

# College NEWS



Winter  
2006



## What is the College doing about.....?

Inaugural meeting of Staff and Associate Specialists Ophthalmologists Group

Halfway through my first year as your president on 'a ticket' to champion excellence in the practice of ophthalmology and what are we doing?

- We've responded with your views on IS-TCs, 'Good doctors, safer patients', prescribing for optoms.
- We've alerted the PCT commissioners and NICE to the need for the new treatments for ARMD to be available to our patients – and the need for ophthalmologists to treat them.
- We have published some interim guidelines on the Management of ARMD and some in draft for Retinopathy of Prematurity.
- We've inaugurated a forum for staff and associate specialist ophthalmologist members at the College with a view to representation on Council.
- We are well on the way to official approval for our continuous electronic record and audit systems for cataract surgery, glaucoma management and diabetic retinopathy treatment.
- We are running pilots for the new specialist training scheme – one of very few colleges to do so – should make 'take off' more comfortable.
- We are the first college to receive approval from PMETB for the new style curriculum – it is on our website. Have a look.

<http://curriculum.rcophth.ac.uk/>

- We have a new exam structure to conform with the PMETB rules.
- We spoke up in support of international medical graduate ophthalmologists.
- We have recruited some excellent new members to our Lay Advisory Group bringing a variety of expertise and experience to inform and assist our work.

### There is much more....

Ophthalmologists are the ones to lead for ophthalmic practice for the patients of our country and we are doing it on your behalf. You have a great team of hard working officers and Council members and many other college members are contributing considerable amounts of time and effort on your behalf, ably supported by the 20 college staff. Thank you.

Make your views on these and any others issues known through your regional rep or to me at the College: [president@rcophth.ac.uk](mailto:president@rcophth.ac.uk) and there is lots more information on the website [www.rcophth.ac.uk](http://www.rcophth.ac.uk) about what we are doing.

*Happy Christmas*

Brenda Billington  
President

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

### Copy deadlines

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

## Congress News

Congress will be making a welcome return to The ICC in Birmingham next year. Please ensure you have the dates in your diary:

**Tuesday 22nd to Thursday 24th May 2007.**

We are delighted that many esteemed ophthalmologists have agreed to chair sessions and we have an excellent programme planned. Sessions include:

*All in the Mind* - Mr Richard Harrad

*Allergic Eye Disease* - Mr. Stuart Cook

*Artificial Vision* - Mr. Winfried Amoaku & Mr. Dinesh Verma

*BOPSS Highlights* - Mr. Anthony Tyers

*Bowman's Club Highlights* - Mr. Stephen Kaye, Mr. Francisco Figueiredo & Mr. Frank Larkin

*British & Eire Glaucoma Association Highlights* - Mr. Ian Cunliffe

*Cataracts in Children* - Mr. Arvind Chandna & Ms. Isabelle Russell-Eggitt

*Common Vertical Deviations* - Mr. Arvind Chandna & Ms. Gill Adams

*Diabetic Maculopathy* - Mr. Jon Gibson

*Diabetic Retinopathy Screening* - Mr. Peter Scanlon & Mr. John Talbot

*Duke Elder Lecture* - Professor Andrew Dick

*Edridge Green Lecture* - Mr. Richard Harrad

*Evolving Techniques in Corneal Surgery: Layer by Layer* - Mr. Stephen Morgan & Professor Harminder Dua

*Infective Uveitis* - Mr. Carlos Pavesio

*Intracranial Aneurysms* - Mr. Mike Burdon

*IOL Design, Wavefront Technology in Cataract Surgery* - Mr. Larry Benjamin

*Lacrimal without Tears* - Mr. Geoffrey Rose

*Medical Ethics* - Mr. Graham Kyle

*Myasthenia* - Dr. Gordon Plant

*Ocular pathology* - Professor Phil Luthert

*Ophthalmology Showcase* - Professor David Wong

*Research Methodology* - Mr. John Sparrow

*Retinal Dystrophies* - Professor Anthony Moore

*Teaching the Teachers* - Mr. David Smerdon & Mr. Michael Nelson

*The Great Debate* - Mr. Larry Benjamin

*To make virtue of necessity: The Primary Care Tales* - Mr. Nick Astbury

*What's New in Glaucoma?* - Professor Peter Shah

Please visit the website for the latest news [www.rcophth.ac.uk/scientific](http://www.rcophth.ac.uk/scientific)

For the energetic among the membership, Bausch & Lomb will be holding a 5 a side football tournament on the Wednesday evening. Please contact Marcia Cotton on 020 8781 2986 or [marcia.cotton@bausch.com](mailto:marcia.cotton@bausch.com)

Heidi Booth-Adams  
Head of the Scientific Department

## Child Protection and The Family Justice Council

In order for the Child Protection system to function properly, experts within the relevant medical disciplines, including ophthalmology, need to engage with the civil and criminal justice systems. Such engagement, however, carries with it a risk to the expert's reputation and career, which has led to a shortage of expert witnesses for these cases.

