QUARTERLY BULLETIN OF ROYAL COLLEGE OF OPHTHALMOLOGISTS

College NEWS

Spring
2009

The College steps into virtual reality

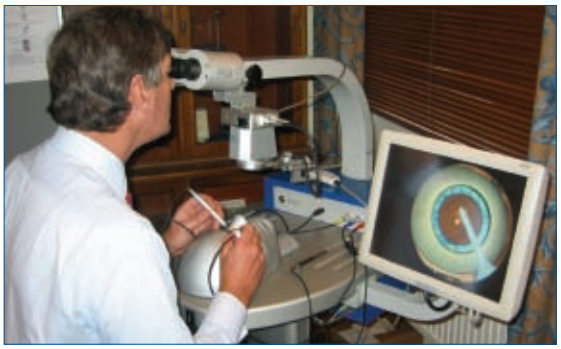
In recent months, the London Deanery has kindly donated money to allow the acquisition of an EYESi ophthalmic surgical simulator, for the benefit not only of London trainees, but of all College members.

This impressive machine gives a very realistic simulation of both cataract and vitreo-retinal procedures and has already been introduced into the Basic Surgical Skills courses. The surgeon operates through a binocular microscope, similar to those used in conventional theatre, using handpieces similar in size to a phaco probe, the ends of which are inserted into the artificial eye housed in a conventional plastic head. From this point on, there is a three-dimensional view of a virtual eye on which he can undertake a variety of procedures, varying from simple training in the basic skills of instrument manipulation, right up to difficult capsulorhexis rescue, membrane peel etc. Each procedure is accompanied by an explanatory description of the task to be performed and, on completion, an assessment score. The score in turn is broken down to show any particular faults, such as endothelial contact or rough tissue handling. The procedure can be watched on a monitor by an observing tutor and replayed if necessary.

The graphics of the simulator are eerily realistic, such that movement of the eye alters the retinal reflex, for example. The programming is also so sophisticated that on attempted rescue of an errant capsulorhexis flap using Little's manoeuvre, the response is as it would be in the natural eye. The opportunities to practise surgical skills will be appreciated by novice surgeons and experienced practitioners alike. Indeed, a competitive streak has been identified in a number of quite senior surgeons who have tried the machine, attempting to outdo each other!

Members are welcome to use the simulator by prior arrangement with Katie Miller (*skills.centre@rcophth.ac.uk*). Because of the delicate nature of the equipment a brief training in its use is first required.

Mr Mark Watts, College Surgical Tutor



Mr Jonathan Jagger using the simulator

The 8th College President

Mr John Lee has been elected as the next College President. He will succeed Miss Brenda Billington at the Annual General Meeting to be held on 20 May 2009 at the Annual Congress, Birmingham.
Thank you to all Fellows and Members who voted.

Vice President and Chairman of the Education Committee
Mr Larry Benjamin will succeed Mr David Cottrell.

Vice President and Chairman of the Training Committee
Miss Carole Jones will succeed Mr Peter McDonnell

The Honorary Secretary: The election of Mr Benjamin has created a vacancy.

The Honorary Treasurer: The election of Miss Jones has created a vacancy.

Any Fellow or Member in good standing who is under 65 years of age may apply for either post. The job descriptions and nomination forms are on the website. Nominations, statements and photographs must be submitted to hon.sec@rcophth.ac.uk by 3 April 2009.

2
News
3
Members' News and Appointments
5
Focus
7
Museum Piece
11
Congress News
12
Education News
14
Honorary Fellows
16
Diary

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

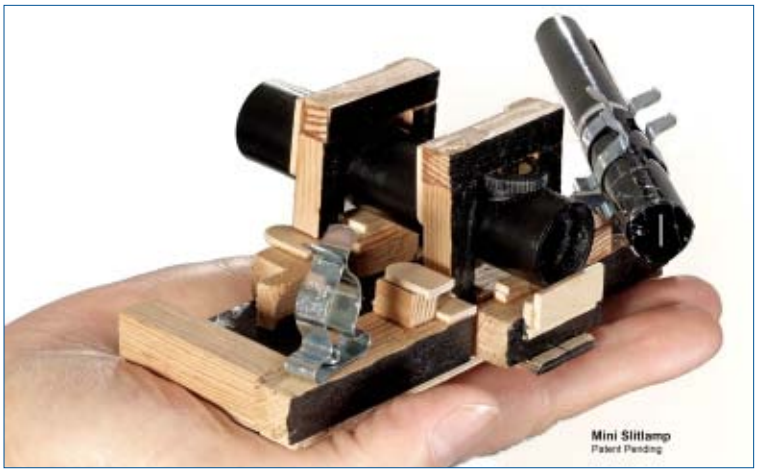
Copy deadlines

Summer	5 May 09
Autumn	5 August 09
Winter	5 November 09
Spring	5 February 10

Medical Futures Innovation Award 2008

A list of the winners of the award appeared in the winter 2008 issue. Over the next few issues a short piece will appear about each winner.

The mini slit-lamp



Mini Slitlamp - patent pending

To the newcomer the view through a slit-lamp is breathtaking and gives a hint of its unique diagnostic power. But the instrument's cost, size, housing and complexity limits its use to the specialist. Even handheld slit-lamps are expensive, and far too large to be carried in a pocket. The Mini Slit-lamp is designed as a pocket companion for medical students and non-specialists.

I made the instrument on my coffee table last year. The prototype, now awaiting development, weighs 100g, and is made from components that cost £50. They include a modified hospital pentorch, condensing lenses, a pocket microscope and a wood platform. The view is monocular, there is no zoom, and the fundus cannot be seen. But like conventional slit-lamps, all based on Allvar Gullstrand's original masterpiece, it brings the structures of the front of the eye into striking view, magnified 5-30 times. A family digital camera records the findings.

Being pocket-sized, it can be taken everywhere. I have tried it on my family, friends, Tabley, my Persian cat, and even my own eyes magnified in a concave mirror. It gives remarkable optical sections of spectacle lenses and wrist watch crystals, highlighting the outer and inner surfaces, and making scratches sparkle. It is also possibly the first time a slit-lamp has been used on drinking glasses in restaurants. Students could gain much experience before examining patients. Perhaps even their teachers might like to have one concealed in the pocket.

Mr Roger H Armour FRCS
Retired Consultant Surgeon, Stevenage

Sight - Sim

We have developed a prototype software-product which we believe achieves a breakthrough in the understanding and rehabilitation of visual impairment. Our product can change digital images to mimic accurately an individual's visual impairment, using their own clinical measurements, to display instantly what the effect of the impairment 'looks like' to a normally sighted viewer.

