QUARTERLY BULLETIN OF THE ROYAL COLLEGE OF OPHTHALMOLOGISTS

College NEWS

Winter
2009

Message from the President

Dear Fellows and Members

I have had a busy and stimulating time since taking up my new job at the May College Congress and I would like to thank my fellow officers for their help and support.

Our College has been involved in implementation of the European Working Time Directive, which seems to be causing us less difficulty than some other acute specialities, but this may change.

Mr Richard Smith, Senior Vice-President and Chair of the Professional Standards Committee, has been extremely active planning the College's guidance on revalidation and recertification. He has formed a Quality Standards development group to articulate the defining characteristics of high-quality clinical care across the breadth of ophthalmology .

We continue our dialogue with the optometric professions regarding referrals for suspected ocular hypertension and Professor Steve Vernon from Nottingham is leading for the College on a joint working party to try to improve the situation.

This year saw the formation of an Academic Group to advise the College, and a first very successful meeting has been held.

We conducted a very constructive Strategy Day in October and a major revision of the College website is to be undertaken in the near future.

Our Patron, HRH the Duke of York, visited the College on 9th November and was shown presentations ranging from "high-tech" (the cataract surgery simulator) to simple and practical (a study from the International Centre for Eye Health at the London School of Hygiene and Tropical Medicine demonstrating that epilation of lashes markedly improves the incidence of corneal blindness from trachoma in Ethiopia).

I wish you all a happy Christmas and a successful New Year.

Mr John Lee

The Patron watching a demonstration of the simulator given by Mr Mark Watts. Dr Ian Curran – Associate Dean leading on Simulation Training, London Deanery is in attendance

Mr Saul Rajak and Mr Matthew Burton who presented on trachoma with Lt.Col Andrew Jacks who talked about ocular trauma

The Patron hearing about Motion Displacement Tests for Glaucoma from Dr Gay Verdon-Roe and Mr Ted Garway-Heath

STOP PRESS

The Ophthalmic Training Club plans a meeting at the RSM on 15 May 2010

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

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

Professional Standards

There is a financial crisis going on: it's time to tighten our cannulae

A routine cataract extraction is underway. The phacoemulsification is complete and the cortical matter has been aspirated. The surgeon is starting to inject viscoelastic into the bag, when suddenly the cannula shoots off the end of the syringe and hits the optic disc. The surgeon jumps up and shouts 'Bullseye!'

Although the surgeon's reaction in this scenario may be an urban legend, the occurrence rate of cannulae shooting off syringes during intra-ocular procedures is certainly not. Most surgeons are aware of this event either happening to themselves or to a colleague, and reports of incidents to the Medicines and Healthcare products Regulatory Agency (MHRA) are not reducing in number. Two reports were received in 2005, one in 2006, three in 2007, four in 2008 and four in 2009. Although these are small numbers, it is important to remember that there is significant under-reporting to the MHRA.

The MHRA and the College would like to make two points:

- It is the individual surgeon's responsibility to ensure that a cannula is safely secured to the syringe on each individual insertion into the eye.
- Clinicians responsible for defining the contents of intra-ocular procedure packs, which are manufactured specifically for them, should consider whether these packs should contain only the much safer Luer Lock syringes rather than standard syringes.

Untoward incidents are distressing for all concerned but from a purely financial perspective, a 2ml normal syringe costs 2.6p, while a Luer Lock costs 10p. Damages for blindness can be up to £140,000, as noted on the National Health Service Litigation Authority website. This additional 7.4p per syringe will therefore be significantly outweighed by the avoidance of a single litigation case due to a 'Bullseye' event.

The MHRA is very keen to promote the on-line reporting of any adverse incidents relating to medical devices at *www.mhra.gov.uk/ophthalmology* These reports enable us to analyse and feedback important safety information for the best practice of clinicians and well-being of patients.

Dr Christopher Brittain MRCOphth
Senior Medical Officer, Clinical Devices
Medicines and Healthcare products Regulatory Agency

News from the Certifications Office

The Certifications Office, London was established using funds from the Guide Dogs. Currently all CVIs (certificate of visiual impairment) in England & Wales are sent to the Certifications Office for epidemiological analysis. We are very grateful to all consultants for completing certificates and will do our best to put all data in the public domain. Analysis of the forms completed between 1 April 2008 and 31 March 2009 is to commence shortly. The analysis for April 2007 and 2008 is now complete but comparison with the last completed analysis of cause of blindness in England & Wales is somewhat hampered by the change in form. The BD8 form very clearly asked for a single main cause of vision loss. The CVI presents a picking list of causes with a comment to the ophthalmologist to asterisk or circle the main cause of visual loss if there is more than one cause. Whilst for BD8 data, just over 3% of forms had a main cause of visual loss due to multiple causes, this figure has increased to just fewer than 17% of CVI forms.

We would ask all those completing CVIs to carefully consider whether it is possible to identify a single main cause using guidance within the explanatory notes for consultant ophthalmologists and hospital eye clinic staff (item 20):

> *If there are different causes in either eye choose the cause in the last eye to become certifiably visually impaired.*
> *If there are different pathologies in the same eye choose the cause that, in your opinion, contributes most to visual loss.*
> *If it is impossible to choose a single main cause asterisk both.*

Dr Catey Bunce,
CVI Project Lead

Aid to Hospitals world wide (ASHww) was featured in College News Autumn 2009. It recycles redundant medical equipment and sends it to the poorest countries of the world. The piece yielded a good response but more microscopes and slit lamps, cameras and VFAs are sought.
See *www.a2hw.org.uk* for more details.

Confidentiality – Guidance from the General Medical Council

The GMC has launched new guidance on Confidentiality, together with supplementary guidance on some of the issues doctors often ask about or find difficult to deal with, such as reporting concerns about patients to the DVLA to responding to press criticism. *www.gmc-uk.org/confidentiality*

Research Fund

The College gratefully acknowledges a generous donation from Allergan.

Congress Videos

The 2009 eponymous lectures are available for members to view in the members' area of the website. *www.rcophth.ac.uk/finance-membership/members/eponymous-lectures*

Members' News and Appointments

Consultant Appointments

Ms Olatokumboh Akerele	Hinchingbrooke Hospital, Huntingdon
Miss Seema Anand	Queen's Medical Centre, Nottingham
Mr Tariq Aslam	Manchester Royal Infirmary, Manchester
Mr Atul Bansal	Clayton Hospital, Wakefield
Mr Bradley Bowling	Victoria Hospital, Blackpool
Miss Cordelia Cole	Whipps Cross University Hospital, London
Mr Jonathan Durnian	The Royal Liverpool University Hospital, Liverpool
Miss Badia Fahad	Royal Shrewsbury Hospital, Telford
Mrs Helen Herbert	Bristol Eye Hospital, Bristol
Mr Venkat Kotamarthi	Leighton Hospital, Crewe
Mr Avinash Kulkarni	Kings College Hospital, London
Ms Maduparna Mitra	Royal Gwent Hospital, Newport
Mr Sivanandy Nagendran	North Cambridgeshire Hospital, Wisbech
Mrs Nirodhini Narendran	New Cross Hospital, Wolverhampton
Mr Vikesh Patel	Royal Preston Hospital, Preston
Mrs Sudeshna Patra	Whipps Cross University Hospital, London
Mr Jonathan Ross	Borders General Hospital, Melrose
Mr George Saleh	Moorfields Eye Hospital, London
Dr Ramesh Sivaraj	Heartlands Hospital, Birmingham

