in prevention of blindness and treatment of eye diseases. Its key activities are:

- Research into the main blinding eye diseases and their treatment
- Training for eye health workers from low income countries
- Information and education for eye health workers worldwide.

Schematic representation of ICEH activities

Global Impact – VISION 2020

ICEH is at the forefront of the three key areas (see diagram), which together make up VISION 2020: The Right to Sight, the Global Initiative to Eliminate Avoidable Blindness. It plays a key role through research into disease control, training of programme leaders through its MSc, Diploma and short courses, developing an international network of training institutions in community eye health, and provision of up-to-date educational materials for frontline eye care workers in low income countries.

Training Courses

A one-week VISION 2020 course is held at ICEH in the first week of July each year, and is a useful introduction for UK ophthalmologists considering working overseas. On 21-23 November this year there is also a tropical ophthalmology course. Contact Emma Sydenham (emma.sydenham@lshtm.ac.uk) for more information. ICEH's flagship courses are its MSc and Diploma in Community Eye Health, the first of their kind in the world and now successfully replicated in other countries. To date over 4,600 students have undertaken courses either in the UK or overseas. Many former MSc students now hold influential positions in Ministries of Health, UN agencies, universities and international NGOs.

International Research

ICEH has a worldwide reputation for its research, currently focused on childhood blindness, cataract and trachoma. The results inform the development of eye care programmes in places where little, if any, reliable information is available.

International Capacity Building

A key objective of ICEH is to strengthen the human resource capacity needed to implement effective and sustainable VISION 2020 programmes in developing countries. In the last four years, 117 training workshops have been held in 57 countries. Workshops are organised, led and implemented locally, with co-ordination by ICEH. The main focus now is the design and implementation of realistic plans for the prevention of blindness at the local community level and maintaining pressure on governments to ensure they invest the necessary resources to make their VISION 2020 plans a success. Good sources of information include:

I. The International Resource Centre

The Centre is housed at ICEH, 8 Bedford Square, London WC1 (tel. 020 7958 8168 or email sue.stevens@lshtm.ac.uk) and is a unique resource for eye health workers. It is available to any College member wishing to obtain information, perhaps prior to a visit overseas.

II. Community Eye Health Journal

The quarterly Journal provides a wealth of practical ideas, reviews and updates and is sent free of charge to 22,500 eye health workers. It is often the ONLY up-to-date information they receive. Back issues can be viewed on www.jceh.co.uk

III. e-Communications

Our communications activities focus on making materials and resources easily available for teaching and learning. An online 20,000 image database will be available on the website and CD-ROM in early 2007. See www.iceh.org.uk

BOSU Surveillance

Study Bursaries 2006 - Closing Date 6 October 2006

The BOSU is offering to provide two awards of £5,000 towards the costs of a one-year ophthalmic surveillance study. These awards are to undertake an epidemiological study using the BOSU case ascertainment system. Applications that involve an ophthalmologist in training will be viewed favourably. It is hoped that this will:

- Add to the body of knowledge of rare eye diseases and conditions.
- Enable Ophthalmologists to develop their research knowledge and skills.
- Promote the role of the BOSU in the surveillance of rare eye diseases
- Encourage ophthalmologists who are not research active to undertake a study of a rare eye disease or condition and which is of scientific or public health importance.

Applications will be assessed upon their suitability for nationwide surveillance, public health and/or scientific importance and the achievability of the research questions. Applications should provide: (max two sides of A4,)

a) General background to the disorder including objectives.
b) A draft case definition.
c) Proposed research questions.
d) If possible, the expected number of case reports.
e) Justification for accepting the study.
a) Name of Study Supervisor (Ophthalmologists in training only)

Contact Barny Foot for an informal discussion, assistance with preparation of applications or to request guidelines. BOSU@rcophth.ac.uk or 07808 581659.

Independent Sector Treatment Centres

In December 2005, the House of Commons Health Committee announced that it would undertake an inquiry into Independent Sector Treatment Centres (ISTCs). The College submitted evidence and Simon Kelly appeared before the Committee.

The main finding of the Committee's report, published in July, was that the Department of Health failed to provide evidence of the benefits of (ISTCs). The Committee supported the separation of elective from emergency care but could not agree that ISTCs provided better value for money than NHS Treatment Centres, or partnership arrangements made with private hospitals.

It held that ISTCs have not made a major contribution to increasing capacity within the National Health Service. Perhaps the most damning point was:

'We were surprised that the Department made no attempt systematically to assess and quantify the effect of competition from ISTCs on the NHS. Given its importance, the Department should have ensured that this was done from the beginning of the ISTC programme in 2003.'

The MPs questioned the wisdom of further investment in ISTCs in Phase 2 and were concerned that the expansion of the ISTC programme would destabilise local NHS trusts, especially those with financial deficits.

The report concluded that ISTCs should only be built where there is a local need and where the local health community agrees there is a need.