These, and other difficulties within the Family Justice system, have led to the Department of Constitutional Affairs establishing the Family Justice Council (FJC). The Council's primary role is to promote an inter-disciplinary approach to the needs of family justice, and through consultation and research, to monitor the effectiveness of the system and advise on reforms necessary for continuous improvement. Local branches of the FJC have been established in many areas, and it is hoped that by a mutual exchange of information between local committees and the council, best

practice can be disseminated throughout the family justice system. The FJC also provides guidance and direction to achieve consistency of practice throughout the family justice system and submits proposals for new practice directions where appropriate.

The FJC advises Government on changes to legislation, practice and procedure to improve the workings of the family justice system.

Issues currently being considered by the FJC include the promotion of strategies to improve the supply and quality of experts, e.g. training and accreditation of expert witnesses.

The FJC meets four times a year, in London, and is supported by a dedicated secretariat based in the Royal Courts of Justice. More information is available at [www.family-justice-council.org.uk/](http://www.family-justice-council.org.uk/). I represent the College on the Experts' Committee of the FJC and would be happy to discuss its work further with interested members.

Michael Clarke

## CONGRATULATIONS

to **Miss Michèle Beaconsfield**, Consultant Ophthalmologist, Moorfields who has been elected as President of the Ophthalmic Section of the Union Européenne des Médecins Spécialistes (UEMS). The four year term will begin in January 2007.

## COLLEGE OFFICERS

The Honorary Secretary, **Mr Larry Benjamin**, will come to the end of his first term in May 2007 and has been nominated to stand again. The Honorary Treasurer, **Mr John Talbot**, has decided to stand down after five years in the post.

Both posts are open to any College member and anyone who wishes to nominate for either post should contact the Chief Executive by 8 January 2007.

# Obituaries

**Mr Derek Ainslie (1919 – 2006), the pioneer of refractive surgery in the UK**, trained at Cambridge and The Middlesex Hospital, graduating in 1944. He immediately joined the Royal Army Medical Corps and was posted to Africa for several years before returning to London to resume his career. He trained in ophthalmology at the Middlesex Hospital, and at Moorfields; being appointed Consultant first at the Middlesex Hospital, and subsequently at Moorfields, City Road in 1960.

He was permitted by Moorfields to confine his own clinical and surgical endeavours to the field that really fascinated him - anterior segment surgery of the cornea, iris and lens - leaving the management of retinal problems to his Senior Registrar.

In Bogotá, Colombia, he studied new techniques for the surgical improvement of the refractive state of the cornea. There were two basic techniques. The first involved lifting up the front surface of the eye by forming a thin, hinged flap under which the shape of the cornea is changed. The second uses corneal tissue from a donor, which is frozen, reshaped and transplanted into the patient.

These techniques, devised by the Spanish surgeon, Professor José Barraquer, were the forerunners of many methods for refractive surgery in current use today. Derek, however, was immensely cautious, mastering the difficult techniques using Barraquer's microkeratome – a device with an oscillating blade designed for creating a corneal flap of 100-200micrometres.

He used donor eyes initially, and then carried out operations on the eyes of volunteers with dense amblyopia. A tiny piece of cornea had to be removed, quick frozen, reshaped on a miniature lathe and then replaced in the eye. A slip would have been calamitous. In order to minimise mistakes, he made a tape recording with step-by-step instructions to play in the operating theatre during the procedure. The results were technically superb but were not reliably followed by excellent visual results. He continued to work with myopic patients and young patients without a natural lens, known as aphakes, for whom he would insert a ground lens of donor corneal tissue within the patient's corneal stroma.

This work was sadly interrupted in 1975 with the onset of a severe illness compounded by visual loss from glaucoma and he retired at the age of 55.

Derek was a man of immense charm, a delight to be with and a keen supporter of Arsenal, whose home games he would attend, complete with hat, scarf and rattle! Lucky juniors who showed the slightest interest would be invited along to lend their own support.

Derek's last years were spent with his loving family, especially with his adoring grandchildren.

Arthur Steele and others

We also note with regret the death of:

**Percival Louis (Val) Allen** Aldershot, Hampshire

**THE ACTON TRUST FOR THE BLIND** (ATFB) has been funded to produce an 80 minute oral history on CD documenting the Second World War, which will go to libraries, schools and museums. It is looking for people who were visually impaired during WW2 and lived, worked or went to school anywhere in London. Contact: 020 8563 2922 or [info@actiontrustfortheblind.org](mailto:info@actiontrustfortheblind.org).

## 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](mailto: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.

Jackie Trevena, Head of Finance and Membership

**THE NETTLESHIP MEDAL** is awarded every 4 years for the best piece of original work by a British ophthalmologist (even in training) published in any journal during the last three years. This year the award goes to **Mr Michael Clarke**, Consultant Ophthalmologist in Newcastle. His paper "randomised controlled trial of treatment of unilateral visual impairment detected at preschool vision screening" was described by the panel of judges as being a definitive study of considerable importance with implications for clinical practice. He joins a distinguished list of ophthalmologists dating back to 1904 that includes, George Coats, Treacher Collins, Sir Stewart Duke Elder and Henry Stallard. David Wong



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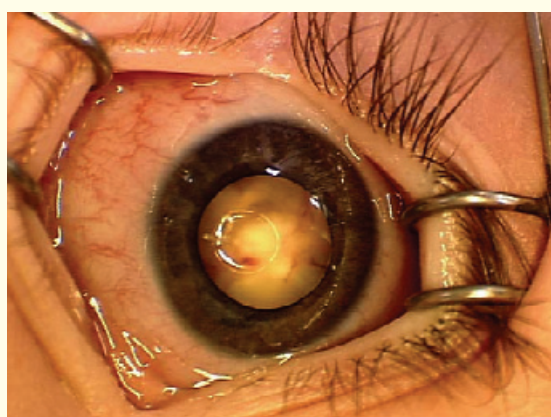
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# Focus



Winter  
2006

## Retinoblastoma



Caption?