Regional Advisers

The table below shows those post holders who will complete a three-year term of office in 2010. Any NHS consultant fellow who is registered for CPD who wishes to stand should contact hon.sec@rcophth.ac.uk

REGION	CURRENT POST HOLDERS	DATE OF RETIREMENT	ELIGIBLE FOR RE-ELECTION
West Midlands	Mr Maurice Headon	March 2010	No
Scotland North East	Dr Chris Scott	March 2010	No
South East Thames	Mr Christopher Hammond	March 2010	Yes
South West Thames	Miss Anne Gilvarry	March 2010	Yes
North Western	Mrs Clare Inkster	June 2010	No
Moorfields	Mr Frank Larkin	Sept 2010	No

Membership information

We have had a good response to the census form sent out with subscription information and we hope that the accuracy of the information held on the membership database will improve as a result. Please contact *database@rcophth.ac.uk* if you get a new email address so that we can keep in touch with you.

Travel expenses

The travel and expenses policy for those attending meetings can be found at *www.rcophth.ac.uk/finance-membership/expenses*. Members are urged to plan ahead to take advantage of lower fares.

College Surgical Skills Tutor

Mr Mark Watts has been appointed for a second term of three years. He has written an article on surgical simulators as used in the skills centre for the International Journal of Clinical Skills. The abstract can be viewed at *www.ijocs.org/issues/vol3iss3abs.aspx#1*

The Olympian Ophthalmologist

Mr Hugh Williams has written and presented a DVD that celebrates the extraordinary life of Mr Henry Stallard. Members attending Congress will be able to collect a copy from the Alcon stand and copies have been sent to paying UK seniors in recognition of their continuing support of the College.

Desperately seeking....

Please contact the Sunderland Eye Infirmary if you have a Goldmann Perimeter to sell or swap *wendy.adams@chs.northy.nhs.uk*

The inaugural Macular Disease Society Awards for Excellence 2009

In the clinical services category, the judges were looking for exceptionally good practice in the care for people with macular disease, including the development of good care and referral pathways, innovation and excellent patient communications.

There were three joint winners:

- The Birmingham and Midland Eye Centre led by Professor Jonathan Gibson
- The Hull and East Yorkshire Eye Hospital led by Mr Jim Innes
- Torbay Hospital led by Mr Mick Cole

Professor Jonathan Gibson and colleagues from the Medical Retina Team, Birmingham and Midland Eye Centre

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THE ROYAL COLLEGE OF OPHTHALMOLOGISTS

Focus

Winter
2009

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

Medical Retina Update

Age-related macular degeneration (AMD), diabetic macular oedema (DMO) and retinal vein occlusion (RVO) account for over 70% of severe visual loss in the developed world. In the past few years, several major studies have further advanced our knowledge in combating these conditions.

Age-related macular degeneration

Lucentis has dramatically changed the life of millions who suffered from wet AMD. Pivotal studies (Anchor and Marina) have shown that at 12 months, on average there is an 8 letter gain in vision on the ETDRS chart after monthly injection of Lucentis. However, monthly injections are costly and carry a significant burden to the patient and the health care system.

Pronto study was a small but important case series. It introduced the concept of the separation of the loading phase and the maintenance phase. In the loading phase, injections are given monthly until the retina is "dry", and typically 3 injections are required. This is followed by monthly monitoring, and the patient is retreated only if there is recurrence, with criteria such as increased retinal thickness in optical coherent topography (OCT), presence of new haemorrhage or visual loss. In this study, an 8 letter gain was achieved. However, the patients in the Pronto study were not treatment naïve, unlike those in the pivotal studies. Despite that, it has become the "standard treatment" in most countries, including Britain. Sustain study is a large scale Pronto, involving over 500 patients. Unlike the pivotal studies, there is no sham treatment group. At 12 months, the average gain in vision was 3.6 letters with average of 5.6 injections. Fewer injections can achieve slightly worse visual outcome.

The Pier study was carried out at the same period as the pivotal studies. A loading phase of 3 injections at monthly intervals was followed by injections given as 3 monthly intervals. At 12 months, no letter gain was achieved but it was much better than the sham treatment group of 16 letter loss. A head to head study comparing monthly injection with the "Pier" treatment schedule (Excite) was reported. Monthly injected patients had on average an 8.3 letter gain (similar to the pivotal studies) as compared to a 3.8 letter gain in the 3 loading doses then quarterly treated patients, which is better than PIER.

So what about combination?

The theoretical benefit of combining photodynamic therapy (PDT) with Lucentis is clear, as they act differently, so it is likely to have synergy effect. The Mont Blanc study compared standard PDT with Lucentis to Lucentis alone, using the "Pronto" type protocol. The Lucentis monotherapy group had a 4.4 letter gain with 5.1 injections while the combination group had a 2.5 letter gain with 4.8 injections and 1.7 PDT treatments. We are still waiting for the Denali study which has a reduced fluence arm, to see whether that would give a better result. Otherwise, combination is not superior to monotherapy and it is not recommended routinely.

What do I think about the results?

Individualisation of treatment has become the buzzword in medicine. However, whether that can be achieved in practice is often in doubt. We have 2 large scale studies (Sustain and Mont Blanc monotherapy arm), using individualisation by monthly monitoring. In these 2 studies, we achieved approximately a 4 letter gain with 5.5 injections. So far, no treatment regimen has better results than monthly injection with 8 letter gain. It remains to be seen whether tighter retreatment criteria and more injections can achieve better result than the "Pronto" regimen. In patients who cannot attend on a monthly basis, using the Excite regimen (loading then quarterly) may be a reasonable but controversial option. In clinical trials, there is approximately a 4 letter gain with 6 injections, which is very similar to the Pronto regimen. Further research is needed to determine which patients should go on to which regimen and we should not forget that about 20% of patients do not need any more treatment after the loading doses.

Diabetic macular oedema

Diabetic retinopathy clinical research network (DRCR.net) has becoming a major research powerhouse. Its objective is to develop and operate a collaborative network to facilitate multicentre clinical research, and is funded by the National Eye Institute, Industry and Charity Foundation. So far, all the centres are based in the US, but they have just started to accept international sites.

I will summarise a few published studies from the DRCR.net related to DMO.

- Comparing traditional ETDRS laser treatment to the more commonly used mild macular grid laser, it was found that both are effective in terms of vision but the traditional method has significantly greater reduction of retinal thickness as measured by OCT.
- Comparing intravitreal triamcinolone (ivTA) to laser for DMO, laser has better results beyond 6 months. Further more, the final result was the same whether the patient was treatment naïve or had previous laser, as well as regardless of baseline retinal thickness. Combination of ivTA and laser was not studied.
- A short study on Avastin with or without laser for DMO found the dosage of 1.25mg or 2.5mg makes very little difference. However, in the short term, Avastin was found to be effective but combination does not add much value. That is not totally unexpected as laser might take a lot longer to work.