Skills Centre Faculty

A Vitreoretinal HST Study Day will held on Friday 13 October. The Closing Date is Friday 15 September

Training the Trainers

Wednesday 27 Sept 06: What to teach/How to teach
Tuesday 7 Nov 06: Improving teaching skills/Feedback and appraisal
Tuesday 21 Nov 06: Assessment/Problem solving
Booking forms available on the Education section of the College website.

Travel Awards and Monetary Fellowships

	Number/Value	Closing date
Dorey Bequest/ Sir William Lister Travel Awards	4 awards of £400 to £600	6 October 2006
Ethicon Foundation Fund Travel Awards	4 awards of £400 to £1,000	10 November 2006
Pfizer Ophthalmic Fellowship	1 award up to £35,000	27 October 2006 Interviews: 8 December 2006
International Glaucoma Association Fellowship	1 award up to £30,000	22 June 2007

For application forms and eligibility requirements please visit the Education section of the College website

THE HEALTH FOUNDATION – QUALITY IMPROVEMENT FELLOWSHIPS

Three fellowships are available for senior NHS leaders who are clinically qualified. They include a place on the clinical effectiveness programme at the Harvard University School of Public Health. See www.health.org.uk
Closing date for applications - **9 November 2006**.

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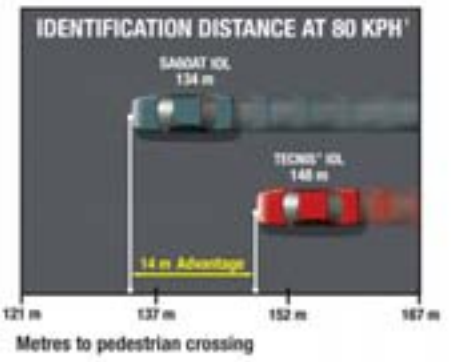

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Cataract National Audit Dataset Standardisation

The Cataract National Audit Dataset was developed so that the majority of its content can be collected as part of the normal clinical process by electronic patient record systems. The team has set out to show the NHS ISB the ease with which this dataset could be adopted by ophthalmic clinics nationally. It recently completed a pilot of the dataset across multiple sites in the UK, including technical 'testing' of the dataset.

The next stage will be a temporary period of implementation to test the dataset 'in action'. A variety of sites will participate to provide sufficient evidence that the dataset works at different types of sites, and with differing data-collection capabilities. The results will feed into the team's next ISB submission: the Full Standard Submission.

Once ISB approved, the dataset will be considered a full operational standard that can be nationally implemented. Members will receive due notice of the implementation and the project and the College will issue guidance.

Research for the Ophthalmology 'User Guide'

The project has highlighted the need for an ophthalmic 'guide' on the common conventions used throughout patient care and the team is researching

- acronyms and abbreviations
- diagrams and data arrangements
- recording conventions

The team will compile comprehensive lists of:

- knowledge access requirements and common 'desktop icons' for ophthalmology (e.g., Athens, NeLH, RCOphth, Choose & Book)
- ophthalmic equipment interfaces (including the type/format of outputs, software, etc.)

The team would be keen to hear from anyone that would be interested in contributing to the dataset or ophthalmic convention work. Please email Michellebrough@nhs.net for further information.

The Sharing Continues

The 'Do Once and Share' Cataract Project was completed in March 2006 and we are delighted that further work has been approved to:

- Take the Cataract National Audit Dataset through the NHS Information Standards Board (ISB) approval process.
- Compile a comprehensive 'user guide' to identify existing conventions used in ophthalmology.

This work, managed by the former Cataract Team project manager, has input from key contributors, including other DOAS teams and the College. The deadlines are tight, but thanks to the help of the ophthalmic community, the team is confident that they can be met.

From the Order of St. John Hospitaller

I am very grateful to those who give time to go to work at the Eye Hospital in Jerusalem, and I am always on the look out for additional volunteer ophthalmologists to help us. The Hospital has had the strongest of links to the United Kingdom since its establishment in 1882.

I know that for those in mid career only a short visit would be possible but perhaps for those of you at the "end" of your NHS work, a longer trip would be feasible.

The Hospital and its surroundings feel quite safe - ask any body that has visited. To work there is remarkably rewarding and it really does help us enormously – not only to give help to our clinical and teaching efforts but to provide a vital link to a hard pressed community in a difficult part of the world. Please contact me:
Anthony Chignell , Priory House, 25 St.John's Lane, Clerkenwell, London EC1M 4PP.

Gifts for the College

Two gifts from immediate past president, Nick Astbury, grace the reception rooms.

The English drop-dial wall clock dates from around 1860. It has an eight day Fusee movement, convex dial and cast bezel with the pendulum visible through a glass window. It will be the duty of the College staff to wind it up every Monday morning!