Currently, those who look after or work or live with people with visual impairment can only infer the impairment from numbers which describe visual acuity and contrast sensitivity; few people understand, let alone correctly interpret these numbers. Our program tackles this issue and gives anyone the ability to see 'though the eyes' of a visually impaired individual.

Our innovative product transforms standard descriptions of acuity into a visual demonstration of the impairment. No inference is necessary. For children, parents can immediately 'see' the impairment and from then on adjust the child's surroundings and home life to help to habilitate the child. Likewise, teachers can improve their teaching strategies by ensuring no educational material contains details which the child cannot see. Using digital imaging technology, any source of material, whether it be camera images or live webcam movies, can potentially be manipulated by our system to allow their contents to be verified as 'visually intelligible'.

For adults with visual impairment, carers, family and colleagues can understand their visual difficulty and compensate accordingly.

We know there is worldwide interest in the product, which we envisage marketing globally via the Internet. It will appeal to those dealing with substantial visual impairment, but also to high street opticians dealing with minor impairments which are correctable with lenses.

We are looking for funding to implement this new development, as we believe that children worldwide will benefit.

Professor Gordon Dutton

The Medicines and Healthcare Products Regulatory Agency (MHRA)

College News (Winter 2008 issue) reported a problem with AMO handpieces. Following investigation, the manufacturing site has changed the method of cleaning the equipment and the reporting hospital has taken more care when packing devices with cables into the reprocessing baskets. MHRA has agreed that the matter is now closed.

Members' News and Appointments

The European Board of Ophthalmology (EBO)

Mr Wagih Aclimandos has been elected as Chairman of the EBO Residency Review Committee exchange programme which is involved in recognition of centres across Europe. He joins the Executive Board as the President Elect.

The European Society of Ophthalmology (SOE)

Mr George Turner will be the College representative on the Board of Directors.

Seniors' Day - Thursday 18 June 2009

This will include an interesting programme of talks, a sit down lunch and plenty of opportunities to catch up with colleagues. It will cost £50, including VAT, but places are limited and priority will be given to those senior members who have not attended previous events. Please contact *sara.davey@rcophth.ac.uk* for further details.

Travel expenses

The College has recently revised its travel and expenses policy for those attending meetings (*www.rcophth.ac.uk/finance-membership/expenses*). The main message is that members are strongly encouraged to plan ahead to take advantage of lower fares to minimise costs.

Email addresses

Please let the membership department know if you change your email address so that we can keep in touch with you. Contact *database@rcophth.ac.uk*

Obituaries

We note, with regret, the deaths of the following members:

Miss Patrica Jane Bateman, Great Shelford, Cambridgeshire.

Professor Hellmut Neubauer, Cologne, Germany

Mr A Stewart Scott, St Clement, Jersey.

Mr John Sibthorpe, Hemingsford Abbots, Cambridgeshire

Consultant Appointments

Miss Sahar Al-Husainy	Birmingham Heartlands Hospital and Solihull, Birmingham
Mr Maghizh Anandan	Derby City General Hospital, Derby
Miss Jessy Choi	Royal Hallamshire Hospital, Sheffield
Miss Claire Daniel	Moorfields Eye Hospital, London
Mr Seyed Ghazi-Nouri	Broomfield Hospital, Chelmsford
Mr Gus Andrew Guzzard	Moorfields Eye Hospital, London
Mrs Emer Henry	King's Mill Hospital, Sutton in Ashfield
Mr Saurabh Jain	Royal Free Hospital, London
Mr Aires Lobo	Moorfields Eye Hospital, London
Mr Sajjad Mahmood	Central Manchester and Manchester Children's University Hospital, Manchester
Mr John Mathews	Glan Clwyd District Hospital, Rhyl
Mr Daniel Morris	University Hospital of Wales, Cardiff
Mr Mohammed Musadiq	University Hospital of North Staffordshire, Stoke on Trent
Miss Bushra Musthtaq	Birmingham and Midland Eye Centre, Birmingham
Miss Bolger Odufuwa	Royal Free Hospital, London
Mr Dimitris Pimenides	Broomfield Hospital, Chelmsford
Mr Narman Puvanachandra	Norfolk and Norwich University Hospital, Norwich
Mrs Christina Rennie	Southampton General Hospital, Southampton
Mr Thomas Ressiniotis	Singleton Hospital, Swansea
Mr Debendra Sahu	Southampton General Hospital, Southampton
Mr Alok Tekriwal	Lincoln County Hospital, Lincoln
Mr Paul Tesha	Lincoln County Hospital, Lincoln
Mr Mandagere Vishwanath	Central Manchester and Manchester Children's University Hospital, Manchester
Mr Bruno Zuberbuhler	Central Manchester and Manchester Children's University Hospital, Manchester

Professorial appointment

Kenneth C S Fong has been appointed Associate Professor of Ophthalmology and Consultant Ophthalmologist at the University of Malaya Medical Centre, Kuala Lumpur, Malaysia.

Regional Advisers

Regional advisers are appointed by Council to act on behalf of the College. They must be:

- Fellows of the Royal College of Ophthalmologists registered with the College for continuing professional development (CPD)
- NHS consultants with an established or honorary contract in active practice. Advisers must stand down on retirement from their NHS post.

The table below shows those post holders who will complete a three-year term of office in 2009. Any person wishing to stand should contact *hon.sec@rcophth.ac.uk*

REGION	CURRENT POST HOLDERS	DATE OF RETIRE-MENT	ELIGIBLE FOR RE-ELECTION
Scotland East	Mr Jaswinder Singh	June 2009	No
Wales	Mr Chris Blyth	Sept 2009	Yes
Yorkshire	Mr Ian Simmons	Dec 2009	Yes
Wessex	Miss Ann Denning	Dec 2009	Yes

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1. Artal P, Alcon E, Villegas E. Spherical Aberration in Young Subjects with High Visual Acuity. Presented ESCRS 2006. Paper 558.
2. Packer M, Fine IH, Hoffman RS. Functional vision, wavefront sensing, and cataract surgery. Int Ophthalmol Clin. 2003 Spring; 43(2): 79-91.

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THE ROYAL COLLEGE OF OPHTHALMOLOGISTS

Focus

Spring
2009

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

External Quality Assurance in Diabetic Retinopathy Management

Dr Peter Scanlon, Programme Director, English National Diabetic Retinopathy Screening Programme

Quality assurance (QA) is an integral component of any national screening programme, to ensure that the programme achieves the highest possible standards. This is essential because screening programmes inevitably have both false negatives and false positives (since no screening test can achieve 100% sensitivity and specificity), and there is thus the potential to do more harm than good if standards drift. Quality assurance is generally distinguished from audit, in that it is a continuous process, where specific achievable and minimal acceptable standards are set. These standards are regularly reviewed and tightened (sometimes relaxed if the initial standard has been set too high), so that quality is maintained and progressively increased. It is not to police programmes but to ensure continuous improvement.