Further information can be found in *www.drcr.net*

Outwith the DRCR.net, Lucentis has been studied in the READ-2 study for 6 months, it compared Lucentis (4 injections), combination of laser and 2 injections of Lucentis and laser alone. The results were 7.6, 3.8 and -1.1 letter gains respectively. Monthly Lucentis as studied in the Resolve Study, patient gains about 10.3 letters as compared to -1.4 letters in sham treated group at 12 months. Macugen was also effective in DMO with 6 weekly injections achieving a 4.7 letter gain at week 36 as compared to -0.4 letters in the sham group.

All these results are encouraging, but none of these studies had included patients with ischaemic DMO. A significant proportion of our patients suffer from ischaemic DMO and it remains the most difficult to treat. These agents have to be studied in ischaemic DMO.

Finally, not all of us would be keen to inject monthly in patients with focal macular oedema. In these patients, laser remains the main treatment option. My group has published a randomised controlled trial comparing micropulse laser to mild macular grid laser. It was found both were equally effective in terms of vision and OCT thickness reduction, but micropulse laser is 8x less likely to have visible scaring. Micropulse laser delivers laser energy in pulses allowing cooling between pulses. This enables high level of energy to the retinal pigment epithelium with less collateral damage in the retina.

Retinal vein occlusion

Osurdex: Osurdex is the first FDA approved treatment for macular oedema caused by retinal vein occlusion. It has not received EMEA approval yet, but in theory, it is available in the UK at least in the private sector. It is an intravitreal implant containing 0.7 mg dexamethasone in the solid polymer drug delivery system, similar to a vircyl suture, which dissolves completely. It can be injected into the vitreous using a 22 gauge needle. The FDA's decision was based on data from 2 multicenter, double-blind, randomized parallel studies (n = 1626). In each individual study and in pooled analysis, dexamethasone was significantly faster than placebo in achieving a 3-line (15 letter) or greater improvement in best-corrected visual acuity ($P < .01$), an effect that was maintained for about 1 to 3 months. For 20% to 30% of patients, the onset of a 3-line improvement in best-corrected visual acuity occurred within the first 2 months of implantation.

Adverse events most commonly reported during the first 6 months of dexamethasone therapy included increased intraocular pressure (25% vs 1% for placebo) and conjunctival haemorrhage (7% vs 5%). Increased intraocular pressure peaked at day 60 and returned to baseline levels within 6 months; during the initial treatment period, only 0.7% of patients required laser or surgical procedures to manage this condition. Further details can be found in *www.allergan.com/assets/pdf/ozurdex_pi.pdf*

Lucentis in BRAVO and CRUISE: BRAVO is a multicenter study of 397 patients using monthly Lucentis in patients with macular oedema secondary to branch-RVO. CRUISE is a similar multicenter study of 392 patients using monthly Lucentis in patients with macular oedema secondary to central-RVO.

Data from the BRAVO study showed at month six, patients who received 0.3 mg of Lucentis had a mean gain of 16.6 letters and patients who received 0.5 mg of Lucentis had a mean gain of 18.3 letters (compared to 7.3 letters in patients receiving sham injections). In the CRUISE study, at month six, patients who received 0.3 mg of Lucentis had a mean gain of 12.7 letters and patients who received 0.5 mg of Lucentis had a mean gain of 14.9 letters (compared to 0.8 letters for patients receiving sham injections). In both trials, a statistically significant mean gain in best correct visual acuity was observed as early as day seven for both doses of Lucentis compared with sham. Further details can be found in *www.gene.com/gene/news/press-releases/display.do?method=detail&id=12367*

Triamcinolone in SCORE: Intravitreal preservative free triamcinolone at 1mg and 4mg were compared with standard care for BRVO (i.e. laser) and CRVO (i.e. observation). In BRVO, laser and triamcinolone have very similar outcomes but laser has a significantly lower frequency of adverse events. Hence, the use of ivTA was not recommended. Nonetheless, combination was not studied.

In CRVO, triamcinolone is better than observation. Both 4 mg and 1mg were equally effective, and 1mg has significantly lower frequency of adverse events than 4mg. So the 1mg dose was recommended to be used in CRVO. However, the study preparation of 1mg is not commercially available. So we do not know whether giving 1mg of commercially available triamcinolone would get the same results. Also it is practically difficult to give 0.025ml. Furthermore, in the CRVO study, the mean change of vision was -12.1, -1.2, and -1.2 for usual care, 1 mg and 4 mg groups respectively. The sham group has much worse results than the sham patients in the CRUISE study, suggesting different patient population.

Conclusion

Anti-VEGF therapies, steroids, and laser appear to be effective in these blinding conditions. The best way of using them remains unclear.

Victor Chong,
Oxford Eye Hospital, University of Oxford, Oxford

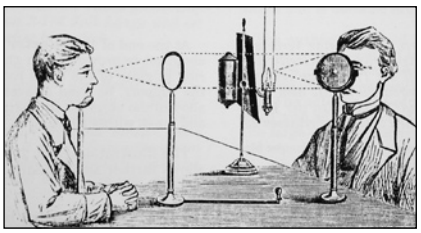
References:

- Mitchell et al., BJO, 2009 May 20 Epub – AMD studies
- Figueira et al., BJO 2009 93: 1341-4 – Micropulse laser
- Nguyen et al., Ophthalmology 2009 116 2175-81 – READ-2
- Cunningham et al., Ophthalmology 2005 112: 1747-57 – Macugen for DME
- Scott et al., Arch Ophthal 2009 127:1115-28 – SCORE BRVO
- Ip et al., Arch Ophthal 2009 127:1101-14 – SCORE CRVO

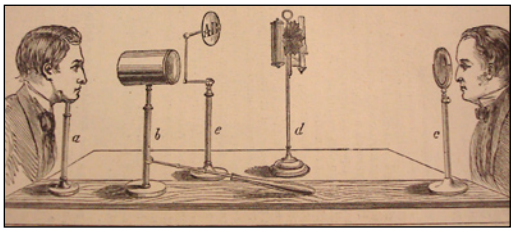
Figure Legend: A) Wet age-related macular degeneration B) Diabetic macular oedema C) Central retinal vein occlusion D) Branch retinal vein occlusion

JABEZ HOGG 1819-1898

Photographer, illustrator, microscopist and ophthalmologist



Brudenell Carter's Demonstration Ophthalmoscope



Hogg's Demonstration Ophthalmoscope

One of the most prized daguerreotypes owned by the National Media Museum shows a photographer, with stop watch in one hand and a lens cap in the other, taking a long-exposure portrait photograph.

The year is 1843 and this is believed to be the first photograph of a photographer at work. The photographer is Jabez Hogg aged 26 who was also to become a microscopist, illustrator and ophthalmologist.

Jabez Hogg as a photographer

Hogg was fascinated by this new invention and wrote a Manual of Photography in 1845. This attracted the attention of the founder and editor of the Illustrated London News. Hogg worked part time for this magazine as illustrator from 1850-66 after studying medicine and having obtained his MRCS in 1850. Hogg wanted to become an ophthalmologist and only five years later by good fortune he became assistant to the great George J Guthrie FRCS at the Royal Westminster Ophthalmic Hospital.