### Introduction

Retinoblastoma is a malignant tumour of the retina, which affects between 35 and 45 children per year in the United Kingdom. The children typically present in the first two years of life and 30% - 40% of them will be bilaterally affected.

All bilaterally affected children, all children with a positive family history and 8%-10% of unilaterally affected children will have a germ line mutation predisposing them to retinoblastoma and carrying implications for their future well being and for the likelihood of family members being affected.<sup>1</sup>

### Presentation

Most children with retinoblastoma present with either leukocoria or strabismus. Buphthalmos, heterochromia, pseudohypopyon, severe inflammation and raised intracranial pressure are all recognised but rare presentations.

There is considerable evidence that early detection offers the best chance of successful treatment of retinoblastoma, and one of the major challenges facing all service providers is to identify affected children whilst the tumours are small enough to allow effective conservative therapy.

In a UK setting, where relatively early presentation is the norm, long-term survival can be anticipated in 95% or more of the children. However, in other parts of the world where diagnosis and/or treatment may be delayed until extra-ocular spread has occurred, 5 year cancer free survival is reduced to less than 20%.<sup>2</sup>

### Diagnosis

Diagnosis of retinoblastoma is essentially clinical, and requires a detailed fundus examination with indentation to

visualise the Ora Serrata. In children of this age there must, therefore, be rapid access to general anaesthesia to allow an adequate examination. The organisation of the UK service into two national centres ensures that the diagnosis and management is always in the hands of experienced clinicians and greatly reduces the risk of false positive and false negative diagnoses.

Examination under anaesthetic is often combined with imaging – particularly ultrasonography to identify calcification within the tumour mass and MRI, looking for evidence of optic nerve involvement.

There is no role for diagnostic biopsy and indeed, breaching the corneo-scleral envelope, either spontaneously or iatrogenically, is associated with a substantial increase in the likelihood of orbital and distant dissemination, which in turn carries with it a much poorer prognosis.<sup>3</sup>

A comprehensive differential diagnosis of leukocoria is well known to all Ophthalmologists, but in reality the major diagnostic dilemmas seen in a retinoblastoma service are Coat's disease, persistent hyperplastic, primary vitreous and retinal dysplasia associated with Norrie's disease. We also see occasional children with tuberous sclerosis or intraocular metastases from other malignancies.

### Management

For more than 50 years it has been recognised that retinoblastomas are vulnerable to the effects of radiation and for most of that period plaque brachytherapy or external beam radiotherapy have been the mainstays of conservative treatment.

While plaque brachytherapy remains an invaluable treatment modality, external beam radiotherapy has largely

been replaced by chemotherapy as the first line conservative management. Increasing recognition of the long-term adverse effects of external beam radiotherapy on the facial skeleton, the neuro-endocrine system and, particularly, the substantial increase in second tumour formation, has led to this fundamental change in approach.

Children with germ line mutations have a relatively high risk of second malignancy in early adulthood by virtue of their dysfunctional tumour suppressor gene. They have a 5 fold increase in risk as compared to the general population with a particularly high relative risk of developing bony or soft tissue sarcomata. That risk of a second malignancy, however, rises to between 18% and 35% by the age of 35 if the children are exposed to external beam irradiation.

The UK chemotherapy regimen employs a combination of Vincristine, Carboplatin and Etoposide given in 3 to 4 week cycles, and most commonly employing 6 cycles. The regimens used elsewhere in the world occasionally employ fewer (right down to carboplatin monotherapy) or more agents. There is particular interest in combining these three agents with Cyclosporin in an attempt to eliminate the problem of tumour multi-drug resistance. At the moment pre-treatment with cyclosporin is not widely used, but there are reports of impressive eye salvage rates in some children with recurrent disease.

The aim of chemotherapy in retinoblastoma treatment is usually to reduce the size of the tumour (chemoreduction) and allow complete tumour control with adjunctive focal therapy. Only rarely is complete tumour control, with chemotherapy alone, the objective.

The focal therapies employed include laser therapy (particularly trans pupillary thermotherapy) cryotherapy and plaque brachytherapy. For tumours situated at the macula, complete control with chemotherapy may be attempted to avoid the effect of macula thermotherapy on the child's long term vision. Once again, the results with this approach are variable.

For those children with tumours that cannot be controlled conservatively, or in children with unilateral disease where there is no possibility of preserving a seeing eye, it may well be deemed inappropriate to expose them to 6 cycles of chemotherapy. In that case enucleation offers a, usually, curative treatment. Both families and clinicians, however, need to remember that approximately 1 in 3 enucleated eyes show adverse histological features (optic nerve or deep choroidal invasion by tumour cells) which will necessitate 4 cycles of chemotherapy to reduce the risk of metastatic dissemination. It is also apparent that a proportion of children who have undergone enucleation in childhood develop significant psychological problems related to their enucleation and artificial eye as they grow older. A comprehensive service to the families needs to take account of these later developments.