Internal quality assurance provides internal processes to reduce the probability of error and provide ongoing service improvement, and raise standards to provide the best possible outcome for the patient.

External quality assurance (EQA) provides external review of programmes against national standards to compare with other services across the country.

The inevitable consequence of the development of a National Public Health Screening Programme for sight-threatening diabetic retinopathy is that interest is being taken by directors of public health in the management outcomes of all patients with diabetic retinopathy.

The screening programme for sight-threatening diabetic retinopathy was the first programme to be introduced after the publication of Shifting the Balance of Power, which meant that screening programmes have to respond to local needs. In order to ensure a consistently high standard across the country, screening programmes are monitored against 19 quality assurance standards (*www.retinalscreening.nhs.uk*). The programme directors have to provide an annual report against these standards and they receive an external quality assurance visit every 3 years.

The QA standards that are relevant for ophthalmologists who are managing patients in eye clinics are standards 1, 10, 11, 12 and 13:

Standard 1

a) Annual blind and partially sighted registration rates
b) Local identification of visual impairment due to diabetes:
VA 6/60 or worse in the better seeing eye
VA 6/18 or worse in the better seeing eye

Standards 10, 11, 12 and 13, with objectives, criteria and minimum and achievable standards are:

	OBJECTIVE	CRITERIA	MIN STANDARD	ACHIEVABLE STANDARD
10	**To ensure timely consultation for all screen-positive patients.**	Time between notification of positive test and consultation:		
		1. Proliferative DR /Advanced diabetic eye diseases, R3	70% <2 weeks	95% <2 weeks
		2. Pre-proliferative DR, R2	70% <13 weeks	95% <13 weeks
		3. Maculopathy, M1	70% <13weeks	95% <13 weeks
		4. All above retinopathy grades	100% < 18 weeks	
11	**To ensure timely treatment of those listed by ophthalmologist.**	Time between listing and first laser treatment, following screening:		
		1. Proliferative DR, R3	90% <2 weeks	95% <2 weeks

12	**To minimise over-all delay between screening event and first laser treatment.**	Time between screening encounter and first laser treatment, if listed at first visit to hospital eye service following screening, does not exceed:		
		1. For patients referred as DR, R3	70% <4 weeks	100% <6 weeks 95% <4 weeks
		2. For patients referred as M1	70% <15 weeks 100% <26 weeks	95% <15 weeks
13	**To follow up screen-positive patients (failsafe)**	Combined cancellation and DNA rate for ophthalmology clinic		
		1. For Proliferative DR, R3 within 1 month	<10%	<5%
		2. For Pre-proliferative DR, R2 within 6 months	<10%	<5%

Electronic data collection systems will need to be put in place for these standards, which will inevitably take time to develop.
At an EQA visit, the following data, which is related to the ophthalmology department, will be looked at:

1. The timelines of a group of patients referred from screening will be looked at to see if patients are being seen and treated within an appropriate timescale.
2. The laser book will be looked at to see if patients who are being treated are on the retinal screening database and were referred in from screening. Even if they present in an ad hoc way, the retinal screening database should have a record of these patients because they have diabetes.
3. A request will be made to see the numbers of patients registered blind from diabetic retinopathy in the last 12 months.

EQA visits are carried out by a team of peer reviewers who are from different disciplines depending on the make-up of the local screening programme. The peer reviewers usually include a public health specialist, regional QA manager, a PCT commissioner, an administrator, a programme manager who carries out a sample grading review and an ophthalmologist.

The format of the day is that the peer review team meets with the local team in the morning and then after the initial discussion, which may last about an hour, the team splits up and the ophthalmologist visits the ophthalmology department. There will have been a request in advance to pull some records that have been identified by the programme manager as ones that have been referred in from screening or identified from the laser book.

Anyone acting as clinical lead for a screening programme or grading within a screening programme will be expected to take part in grading the EQA test set of images that is being developed. In cervical screening, all pathologists and cervical cytologists involved with the programme have to grade a certain number of EQA slides every year. Similarly a test set of digital images has been developed and is being piloted for the National Diabetic Retinopathy Screening Programme. Once the pilot is complete, this will be made available to everyone working within the programme. The exact number and frequency of image grading that will be required has not yet been determined.

Participation in quality assurance is important to avoid incidents such as that in cervical screening at the Kent and Canterbury Hospital in 1995. The Inquiry identified failure to participate in adequate internal and external QA and the development of bad habits in laboratory procedures and slide interpretations. As a result, some cancers were missed.

It is recommended that a single ophthalmologist within a unit should take responsibility for patients with diabetic retinopathy and that this lead ophthalmologist should:

- Ensure that all ophthalmologists seeing patients referred from the screening programme
  - have access to a system which enables them to record the outcome of that appointment for the screening programme, including non attendance;
  - complete the data set for each patient and report the outcome to the local screening service;
  - grade retinopathy levels according to the national criteria;
  - ensure that the screening administration office is informed of discharges from the care of the hospital eye service, as well as the GP.
- Ensure that outcome data on those patients requiring slit lamp bio microscopy assessment due to ungradable images is returned to the screening administration office, if the assessment of these patients is under the hospital eye clinic.
- Ensure that all patients with diabetes under the care of the hospital eye service for any reason are screened annually to national standards. This can be achieved by annual photography and/or slit lamp bio-microscopy in the eye clinic.
- It is recommended that patients are seen by a consultant, associate specialist, staff grade or SPR year III or higher with at least one year's experience of medical retina clinics and is familiar with the aims and objective of the English Diabetic Retinopathy Screening Programme and in the classification of diabetic retinopathy according to NSC guidelines. Alternatively, staff may be assessed as competent using the recommendations for slit lamp biomicroscopy examiners available on the NSC retinopathy website (*www.retinalscreening.nhs.uk*).
- If patients are under the hospital eye service for another chronic eye disease e.g. glaucoma (or being seen in the private sector), a report of the retinal examination performed by an ophthalmologist back to the screening programme is desirable to minimise the number of appointments for the patient. If this is not available, then the patient should continue to be offered a screening appointment.
- Informing the screening programme of any patients who should be excluded from screening because they have no perception of light in BOTH eyes;
- The clinical lead should ensure that adequate incident reporting mechanisms are in place to record incidents, near misses and Serious Untoward Incidents (SUIs) and to ensure that these are routinely reviewed at multidisciplinary team meetings and programme boards.

In summary, quality assurance applies to screening processes as well as the hospital eye service. It is apparent that there may need to be significant changes from current practice for many eye units. Eye units will need to put in place mechanisms to collect the appropriate data and to liaise closely with their local screening service.