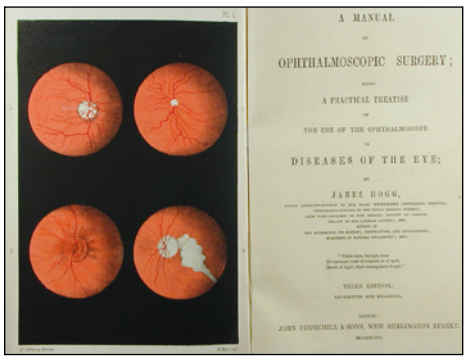
Whilst holding down a job at the hospital and part time activity at the Illustrated London News he found time to write a profusely illustrated book in 1854 on The Microscope: its History, Construction, and Application, which went into 15 editions, the last one being in 1898.

Hogg continued his writing by publishing a slim volume on The Ophthalmoscope in 1857. A second edition followed the next year.

Hogg was the first in Great Britain to advocate the value of the instrument that was to change ophthalmology when he published this book. Emboldened by his success Hogg produced a third edition, much revised and enlarged, with the inexplicable title "A Manual of Ophthalmoscopic Surgery". There is no surgery in it.

In the first edition of the Ophthalmic Review in 1865, edited by its founder John Zachariah Laurence, three books on the ophthalmoscope were reviewed. One was by George Rainy (Glasgow Eye Infirmary) 1860, another by John W Hulke (King's College Hospital) 1861 and the third by Jabez Hogg 1863. The first two reviews were, by and large, complimentary but the one for Hogg's book most certainly was not.

The reviewer felt that there was a prima-facie case for consideration of this book, being in its third edition and dedicated to the most illustrious personages in England including dukes, earls etc .



A manual of Ophthalmoscopic surgery

What followed must surely be the worst review of any medical book, ever. The editor starts in a fashion that lasts for thirteen pages.

"His book is so utterly and unutterably bad, and is, from beginning to end, such an incoherent mass of errors and misstatements about every subject with which it deals, that we almost despair of being able to impart anything like a correct impression it demerits. His book has no arrangement... no sequence, no method, no beginning, middle or end."

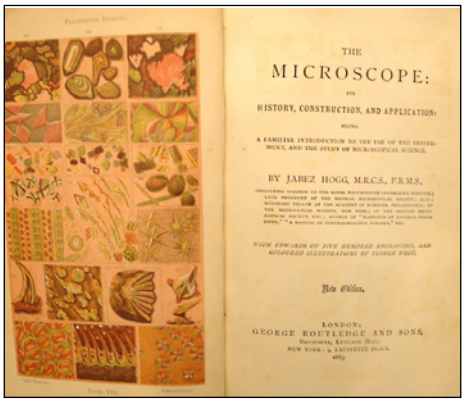
It seems that Hogg even had difficulty in understanding the difference between direct and indirect ophthalmoscopy!

H Stanley Thompson (Emeritus Professor, University of Iowa), in a paper read at the 2009 Cogan Ophthalmic History Society, has suggested that Hogg may have had a specific dyslexia unrecognised at that time. This might explain the high level of illustrations accompanying and explaining the text in all but his book on the ophthalmoscope.

Arnold Sorsby suggested that the author of this review may have been Robert Brudenell Carter. He would certainly have felt piqued at seeing his demonstration model ophthalmoscope in 1872 imitated by Hogg a few months later but this was seven years after the review, so it was probably not him.

Jabez Hogg never achieved his FRCS and continued to practice as an ophthalmologist at the Royal Westminster Hospital for many years and was still honorary consultant surgeon when he died at the age of 82.

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



The Microscope by Hogg

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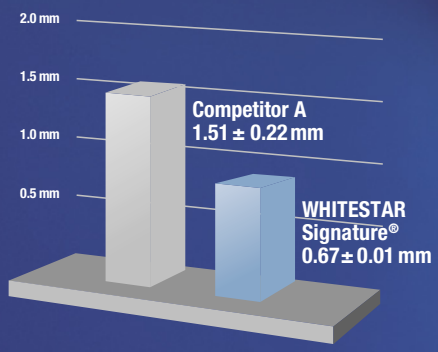
COMPARISON OF SURGE



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1. Georgescu D, Kuo AF, Kinard KI, Olson RJ. A fluidics comparison of Alcon Infiniti, Bausch & Lomb Stellaris, and Advanced Medical Optics Signature phacoemulsification machines. Am J Ophthalmol. 2008;145(6):1014-1017.

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SCIENTIFIC NEWS

Annual Congress: 25-27 May 2010

The UK's largest ophthalmic conference and exhibition return to the Arena and Convention Centre, Liverpool and registration starts on 15 February.

Eponymous lectures

Allen Foster will be delivering the inaugural Barrie Jones Lecture. Robert F. Frank, Detroit will deliver the second Optic UK Lecture. This year's Edridge Green Lecture is by Graham Holder, and Brenda Gallie, from Toronto, will deliver the Bowman Lecture.

New for 2010 – Retina Day on 24 May

Our first sub-specialty day will be chaired by Som Prasad and Winfried Amoaku. It has an exciting programme covering all aspects of medical and surgical retina. Chi-Chao Chan will be joining us from National Eye Institute, Bethesda. Peter Stalmans from Leuven, Belgium will be talking on new indications for sutureless vitrectomy and which colour suits the VR surgeon. We have two keynote speakers – Stanislao Rizzo, Santa Chiara Hospital, Pisa, and Robert Mullins, University of Iowa, who specialises in cell biology. There will be a small dedicated exhibition and a drinks reception for all delegates.

Seminar for allied health professionals

2010 sees the return of a session specifically for allied health professionals. Mark Batterbury and Sandy Taylor from Liverpool are putting together an interesting and inspiring day for all those involved in providing eye care services.

Focus on AMD regional symposia

This series of regional seminars will take place in venues around the UK. They are to address some of the common queries received on treatment, re-treatment and discontinuation of anti-VEGFs (Vascular Endothelial Growth Factor A), an overview of data, service set up and delivery. More details will become available at *www.rcophth.ac.uk/scientific*

Northern Ireland: Belfast	22 January
Chaired by: Professor Usha Chakravarthy	
Surrey & South: Frimley Park Hospital	10 February
Chaired by: Mrs Geeta Menon	
Trent: Derby	12 February
Chaired by: Mr Pankaj Puri & Mr Winfried Amoaku	
North East England: Bradford Royal Infirmary	16 February
Chaired by: Mr Faruque Ghanchi	
Midlands: Birmingham	12 March
Chaired by: Professors Jon Gibson & Yit Yang	
South West England University Hospitals: Bristol	26 March
Chaired by: Miss Clare Bailey	
London & South East England	TBC (April)
Chaired by: Mr Adnan Tufail	
East Anglia	TBC (June)
Chaired by: Mr Douglas Newman	

Mrs Heidi Booth-Adams
Head of the Scientific Department

The UK Neuro-ophthalmology Special Interest Group

– an update

To date, eight meetings/courses have taken place of the Neuro-ophthalmology Special Interest Group. Breakfast meetings were held at the Association of British Neurologists in September 2005 and April 2007, and around 40 people attended a breakfast meeting during the 2007 College Congress. At the ABN Meeting in London in November 2007 the group staged a two-hour teaching course on 'bedside' neuro-ophthalmology and at the 2008 Congress in Liverpool a similar session on special investigations.