### Genetics

Traditional genetic counselling for families with an affected member has been derived from a statistical analysis of risk. Review of 1600 UK families, for example, showed that if a parent had bilateral disease then the risk of the offspring

carrying the germline mutation is 50% and the risk to the offspring of developing retinoblastoma is 45%. The equivalent figures for the offspring of a unilaterally affected parent is a 4% chance of developing retinoblastoma, which if it occurs will almost always be bilateral.

Though this data is useful for guidance, in any individual it fails to provide absolute information. The identification of the retinoblastoma gene on the long arm of chromosome 13 has facilitated much more precise guidance to families, has introduced the possibility of pre-natal diagnosis and has led to a detailed, though as yet incomplete, understanding of the basic mechanisms involved in retinoblastoma formation.

The retinoblastoma gene, located at the 13q14 site of chromosome 13, is a large 27 exon 18 kbase gene responsible for the production of retinoblastoma protein (pRb). The Rb gene is a ubiquitous oncogene, and both alleles must be lost from a cell for it to undergo malignant transformation. In children with a germ line mutation one allele is missing from all cells and only the "second hit" causing loss of the homologous gene is necessary for retinoblastoma to develop. Loss of that homologue may be triggered by a number of agencies, but oncoviruses and radiation seem to be particularly important.

Gene sequencing enables mutation detection in the vast majority of children with a germ line mutation. This in turn means that family members can be screened and either eliminated from the need for repeated screening, or placed on an intensive screening programme to facilitate early tumour detection and treatment. An assessment from Toronto has suggested that mutation analysis has allowed 112 Ontario families to avoid 630 EUA's and 1416 clinic appointments. It also provides the information which allows prenatal diagnosis (using amniocentesis or chorionic villus sampling) and even embryo screening.

### Basic Mechanisms

Whilst cells are in the G1 phase of the cell cycle they may enter a quiescent stage, they may undergo senescence, apoptosis or they may differentiate. Once the cell progresses to the S phase then they proceed inevitably to cell division. The movement into the S phase is enabled by a number of transcription factors, of which E2F is pivotal. The role of retinoblastoma protein is to bind E2F and prevent the uncontrolled progression into S phase. Without its influence, cells show uncontrolled replication, which is the hallmark of malignancy.

This fundamental role of pRb in cell division explains not only the 90% incidence of retinoblastoma in germ line mutation carriers, but also the very significant increase in risk of other malignancies (sarcoma, melanoma, epithelial cancers) amongst carriers. In the future it may become possible to target this basic failure in the cell biology, in the hope of avoiding the general systemic effects of chemotherapy. Targeted therapy aiming to manage the gene defect or modify the cellular response to the defect, may well represent the "golden bullet" of retinoblastoma treatment.

Harry Willshaw

Consultant Ophthalmologist, Birmingham Children's Hospital

### References

- 1 Sanders BM, Draper GJ, Kingston JC "Retinoblastoma in Great Britain 1969-1980: Incidence, treatment and survival" Br J Oph (1983) 72 ; 576-583
- 2 Antonelli C, Steinhörst F, Ribeiro K et al "Extraocular retinoblastoma: A 13 year experience" Cancer (2003) 98 ; 1292-1298
- 3 Stevenson KE, Hungeford JL, Garner A "Local extension of retinoblastoma following intraocular surgery" Br J Oph (1989) 73 ; 739-742



# Museum Piece

## 150th Anniversary

### The Western Eye Hospital



The Western Ophthalmic Hospital 1856



The Western Ophthalmic Hospital 1956



Sir William White Cooper 1816 - 1886

The Western Eye Hospital is celebrating its 150th anniversary this year. It was founded in 1856 by Henry Obré FRCS and John Woolcott FRCS in a building at 1 St John's Place off Lisson Grove and was called the St Marylebone Eye and Ear Institution. Three years later it dropped "Ear" from the name.

In 1860 a building was rented at number 155 on Marylebone Road. Six years later the Institution was renamed The Western Ophthalmic Hospital which remained its name until recently when "Ophthalmic" was replaced by "Eye".

The hospital expanded in 1889 with the purchase of adjoining buildings and its own freehold.

This building was demolished in 1930 and the present hospital built on the same site.

In 1951 the ophthalmic outpatient department of St Mary's Hospital was moved to the Western Ophthalmic, and four years later, all ophthalmic work and post graduate training.

The only ophthalmologist who served at both hospitals in the 19th century was Sir William White Cooper (1816 – 1886) who was the first ophthalmologist at the newly opened St Mary's Hospital in 1851.

He was consultant ophthalmologist to the Western in 1876. In 1859 he had been made oculist to Queen Victoria who made him a knight in 1886. Two days after the announcement he caught pneumonia and died before he could be dubbed.

Among an impressive number of publications he is best known for 'Wounds and Injuries of the Eye', 1859, the first book written exclusively on the subject.