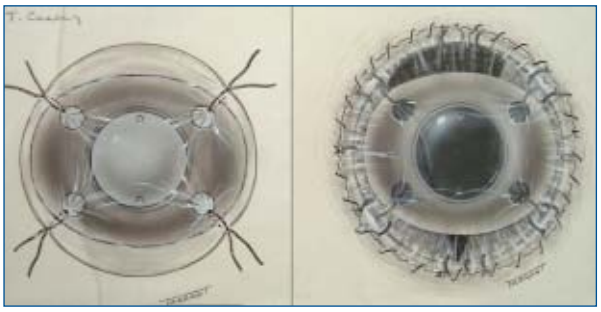
Museum Piece

TERRY TARRANT FRCOphth (hon) - ophthalmic artist

Terry Tarrant, July 2008

Early paintings and illustrations

Fundus painting - 1973



Tarrant illustrations

The late Dr Paul Henkind, on his frequent visits to the Institute of Ophthalmology from New York, would always greet Terry Tarrant with the words "How's the greatest ophthalmic artist in the world?" Few who are familiar with Terry Tarrant's prodigious output of beautiful paintings of the fundus and external eye will argue with this declaration. Terry was born in South London in 1930. His education was cruelly disrupted by the war when his family had to move three times when bombs destroyed consecutive homes.

Later, during a spell in hospital where he sketched to pass the time, his talent was recognised by Dick Smellie, of Theodore Hamblin Ltd, who had been responsible for setting up the company's illustration department in Wigmore Street in the 1920s. At the age of 15, Terry was taken on by Hamblins as an apprentice optical technician and, after a probationary period, joined the small team in Wigmore Street.

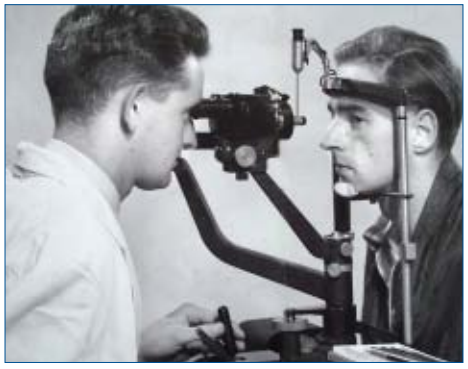
He started by copying fundus paintings from the large stock of what was referred to as 'typicals'. These were paintings done by other artists which formed part of the collection of ophthalmic diseases at the disposal of ophthalmologists for lecturing and publication purposes. During the lunch break Terry would visit a museum, the Wallace Collection, and buy postcards of the famous paintings which he would then copy for practice and pleasure.

Terry did his National Service in the Royal Army Medical Corps at the Queen Alexandra Military Hospital, Millbank and it was no coincidence that he continued his work as an ophthalmic artist.

In 1950, Sir Stewart Duke-Elder's Institute of Ophthalmology was setting up a medical illustration department under Dr Peter Hansell. Terry was recruited at Judd Street and stayed there for most of his 35-year career.

Terry used a Lister Morton battery-operated ophthalmoscope to examine the fundus of patients referred to him. He would observe for five seconds, then sketch and repeat the process until he had the details on paper that he wanted. He would then transfer the sketch to a prepared water-colour paper and proceed to work up the painting with washes of watercolour followed by detailed pathology with fine sable brushes. From the examination of the patient to a completed painting would take the best part of a day.

The introduction of the indirect ophthalmoscope into the UK in the late 1950s by Mr Lorimer Fison transformed Terry's ability to examine the fundus, enabling him to view it three dimensionally and out to the periphery. For external diseases of the eye he also became proficient in the use of the Gullstrand, and, later, the Haag Streit slit-lamp microscopes as well as the gonioscope.



Using the corneal microscope

Terry spent two years at the High Holborn branch of Moorfields Eye Hospital when the illustration department at the Institute was closed and he retired in 1984 to Dorset from where he continued to work on ophthalmic illustrations for books such Mr Jack Kanski's Clinical Ophthalmology.

Ophthalmology salutes a rare and brilliant talent in his retirement.

Terry has warm memories of the many ophthalmologists for whom he did work and would welcome hearing from any of them.

(Terry Tarrant, Woodlands, Rectory Lane, Child Okeford, Blandford Forum, Dorset DT11 8DT)

Richard Keeler
Museum Curator, rkeeler@blueyonder.co.uk

The Lay Advisory Group has vacancies for two new lay members

The LAG is an important part of College life, making a valued contribution to the deliberations of standing committees, to aspects of training and to maintenance of standards. Members are invited to bring these vacancies to the attention of non-clinicians who are interested in ophthalmic care and are prepared to give their time. The terms of reference for the committee and the application form are on the website *www.rcophth.ac.uk*

The closing date: 31 March 2009
Interview date: 23 April 2009

The Revalidation Fellow

Mr Kashif Qureshi has been appointed by the College to develop the cataract dataset. This work will be funded by the Academy of Medical Royal Colleges and he will work closely with Mr John Sparrow and Mr Rob Johnston, the College's Revalidation Lead.

The Health Foundation Awards: "Closing the Gap through Clinical Communities"

This is to fund clinical teams who work with patients to make improvements that will bridge an identified gap between best and current practice. The award will include opportunities for learning and development in quality improvement.

Projects in any condition, disease or service may be proposed for which there is authoritative best practice.
www.health.org.uk

Closing date: Friday 27 March 2009

The Chief Medical Officer's Public Health Awards

These newly established awards are open to anyone working in public health in England, regardless of job title or role. Entries must demonstrate evidence of impact and sustainability of the initiative or project.

The winners of the gold, silver and bronze Chief Medical Officer's Public Health Award 2009 will be announced on 30 June 2009, at an awards ceremony at the Royal College of Physicians in London.
www.dh.gov.uk/cmo

Closing date: Wednesday 22 April 2009.

Eye injuries from fireworks

– *the Dutch perspective*

In the Netherlands, at the stroke of midnight, the New Year is spectacularly celebrated with fireworks. People go outside, greet their neighbours and let off fireworks in the street, in a magnificent and concerted effort.

During December 2008, a huge publicity exercise was mounted by the Netherlands Ophthalmological Society (NOG) encouraging the Dutch public to buy safety glasses costing about 3 Euro (£2.50) for the New Year fireworks. For the first time, the NOG also carried out a national survey of the number and extent of eye injuries from fireworks over the 2008-09 year change. Despite it being a relatively quiet celebration this year, Jan-Tjeerd de Faber, the NOG chairman, reported that the number of injuries this New Year in the Netherlands (population 15 million) was equivalent to half the eye injuries sustained by American forces during the first three and a half years of operations in Iraq from 2003-06 (Weichel et al (2008) Ophthalmology; 115 2235-2245).

