QUARTERLY BULLETIN OF THE ROYAL COLLEGE OF OPHTHALMOLOGISTS

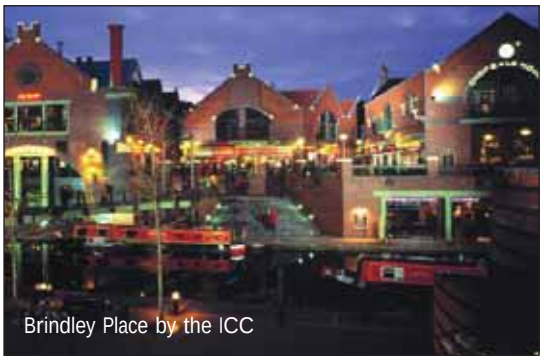
College NEWS

Spring
2007

ANNUAL CONGRESS 2007

Congress 2007 sees a welcome return to the ICC in Birmingham. The preliminary programme has been distributed, the Scientific Department is busy behind the scenes organising what promises to be an outstanding Congress and we have a new scientific & events assistant, Sarah Horne.

We have chosen 30 rapid fire presentations and there will be 200 posters on display over the three days. To date we have 140 speakers scheduled to talk with more to confirm and we are pleased to announce that the registration system is now live at www.rcophth.ac.uk/scientific



Brindley Place by the ICC

Eponymous lecturers

For the first time, we are providing a preview to our eponymous lecturers' talks. Visit the website for information from Andrew Dick and Richard Harrad on their presentations.

Allied professions

Rosalind Harrison has put together a superb AHPO/OIA programme which is contained in the preliminary programme. This forms part of the Congress for the first time and we do hope you will bring it to the attention of your colleagues.

Birmingham canal area

The ICC, Birmingham

An excellent programme specifically for nurses, organised by Yit Yang and Jenny Nosek, will take place on Wednesday 23 May. Details appear on our website. Please encourage your nurses to attend.

We do look forward to welcoming you all to Birmingham.

Heidi Booth-Adams
head of the Scientific Department

The Annual General Meeting

will be held on Wednesday 23 May at 3.45pm. All members are entitled to attend the AGM even if they are not registered for the rest of the day.

The Staff And Associate Specialist Ophthalmologists (SAS) Group

invite interested members to the SAS Forum to be held at Congress on: **Tuesday 22 May, 5pm-6pm** Written questions may be submitted in advance for a panel of College Officers to consider. Please contact kathy.evans@rcophth.ac.uk

The **DVLA** has ruled that drivers who have adapted to a stable visual field problem can apply for a licence re-instatement. A DVLA-based assessment is normally involved. A fuller explanation will appear in the Summer edition.

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

Summer	5 May 07
Autumn	5 August 07
Winter	5 November 07
Spring	5 February 08

Editor of *Eye*

Professor Ian Rennie has edited *Eye*, the scientific journal of the College, since 1996. He has presided over a great success story with commitment and flair. *Eye*, now a monthly journal, is published in partnership with Nature Publishing Group and is available in print and on-line.

Professor Rennie will complete his term of office in December 2007. A job description is on the website **www.rcophth.ac.uk** and suitably qualified members are invited to apply. It is envisaged that interviews will be held in July and that the new editor will start in January 2008.

THE NATIONAL SPECIALIST COMMISSIONING ADVISORY GROUP (NSCAG)

has funded an eye pathology website, **www.eyepathuk.co.uk** It has a strong educational element with cases of the month and eye pathology lectures for part 3 candidates, and is relevant for CPD.

NATURE PUBLISHING GROUP (NPG) IS NOW IN A POSITION TO OFFER COLLEGE MEMBERS A DISCOUNT ON PERSONAL SUBSCRIPTIONS TO A VARIETY OF NPG PUBLICATIONS, AS A SPECIAL BENEFIT OF MEMBERSHIP:

50% discount on a personal subscription to publications including:

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Ophthalmology gains a Biomedical Research Centre

The Institute of Ophthalmology in partnership with Moorfields Eye Hospital NHS Foundation Trust has been chosen as one of the sites for the new biomedical research centres for England.

Over the next five years, 11 centres, specialising in a variety of branches of medicine, will share around £450 million in funding to undertake research, beginning in April 2007.

The competition for biomedical research centre status was intense with 14 other specialties competing and the award of one site to ophthalmic research is very heartening.

The Centre at the Institute and Moorfields plans to act as a co-ordinator for a National Ophthalmic Research Network to support clinical research in eye health. For this to succeed there will need to be a partnership with all academic eye units in England and support from eye health charities, funding bodies and international organisations focusing on eyes and vision.

Wendy Franks

The Moorfields & Whittington Research Ethics Committee

has monthly meetings (on Wednesdays), either at Moorfields Eye Hospital or the Royal Free Hospital and has members from the general public and the health services. Members are appointed as individuals not as a representative of any groups with particular interests or responsibilities in connection with health issues. Applications are welcome from ophthalmologists with or without relevant clinical research experience. These are unpaid voluntary posts but training is provided and expenses are reimbursed. Members of black and ethnic minority backgrounds as well as people with disabilities are particularly encouraged to apply.
For more details contact: Katherine.clark@royalfree.nhs.uk

BRIGHTON'S SUSSEX EYE HOSPITAL TURNS 175

If you have ever worked at the Sussex Eye Hospital, we would like to hear from you. Please let us know where you are, what you are doing, and we will contact you again shortly. There is likely to be an academic and social gathering later in the year, most probably on 23 November 2007. Contact: Christopher.Liu@bsuh.nhs.uk

ROBERT MACLAREN has become the first ophthalmologist to be appointed to the King James IV Professorship of Surgery at the Royal College of Surgeons of Edinburgh. This international award is made annually and the College has Royal approval to confer the title of 'King James IV Professor' to recipients. Mr MacLaren is an honorary consultant vitreoretinal surgeon at Moorfields Eye Hospital, lecturer in human anatomy at Merton College Oxford and a research fellow at the UCL Institute of Ophthalmology. The award is in recognition of his research into retinal regeneration and contributions to medical teaching over the last 15 years.