At the 2008 College Congress, Neil Miller presided over a 'meet the expert' session. The 200 attendees at this breakfast meeting showed enormous interest in intracranial hypertension and optic neuritis, as demonstrated by numerous comments and questions from the floor.

The first all-day meeting was held on 18 March 2009 at St Thomas' Hospital, which also hosted the annual meeting of the Medical Ophthalmology Society on the following day. The programme included a symposium on the management of idiopathic intracranial hypertension with guests Francois Borruat and Aki Kawasaki from Lausanne.

At the 2009 College Congress in Birmingham another 'meet the expert' session featured Professor Deborah Friedman – (cases were presented from Darwin, Australia and Newcastle, England), followed by a symposium on migraine. These two sessions each attracted over 300 attendees.

Future meetings

The second annual meeting will take place on 17 March 2010 (see page 16 for details). A session on paediatric neuro-ophthalmology will include contributions from David Taylor, Gordon Dutton, Bill Newman and Creig Hoyt. Mr Hoyt will deliver the Swithin Meadows Lecture that evening. Please contact me if you wish to attend.

In 2010, another 'meet the expert' session will be held on 26 May at the College Congress with David Zee. Anyone wishing to present a case, which should have an ocular motor flavour, should contact me by email.

In conclusion, there is considerable demand from neurologists and ophthalmologists for a national organisation committed to continuing professional development in neuro-ophthalmology. The next phase will be to extend our activities to the promotion of research and the setting of standards in training.

Dr Gordon T Plant
gordon@plant.globalnet.co.uk

Obituaries

Professor Barrie R Jones

CBE, BSc(NZ), FRCS(Eng), FRCP(Lon), Hon FRACS, FRCOphth(Hon)

Born in New Zealand in 1921, Barrie Russell Jones studied medicine at the University of Otago, Dunedin. In 1950 he was Registrar in Ophthalmology under Professor Rowland Wilson. Wilson, who had been in charge of the Gizeh Ophthalmic Memorial Laboratory in Cairo, inspired in him a lifelong love of research-based medicine and the study of ocular infections, particularly trachoma. In 1951 Barrie came to the UK with the intention of gaining a PhD before returning to Dunedin to take over from his mentor.

Once in London, however, the course of his life, and with it the future direction of British ophthalmology, changed for ever when he secured a training post at Moorfields Eye Hospital followed by a research post at the recently formed Institute of Ophthalmology.

In 1963, he was appointed to the prestigious academic post of Professor of Clinical Ophthalmology in the University of London. The department was based at the Institute of Ophthalmology, but its clinical component was embedded in Moorfields where it was granted considerable space and over 20 beds. Barrie, using his exceptional clinical and interpersonal skills, changed ophthalmic practice at the hospital and transformed the relationship between clinicians and researchers.

He brought about two fundamental changes in clinical practice in the UK. Firstly, he insisted on the use of the operating microscope by all trainees at Moorfields, which spawned a new generation of micro-surgeons. Secondly, he realised that ophthalmology would only progress by encouraging sub-specialisation. He had powerful allies in Lorimer Fison, who was committed to the modernisation of retinal detachment surgery, and in Redmond Smith, who took a similar line with glaucoma. His sub-specialty interests were surgery of the eyelids, often those deformed by trachoma, and the microsurgery of the lacrimal drainage system, where he introduced a new, effective operation, the canaliculodacryocystorhinostomy (CDCR).

From 1975 onwards, he set about realising his life's ambition to create a centre to advance preventive ophthalmology worldwide. In 1981 he became the first Director of the International Centre for Eye Health. After his 'retirement' in 1986, he continued teaching and researching as Emeritus Professor in the University of London. It was not until 2002 that he, and his beloved wife Pauline, finally returned home to New Zealand to enjoy true retirement. The International Centre, now based at the London School of Hygiene and Tropical Medicine, continues to thrive, as does the worldwide movement for eye health, with training centres in Africa, India and America.

He delivered many prestigious lectures, including the Jackson Memorial Lecture in the USA (1974) and the Bowman Lecture (1975) and received countless honours, including the CBE, the Gonin Medal – the highest award in international ophthalmology – and the King Feisal International Prize in Medicine. In 2004 the International Agency for the Prevention of Blindness gave him its Global Achievement Award.

Barrie possessed a powerful intellect, excellent clinical judgement, fine surgical skills, a highly developed sense of curiosity, boundless energy and determination, all encompassed by personal charm and a puckish sense of humour. No man has had a more profound influence on the conduct of a medical specialty and the pursuit of worldwide eye health.

Mr Peter K Leaver

The inaugural Professor Barrie Jones Lecture will be delivered by Professor Allen Foster OBE, Director, International Centre for Eye Health, at the Annual Congress on 25 May 2010.

Professor Colin M Kirkness

BMed Biol, MBChB, FRCSEd, FRCSGlas, FRCOphth, DEBO

Professor Kirkness was immensely proud of his Orcadian roots. He obtained an entrance bursary (scholarship) to Aberdeen University where, in addition to his medical studies, he completed a BMed Biol course in physiology and continued his research interests with the help of Carnegie Scholarships.

Colin later moved to London to train in ophthalmology and he himself thanked Hugh O'Donohue (later Professor of Ophthalmology in Dublin) and Croydon Eye Unit's Dermot Pierce for teaching and inspiring him. This led him to choosing ophthalmology, ophthalmic surgery and the cornea, in particular. On completing the Moorfields Eye Hospital rotation, he was appointed to that professorial unit as Lecturer in Corneal Diseases and later he became a Subdean at the Institute of Ophthalmology and a Director of the Pocklington Transplantation Unit. He was well recognised as a devoted teacher and a very competent and innovative surgeon.

In 1990 he was appointed Tennent Professor of Ophthalmology at Glasgow. Three of his important contributions to eye disease and cornea were: botulinum toxin ptosis for corneal ulcer protection, chlorhexidine drops for the management of acanthomoeba keratitis and a safe surgical procedure for control of keratoglobus.

Along with teaching and innovative surgery Colin was honoured to be elected Chairman of Examinations at the RCOphth and also Secretary of EUPO and President of the European Board of Ophthalmology. He published over 120 original papers and chapters.

Colin retired early to look after his increasingly frail mother. He had many outside interests including travel, photography, skiing, cooking and oenology.

