QUARTERLY BULLETIN OF THE ROYAL COLLEGE OF OPHTHALMOLOGISTS

College NEWS

Spring
2010

The new MRCOphth

There is a new classification of Membership of the College for examination candidates who have successfully completed the Refraction Certificate and Diploma examinations (previously referred to as *Diploma Plus*).

The MRCOphth is a postgraduate ophthalmic qualification for doctors who have experience and knowledge of ophthalmology but who are not independent practitioners. It is a particularly suitable qualification for those training as medical ophthalmologists and for staff and associate specialist ophthalmologists.

The benefits of Membership to candidates passing the Diploma and Refraction Certificate examinations include:

- Internationally recognised post-nominals: MRCOphth
- An entry qualification to the ophthalmic medical practitioner register

Those holding the following historic examinations are also eligible to apply for the new classification of membership:

Have passed both the Diploma (DRCOphth) since November 2001 AND:

- Part 2 MRCOphth (Nov 1997–Nov 2008)
- Optics and Refraction Module (May 1989–November 1998) OR
- Passed the Diploma (DRCOphth) including compulsory Practical Refraction component (June 1997–June 2001).

New Members via this route are not eligible to sit the Fellowship Assessment. Those wishing to obtain Fellowship of the College must pass the Part 1 FRCOphth examination, the Refraction Certificate and the Part 2 FRCOphth examination.

Application forms for the new classification of membership are available on *www.rcophth.ac.uk/exams/new-membership*

Membership certificates will be presented to new members at the Admission Ceremony in September each year for which invitations are issued in early July.

Emily Beet
Head of the Examinations Department

The Royal College of Ophthalmologists 2010 Annual Congress

Tuesday 25 May – Thursday 27 May at the Arena & Convention Centre, Liverpool.

We have worked hard on the scientific programme and have chosen the best speakers in their different fields. We are very pleased to welcome Allen Foster, Robert Frank, Brenda Gallie and Graham Holder who will be delivering our eponymous lectures.

This year also sees the return of the successful wet labs and retinal imaging courses. Please register early for these sessions as places are on a first come, first served basis.

The first Retina Day at Congress will be held on Monday 24 May and the presentations will complement the meeting. Separate registration is required for this event.

Please visit the website for details of the eponymous lecturers, symposia, courses, posters, DVDs, drinks receptions and the commercial exhibition.

This promises to be a great meeting and we very much look forward to welcoming you to Liverpool again.

Registration is now open and there is an early bird discount until 19 April. More details are at *www.rcophth.ac.uk/scientific*

Mr Winfried Amoaku
Vice President and Chairman of the Scientific Committee

This issue contains the AGM papers and a summarised report for 2009. The full electronic annual report is on the website *www.rcophth.ac.uk*
Tell us what you think of this approach *kathy.evans@rcophth.ac.uk*

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 10
Autumn	5 August 10
Winter	5 November 10
Spring	12 February 11

Preparing for revalidation

In January 2010 the General Medical Council approved the standards for the revalidation of ophthalmologists proposed by the College. These standards are to be piloted in NHS organisations during 2010, with a view to their general introduction in April 2011.

The most important specialty-specific elements for ophthalmologists will be evidence of clinical outcomes, patient-centred care and safe practice obtained via methods such as clinical audit, external quality assurance and patient feedback in the ophthalmologist's main areas of specialist practice. In some areas of practice, such as cataract surgery, the majority of ophthalmologists routinely collect data on complication rates, visual outcomes and refractive outcomes. The College believes that this should become a requirement for all cataract surgeons.

In other areas of practice there are few applicable measures of individual performance but there are well established quality measures of the clinical service to which the ophthalmologist contributes. Diabetic retinopathy assessment and treatment services are an example. In this case, ophthalmologists will be asked to provide information in their revalidation portfolio about the local service and their contribution to safeguarding good clinical standards within it, but we do not propose to prescribe exactly what that information should be.

Many ophthalmologists are engaged in areas of new or emerging practice where treatment protocols are evolving, e.g. age-related maculopathy. We propose that ophthalmologists collect evidence of the acquisition or development of new skills, and participation in collaborative audit or relevant research with colleagues.

It is sometimes necessary for ophthalmologists to maintain skills in areas of practice which are only used occasionally – for instance in emergency situations or in order to provide a clinical service in a remote area. We will expect that ophthalmologists will review areas of occasional practice in their revalidation portfolios periodically to ensure that these skills are being maintained at a safe level.