**Richard Keeler**  
Museum Curator



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**TOPICAL  
ANAESTHESIA?**





## INTERNATIONAL NEWS

### The British Council for Prevention of Blindness (BCPB)

'For she's a jolly good Fellow and so say all of us'. This is the view of the Trustees of the British Council for Prevention of Blindness (BCPB) of Dr Wanjiku Mathenge, whose PhD project will address the causes of some specific forms of blindness in her homeland of Kenya.

She is the holder of the Charity's first Sir John Wilson Fellowship, which honours one of our founder Trustees. The aim of this Fellowship is to support, to the tune of £60,000 per annum for three years, carefully selected individuals who will return home to set up units that will teach their compatriots how to develop and run blindness prevention programmes.

The Trustees hope shortly to make an appointment to a complementary Fellowship, the eponym of which will recognise the tremendous contribution that a past member of Council has made to the prevention of blindness worldwide. The Barrie Jones Fellow will be someone who aims to hold a senior appointment in the UK but whose research work will involve spending time in a low income country. Again, the

funding will be £60,000 a year (for two or three years, depending upon the appointee's career plans).

These recent developments result from a logical evolution of the BCPB's contribution to the prevention of blindness over the past thirty years.

Importantly, they combine research and training, both of which are cardinal features of the Charity's support in this field. One of the highlights of research we funded led to the introduction of Ivermectin, which has been so successful in the treatment of those with onchocerciasis. (It was a current Board member, Lady Wilson who, when travelling with her late husband in Africa, coined the readily remembered catchphrase 'River Blindness'). As regards training, we have contributed, over the past twenty five years, to the further education of some fifty MSc students (Boulter Fellows) studying at the International Centre for Eye Health, the brainchild of Professor Barrie Jones.

The present Trustees fully endorse the ambitious aims of VISION 2020 and believe the Charity is well placed to continue making a significant contribution to the prevention of avoidable blindness throughout the World.

For further information please visit [www.bcpb.org](http://www.bcpb.org)

Andrew Elkington

### International Ophthalmology Links and the Vision 2020 Links Programme

In Africa there is on average only one ophthalmologist per million people compared with 15 per million in the UK. The VISION 2020 Links Programme, based at the International Centre for Eye Health, works with eye training institutions overseas to identify their main needs and priorities and match them with a suitable UK training eye centre.

In July a letter went out to all UK consultant ophthalmologists seeking information about involvement (past or present) with overseas institutions with the intention of establishing a database of ophthalmic staff that have worked abroad or might be willing to be part of new initiatives to help eliminate avoidable blindness overseas.

There has been a wonderful response with over 185 ophthalmologists returning information which shows that over half are already associated with hospitals in 45 countries around the world. Almost all have indicated that they would like to be part of developing a link and 40% have been encouraging about their trust's potential willingness despite the present financial climate in the NHS.

By gathering this information we hope to be able to put people in touch with one another and match the needs of overseas partners with appropriate UK ophthalmic staff, eye departments or trusts. At present we have 17 links programmes either being developed or underway and in several cases the trust CEOs or Chairs are personally involved.

There is much to be done at home, but an even greater challenge is for us to share expertise, teach and train in parts of the world that are under-resourced and for whom blindness is part of daily life.

Thanks for your replies so far. The letter and form are on the ICEH website at: [http://www.iceh.org.uk/files/linksprograme/Links\\_UKdatabase.doc](http://www.iceh.org.uk/files/linksprograme/Links_UKdatabase.doc)

and if you would like more information on links please contact:

[nick.astbury@virgin.net](mailto:nick.astbury@virgin.net) or  
[marcia.zondervan@lshtm.ac.uk](mailto:marcia.zondervan@lshtm.ac.uk)

Nick Astbury

#### ROYAL COLLEGE OF OPHTHALMOLOGISTS STUDY TOUR

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# THINK

**LIKE YOU'VE  
NEVER THOUGHT  
BEFORE.**

# DO

**WHAT YOU'VE  
NEVER DONE  
BEFORE.**

# FEEL

**LIKE YOU'VE  
NEVER FELT  
BEFORE.**



# NEWS FROM THE EDUCATION AND TRAINING DEPARTMENT



## ORYCLE 2007

29-30 March

<b>Organised by:</b>	The RCOphth Ophthalmic Trainee Group (OTG)
<b>Topics to include:</b>	What being a consultant is really like, working with ORBIS, e-learning, how to be a good trainer.
<b>Venue:</b>	Princess on Portland Hotel, Manchester
<b>Cost:</b>	Course fee £155 (for dinner, accommodation and course fee)
<b>Day rate:</b>	£60

The Programme details and application forms are available on the college website [www.rcophth.ac.uk/training/otg](http://www.rcophth.ac.uk/training/otg), please email other queries to: [otg@rcophth.ac.uk](mailto:otg@rcophth.ac.uk)

## THE NEW CURRICULUM

In August 2007 there will be a major change in UK specialist training as the unified ("run-through") training grade begins. The College's Curriculum Sub-committee has devoted innumerable hours to developing a new Curriculum. It has also worked closely with the Training and Examinations Committees to ensure that learning and assessment is fully integrated and coordinated. The result is a curriculum written as a Learning Outcomes document based around 179 such outcomes. Widely lauded as an excellent piece of work, it has been approved by the Postgraduate Medical Education and Training Board, (PMETB), subject to the outcome of the pilot project currently running in two deaneries.