WANTED

Locum cover in April to allow Vitreo-retinal Consultant in Middlesborough to work at St John's Jerusalem.
Please contact:
Chrisjan.Dees@stees.nhs.uk

Obituaries

William Ian McDonald (1933–2006) was appointed to Queen Square in 1966 and to Moorfields in 1969. Very nearly every neurologist who trained at Queen Square for more than 25 years spent time in his 'physicians' clinic. A healthy interest in the neurology of the eye was fostered in an entire generation; continuing a tradition that can be traced back to the work of Jonathan Hutchinson and William Gowers. I was astounded when I first visited neurology departments elsewhere in Europe where neurologists do not use or own ophthalmoscopes: astounded because the eye examination had been such an integral part of my training. In this as in so much Ian was an inspiration to us. Ian's research as well as his clinical practice was heavily influenced and directed by the case mix coming through Moorfields and as he once pointed out to me it was his interest in multiple sclerosis that had enabled him to take such productive advantage of the Moorfields clinic.

Ian will be remembered for his studies of experimental demyelination in the 1960's, for his work on the visually evoked potential in the 1970s and for his pioneering work utilising magnetic resonance imaging for the remainder of his career. The interest in the optic nerve was ever present during each of these periods and he was Doyne Lecturer in 1983. He was elected honorary fellow of The Royal College of Ophthalmologists in 1999. It is a testament to the continuing interest in his ideas that in the last year of his life he published in *Brain* an account of the inability to read music that was the first symptom of his stroke and that two seminal papers with Tom Sears from 1970 were selected by the editor for special tribute.

Ian had many talents and interests both within and outside medicine. He was many things to many people; but whether he was speaking to a patient, lecturing or playing the piano the common thread to every aspect of his life is that he was quite simply the most natural and accomplished communicator I have ever met.

Ian was fascinated by history and a great bibliophile and became Harveian Librarian of The Royal College of Physicians in 1997. I can recall seeing him at the College on one of the early days in this role, he told me that he had the onerous task of writing the obituaries of fellows and was already tackling his first. A few hours later I ran into him again, appearing ever so slightly disconcerted, he said "You won't believe it, Gordon, another three have landed on my desk."

Deficit omne quod nasciture.

Gordon Plant

A memorial service for Professor McDonald will be held on Tuesday 24 April at 5pm, at St Marylebone Parish Church, London. Reception at the Royal College of Physicians.

Mary Elizabeth (Betty) Fisher (1939–2006) was Chairman of the Lay Advisory Group from 2003 to 2006. I first met Betty when she and I had the privilege of visiting the St John Eye Hospital in Jerusalem together in 1996. At that time the College was setting up the Lay Advisory Group and it was obvious that Betty would be an excellent addition to the Group. Her contribution over the years was instrumental in the success of the Group. Her background in disability employment gave her an insight into the needs of patients and this, together with her open approach to everyone with whom she worked, made her a perfect choice to succeed Mrs Carol Gilmore as chairman.

Betty will be remembered by all who knew and worked with her as sincere and compassionate and this, together with her wonderful sense of humour, made her a true friend.

Ill health forced her early retirement as chairman. She will be sadly missed. She is survived by her husband, son, daughter-in law and her baby granddaughter.

Margaret Hallendorff

We also note with regret the death of:
Dr Joan Mary Bronte-Stewart, Glasgow

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THE ROYAL COLLEGE OF OPHTHALMOLOGISTS

Focus

Spring
2007

An occasional update commissioned by the College. The views expressed are those of the authors.

Corneal Endothelial Transplantation

The artificial anterior chamber with the microkeratome used for preparing the donor lenticule.

The first successful human corneal transplant surgery was performed one hundred years ago on 7 December 1905. Since then advances in microsurgical techniques, instrumentation, pharmacology and our understanding of the physiology and immunobiology of the eye have contributed to the improved success of corneal transplantation, (85% graft survival rate at two years; data courtesy of United Kingdom Transplant Service [UKTS]). Until recently penetrating keratoplasty (PK) has been the only reliable method for treating corneal edema from endothelial decompensation. Although PK can yield an optically clear cornea, it is associated with inherent problems related to sutures and wound healing. Its Achilles heel has been the high and often unpredictable refractive errors that ensue and contribute to long delay in visual rehabilitation. Other problems include suture-related infections, epithelial healing problems and an inherently weak wound created by a full thickness incision. The last decade has seen rapid advances in the field of lamellar surgery and, in particular, posterior lamellar surgery for endothelial dysfunction. This article will provide a review of the evolution of posterior lamellar surgery, the new nomenclature and the current status of endothelial transplantation.

Corneal transplantation for endothelial dysfunction

In the Western world, corneal endothelial dysfunction is the leading cause of corneal visual loss. Pseudophakic bullous keratopathy is the most common indication for corneal transplantation in the USA and endothelial dysfunction accounts for over 44% of corneal transplants performed in the UK (data courtesy of UKTS). The two most common causes for endothelial dysfunction are Fuch's dystrophy (21.7%) and pseudophakic bullous keratopathy (20.5%, UKTS data).

Evolution of lamellar keratoplasty

The first successful lamellar keratoplasty (LK) was performed by Arthur von Hippel in the last quarter of the 19th century. The evolution of LK over the last 25 years is no less dramatic than the first surgical step taken by von Hippel. The rapid progression and refinement of this surgical procedure has been fueled not only by advances in microsurgical techniques and instrumentation but also by greater understanding of corneal immunobiology and the treatment of graft rejections. The inherent philosophy of LK is to replace only the diseased part of the cornea, leaving the recipient's unaffected corneal layers undisturbed. That is, to do the minimal amounts of resection for the greatest amount of benefit by replacing only the diseased anterior or posterior corneal layers.