As far as possible, the information required for revalidation is information which is (or should be) collected routinely. Some eye departments already have electronic systems for the data collection, either as locally developed databases or commercially available software systems. It will be possible to collect information for revalidation using paper methods but the College wishes to encourage the NHS to invest in clinical information systems, capable of collecting and auditing clinical information reliably.

Many ophthalmologists work partly or wholly outside NHS hospitals in independent practice, in primary care, in non-clinical areas or as ophthalmic medical practitioners. We hope to pilot the appraisal process with these groups to ensure that they are not placed at a disadvantage as they seek revalidation in their areas of practice.

More detailed information to help ophthalmologists to prepare for strengthened appraisal and revalidation will be provided during the coming months.

Other news:

Kashif Qureshi, the College's Revalidation Research Fellow is working with the ophthalmic subspecialty societies to obtain consensus on the best available measures of clinical care in the main subspecialties.

The College is in the process of establishing a national ophthalmic database to be populated with data derived from electronic medical records systems to allow individual ophthalmologists or units to compare their outcomes with those of a wider group of their peers. The College is grateful to ophthalmologists who have already contributed high quality data on cataract surgery and trabeculectomy.

The GMC is running a consultation of revalidation, closing date: 4 June 2010.
Visit *www.gmc-uk.org/doctors/licensing/5786.asp*

Mr Richard Smith
Vice President and Chairman of Professional Standards Committee

Eye Care in Cuba

28 April – 10 May 2010

This fully escorted tour for ophthalmologists and optometrists will give you the chance to explore many aspects of a unique society including its pioneering healthcare system and meet with some of the people who help shape Cuba today.

A highlight of the tour is a keynote speech by Dr Aleida Guevara, Che Guevara's daughter. Dr Guevara will be talking about Operation Miracle, a Cuban project that provides free eye surgery to the Caribbean islands.

Meet local ophthalmologists, visit a polyclinic, the Pando-Ferrer Eye Hospital in Havana and the Latin American Medical School. Visit the cigar factory, farms, villages, and examine old Havana. Enjoy live music, glorious colonial architecture, beautiful landscapes, stunning beaches and the vivaciousness of Cuba.

For a brochure, full itinerary and cost call Jon Baines Tours on 020 7223 9485. Email *info@jonbainestours.co.uk* or visit the website at *www.jonbainestours.co.uk*

Members' News and Appointments

Consultant Appointments

Ms Rajitha Ajit	Furness General Hospital, Barrow-in-Furness
Mr Mrinal Anand	Goole and District Hospital, Goole
Mr Rajan Bhojwani	Goole and District Hospital, Goole
Mr Richard Bowman	Whipps Cross Hospital & Great Ormond Street Hospital, London
Dr Vikas Chadha	Gartnavel General Hospital, Glasgow & Stobhill Hospital
Mrs Anshoo Choudhary	Royal Liverpool University Hospital, Liverpool
Ms Edel Cosgrave	Harrrogate District Hospital, Harrogate
Mr Ankur Das	Royal Glamorgan Hospital, Llantrisant
Mr Amit Gaur	Royal Preston Hospital, Preston
Mr Dharmalingam Kumudhan	Queen's Medical Centre, Nottingham
Mr Ibraheem El-Ghrably	The James Cook University Hospital, Middlesbrough
Mr Usman Mahmood	University Hospital North Staffordshire, Stoke on Trent
Mr Sridhar Manvikar	Darlington Memorial Hospital, Darlington
Mr Stuart McGimpsey	Royal Victoria Hospital, Belfast
Dr Kamiar Mireskandari	The Hospital for Sick Children, Toronto
Mr Krishnamoorthy Narayanan	Darlington Memorial Hospital, Darlington
Mr Fahd Quhill	Royal Hallamshire Hospital, Sheffield
Mr Bishwanath Pal	Moorfields Eye Hospital, London
Mr Neil Rogers	Royal Hallamshire Hospital, Sheffield
Professor Peter Shah	Selly Oak Hospital, Birmingham
Mrs Sabrina Shah-Desai	Queen's Hospital, Romford
Mr Kaleem Siddiqui	Goole and District Hospital, Goole
Mr Kasra Taherian	Royal Preston Hospital, Preston
Miss Grace Yuen Wu	Darlington Memorial Hospital, Darlington

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
North Western	Mrs Clare Inkster	June 2010	No
Moorfields	Mr Frank Larkin	Sept 2010	No

Obituaries:

We note with regret the death of:

Mrs Trudi Blamires, Kettering

Mr William Desmond Hopkins, Chester

Mr Hugh Kennedy, Glasgow

Dr Edouard Mawas, Paris

Miss Dorothy Field Potter, New Zealand

Dr Sivaguru Selvarajah, Kuala Lumpur, Malaysia

Mr George Augustine Sutton, Birmingham

New Year Honours

Dr David Murray McGavin has been awarded an MBE for service to eye care in the developing world.