Those entering Ophthalmic Specialist Training (OST) with a new Training Number from August 2007 onwards must follow the new curriculum. Existing SpRs will normally continue on the old curriculum, although they may be given a chance to swap at some stage.

The Curriculum has been produced as a web-based document and the College acknowledges the educational grant from Pfizer Ophthalmology. Please visit [www.rcophth.ac.uk/education/new-curriculum](http://www.rcophth.ac.uk/education/new-curriculum)

If you have any queries or concerns please contact: [curriculum@rcophth.ac.uk](mailto:curriculum@rcophth.ac.uk)

## EXAMINATIONS NEWS

To **Mrs Emily Beet**, The Head of the Examinations Department, a daughter, Heather Louise Elizabeth, born 28 October. Congratulations to Emily and Steve.

The European Board of Ophthalmology Diploma examination will be held in Paris at the Palais des Congrès on the 4th & 5th of May 2007. The exam consists of an MCQ and four 15 minute vivas; success confers the Diploma of the EBO, recognised as necessary for specialist registration in several EU member states. Details may be obtained from the EBO website, [www.ebo-online.org](http://www.ebo-online.org)

**Training the Trainers:** These popular courses are offered in modular form and take place at the College.

Module	Title	Spring	Autumn
1	What to teach	Tuesday 27 March	Tuesday 25 September
2	How to Teach		
3	Improving Teaching Skills	Tuesday 8 May	Tuesday 2 October
4	Feedback and Appraisal		
5	Assessment	Tuesday 29 May	Wednesday 14 November
6	Problem Solving		

Please note that the course on modules 5 and 6 planned for Tuesday 21 November 2006 has been postponed until 23 January 2007. Places are still available. The website reference is <http://www.rcophth.ac.uk/education/traintrainers>.



# Professional standards

The following topics have been brought before the Professional Standards Committee:

## Luer Lock Cannulae Hazard

The danger of incorrectly mounted Luer lock intra-ocular cannulae as a potential risk in intraocular surgery has recently come again to the College's attention. Following a case report submitted to EYE the National Reporting and Learning (NRLS) database at the National Patient Safety Agency (NPSA) was searched for potential similar patient safety incidents. On this database 3 more similar cases and 1 'near miss' were retrieved. These cases and one other that also came to attention from another source, share a common theme. This is of intraocular cannulae –such as Rycroft, hydro-dissection or wound hydration cannulae- 'exploding' from syringes during cataract surgery and travelling harpoon like into the eye. Failure correctly to engage Luer lock cannula appears to be an issue, though faulty design cannot be ruled out. It is prudent to highlight such incidents to the Medicines and Healthcare products Regulatory Agency (MHRA) so that any device products concerned might be investigated further. Devices should be retained locally for further investigation if thought to be faulty. See [www.mhra.gov.uk](http://www.mhra.gov.uk) for more detail and contact your hospital's clinical risk manager.

Ophthalmic staff should be aware of this potential risk with intraocular cannulae despite Luer lock connectors to syringes. The prudent ophthalmic surgeon checks that the cannulae is firmly mounted on the syringe and first squirts some fluid through the cannula -away from the eye- to ensure that all is working correctly prior to intraocular use.

Simon Kelly

## The National Decontamination Project “Where was your phaco hand-piece last night?”

**Q.1 Concerned regarding cleaning of ophthalmic instruments?**

**Q.2 Experiencing instruments tray turnaround time problems?**

If you answered “yes” to either question above, you might enquire what is happening to your local Hospital Sterilisation and Decontamination Unit (HSDU) – or CSSD. If your local service hasn't undergone a major

revamp recently, it is likely to in the next few years.

The National Decontamination Project, run by the Department of Health (DH), started in 2000 within NHS Estates. It followed a report by the National Audit Office (NAO) on management & control of Hospital Acquired Infection (HAI) in England. UK decontamination practices gave rise to concern and advice was sought from the Spongiform Encephalopathy Advisory Committee (SEAC).

The Project aims to ensure all NHS hospitals have access to decontamination services of agreed standards. Similar projects are underway in Scotland and Wales. The main difference for England is a trend towards centralisation of services.

“Little Sister” bench-top autoclaves were quoted as example of variable, and impossible to verify, decontamination processes. These devices have now been phased out over recent years.

MHRA guidelines apply not only to NHS establishments, but also to private facilities. All will be subject to scrutiny by the Healthcare Commission (England) or equivalent body.

It is expected that decontamination standards will rise, and the whole process monitored. It is planned that instruments are tracked throughout the decontamination process by trays, if not individually. Instruments are expected eventually to be etched with unique identifying machine-read codes.

The DH is supporting the Project with considerable investment in England, but several commercial “super centres” with private investment are planned in “waves” over the next few years. With services covering several trusts, many hospitals will decommission HSDU departments. This will entail instruments in some areas spending longer in transit. It is unknown whether this will pose problems or not.

Please let me know how the project has worked in your area: [Nick.Hawksworth@pr-tr.wales.nhs.uk](mailto:Nick.Hawksworth@pr-tr.wales.nhs.uk) (include HSDU in the subject line).