A total of 232 patients (269 eyes) were managed by Dutch ophthalmologists. A third of these eyes (94) were seriously damaged, 45 sustaining permanent vision loss. Of these, 23 were completely blind and 14 eyes had to be removed. Around 60 per cent of casualties (137) were bystanders while 40 per cent (95) were injured while setting off fireworks. Just over half the patients were children (118) between 3 and 18 years old. Males were more likely to be injured than females (12 per cent). Orbital injuries, burns, head, hand and eyelid injuries were also common, especially in those setting off fireworks.

Most injuries were caused by bangers (77), 54 by ornate fireworks and 44 by rockets. Fifty five were of unknown origin. This resulted in 100 operative procedures with 30 patients needing further surgery. The comparison with the war situation in Iraq is salutary.

The Dutch Ophthalmological Society is of the opinion that despite significant safety measures and advice, the use of fireworks by the public is still a major public health issue that needs both public and political discussion if this annual loss of sight is to be avoided.

Translated and summarised by Mr Will Sellar

Laser refractive assessment success

The numbers of candidates for the College's new laser refractive assessment have steadily increased from the four who were booked on the first course in October 2007 to four in March 2008, 11 in October 2008 and now 29 booked on the course in March 2009.

The laser refractive eye surgery assessment was developed because there was felt to be a demand for surgeons performing these treatments to be able to demonstrate an appropriate level of training and expertise. The assessment has been developed by refractive surgeons and provides evidence that successful candidates have reached a required safe standard for practice in this field.

The assessment is aimed at established and aspiring laser refractive surgeons. Successful candidates receive a certificate of competence to practise, subject to satisfactory yearly appraisals and continuing professional development.

The next Certificate in Laser Refractive Surgery will take place in London on 12–13 October 2009. The closing date is 17 August 2009.

More information is available from
www.rcophth.ac.uk/exams/laser-refractive-surgery

OCT to go!

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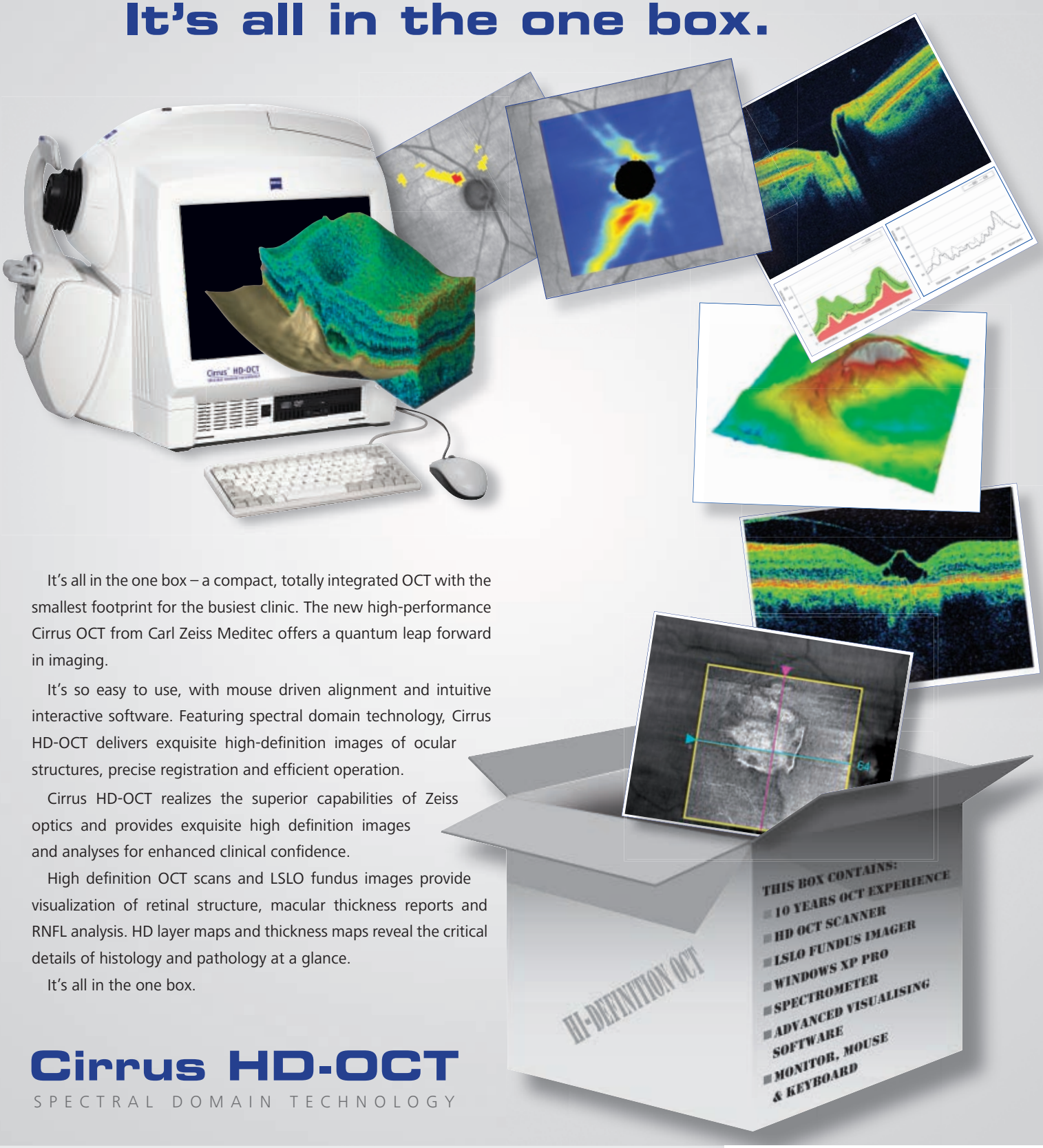

It's all in the one box – a compact, totally integrated OCT with the smallest footprint for the busiest clinic. The new high-performance Cirrus OCT from Carl Zeiss Meditec offers a quantum leap forward in imaging.

It's so easy to use, with mouse driven alignment and intuitive interactive software. Featuring spectral domain technology, Cirrus HD-OCT delivers exquisite high-definition images of ocular structures, precise registration and efficient operation.

Cirrus HD-OCT realizes the superior capabilities of Zeiss optics and provides exquisite high definition images and analyses for enhanced clinical confidence.

High definition OCT scans and LSLO fundus images provide visualization of retinal structure, macular thickness reports and RNFL analysis. HD layer maps and thickness maps reveal the critical details of histology and pathology at a glance.

It's all in the one box.

Cirrus HD-OCT

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Interested in joining the vision panel?

The Honorary Medical Advisory Panel on Visual Disorders and Driving wishes to recruit another member to succeed Mr John Elston who recently retired from the Panel. The new member should be a consultant ophthalmologist with expertise in strabismus. He/she would need to attend those meetings in which there were matters to discuss relevant to this area of special interest and advise on individual cases referred by the Driver and Vehicle Licensing Agency (DVLA).