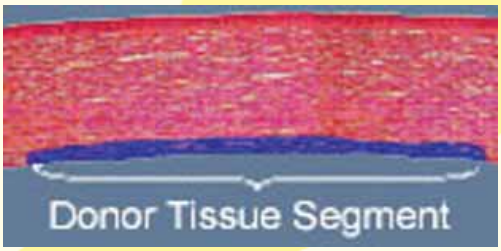
Slit lamp photograph at one week showing a clear cornea following Endothelial transplant.

Evolution of corneal endothelial transplantation

The quest for a lamellar surgical technique for endothelial transplantation has taken two different pathways: the corneal flap technique and the corneal lamellar dissection technique. In 1998, Jones *et al* used a microkeratome to create an anterior cornea flap that was retracted to gain access to the mid and posterior stroma. The posterior diseased cornea was trephined and removed, the donor cornea was secured in place with one or more sutures and the anterior corneal flap was sutured back in position. This technique was termed endothelial lamellar keratoplasty (ELK) by Jones et al (1998), endokeratoplasty by Busin *et al* (2000) and microkeratome-assisted posterior keratoplasty by Azar et al (2001). Although this procedure had the advantages of a microkeratome assisted smooth dissection and easy 'open-sky' access for other intraocular procedures, it suffered from the same inherent problems as PK in terms of surface corneal incisions and sutures.

The other technique involved creating a corneal stromal lamellar pocket through a limbal or scleral incision. The

posterior stromal disc along with the diseased endothelium is excised using an intrastromal circular trephine and healthy donor posterior stroma and endothelium is placed endothelial side down on a viscoelastic covered spatula for insertion into the recipient eye through a 9 mm limbal / scleral incision. A large air bubble placed in the anterior chamber intraoperatively pushes the donor 'disc' towards the recipient stroma. As the air bubble gets reabsorbed, the donor disc adheres itself to the recipient stroma through the endothelial pump mechanism, thereby eliminating the need for any corneal sutures, requiring only scleral sutures to close the scleral / limbal wound. This technique was first described by Gerrit Melles in a laboratory study in 1998 and he coined the term posterior lamellar keratoplasty (PLK). [1] The preliminary clinical results of PLK showed promise with respect to post operative astigmatism and endothelial cell viability. [2] At 6 - 12 months follow-up Melles' initial cohort of seven patients had an average post operative astigmatism of 1.45 D and an average postoperative endothelial cell density (ECD) of 2520 cells / mm^2. As a modification of the large incision PLK, Melles described the technique of sutureless PLK in which a 5 mm superior scleral tunnel incision was fashioned through which custom-made corneal stromal microscissors were used to excise the recipient posterior lamellar disc. [3] In a whole donor globe a deep corneal pocket was dissected at 80-90% stromal depth using custom-made blades (DORC International, Zuidland, Netherlands). The corneoscleral rim was excised and an 8.5 mm trephine was used to punch the cornea from the endothelial side. The donor endothelium was protected with a viscoelastic and the disc was folded and inserted into the AC through a 5 mm scleral wound. The disc was unfolded within the AC and was positioned against the recipient stroma, a large air bubble helping the donor disc to adhere to the recipient stroma. During this time Mark Terry from Portland, Oregon, USA, using Melles principle, modified the instrumentation and surgical technique and popularised this technique in the USA as deep lamellar endothelial keratoplasty (DLEK). [4] Later Terry described the technique of small-incision DLEK in 2005. [5] Both short-term (up to 6 months) and medium-term (up to 3 years) studies have shown that both PLK and DLEK offer early and rapid visual rehabilitation, with minimal induced astigmatism and ECD's comparable to that obtained with traditional PK's. As a modification of PLK, Melles in 2004 described a simpler technique of descemetorrhexis to excise descemet's membrane from the recipient cornea. In this procedure, a custom-made scraper was used to peel the descemet's membrane from the posterior stroma. Frank Price from Indianapolis, USA was the first surgeon to publish clinical results of this descemetorrhexis technique, renaming it descemet's stripping endothelial keratoplasty (DSEK). [6] DSEK has now evolved into DSAEK (descemet's stripping automated endothelial keratoplasty) in which a motorised microkeratome is used to harvest the donor posterior lamella and endothelium. [7] This technique has rapidly gained in popularity among corneal surgeons as it is technically easier to perform in comparison to PLK / DLEK since these involve a difficult lamellar stromal dissection and excision of the posterior lamellar disc using either an intrastromal trephine and / or scissors.



Schematic diagram showing the donor Lenticule consisting of the posterior stroma and healthy endothelium.

The current state

Descemet's stripping with endothelial keratoplasty (DSEK) has several advantages over PLK and DLEK procedures. It is a technically easier procedure to perform and is less traumatic to the cornea and to the anterior segment when compared to PLK and DLEK. It maintains the structural integrity of the corneal stroma and leads to a smoother interface, as the stromal lamella is not dissected. With the recent introduction of an artificial AC and an automated motorised microkeratome the need for manually dissecting the donor cornea is also avoided (DSAEK). The automated microkeratome not only reduces the intraoperative time required to prepare the donor disc but also provides a smoother interface which may also improve visual acuity. The story does not end here: in the September issue of Cornea 2006, Melles described a new technique of pure Descemet's membrane transplantation through a small incision – termed Descemet's membrane endothelial Keratoplasty (DMEK). It is hoped that with further developments in eye banking, provision of endothelial discs using either an automated microkeratome or femtosecond laser will make the surgical technique much easier and more reproducible. Clearly, further advances are on the way!