Miss Deirdre Flaye

We note with regret the deaths of:
Mr Thandalan Kalyanasundaram, Burton-on-Trent
Mr John Ormrod, Maidstone, Kent

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SUMMARY OF PRODUCT CHARACTERISTICS **1. NAME OF THE MEDICINAL PRODUCT** Mydriasert 0.28 mg/5.4 mg ophthalmic insert **2. QUALITATIVE AND QUANTITATIVE COMPOSITION** Each ophthalmic insert contains 0.28 mg of tropicamide and 5.4 mg of phenylephrine hydrochloride. For a full list of excipients, see section 6.1. **3. PHARMACEUTICAL FORM** Ophthalmic insert. White to yellowish-white, oblong, 4.3 mm x 2.3 mm insert. **4. CLINICAL PARTICULARS** **4.1 Therapeutic indications** Mydriasert is indicated: - to obtain pre-operative mydriasis, - or for diagnostic purposes when monotherapy is known to be insufficient. **4.2 Posology and method of administration** Restricted use to health-care professionals. This medicine is reserved to adults. There are no data in children and adolescents. Mydriasert is not recommended in these patients. **Posology** One ophthalmic insert per operated eye, a maximum of 2 hours before surgery or the investigative procedure (see also 5.1). **Method of administration** Cut the sealed edge along the dotted line, open the sachet and locate the insert. Hold the insert with disposable sterile forceps with rounded ends provided in the packaging, making sure not to damage it. Pull down the lower eyelid by pinching it between the thumb and index finger (A), and apply the ophthalmic insert, using the disposable sterile forceps, in the lower conjunctival sac (B). **Instructions for use** Do not leave the ophthalmic insert for more than two hours in the lower conjunctival sac. The practitioner can remove the ophthalmic insert as soon as mydriasis is deemed sufficient for the operation or procedure to be carried out, and at the latest within the next 30 minutes. In the event of discomfort, ensure that the insert has been placed correctly at the base of the lower conjunctival sac. Manipulate aseptically. It is recommended to avoid excessive manipulation of eyelids. **CAUTION: Removal of the ophthalmic insert** Before an operation or procedure, and as soon as the required mydriasis has been obtained, the ophthalmic insert should be removed from the lower conjunctival sac (C) by using either sterile surgical forceps, or a sterile swab or a sterile irrigation or washing solution, by lowering the lower eyelid. Do not reuse the insert. Discard the insert after use immediately. **4.3 Contraindications** - Hypersensitivity to the active substances "phenylephrine hydrochloride and tropicamide" or to any one of the excipients. - Risk of angle-closure glaucoma: Patients with closed angle glaucoma (unless previously treated with iridectomy) and patients with narrow angle prone to glaucoma precipitated by mydriatics. **4.4 Special warnings and precautions for use** ***Special warnings:*** Because this medicinal product causes long lasting visual disturbances, the patient should be advised to be accompanied when attending the consultation (see 4.8). Protect the eye against bright lighting after the end of intervention/consultation. Ocular hypoemia can increase the absorption of the active ingredients contained in the insert. ***Special precautions for use:*** The shifting or, more rarely, the expulsion of the insert is possible. In this case, do not re use the removed insert, take a new one (see section 4.2). Mydriasert should not be left in the conjunctival sac for more than 2 hours. In cases where Mydriasert was forgotten, local adverse reactions were observed (see section 4.8). Because of uncommon potential irritation on conjunctiva, special care should be taken with patients suffering from severe dry eyes (use of Mydriasert in some patients may necessitate the addition of a drop of saline solution to improve insert tolerance). All mydriatic agents may trigger an acute attack of glaucoma through the mechanical obstruction of the excretory pathways of aqueous humour in subjects presenting with a narrow iridocorneal angle. Although not anticipated with Mydriasert due to negligible systemic passage of active ingredients, it is however reminded that phenylephrine has sympathomimetic activity that might affect patients in the event of hypertension, cardiac disorders, hyperthyroidism, atherosclerosis or prostate disorders and all subjects presenting with a contraindication to the systemic use of pressor amines. Sportsmen and athletes should be warned that this proprietary medicinal product contains an active principle (phenylephrine) which may produce positive results to tests for prohibited substances. The wearing of soft hydrophilic contact lenses is inadvisable during treatment. After the insertion of Mydriasert, and if the administration of other mydriatic agents cannot be avoided, account must be taken of the doses in the insert of approximately one drop of a 10% solution of phenylephrine and approximately one drop of a 0.5% solution of tropicamide. **4.5 Interactions with other medicinal products and other forms of interaction** No specific studies interaction studies have been performed with Mydriasert. **4.6 Pregnancy and lactation** ***Pregnancy*** There are no adequate data from the use of phenylephrine and tropicamide in pregnant women. Animal studies are insufficient with respect to effects on pregnancy, embryonal/foetal development, parturition and postnatal development (see section 5.3). Even though a negligible systemic uptake is expected, a low systemic exposure can not be excluded. Therefore, Mydriasert should not be used during pregnancy unless necessary. ***Lactation*** No data are available concerning the passage of phenylephrine or tropicamide into breast milk. However, phenylephrine is poorly absorbed orally, implying that absorption by the infant would be negligible. On the other hand, infants may be very sensitive to anticholinergics, and despite the expected negligible systemic exposure, tropicamide is therefore not recommended during breast feeding. Therefore, Mydriasert should not be used during breast feeding. **4.7 Effects on ability to drive and use machines** Mydriasert has major influence on the ability to drive and use machines. Patients should be warned of the risks related to mydriatic and cycloplegic agents, which may cause visual disturbances like dizziness, drowsiness and impaired concentration: application of the Mydriasert ophthalmic insert causes disabling mydriasis for several hours; consequently, after application, the patient should be advised not to drive and/or use machines while the visual disturbances persist and/or not to perform other hazardous activities. **4.8 Undesirable effects** The following transient effects have been reported during clinical studies: ***Eye disorders*** *Common* (> 1/100): - stinging, - blurred vision, - visual discomfort *Uncommon* (> 1/1000, < 1/100): - tearing, irritation, - disabling mydriasis because of prolonged pupil dilation, photophobia, - superficial punctuate keratitis. *Rare* (< 1/1000): - blepharitis, - conjunctivitis, - risk of angle-closure glaucoma, intraocular hypertension. Very rare cases of corneal ulcer and corneal oedema were observed due to forgotten insert. Although administered via the topical route, the mydriatic agents contained in this insert may cause the following systemic effects which must be taken into account: - elevation of blood pressure, tachycardia, - very rarely, major accidents such as cardiac arrhythmia, - tremor, pallor, headaches, dry mouth. **4.9 Overdose** Although unlikely due to single administration of Mydriasert (for either pre-operative or diagnostic purposes), a risk of overdose may nevertheless occur in the event of the additional instillation of mydriatic eyedrops. Symptoms of a phenylephrine overdose include extreme tiredness, sweating, dizziness, a slow heartbeat, and coma. Because severe toxic reaction to phenylephrine is of rapid onset and short duration, treatment is primarily supportive. Prompt injection of a rapidly acting alpha-adrenergic blocking agent such as phentolamine (dose 2 to 5 mg i.v.) has been recommended. Symptoms of tropicamide ophthalmic overdoses include headache, fast heartbeat, dry mouth and skin, unusual drowsiness, and flushing. Systemic effects from tropicamide are not expected. Should an overdose occur causing local effects, e.g. sustained mydriasis, pilocarpine or 0.25% w/v physostigmine should be applied. **5. PHARMACOLOGICAL PROPERTIES** **5.1 Pharmacodynamic properties** Pharmacotherapeutic group: MYDRIATICS and CYCLOPLEGICS, Tropicamide combinations. ATC code: S01F A56 Mydriasert is an ophthalmic insert which combines two synthetic mydriatic agents (phenylephrine, alpha sympathomimetic, and tropicamide, anticholinergic). Clinical trials have shown a time to reach a stable and sufficient mydriasis between 45 and 90 min. The maximal mydriasis (pupil diameter of 9 mm) was reached in 90 to 120 minutes. The mydriasis, when reached, lasted at least 60 minutes. **The recovery of the pupil reflex was seen at 90 minutes at the average. 5.2 Pharmacokinetic properties** After application of an insert for 2 hours in 138 patients scheduled for cataract surgery, the concentrations of the active ingredients assayed in aqueous humour were very low: 1.9±3.4 µg/ml for phenylephrine and 0.85±2.06 µg/ml for tropicamide. The cumulative quantities of the active ingredients released in 2 hours by the insert represent less than 40% of the doses contained in the insert. In the same conditions, the plasma levels of phenylephrine measured during 6 hours in healthy volunteers were not detectable (< 0.5 ng/ml). **5.3 Preclinical safety data** Safety pharmacology, genotoxicity and conventional reproductive studies have not been conducted with phenylephrine, tropicamide or the fixed combination. In rats, administration of phenylephrine (12.5 mg/kg, s.c.) resulted in reduced uterine blood flow (86.8% reduction in about 15 minutes), thereby exhibiting foetotoxic and co-teratogenic properties. A 14-day local tolerance study was conducted in the rabbit, with insertion during 6 hours daily. This study demonstrated a mild irritating effect of the conjunctiva at the site of application. **6. PHARMACEUTICAL PARTICULARS** **6.1. List of excipients** Ammonio methacrylate copolymer (Type A) Polyacrylate dispersion 30% Glycerol dibehenate Ethylcellulose. **6.2. Incompatibilities** Not applicable. **6.3. Shelf life** 18 months. After first opening of the sachet: Use immediately. After first use: Discard the used insert immediately. **6.4. Special precautions for storage** Do not store above 30°C. Use immediately after first opening the sachet. **6.5. Nature and contents of container** Ophthalmic insert in a sachet (Paper/PE/Aluminium/PE) and disposable sterile forceps in a sachet (Paper/PE/Aluminium/PE). Box of 1, 10, 20, 50 and 100 inserts together with respectively 1, 10, 20, 50 and 100 forceps. Not all pack sizes may be marketed. **6.6. Special precautions for disposal** Cut the sealed edge along the dotted line, open the sachet and locate the insert. Hold the insert with disposable sterile forceps with rounded ends provided in the packaging, making sure not to damage it; place it at the base of the lower conjunctival sac, having pulled down the lower eyelid with the thumb and index finger. For single use only. Use immediately after first opening the sachet. Discard the used insert immediately. Any unused product or waste material should be disposed of in accordance with local requirements. **7. MARKETING AUTHORISATION HOLDER** Ishtech S.A. Avenue Paul Langevin BP 5 17053 La Rochelle Cedex 9. France **8. MARKETING AUTHORISATION NUMBER(S) 9. DATE OF FIRST AUTHORISATION/RENEWAL OF AUTHORISATION** **10. DATE OF REVISION OF THE TEXT** Final SmPC - FR/H/273/01 - 14.06.2006