The Vision Panel meets twice yearly, usually at the Department of Transport, in order to advise the DVLA on vision standards for driving and their interpretation and application. The challenge is to achieve a balance between safety and freedom to drive whilst ensuring any standards are as evidence-based as possible. The Panel is currently chaired by Mr Michael Miller, and Mr Andrew Elliott, who is Vision Standards representative on the Professional Standards Committee, is on the Panel. Andrew would be happy to answer any questions although potential applicants should contact the College's Chief Executive in the first instance: *kathy.evans@rcophth.ac.uk*

BOOST - II UK

Benefits of Oxygen Saturation Targeting

The BOOST II Study – needs help from all UK ophthalmologists who screen for or treat Retinopathy of Prematurity (ROP) and from paediatric ophthalmologists

This is a major opportunity to contribute to a landmark trial

This significant, multi-centre randomised controlled trial (RCT) investigates the outcomes of two different levels of oxygen saturation for premature babies. It is a double-blind RCT to compare the outcomes for premature babies (<28 weeks gestation) of either 85 -89% O_2 or 91%-95% O_2. ROP and associated visual disability are key outcomes for this trial.

Ophthalmologists who screen and/or treat babies for ROP will be asked to complete the BOOST II ophthalmology forms each time they see a baby in the trial. This applies to ophthalmologists in participating UK centres and in "step down" units that accept babies after an initial period of intensive care. Participation in BOOST does not require a Retcam, just the clinical data which will be entered centrally onto the BOOST database to provide the study data for the ROP outcomes. If a Retcam is available, the stored images will be used for additional detailed analysis at a later date. The New Zealand arm of BOOST II (*www.boostnz.info/ROP*) has sample images for ophthalmologists to review and assess.

Separately funded but closely linked studies with the same design are happening in the USA, Canada, Australia and New Zealand: a meta-analysis of all these data will start once sufficient data has been collected.

Outcomes at age 2 years

Follow up of these babies at 2 years will depend on local paediatric ophthalmologists who agree to undertake the follow up examinations. Members' involvement and participation would be greatly appreciated.

The advisory group for ROP and vision studies within BOOST would welcome views of participating or interested ophthalmologists on any aspect of the trial.

Contact: Ophthalmology Trial Development Group c/o *alex.gardiner@npeu.ox.ac.uk*

Updates and feedback will also be available at the Annual College Congress meetings.

Dr Brian Fleck

VISION 2020

The College is a member of VISION 2020 UK, the umbrella organisation which facilitates greater collaboration and co-operation between organisations which focus on vision impairment. The overarching objective is to prevent avoidable blindness. It has a useful library section on its website: *www.vision2020uk.org.uk/library*

Recent additions include:

- People from Black and Minority Ethnic (BME) Communities and Vision Services: A Good Practice Guide – Thomas Pocklington Trust
- Network 1000 - Access to information, services and support for people with visual impairment – University of Birmingham. Data from interviews with 884 people registered as either blind or partially sighted and living in Great Britain.
- Educational provision for blind and partially sighted children and young people in England: 2007 – The Royal National institute for the Blind and the National Foundation for Educational Research

Congress News
19–21 May, Birmingham

With Congress only a few months away, we have been working hard to put together a fantastic scientific programme, which brings together the best ophthalmologists in their field. We are pleased to welcome three dynamic, internationally renowned speakers for our named lectures.

The Optic UK Lecture will be delivered by Professor Alfred Sommer from Baltimore. Professor Anthony Moore of Moorfields Eye Hospital will deliver the Duke Elder Lecture and the Edridge Green Lecture will be delivered by Professor Irene Gottlob from Leicester.

Updates to the scientific programme include a breakfast meeting of the Neuro-ophthalmology Special Interest Group entitled Meet the Experts, chaired by Dr Gordon Plant. He has requested that those who wish to present a case should contact him by email: *gordon@plant.globalnet.co.uk*

Another breakfast meeting is Central Retinal Vein Occlusion – Pathogenesis & Treatment & Choroidal Imaging by Optical Coherence Tomography chaired by Professor Jonathan Gibson, with Dr Richard Spaide from New York as the guest speaker.

We will be running more courses with restricted places, which are given on a first come/first served basis. These include Achieving Success with Multifocal IOLs, which is an interactive course targeted at people who want to improve their clinical outcomes and will be chaired by Mr Milind Pande. Back by popular demand, having been oversubscribed last year, the two-part Retinal Imaging course provides the latest information. The first course is complemented by the practical session.

Other courses include Orbital Cellulitis Diagnosis & Management, which will be chaired by Mr Raghavan Sampath, and will highlight the diagnosis and multidisciplinary management of this potentially life threatening condition. Mr Declan Flanagan will chair a course entitled Laser Safety Update, which aims to highlight that the safety of patients and staff is dependent on awareness of and adherence to good working practices by all members of the clinical team. Please book early to avoid disappointment.

Registration opened on Monday 16 February 2009 at *www.rcophth.ac.uk/scientific* with the latest news and programme developments being updated all the time.

We look forward to welcoming you to Birmingham in May.

Mr Winfried Amoaku,
Chairman, Scientific Committee

Call for Nominees
– the Nettleship Medal

On the occasion of Mr Edward Nettleship's retirement from practice in 1901, a fund was inaugurated by his friends and pupils with the object of founding an Edward Nettleship Prize for the encouragement of scientific ophthalmic work.

The scientific department is seeking nominations for the piece of original work by a British ophthalmologist published in any journal during the last three years. Please send your or a colleague's name and details of the published work to the Head of the Scientific Department: *heidi.booth-adams@rcophth.ac.uk* .

The Annual General Meeting

The AGM will take place at 3.45pm on Wednesday, 20 May 2009 and all members are eligible to attend. Those members who are not registered for Congress but wish to attend the AGM only must present themselves at the registration desk at 3.00–3.30pm so that a security pass can be made.

Have your say

There will be an opportunity to put questions to College Officers in a convivial atmosphere at the following fora:

- Staff and Associate Specialists Forum
Tuesday, 19 May 2009 4.45 to 5.45pm
Questions should be submitted by 5 May to *sas@rcophth.ac.uk*

- OTG Forum
Wednesday, 20 May 2009 5.15 to 6.15pm
Questions should be submitted by 6 May to *otg@rcophth.ac.uk*

Sponsored bike ride

There has been insufficient interest in the proposed trip from London to Birmingham and it will not now take place.

Education News

A new benefit of membership

The College has teamed up with the American Academy of Ophthalmology to offer members (excepting those resident in the US) a free subscription to the Academy's Ophthalmic News and Education (O.N.E.) Network. The O.N.E. Network is an online educational resource center that brings together the most clinically relevant content, news and tools from a variety of trusted sources for ophthalmologists worldwide. It allows members to maintain and enhance their knowledge, conduct precise clinical searches and keep up-to-date.