Evolution of new nomenclature in corneal transplant surgery

ELK Endothelial lamellar keratoplasty (Jones and Culbertson 1998)

PLK Posterior lamellar keratoplasty (Gerrit Melles1998)

- Large incision PLK -1999
- Sutureless PLK- 2002

DLEK Deep lamellar endothelial keratoplasty (Mark Terry 2001)

- Large incision DLEK- 2001
- Small Incision DLEK- 2004

Descemetorhexis (Gerrit Melles 2004)

DSEK Descemet's stripping and (automated) endothelial keratoplasty (Francis Price 2005)

DSAEK Descemet's stripping and (automated) endothelial keratoplasty

DMEK Descemet's membrane endothelial keratoplasty (Gerrit Melles 2006)

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3 Melles GR, Lander F, Nieuwendaal C. Sutureless, posterior lamellar keratoplasty: a case report of a modified technique. *Cornea.* 2002;21:325–27.
4 Terry MA, Ousley PJ. Deep lamellar endothelial keratoplasty in the first United States patients: early clinical results. *Cornea*. 2001;20:239–43.
5 Terry MA, Ousley PJ. Small incision deep lamellar endothelial keratoplasty (DLEK): 6 months results in the first prospective clinical study. *Cornea*. 2005;24:59–65.
6 Price FW, Price MO. Descemet's stripping with endothelial keratoplasty in 50 eyes: a refractive neutral corneal transplant. *J Refract Surg*. 2005;21:339–45.
7 Gorovoy MS. Descemet-stripping automated endothelial keratoplasty. *Cornea* 2006;25:886–89.

Museum Piece
The Oxford Room and it's portraits

The Oxford Room

John Hunter

John Taylor

Benjamin Travers

William Bowman

The Oxford Room was named in recognition of a generous donation from the Oxford Ophthalmological Congress. It has been furnished as a useful meeting room within the College.

Robert Walter Doyne (1857–1916) founded the Oxford Congress, 'where young and old may discuss scientific matters on an equal footing' in 1909. His presence has long been felt by a large photographic portrait of him which has now been enhanced by a life size bust.

Doyne was founder of the Oxford Eye Hospital in 1886 and his illustrious career as an outstandingly acute and accurate clinical observer is remembered with his name being associated with many clinical conditions.

Another picture in the Oxford Room is of a portrait of Sir William Bowman (1816-1892).

Bowman, who discovered important parts of the anatomy of the eye, subsequently named after him, was trained at King's College and for 25 years was surgeon at the Royal London Ophthalmic Hospital, Moorfields. He was cofounder and first chairman of the Ophthalmological Society of the United Kingdom in 1880.

There are three other portraits in the Oxford Room, those of Benjamin Travers, John Taylor and John Hunter.

Benjamin Travers was trained at Guy's and was a pupil of Sir Astley Cooper. His book *Synopsis of Diseases of the Eye* was the most important English work of its time. He was elected surgeon at the London Eye Infirmary, Moorfields in 1810 and became surgeon extraordinary to Queen Victoria.

He was largely responsible for making ophthalmology respectable and rescuing it from quacks such as John Taylor (1708-1793) also known as The Chevalier Taylor, Ophthalmiator. Taylor studied under William Cheselden and became a dextrous operator. On arriving in Paris he declared himself 'the greatest ophthalmologist of all time'.

The final portrait, a gift from Michael Sanders, is of John Hunter (1728-1793). The youngest of ten children, Hunter joined his brother William in London studying anatomy at St Bart's and becoming surgeon at St George's Hospital in 1756. He was a great observer and was the first to describe the muscular layer of the iris.

Richard Keeler
Museum Curator

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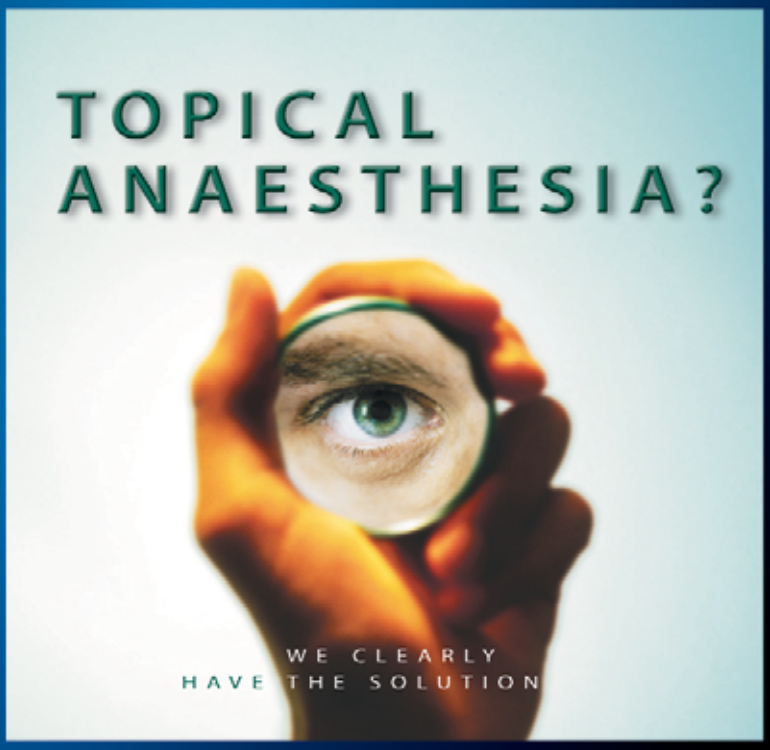

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CVI

There is a worrying drop in the number of CVI certifications as the graph below demonstrates. The reasons for the decline are not clear and we would like feedback from College members about the process (penny.jagger@rcophth.ac.uk). There will be a poster associated with the CVI project shown at the Annual Congress and members are invited to discuss their concerns with Catey Bunce, the lead statistician, and her co-workers. The Paediatric Subcommittee has worked with Dr Bunce on a form to collect epidemiological information about children with visual impairment. See www.rcopth.ac.uk/scientific/publications please contact m.p.clarke@ncl.uk with any queries or comments.

A member of the College's Lay Advisory Group gives her perspective as a social worker:

Misconceptions about registration

In 35 years of working with blind and partially sighted people and their supporters, there is one issue that invokes a sense of despair. Each year one or two people would ask why registration was not deemed appropriate for individuals whose visual impairment was caused by 'brain damage'. One man summed it up: 'Surely blind means blind?'