Nick Hawksworth

Further reading:

[http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/EstatesAndFacilitiesManagement/EngineeringEnvironmentAndTechnology/EngineeringEnvironmentArticle/fs/en?CONTENT\\_ID=4118225&chk=QGWbyF](http://www.dh.gov.uk/PolicyAndGuidance/OrganisationPolicy/EstatesAndFacilitiesManagement/EngineeringEnvironmentAndTechnology/EngineeringEnvironmentArticle/fs/en?CONTENT_ID=4118225&chk=QGWbyF)

## PARTICLES FOUND IN PATIENTS' EYES FOLLOWING PHACOEMULSIFICATION

Members are reminded that the Medicines and Healthcare products Regulatory Agency (MHRA) should be informed if the above situation should occur. [www.mhra.gov.uk](http://www.mhra.gov.uk)

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- DESCENDING STAIRS
- COOKING • KNITTING • WORKING
- TRAVELLING • GARDENING FLOWER BEDS
- READING THE MAIL • GETTING UP AT NIGHT
- PLAYING GOLF • TELLING THE TIME • EMAILING
- WALKING THE DOG • CAMPING • DINING



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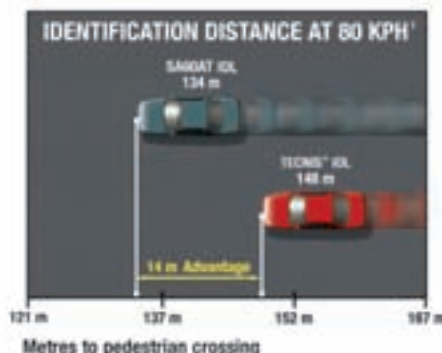
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# HONORARY FELLOWS – 2006



The President with Professor Taylor

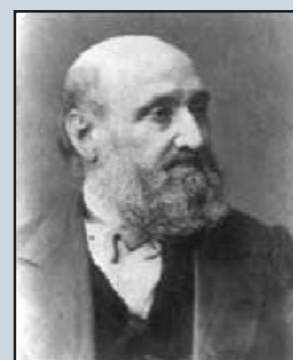
*Below is the citation given for Professor David Taylor at the Admissions ceremony in June. It has been edited for reasons of space.*

Ladies and Gentlemen, Madam President, it gives me great pleasure to deliver this citation to David Taylor, Professor of Ophthalmology and Head of the Visual Sciences Unit at the Institute of Child Health, London. He was born in Hobart in 1942 after his mother fled Singapore on one of the last ships to leave before the Japanese invasion. His father was interned in Burma and they did not meet until David was 3 years old. David went on to study medicine in Liverpool and after commencing ophthalmology training there, moved to London to join his future wife Anna. He obtained a post in ophthalmology at Great Ormond Street Hospital (GOSH) which was to determine the direction of his future career. At GOSH he worked for Kenneth Wybar, who became his mentor, and developed a love for paediatric ophthalmology and for the institution of GOSH. Unusually for the times, he was appointed to the house at Moorfields on his first attempt. In 1976 he was appointed to a joint consultant post at the National Hospital for Nervous Diseases and GOSH on the condition that he obtained further training in Neuroophthalmology which he gained in the US under Bill Hoyt. For a period of ten or more years,

David was one of the few specialist paediatric ophthalmologist in the UK and was indefatigable in championing paediatric ophthalmology as a specialty in its own right. A generation of ophthalmologists, across the world, has been taught by David that in order to be effective as a paediatric ophthalmologist, it is not sufficient just to have technical ophthalmological expertise; instead the effective paediatric ophthalmologist must take into account the general physical and psychological health of the child and, sometimes, the parents – in short he or she needs to be a physician rather than a technician. That the worldwide medical community has valued this message, and his skills as a communicator, is demonstrated by his accumulation of 13 visiting professorships, 13 invitations to give named lectures, and 49 other overseas guest lectureships on every continent bar Antarctica. David has promulgated his philosophy of paediatric ophthalmology not only through the annual paediatric ophthalmology course he has run with the Institute of Ophthalmology since 1977, or via his home and overseas British Council courses, but also through articles and textbooks; an astonishing 57 authored book chapters culminated in the encyclopaedic prize winning Paediatric Ophthalmology, now in its third edition. While the current edition is co-edited with his old friend and motor cycling buddy Creig Hoyt, he edited the first 2 editions alone. The Sunday night phone call from David enquiring how the chapter was going became a regular, and sometimes dreaded, event in the homes of paediatric ophthalmologists up and down the land. It is a tribute to his skills as a leader and organiser, and to his standing in the paediatric ophthalmic community, that he marshalled his authors to produce

the most comprehensive and useful book ever written on the subject. David has also been a researcher, and the bare figures of 246 publications and nearly £5 million in research income demonstrate success in this arena too. But successful research is about more than just such headline figures; it is about determination and forming successful working relationships. While David's primary clinical interest has been in congenital cataract, his most successful collaborators have been visual electrophysiologists. He was also instrumental in setting up a unique eye movement recording research and study facility at the ICH. In 2003 David was promoted to Professor and Head of the Visual Sciences Unit at the Institute of Child Health. There are now over 100 paediatric ophthalmologists in the UK, many of whom have trained with David and all of whom have been influenced by his teachings. David, you truly deserve to be called the father of paediatric ophthalmology in the UK.