To locate and utilise the many valuable features and resources of the O.N.E. Network, take the O.N.E. Network's online guided tour *(http://one.aao.org/Tutorials/ONETutorial/player.html)*. It is an excellent way to get started!

Travel awards and fellowships 2009

AWARD	AMOUNT	CLOSING DATE
Patrick Trevor-Roper Undergraduate travel award	Two awards of £500 each	Friday 5 June 2009
Sir William Lister travel award	*Circa* two awards £400 - £600 each	Friday 2 October 2009
Dorey Bequest travel award	*Circa* two awards £400 - £600 each	Friday 23 October 2009
Pfizer Ophthalmic Fellowship	One award of up to £35,000	Friday 23 October 2009
Ethicon Foundation Fund	Four to six awards of *circa* £400-£800 each	Friday 6 November 2009

Information and application forms for all awards are available on the College website: *www.rcophth.ac.uk/education/travelawards*

Ophthalmology as a career

This completely revised document is now on the College website: *www.rcophth.ac.uk/education/undergraduateophthalmology.* It includes illustrations and a number of vignettes from trainees as to why they enjoy the specialty.

The Skills Centre goes to Egypt

In January, Mr Khaled El Ghazali, Mr Simon Hardman Lea, Mr Prasad Palimar and Mr Niral Karia, ably assisted by Katie Miller, ran a Skills Centre course at The National Eye Centre in Cairo. This is the largest Government Eye Hospital in Egypt, the official training centre for the Egyptian Board in Ophthalmology and has the only ocular oncology department in the country. The course was funded by Alcon Laboratories (UK) Ltd and the Egyptian Ministry of Health.

Eye

Eye has begun an exciting new partnership with Medscape to provide its readers with a practical and innovative method of accessing online continual medical education (CME), which is part of continuing professional development (CPD). It will be one of the first ophthalmic journals to routinely offer access to Medscape electronic CME points via a web interface.

Medscape is a medical website organised by specialties and provides some of the internet's most robust and integrated medical information and educational tools. In forthcoming issues of *Eye* an article will be selected for CME. Readers can access the educational questions associated with these articles via a hyperlink available on the online version of *Eye* which will link through to the Medscape website.

Once the questions are complete, readers will have the opportunity to print out a certificate of their CME activity. In addition, another article will be highlighted from *Eye* on the Medscape website monthly. We are proud of these innovations for *Eye* and hope you will find them useful.

Professor Andrew Lotery

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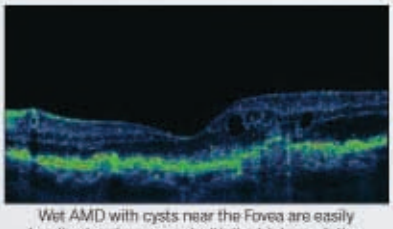
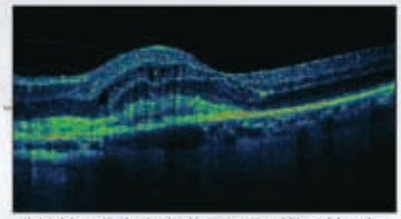
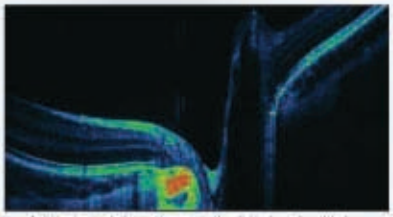


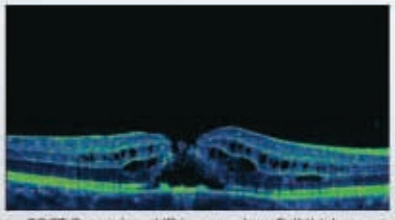
Wet AMD with cysts near the Fovea are easily localized and measured with the high resolution technology of SOCT Copernicus HR



A highly pathological retina showing Vitreo-Macular Traction, formation of cysts and a possible membrane with suspected leakage



A 2D view of Disc Drusen, the 2D view facilitates detailed analysis of the pathological impacts on other parts of the retina.



SOCT Copernicus HR images show Full thickness Macular Hole and its effect on the neurosensory retina. Intraretinal cystoid spaces are also evident on the image.

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Honorary Fellows

Madam President, colleagues, ladies and gentleman, at the admissions ceremony in June 2008, an Honorary Fellowship was awarded to Mr Ronald Pitts

This is an edited version of the citation given in his honour.

It is a great honour for me to say a few words about Mr Ronald Pitts Crick. It is of course an opportunity to remind those who had the privilege of knowing him what a great man he is. More importantly, his achievements should be an inspiration to every young doctor. Politics, systems and institutions do change. We run the risk of getting too excited or depressed by such changes. Ronald's career is a lesson to all of us. He has seen many changes in a career of over almost 70 years. His calmness, integrity, determination and perseverance underpin a truly remarkable success story.

He was born in Canada in 1917, educated at Latymer Upper School and he graduated from King's College Medical School in 1939. He served in the Navy from 1939 to 1946, which took him around the world to South America, Africa, India and Australia. Not a time for the faint hearted.

In 1946 he became Resident House Surgeon at King's, and its three associated hospitals, to Mr Lewis Savin, in due course becoming part-time Senior Registrar. Independently he became Consultant Ophthalmologist to two other hospitals. In 1950 he decided that the time had come for him to sit the FRCS examination. Times have changed! In1950 he became Consultant at King's College Hospital.

Ronald delivered many invited lectures, mainly on glaucoma epidemiology, across most continents. He wrote, with the late Roger Trimble, a textbook of Clinical Ophthalmology in 1986 and for the 1997 and 2003 editions, he joined forces with Professor Peng Khaw. In the 1950s he worked closely with Dr Clifford Hoyle at King's and the Brompton on sarcoidosis, introduced conjunctival biopsy for diagnosis in 1955 and in1961 he reported in detail the ocular aspects of 185 sarcoid cases. Such patients were referred from the Brompton Hospital for his opinion until his retirement in 1982.

However, most of Ronald Crick's professional life was devoted to glaucoma. Almost 40 years ago, in 1969, he introduced at King's the very first, long-running and detailed computerised recording of glaucoma patient data. The late Jack Daubs, an epidemiologist at Harvard, taught him the most modern techniques and offered to assist in the analysis. This produced some of the most relevant publications in this field, which quantified the surprising proportion of low tension glaucoma, even in clinic patients and the dangerously misleading idea of a 'normal' intraocular pressure. He was involved in the pre-release trials of Timolol and other medications. Subsequently in 1990 Professor Christopher Bulpitt at the Hammersmith Hospital, helped analyse data over many years in four papers on the visual field in glaucoma and its relationship to the level of intraocular pressure.