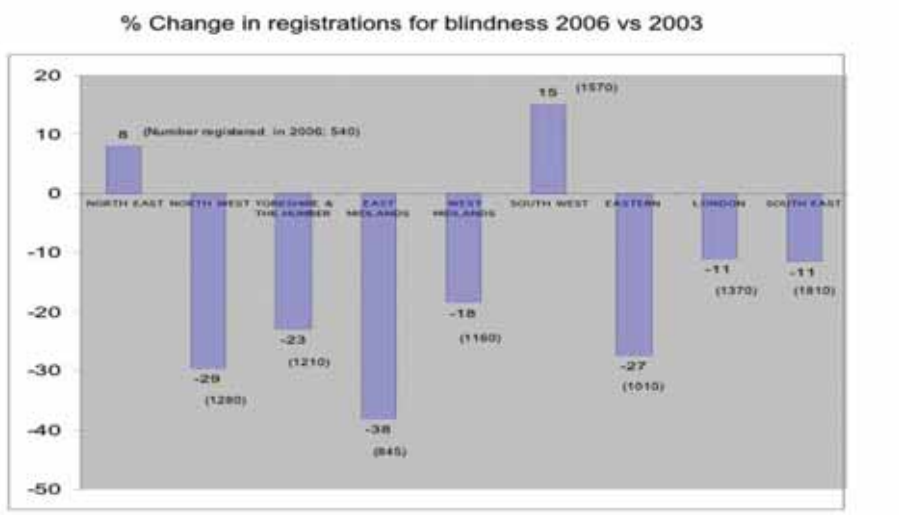
In time I learned that there were certain 'groups' of people where registration was not always discussed:

- *People with cerebral visual impairment* (mainly people with cerebral palsy) – I was sometimes informed that GPs or optometrists would not refer such people to ophthalmologists because 'their eyes are perfect'. Occasionally a relative would announce that an ophthalmologist had said they could not register someone because 'there is nothing wrong with their eyes'.
- *People with severe learning disabilities may not be registered*, despite family and professionals knowing they were born with a visual impairment. There may be many reasons for this, but mostly commonly I was told that registration is 'irrelevant' to the individual as 'they are getting all the benefits to which they are entitled'. This is untrue. It is important that people with severe learning disabilities are registered. Much can be achieved when they receive the right help.
- *People with advanced dementia affecting vision*. Involvement by rehabilitation officers for the visually impaired may prevent people from becoming even more confused by their environment. Relatives are often keen to obtain all the appropriate benefits, including the blind person's tax allowance – especially when people are living in expensive nursing homes.

The Blind Person's Act 1920 and subsequent legislation allows that: *People who are blind/severely sight impaired or partially sighted/sight impaired are entitled to be registered – regardless of the cause of their sight problem.*

Help from a rehabilitation officer for the visually impaired can make a substantial difference to people's quality of life. Registration is a 'passport' to services. People need this help. They have a right to it!

Gill Levy
Lay Advisory Group Member



Mr Peter Leaver, on behalf of the Moorfields Surgeons' Association, presented the College with a leather-bound three volume set detailing the first 200 years of the Hospital's history.

The President with Mr Peter Leaver, following the December Council

College appointments

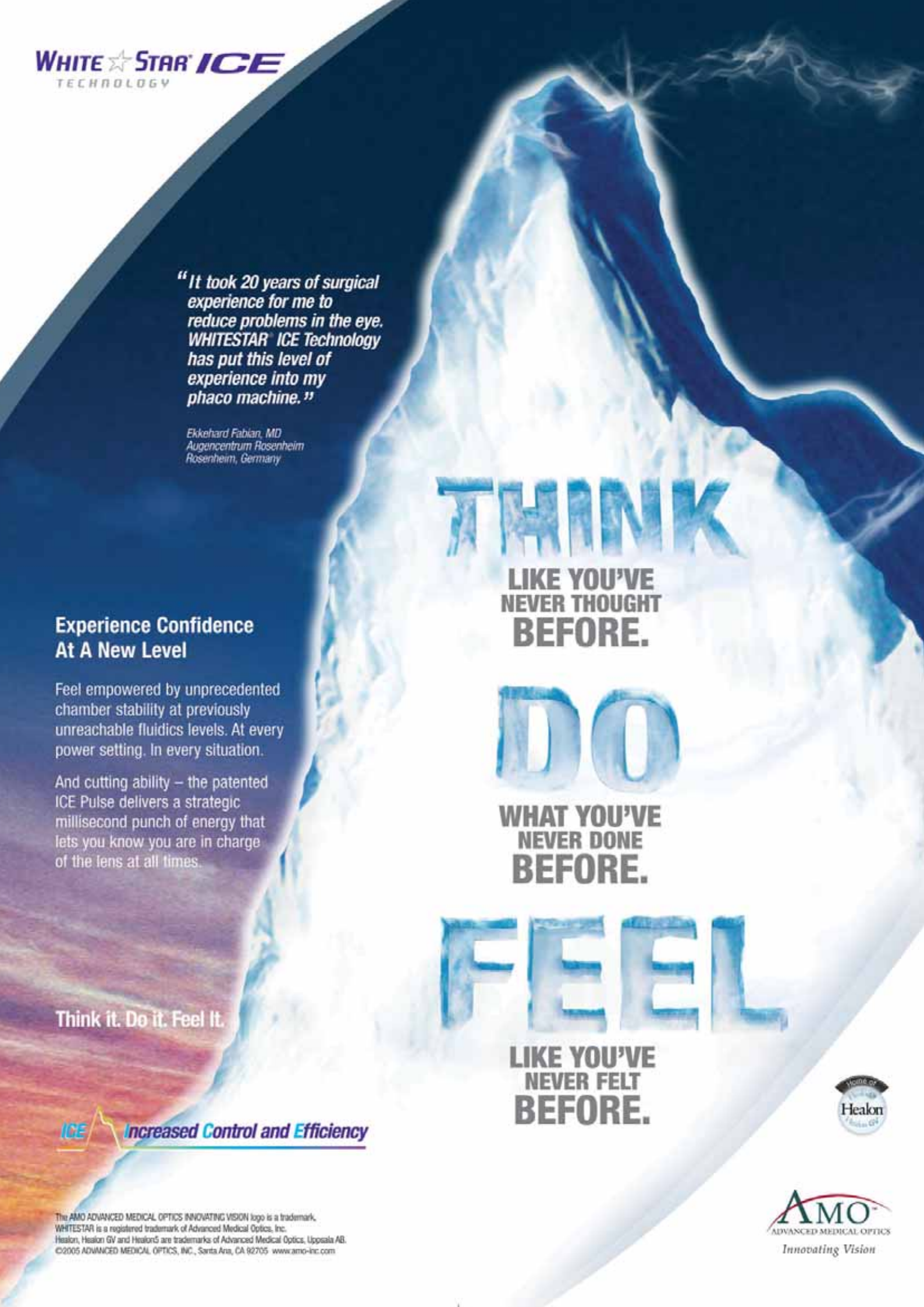
Mark Watts
College Surgical Skills Tutor