The oil painting is a still-life by Sargy Mann (b 1937), before and after undergoing cataract surgery in 1973. He was myopic and suffered recurrent complicated retinal detachment, becoming blind in 2005. His notes about the painting reveal the remarkable change in subjective awareness of colour following cataract surgery.

"Everything looked extremely blue through my operated eye. Blues and violets seemed quite amazingly intense. Where this is most remarkable is in the reflection of the blue sky in shining leaves in deep shadow. I keep on coming across caches of jewel-blue laurel or bay leaves, cushions encrusted with unbelievably blue ivy leaves, carpets of blue periwinkle."

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College Seminar Programme 2006

Diabetic Eye Disease
13 September
The Institute of Physics,
76 Portland Place, London
CHAIRED BY: Miss Clare Bailey, Bristol

Advances in the Investigation and Treatment of Corneal Disease
29 September
The Institute of Physics,
76 Portland Place, London
CHAIRED BY: Mr Jeremy Prydal, Leicester

Elizabeth Thomas Seminar – Macular Disease
13 October
East Midlands Conference Centre, Nottingham
CHAIRED AND ORGANISED BY:
Mr Winfried Amoaku, Nottingham

Clinical Skills and Imaging Techniques in Age Related Macular Degeneration
1 November
The Royal College of Ophthalmologists, London
CHAIRED BY: Mr Ian Pearce, Liverpool, Mr Yit Yang, Wolverhampton

Neuro ophthalmology
22 November
The Royal Society of Medicine
CHAIRED BY: Mr James Acheson

Regional Study Days

Nerves and Orbits
11 September
Royal Glamorgan Hospital, Llantrisant
CHAIRED BY: Mr Nick Hawksworth
CONTACT: Gaynor Howells
01443 443588

Please visit:
www.rcophth.ac.uk
for latest on The UK National Anophthalmia and Microphthalmia Study

Other events

2006

9 September
UKISCRS Annual Meeting at ESCRS
Excel, London
ukiscrs@onyxnet.co.uk

13 - 16 September
European Oculoplastic Meeting
Joint ESOPRS and BOPSS (European Society of Ophthalmic Plastic and Reconstructive Surgery) and (British Oculoplastic Surgery Society
Imperial College, London
www.bopss

15 September
Vision Research 2006
University Of Bristol
www.bris.ac.uk/ophthalmology/news.html
maggie.cook@bristol.ac.uk

2 – 6 October
Macular Course
The Museum of London
courses@moorfields.nhs.uk

17 November
Medical Contact Lens & Ocular Surface Association Annual Scientific Meeting
The Royal College of Obstetricians & Gynaecologists, London
www.mclosa.org.uk
jackie@events01.globalnet.co.uk

22 November
3rd Annual Tensions in Glaucoma Meeting
Lumley Castle, Chester le Street, Durham
psphelan@doctors.org.uk

22 - 24 November
Western Eye Hospital – celebrations for 150 years
22 November – Dinner at the Landmark Hotel, London
23 November – Open Day
24 November – Scientific Meeting
catherine.pattemore@st-marys.nhs.uk

24 November
2nd Birmingham "GLAUCOMA MASTER CLASS"
The National Motorcycle Museum, Solihull,
cheryl.frost@alconlabs.com

14 December
2nd Aberdeen Neuro-ophthalmology Symposium
Institute of Medical Sciences, University of Aberdeen,
m.m.mcconnell@abdn.ac.uk

2007

14 June
Seniors Day
The Royal College of Ophthalmologists
Details to be announced in future editions

12 – 14 January
ARCUS
Four Pillars Hotel, near Bristol
www.four-pillars.co.uk
anne.williams@bristol.ac.uk

1 – 4 February
The 65th Annual Meeting of the All India Ophthalmological Society,
Hyderabad, India
www.sunayana2007.org
pswarup@satyam.net.in

28 - 31 March
6th International Glaucoma Symposium
Athens, Greece
Deadline for abstracts - 2 November 2006
www.kenes.com/glaucoma
reg_IGS2007@kenes.com

15 June
Annual Scottish Glaucoma Symposium
The Royal College of Surgeons, Edinburgh
denise.grosset@faht.scot.nhs.uk

Look at the College website www.rcophth.ac.uk for details of the RCOphth Study Tour to Syria, February 2007

New appointments

Mr Jonathan Rossiter	Taunton & Somerset Hospital, Taunton
Miss Shuaib Chaudhary	Birch Hill Hospital, Rochdale
Mr Mark Williams	Moorfields Eye Hospital, London
Mr Alan Ang	Royal Hallamshire Hospital, Sheffield
Mr Moin Mohammed	St Thomas' Hospital, London
Miss Athina Kipioti	Birmingham Heartlands Hospital
Mr Simon Woodruff	Addenbrooke's Hospital, Cambridge
Dr Wing Chuen Chan	Royal Victoria Hospital, Belfast

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College News is published by The Royal College of Ophthalmologists. Editorial and design services by Chamberlain Dunn Associates. Printing by Annodata