Ronald founded the International Glaucoma Association (IGA) in order to help patients understand their condition. At the inaugural meeting held in 1974, he emphasised the insidious nature of the chronic type and importance of screening. He carried out a long-term project in association with Maurice Tuck, formerly Director of Economics at ICI, on the possible co-operation of the College and the Association of Optometrists and their members in selective screening for glaucoma. All aspects were covered by a series of 17 papers between 1989 and 2003 with much discussion and the main objectives achieved.

IGA's own research is now centred on genetics. In 1991 Ronald negotiated with Professor Sarfarazi, molecular eneticist of Connecticut University, and clinical geneticist Dr Anne Child of St George's Hospital to form a group with the IGA to study genetics in our large database of families. It has made a great contribution to the identification of loci of glaucoma genes, the last in 2007. The work continues and may result in genetic treatment.

Ronald played a pioneering role in the development of the operating microscope and, with Keeler Optical Products Ltd, he showed the first British simple model at the 1958 Oxford Congress. Two years later a model with most of the facilities of the modern ones had been developed, which surgeons in training used at the Royal Eye Hospital for years before microsurgery became general. This prototype was donated to Senior Registrar Abhay Vasavada who was returning to India. He assured me only last week that this microscope still works and has been used by several generations of ophthalmologists in Ahmadabad.

Ronald was Chairman of the IGA from 1974 to 2000 and became President until 2005.The Association is going from strength to strength.

Madam President, I present to you Mr Ronald Pitts Crick.

Mr Wagih Aclimandos

The President with Mr Ronald Pitts Crick and Mr Wagin Aclimandos

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Annual Congress 2009

19–21 May
The largest ophthalmic meeting in the UK
ICC, Broad Street, Birmingham

College Seminar Programme 2009

All seminars take place at the College, unless otherwise stated

17 March
Retinopathy of Prematurity
Institute of Physics, 76 Portland Place, London
Chaired by: Mr Ayad Shafiq

19 June
IXth State of the Art Refractive & Cataract Surgery Symposium
The University of Hull, Cottingham Road, Hull
Chaired by: Mr Milind Pande

16–17 July
Retinal Imaging Course
Institute of Physics, 76 Portland Place, London
Chaired by: Mr Yit Yang

8 September
Use of glaucoma imaging in clinical practice – Who, when and how to scan your glaucoma suspects/patients
Chaired by: Professor Stephen Vernon

16 September
Advances in Keratoplasty – Layer by layer: How Selective Lamellar Corneal Surgery is the Shape of Things to Come
Chaired by: Mr David Anderson

2 October
Intravitreal Therapies
Chaired by: Professor Sue Lightman

13 October
Ocular Oncology – managing adult ocular tumours
Chaired by: Professor Bertil Damato and Miss Sarah Coupland

12 November
Shared Care Services in Ophthalmology – The provision of routine glaucoma management
Chaired by: Mr Jeremy Diamond

19 November
Shared Care Services in Ophthalmology – Review of current successful schemes
The Royal College of Surgeons, Edinburgh
Chaired by: Mr Augusto Azuara-Blanco

27 November
Elizabeth Thomas Seminar – Update on recent developments in macular disease
The East Midlands Conference Centre, Nottingham
Chaired by: Mr Winfried Amoaku

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

Training the Trainers

This course consists of six half-day modules to be run over three days and is particularly useful for programme directors, college tutors and educational supervisors.

7 April and 20 October
Improving teaching skills / Feedback and appraisal

22 June
Assessment / Problem Solving

29 September
What to teach/how to teach

Please visit www.rcophth.ac.uk/education/traintrainers for further details.

College Skills Centre Programme 2009

Ten Basic Microsurgical Skills Courses are planned, details on the website at *www.rcophth.ac.uk/skillscentre/*.
Additional courses are listed below and these take place at the College.

28 April
Oculoplastics

7 May
Intermediate Phacoemulsification

7 December
Medical Retina

RSM Ophthalmology section

12 March
Laser 'Weapons' in Ophthalmology and in War
Chaired by: Professor John Marshall

14 May
Plastic and Oculoplastic
Chaired by: Miss Fiona Robinson

11 June
Trainees Meeting: Posters and Presentations

Other events 2009

18 March
Neuro-ophthalmology Conference
St Thomas's Hospital
www.msouk.co.uk

19 March
The Medical Ophthalmological Society (UK)
Governor's Hall, St. Thomas' Hospital, London
lindy.gee@mosuk.co.uk
www.mosuk.co.uk

27 March
MDA Annual Eye Surgery Update
County Hall, Cardiff, South Wales
laservision@mdaclinic.co.uk
www.mdaclinic.co.uk

28–31 May
The British Contact Lens Association's 2009 Clinical Conference
Manchester
The programme will include a specially designed basic course in 'Contact lens fitting for ophthalmologists' on 30 May, with a hands-on workshop and practical guidance on contact lens fitting and management
conf@bcla.org.uk
www.bcla.org.uk

22–26 June
The Annual Meeting of the Association of British Neurologists
The Arena and Convention Centre, Liverpool
www.theabn.org/meetings/ABN.php

26 June
Stoke Mandeville – opening of new eye unit and reunion
Past employees most welcome to attend. Please send your contact details to:
bruce.james@buckshosp.nhs.uk

30 June
Acquired Sensory Impairment - Confronting the Challenges Faced by Older People.
Organised by the Thomas Pocklington Trust at Birmingham University
lindahartwell7@tiscali.co.uk

5–8 July
Oxford Ophthalmological Centenary Congress
The Oxford Playhouse
To celebrate 100 years since it was founded by Robert W Doyne there will be a boat trip to mirror that taken at the first meeting and the Annual Dinner will be held in Blenheim Palace.
o_o_c@btinternet.com

2–4 September
39th Cambridge Ophthalmological Symposium
St John's College, Cambridge, The Chorioretinal Vasculature
bm.ashworth@tiscali.co.uk

8–12 September
ICOO 2009
The Biennial Congress of the International Society of Ocular Oncology, St John's College, Cambridge
bm.ashworth@tiscali.co.uk

20 November
The Medical Contact Lens & Ocular Surface Association, UK
16th Annual Scientific Meeting
The Royal College of Obstetricians and Gynaecologists / mclosa.admin@gmail.com
To submit an abstract contact:
s.rauz@bham.ac.uk
www.mclosa.org.uk

26–27 November
Trends in Ophthalmology Meetings
The Royal Society, 6-9 Carlton House Terrace, London
info@trendsinophthalmology.com
www.trendsinophthalmology.com

The Royal College of Ophthalmologists
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Editor of Focus: **Professor Victor Chong**