Jonathan Ross
Chairman of the Ophthalmic Trainees Group

INFORMATION FROM THE PAEDIATRIC SUBCOMMITTEE FOR HEALTHCARE PROFESSIONALS

This new section on the website includes documents on juvenile arthritis and ambloypia management. Members are welcome to send comments on them to m.p.clarke@ncl.uk

WHITE STAR ICE
TECHNOLOGY



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NEWS FROM THE EDUCATION AND TRAINING DEPARTMENT

Continuing Professional Development

CPD plays a vital role in the lives of most doctors and forms a major cornerstone of the appraisal system in the UK. It is something we all do. What still remains difficult for us is recording regularly what we do and finding out how CPD is translated into improving patient care.

All ophthalmic SpRs are now encouraged to participate in CPD and record activities on the on-line diary system. It is hoped that this will get them used to making regular diary entries and avoid the problem of the 'last minute.com' prior to an appraisal.

In April the CPD Subcommittee will audit category B activities. CPD Coordinators will contact 10% of their membership to provide evidence of attendance at meetings. So please remember to keep certificates, final programmes, badges and receipts as evidence of attendance at meetings during the year.

The American Academy has offered College members access to its on-line focal points, an excellent publication of quarterly topic updates with CPD accreditation. We need a minimum of 200 members to sign up at the reduced price of $100 per year. Interested members should email Carol Welch – cpd@rcophth.ac.uk.

For those of you struggling to find enough IT or management courses to claim points in category D, the Subcommittee has decided to place visits to other centres into this category as well. Remember you need to get points in all categories over the five-year cycle.

I will step down as chairman of the CPD Subcommittee in April. Graham Kirkby from Birmingham will take over and I wish him well in this important role for the College.

John Jacob
chairman – CPD Subcommittee

Foundation year 2 (F2) in ophthalmology: a trainee's perspective

College News has received an interesting article from Anish Shah – the first F2 doctor employed by the Western Eye Hospital. It can be read in full on the website www.rcophth.ac.uk Below is an extract:

One of the stated aims of foundation year two is to enable doctors to arrive at a more informed decision of career. For example, house officers considering surgical careers usually apply for F2 rotations involving a surgical post; those considering general practice will have the opportunity to work in primary care, and so on.

For doctors considering ophthalmology, the opportunity to work in the specialty during F2 will be invaluable in confirming or rejecting their career intention. Consequently, ophthalmic units at large will receive specialty trainees who have made a more considered and appropriate career choice.

There are other benefits of eye units employing F2 doctors. Ophthalmology is a hectic specialty with high patient turnover, and many tasks which in medicine and surgery are reserved for house officers, such as clerking patients for general anaesthesia, organising theatre lists, and ordering and chasing up out-patient investigations, fall to the SHOs who are already extremely busy.

The Ethicon Foundation Award

The award enabled me to undertake a 12-month clinical fellowship in Cornea and external diseases at the Department of Ophthalmology and Vision Sciences, Toronto Western Hospital, University of Toronto, Canada. It was a year of intense training in the medical and surgical management of external diseases, and corneal and anterior segment pathologies. The University of Toronto has the largest fellowship training programme in Canada and the corneal unit at the Toronto Western Hospital performs the highest number of corneal transplants (250 annually) in the country. This fellowship offers an excellent 'hands on' opportunity for trainees to train under two preceptors (Drs David Rootman and Allan Slomovic). My surgical experience included the use of fibrin glue in pterygium surgery, ocular surface reconstruction, anterior and posterior lamellar cornea surgery, anterior segment reconstruction and the use of femtosecond laser for therapeutic keratoplasty and refractive surgery. The most gratifying aspect of the fellowship training was the opportunity to learn posterior lamellar corneal surgery and to come back and share this knowledge with my colleagues, leading to the development of corneal endothelial transplantation in Liverpool *(see this issue's Focus)*.

I would like to thank the Ethicon Foundation Award Committee; it was an exciting and humbling experience.

Sathish Srinivasan
recipient of the 2004 Ethicon Award

Leber Hereditary Optic Neuropathy Treatment Trial

The Newcastle Mitochondrial Research Group has set up a double-blind, randomised, placebo-controlled trial of the efficacy of idebenone (SNT-MC17) in the treatment of patients with leber hereditary optic neuropathy (LHON). The study is sponsored by Santhera Pharmaceuticals (Switzerland) Ltd and has regulatory approval. We invite ophthalmologists in the UK to refer eligible patients and inform LHON families under their care of this trial.