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Inside Out

The first ten years of the Lay Advisory Group

The College's Lay Advisory Group (LAG) first met on 5 August 1999. It now comprises 15 members including two members nominated by Council and a representative from the Staff and Associate Specialists group. Meetings are chaired by a lay member and are attended by the President and the Chief Executive. Usually, a chair of one of the College committees presents an aspect of the College's work.

Lay members are recruited through open advertisements in national newspapers and interview. They serve for three years, renewable once. Members of distinction can also be co-opted to the Committee. They elect their own chair who serves for three years, renewable once. There is a facility to dismiss lay members for non attendance, which has been invoked once.

The LAG has met 36 times in its first 10 years. Its discussions have covered some 235 subjects across the whole range of issues in ophthalmology and health. Curiously, revalidation was a major talking point on both the first and the 36th agenda.

The top ten topics which took the most discussion at the time are shown below:

- BUPA approved list of ophthalmologists (2006) – BUPA wished to approve ophthalmologists in the delivery of ophthalmic care. Much anxiety was generated and the LAG was supportive of the College's stance.
- The Consultant Ophthalmologist (2009) – Various comments were made on the draft including a suggestion that the term 'ophthalmologist' had not been explained.
- Inter-collegiate meetings (1999)/ Meeting of lay chairmen (2003) – The Royal College of Psychiatrists invited a lay member to their patient group's annual meeting in 1999 and subsequently a variety of invitations of this sort have been accepted including that in 2003. These meetings were thought to 'not achieve a great deal'.
- Surgical results (2006) – This was an opportunity to persuade the College to enter into 'the collation of surgical results for members'. This work has now been taken up by the College's Revalidation Fellow who spoke to the LAG in 2009.
- Membership status of lay advisers (2008) – Council reviewed the ordinances and byelaws as part of its preparation for the 20th anniversary. In early 2009, a category of lay member was proposed.
- Confidentiality and privacy of patients during examinations (2008) – The Examinations Committee sought a view as to whether it was acceptable for more than one patient to be present in the room during examinations. The LAG view was that patients should not overhear the discussions of the candidate and his/her patient.
- EIDO Healthcare Ltd (2007) – The LAG had been asked to comment on documents on glaucoma, retinal detachment, corneal grafts and cataracts.
- Lay examiners for the communication module (2007) – The invitation from the Chair of the Examinations Committee was well received and was the start of the current degree of involvement by lay members in College examinations.
- Developing links with the College of Optometrists (2006) – During the time of discussion about extending the role of optometrists to undertake prescribing, the College of Optometrists was active in seeking ways to maintain good relations. These contacts between the lay members have continued with further visits and meetings.
- Hospital information group (2004) – The LAG was surprised to be told that there were 290 different sources of advice about eye health. The Hospital Information Group was trying to help with the production of baseline standards and criteria.

Concluding comment

Most of the lay members have enjoyed their experience. Only one has left because he could not get to grips with the subject area but most others have pressed on hopefully. Their efforts have been rewarded by a warm welcome, endless patience and kindness, and an overwhelming sense of the purpose and value of the College and its work.

Mr Tim Battle
Lay member

College travel awards and fellowships 2010

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

AWARD	AMOUNT	CLOSING DATE
Fight For Sight	One award of £5,000	Friday 5 February 2010
Keeler Scholarship	One award of up to £20,000	Friday 12 February 2010
Pfiser Ophthalic Fellowship	One award of up to £35,000	Friday 12 February 2010

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Honorary Fellows

At the Admissions Ceremony in June 2009, an honorary fellowship was awarded to Mr Redmond Smith. This is an edited version of the citation given in his honour

It gave me great pleasure to prepare this citation, for Redmond belonged to that generation of ophthalmologists where our specialty was not only our employment, but also a hobby as well a stimulus for intellectual development. He is a truly remarkable renaissance man for he found time to pursue a myriad of different pursuits outside our specialty. His career was long, varied and successful and I shall touch on some of these today.

He was born in Barnes in 1923 into a medical family. He was educated at the Oratory School, Caversham, and entered St Mary's in 1941. Redmond qualified in 1946 and became house sur¬geon to the ENT and ophthalmic departments at St Mary's. At this time he started his interest in ophthalmology. After his residency training he spent a formative period working under Norman Ashton at the Institute of Ophthalmology before his appointment as Consultant Surgeon to The Royal Northern Hospital in 1954. He was appointed to the Staff at St Mary's Hospital in 1958, a position he held until retirement in 1988, and he was also appointed to Moorfields Eye Hospital in 1960.