Michael Clarke



**THE WILLIAM FARR MEDAL** - awarded to a medical practitioner who has made a significant contribution to the management of elderly people as part of original clinical or research work in the UK.

Please contact:

[kathy.evans@rcophth.ac.uk](mailto:kathy.evans@rcophth.ac.uk) for more details by 15 January 2007



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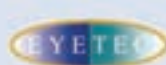
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## College Seminar Programme 2007

### Intravitreal Therapies

20 March

The Royal College of Ophthalmologists

CHAired BY: Professor Usha Chakravarthy

### Writing Research Proposals

28 March

The Royal College of Ophthalmologists

CHAired BY: Professor Harinder Dua and Professor Alan Stitt

### Intravitreal Therapies

14 September

The Royal College of Ophthalmologists

CHAired BY: Professor Sue Lightman

### Oculoplastics

10 October

Location TBA

CHAired BY: Mr Tony Tyers

## Regional Study Days

### VIIth State of the Art Refractive and Cataract Symposium 2007

22 June

Hull and East Riding Medical Education Centre

CHAired BY: Mr Milind Pande

## College Events

### Annual Congress

22 – 24 May

The ICC, Broad Street, Birmingham

Please visit [www.rcophth.ac.uk/scientific/congress2007](http://www.rcophth.ac.uk/scientific/congress2007) for more details.

### Seniors Day

14 June

The Royal College of Ophthalmologists  
Details to be announced in future editions.

### Royal College of Ophthalmologists Study Tour to Syria

11th to 17th February

For details please contact

Christopher Liu on: [cscliu@aol.com](mailto:cscliu@aol.com)

## Other events 2007

12 – 14 January

### ARCUS

Four Pillars Hotel, near Bristol

[www.four-pillars.co.uk](http://www.four-pillars.co.uk)

[anne.williams@bristol.ac.uk](mailto:anne.williams@bristol.ac.uk)

1 – 4 February

The 65th Annual Meeting of the All India

Ophthalmological Society

Hyderabad, India

[www.sunayana2007.org](http://www.sunayana2007.org)

[pswarup@satyam.net.in](mailto:pswarup@satyam.net.in)

9 – 10 February

A Glaucoma Symposium to mark the achievements of Professor Roger Hitchings

Mermaid Conference Centre, London

[hitch-hikers@moorfields.nhs.uk](mailto:hitch-hikers@moorfields.nhs.uk)

28 February

Second Newcastle Peri-ocular Tumour Course

[info@bopss.org](mailto:info@bopss.org)

23 – 24 March

### Brighton Cornea Course

For SHOs SpRs and Fellows. Lectures and videos on management of corneal and external eye conditions.

[Christopher.Liu@bsuh.nhs.uk](mailto:Christopher.Liu@bsuh.nhs.uk)

28 - 31 March

6th International Glaucoma Symposium

Athens, Greece

Deadline for abstracts - 2 November 2006

[www.kenes.com/glaucoma](http://www.kenes.com/glaucoma)

[reg\\_IGS2007@kenes.com](mailto:reg_IGS2007@kenes.com)

5 – 9 May

Annual Congress of the Société Française d'Ophthalmologie

Palais des Congrès, Place de la Porte Maillot, Paris

[www.sfo.asso.fr](http://www.sfo.asso.fr)

[Alan.E.Ridgeway@manchester.ac.uk](mailto:Alan.E.Ridgeway@manchester.ac.uk) – for information on joining SFO.

9 – 12 June

SOE/AAO 2007: a Joint Congress of the European Society of Ophthalmology (SOE) and the American Academy of Ophthalmology (AAO), in association with the Austrian Ophthalmological Society (ÖOG)

Vienna, Austria

[soe2007@congrex.com](mailto:soe2007@congrex.com)

[www.soe2007.org](http://www.soe2007.org)

Abstract submission deadline:

11 January 2007.

15 June

Annual Scottish Glaucoma Symposium

The Royal College of Surgeons, Edinburgh

[denise.grosset@faht.scot.nhs.uk](mailto:denise.grosset@faht.scot.nhs.uk)

5 - 7 September 2007

37th Cambridge Ophthalmological Symposium

The Vitreous

St John's College Cambridge

CHAired BY: Mr Martin Snead

[b.ashworth@easynet.co.uk](mailto:b.ashworth@easynet.co.uk)

## New appointments

We apologise that **Mr Danny Morrison's** appointment at Guy's and St Thomas's, London in September 2005 has not been previously noted.

**Miss Tina Dukes** is a Consultant at the Royal Gwent Hospital and not Llanfrecha Grange Hospital as previously reported.

**Miss Jane Ashworth**

**Mr Craig Burnett**

**Mr Sean Chen**

**Mr José Gonzalez-Martin**

**Mr Tim Jackson**

**Mr Jonathan Edward Moore**

**Dr Peter Scanlon**

Manchester Royal Eye Hospital

Hull and East Yorkshire Hospital

Alderhey, Liverpool

Southport and Ormskirk District General

Kings College Hospital, London

Mater Hospital, Belfast

Gloucestershire Royal Hospital,

Cheltenham

The Royal College of Ophthalmologists, 17 Cornwall Terrace, London NW1 4QW

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