LHON is the most common of the mitochondrial genetic disorders and it is characterised by bilateral, subacute, painless loss of vision. No treatment is available and the majority of patients are severely affected with visual acuities 6/60. Idebenone is a potent neuro-protective agent with a very good safety profile. It protects cell membranes and mitochondria against oxidative damage and helps to maintain mitochondrial ATP production under ischaemic conditions. There are published case reports of its efficacy in LHON and given its mode of action, idebenone is a strong therapeutic candidate that needs to be investigated further.

We are recruiting UK LHON patients aged 16 to 65 who have experienced visual loss for less than three months. These patients must have one of the three most common mitochondrial LHON mutations (3460, 11778 and 14484). The primary objective of this trial is to determine whether oral administration of idebenone in the acute stage of LHON can improve final visual outcome.

The trial centre is based at the Royal Victoria Infirmary, Newcastle and patients must attend six times in a 10-month period. Travel and accommodation expenses can be reimbursed.

Mr Patrick Yu Wai Man, Mr Philip Griffiths, Professor Patrick Chinnery

The Medicines and Healthcare products Regulatory Agency (MHRA)

MHRA has launched a campaign to highlight the status of medical devices that are designed for single use, i.e. one episode of use on one patient and then discarded. The reprocessing and re-use of single-use medical devices is still fairly common and there have been some serious patient safety incidents associated with this practice. The new logo shown below will be displayed on the device or its packaging if it is intended for single use. Potential hazards associated with reprocessing or re-use of single use devices include contamination with bacteria, viruses, prions or endotoxins, persistence of residues from chemical decontamination agents, degradation of the material of the device and mechanical failure. Anyone who re-uses or reprocesses a device intended for single use acquires the same legal responsibilities for its safety as the original manufacturer and may be contravening Health and Safety legislation and the Consumer Protection Act 1987. It is unlikely that professional indemnity insurance would cover a doctor in this situation.

LATANAPROST An 86-year-old retired doctor contacted the College recently. After being put on Latanaprost eye drops for glaucoma, he experienced a cardiac dysrhythmia which occurred an hour or so after instilling the drops on a number of occasions. The effect consisted of apparent missed beats and lasted for about two hours. It ceased after the drug was discontinued. If anyone has encountered a similar phenomenon in a patient please contact pennyjagger@rcophth.ac.uk

Richard Smith, chairman, Professional Standards Committee

EFFECTIVE HOME IMPROVEMENT AGENCY SERVICES FOR PEOPLE WITH SIGHT LOSS

The Thomas Pocklington Trust (TPT) provides housing, care and support for people with sight loss, and commissions social and public health research.

Home improvement agencies (HIAs) are small, local organisations providing advice, support and assistance to older, disabled and vulnerable homeowners and private sector tenants. Funded by central and local government, they are co-ordinated nationally by an organisation called Foundations.

TPT commissioned an 18-month project with Foundations and the University of York, to:

- identify awareness of HIA services among visually impaired adults, their relatives and support networks
- Examine ways of improving HIA service delivery to visually impaired adults
- Identify staff training needs.

FINDINGS INCLUDE:

- Awareness of HIAs, and the services they offer, is limited among visually impaired people and specialist impairment organisations
- Since people with sight difficulties often do not register or contact specialist visual impairment organisations, HIAs should not rely solely on such sources to reach this client group
- HIAs act conscientiously as advocates for their clients, but lack of knowledge and skills about the needs of visually impaired people means that inappropriate methods of communication, assessment and recording of data are sometimes used
- awareness and working practices can improve when HIAs are introduced to the social model of disability and given training
- various technical solutions are appropriate e.g. use of space, lighting, levels of illumination and flexibility, reflections, glare and stray light, decorations and finishes including use of colour or tone contrast, use of texture and changes to highlight key features.

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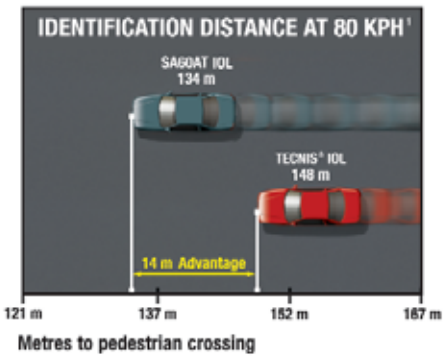

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HONORARY FELLOWS – 2006

The President with Keith Waddell CBE

*Below is the citation given for **Keith Waddell CBE** at the Admissions Ceremony in June 2006. It has been edited for reasons of space.*

It is a privilege to be able to give this citation for Keith Waddell. Many of you may not know him well because he has spent all his working life in rural Uganda. Quite a few of us may have dipped our toes in the invigorating but very challenging waters of overseas ophthalmology, but Keith has plunged right in and has stayed there up to his neck in them, and he is still there now, 40 years later.

When he went to Uganda in 1964, it was the pearl in the heart of Africa. The pearl became hideously tarnished with almost all expatriates leaving because of fears for their personal safety, or frustration that they could not get any work done, but Keith stayed on. So that is the first side of Keith, his unswerving commitment to the poor and the needy.

Then there is Keith the visionary planner. When I first met him in Leicester in the early 1980s, his plan was to run a training programme for ophthalmic assistants to try to cover the whole of rural Uganda outside Kampala with a programme of eye care. In this way he set up his own Vision 20/20 programme many years before it had been thought of by the World Health Organization.

Next there is Keith the academic, proof that you do not have to be attached to a centre of excellence to do outstanding academic work. He is a world expert in leprosy. He has done some beautifully and meticulously researched studies on the changes in child blindness over the years in rural Africa, and his studies into conjunctival carcinoma and its relationship to HIV have earned him a doctorate of medicine at Oxford University; this in his mid-sixties when most of us would be thinking of putting on our slippers and resting by the fireside in the evening.

Keith has always identified totally with Africa and Africans. He speaks at least three African languages fluently and lives as they live, for much of his life this has been in a mud hut with no water and no electricity, and yet he remains impeccably turned out – which is very important in African culture. It is small wonder that the people of Uganda have taken him totally to their hearts and see him as one of them.