Redmond was an inspiring teacher. He would always make us, the students, work out answers using logic as well as observation. Book learning was a necessary accompaniment but not the prime source of information. He instinctively followed the Conan Doyle approach of observation without prejudice, combined with the Holmesian view that if the obvious (solution) was not possible then the less obvious, however improbable, should be considered. He was one of the earlier surgeons in the UK to routinely use the operating microscope for cataract surgery, and a significant part of his surgical teaching was how to 'manage the microscope'. Redmond was the first to try internal trabeculotomy as a treatment for primary open angle glaucoma. Although the operation did not catch on – technically it was too difficult for most of us – Redmond was able to show that his thinking was well ahead of his time. He wrote *Clinical Glaucoma*, an essential primer for all ophthalmology residents, and co-wrote the glaucoma section in *The System of Ophthalmology* with Sir Stewart Duke Elder.

Norman Ashton demonstrated the neovascular response in the eyes of kittens following sudden withdrawal of oxygen. Redmond discovered that new vessels appeared in the anterior chamber angle following retinal vein occlusions, and considered the mechanism to be the same (in contrast to the earlier held view that it was glaucoma that caused the neovascularisation). Norman Ashton suggested destruction of the anterior retina as a form of treatment, which Redmond was able to do and show the subsequent regression of the new vessels.

His interests outside ophthalmology are protean. Cricket, tennis, fishing, DIY, the 'cello, carpet weaving, coracle building, gardening, picture restoring and reading are a list of hobbies that indicate the wide range of his interests. I remember him telling me at a Moorfields dinner a few years ago how he had discovered a new rose. A benefit from such a discovery was that he could name it. It was with pride that he told me how he had named it after his granddaughter.

Mr Roger Hitchings

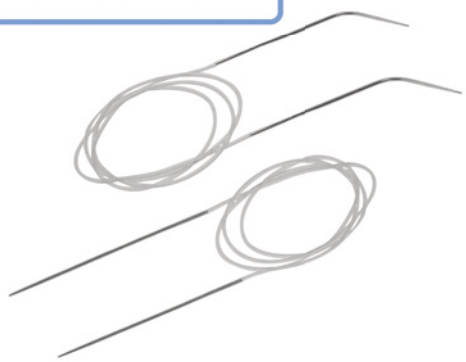
Mr Redmond Smith with the President, Mr John Lee, at the 2009 Admissions Ceremony

Cluedo and the ophthalmic connection

It was reported in The Times (24 October 2009) that George Black, an ophthalmic surgeon in Leeds, was the inspiration for the victim in the game of Cluedo, Dr Black. The theory was confirmed by his neighbour Mr Watson, managing director of Waddingtons, who launched Cluedo in 1949. The family believes that 'his name and features live on for ever, whatever Colonel Mustard and his murderous friends may try'.

instruments & instrument care

Bodkins are back



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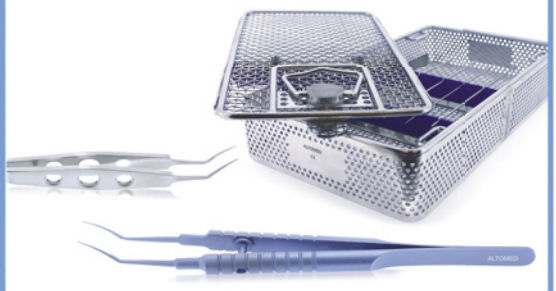

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College Seminar Programme 2010

All seminars take place at the College, unless otherwise stated

26 March
Highlighting Translational Research by UK Ophthalmologists and Vision Scientists
Institute of Physics, 76 Portland Place, London
Chaired by: Professor Andrew Dick & Professor Andrew Lotery

18 June
10th Annual Regional Study Day
Derwent Building, Hull University Business School
Chaired by: Mr Milind Pande

15–16 July
Retinal Imaging Seminar
Institute of Physics, 76 Portland Place, London
Chaired by: Professor Yit Yang & Dr Heinrich Heimann

16 September
Diabetic Retinopathy Screening
Chaired by: Miss Gilli Vafidis

21 September
Glaucoma: The Controversy of Neuroprotection
Chaired by: Mr James Morgan

5 October
Management of Cataracts in Children
Chaired by: Mr Chris Lloyd

2 November
Advances in Vitreoretinal Surgery
Chaired by: Dr Martin Snead & Mr Paulo Stanga

19 November
The Elizabeth Thomas Seminar – Update on Recent Developments in Macular Disease
The East Midlands Conference Centre, Nottingham
Chaired by: Mr Winfried Amoaku

24 November
Understand Revalidation and Face it with Confidence
Chaired by: Mr Richard Smith

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. Dates for 2010 are still to be confirmed. Please visit: www.rcophth.ac.uk/education/traintrainers for further details.

College Skills Centre Programme 2010

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.

15 March
Phaco Complications Course
Mr David Steel

23 March
Oculoplastics
Mr Bijan Beigi & Miss Jane Olver

7 May
Vitroeretinal
Mr Paul Sullivan

Other events 2010

Closing date of 6 January
Oxford Ophthalmological Congress: Call for Papers
Abstracts should be received online by the Editor, Professor A D Dick,
www.oxford-ophthalmological-congress.org.uk

9 January
Ophthalmology ST Interview Skills Course
ophthalmologycourse@yahoo.co.uk
www.ophthcourse.webs.com

4–5 February
Trends in Ophthalmology Meetings
The Royal Society, 6–9 Carlton House Terrace, London
Info@trendsinophthalmology.com
www.trendsinophthalmology.com

12 February
One-Day Symposium on Lacrimal Surgery
carol.bolton@ipwichhospital.nhs.uk

4–7 March
The World Congress on Controversies In Ophthalmology (COPHy)
Clarion Congress Hotel, Prague, Czech Republic
info@comtecmed.com
www.comtecmed.com/cophy/2010/

17 March
The UK Neuro-ophthalmology Special Interest Group
St Thomas' Hospital, London
gordon@plant.globalnet.co.uk

18 March
The Medical Ophthalmological Society
St Thomas' Hospital, London
lindy.gee@mosuk.co.uk
www.mosuk.co.uk

16–18 June
Bicentennial Meeting for Bristol Eye Hospital
The BEH will hold a meeting to celebrate 200 years of service. Alumni are asked to contact Mr Rodney Grey rodney.grey@btinternet.com to ensure that they receive an invitation.

4–7 July
Oxford Ophthalmological Congress
Oxford Playhouse Theatre, Oxford
www.oxford-ophthalmological-congress.org.uk
o_o_c@btinternet.com

8–10 July
14th International Conference on Behçet's Disease
Queen Mary University Conference Centre, London
Icbd2010@serenas.com.tr
www.serenas.com

20–22 September
2nd World Congress on Refractive Error
International Centre for Eye Education and the International Agency for the Prevention of Blindness
Durban, South Africa
www.icee.org

Annual Congress 2010

Abstract results published: 19 January

Registration opens: 15 February

Arena & Convention Centre, Liverpool: 25 - 27 May

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