Although Keith has never married, he bears out the biblical statement that if one forsakes family for Christ's sake, one will receive a hundred fold, and Keith has an enormous and very real family in Uganda.

First of all there are one or two orphans who have attached themselves to him from their early childhood and who in every respect see him as their father.

Secondly there are all the blind and visually impaired children in Uganda. He once wrote to me saying how 20 or so people sat down for Christmas lunch with him in his small house. The main problem was plucking the chicken, preparing the vegetables, and taking the stones out of the rice because there were only five normal seeing eyes amongst these 25 people.

His third family are all the ophthalmic assistants whom he has trained, supervised and mentored, and who also look up to him as a father. They are a wonderful lot to work with.

As any of us with families will know, they bring immense pleasure but also a lot of heartache, and Keith has had so much heartache from his family. The AIDS epidemic, the endless wars and civil disturbances in Uganda, and various accidents have struck down so many of those he has loved and nurtured and cared for – enough to break the heart of many people.

Keith once told me that when he was in the Oxford University Air Squadron, he won the aerobatics prize for looping the loop. At first, I was rather surprised because he is so careful and meticulous in all that he does, but then I realised that in so much of his work there is a risk that he has to calculate whether or not to take in travelling to help the many desperately needy people in the less settled parts of Uganda.

Those of us who know Keith often wonder how he manages to do – and keep on doing – all that he does, and I think Keith would like me to say that he has been a Christian missionary all his working life, and his strength and his inspiration come from the Lord whom he so quietly but determinedly loves and serves.

Keith, we would like to add the highest honour our College can give, to those of the MBE and CBE which you have already received from her Majesty.

John Sandford-Smith

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College Seminar Programme 2007

All seminars take place at the College, unless otherwise stated.

Vitreo-retinal Update
23 Apri
Chaired by: Mr Ian Pearce

Retinal Imaging Course
19 - 20 July
Chaired by: Mr Yit Yang / Mr Amresh Chopdar

Intravitreal Therapies
14 September
Chaired by: Professor Sue Lightman

Oculoplastics
10 October
Chaired by: Mr Tony Tyers

Retinal Vein Occlusions
19 October , The Institute of Physics, 76 Portland Place, London
Chaired by: Mr Declan Flanagan and Mr Winfried Amoaku

The Elizabeth Thomas seminar: AMD
30 November, The East Midlands Conference Centre, Nottingham
Chaired by: Mr Winfried Amoaku

Please visit www.rcophth.ac.uk/scientific/seminars for more details.

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 for more details.

Seniors' Day
14 June
The Royal College of Ophthalmologists
Sara.felton@rcophth.ac.uk

The Royal College of Ophthalmologists, 17 Cornwall Terrace, London NW1 4QW
Tel. 020 7935 0702; Fax 020 7935 9838
www.rcophth.ac.uk
Editor of Focus: Mr William Newman, Royal Liverpool Children's Hospital

Other events 2007

23 March
Oculoplastic Surgical Workshop
Oxford
thomaskersey@doctors.net.uk

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

27/28 – 30 March
Clinical Electrophysiology of Vision
Moorfields Eye Hospital, London
courses@moorfields.nhs.uk

28 March
NEOS Spring Meeting - Neuro-Ophthalmology
Newcastle Racecourse
executive@neos.org.uk
www.neos.org.uk

29 March
Basic Phacoemulsification Course
Scunthorpe General Hospital
gazi.ali@nlg.nhs.uk

22 - 24 April
Advanced Contact Lens Course Part
Moorfields Eye Hospital, London
courses@moorfields.nhs.uk

21 May
UKISCRS Satellite Meeting - New Ways of Working Together
Thinktank, Birmingham, 11am-5.30pm
ukiscrs@onyxnet.co.uk

5 – 9 May
Annual Congress of the Société Française d'Ophtalmologie
Palais des Congrès, Place de la Porte Maillot, Paris
www.sfo.asso.fr
Alan.E.Ridgway@manchester.ac.uk
for information on joining SFO

26 – 29 May
8th European Neuro-ophthalmology Society Meeting (EUNOS 2007)
Military Museum and the Cultural Centre, Istanbul
aydinp@eunos2007.org

8 – 9 June
A Practical Clinical Approach to the Diagnosis and Management of Intraocular Inflammation and Infection – with Patients
Moorfields Eye Hospital, London
s.mayhew@ucl.ac.uk.

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
www.soe2007.org

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

15 June
New Frontiers in Deafblindness
Conference organised by the Dept. of Audiology, Sahlgrenska University Hospital, Gothenburg and the Dept of Otolaryngology, QMC, Nottingham.
The Royal Society of Medicine, London
brian@earfoundation.org.uk

27 June
NEOS Summer Meeting
Crown Plaza Hotel, Chester
executive@neos.org.uk
www.neos.org.uk

28 – 29 June
Introduction to research methods and medical statistics
Dept. of Optometry and Visual Science, City University, London
d.crabb@city.ac.uk

5 – 7 July
3rd International Uveitis Symposium
Institute of Child Health, London
courses@moorfields.nhs.uk

5 - 7 September
37th Cambridge Ophthalmological Symposium, The Vitreous
Chaired by: Mr Martin Snead
St John's College Cambridge
b.ashworth@easynet.co.uk

14 September
Vision Research 2007, academic meeting Development and Genetics, Inflammation and Eye Disease
University of Bristol
maggie.cook@bristol.ac.uk

27 – 28 September
UKISCRS Annual Meeting
Harrogate International Centre
ukiscrs@onyxnet.co.uk

Consultants appointments

Mr Andrew Chung	Pinderfields General Hospital, Wakefield
Miss Sobha Sivaprasad	Pinderfields General Hospital, Wakefield
Miss Nagini Sarvananthan	Leicester Royal Infirmary
Mr Quresh Mohamed	Gloucester Royal Hospital
Miss Charlotte Sullivan	Good Hope Hospital, Sutton Coldfield

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