VISION 2020 UK

Learning Disability Sub-Group seeks an ophthalmologist to attend meetings in central London 4 times a year. Contact *kathy.evans@rcophth.ac.uk*

Membership information

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.

Seniors' Day – Thursday 17 June 2010

There will be 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 *penny.jagger@rcophth.ac.uk* for further details.

Double success for the UHBFT Ophthalmology Team

The University Hospitals Birmingham NHS Foundation Trust has been recognised with two awards. Its Lucentis service won the clinical category of NICE shared learning awards. The service was planned and developed in anticipation of NICE guidance in August 2008; no patient waits longer than one week from the receipt of the referral to the initial assessment and since the commencement of the service no actively treated patients have been registered blind. The service was also highly commended at the Health Service Journal awards.

Consultants Mr Nicholas Glover, Miss Helen Palmer and Miss Marie Tsaloumas with the nurse manager Abdullah Mahmood at the NICE shared learning awards

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THE ROYAL COLLEGE OF OPHTHALMOLOGISTS

Focus

Spring
2010

Giant cell - temporal - arteritis (GCA) in ophthalmic practice

Introduction:

Giant cell- temporal- arteritis (GCA) is a systemic vasculitis of the elderly that affects large and medium sized arteries with internal elastic lamina. It commonly affects branches of carotid circulation and hence is also known as cranial arteritis. Apart from the temporal arteries, this occlusive arteritis commonly involves the posterior cilliary arteries which can lead to severe visual loss by inducing ischaemic optic neuropathy. It is essential to establish prompt diagnosis and initiate treatment urgently as untreated arteritis can lead to progressive loss of vision and that of second eye involvement.

Clinical Features:

The varied clinical features of GCA reflect the systemic involvement, which can potentially involve any circulation. The clinical features can be described as systemic and ischaemic in nature. The systemic features often overlap with the related, milder inflammatory disorder- polymyalgia rheumatica. Proximal limb girdle weakness and stiffness, loss of appetite, weight loss and low grade fever may precede development of GCA. The onset of new headache is often a presenting symptom. A temporal headache and temporal tenderness are presenting symptoms at first consultation. Tenderness to touch the scalp is also a classic symptom. The history taking should include enquiry about jaw claudication (masseter muscle claudication), occipital headache or neck pain (occipital artery involvement), facial pain or swelling (involvement of facial artery). Tongue claudication is less frequent. The claudication symptoms are suggestive of intermittent ischaemia; scalp necrosis is rare but is indicative of established ischaemia. It is important to recognise that up to 20% of patients may not have any systemic symptoms and would still have occult GCA.

Ophthlmological complications:

The commonest presentation of GCA in ophthalmic clinic is with anterior ischaemic optic neuropathy (AION). It may be preceded by other transient ischaemic symptoms, e.g. amaurosis fugax, photopsia, or purple vision or diplopia. The optic nerve head classically has pale swollen appearance not dissimilar to a cotton wool spot. Often a cotton wool spot like swelling may be seen spilling over from the optic disc in to adjoining retina. (Fig. 1A). Arteritic (a) AION is associated with sudden loss of vision and an afferent pupil defect and altitudinal field loss is usually found. Unlike non-arteritic (na) AION, the aAION is associated with more severe loss of vision, chalky white swelling of the optic disc, normal/any sized optic disc (unlike small disc with no cup in fellow eye in naAION) and other vascular anomalies (e.g. choroidal non filling on Fluorescein Angiography). These features can be used in clinical assessment to support the clinical diagnosis of GCA.

Rarely a non embolic central retinal artery occlusion may be found responsible for loss of vision. A branch retinal artery occlusion is unusual but cilio-retinal artery involvement has been described. Occasionally a retinal artery occlusion may coincide with AION (Fig. 1B). The simultaneous involvement of two circulations (retinal and posterior ciliary) is highly suggestive of GCA. Some patients may have cotton wool spots in the retina preceding the development of AION. (Fig.1C)

Ocular ischaemic syndrome is a rare complication which indicates more generalised arteritic involvement of ophthalmic artery. The clinical features include ocular inflammation, low intraocular pressure and retinal/optic nerve ischaemia associated with ocular pain and loss of vision.

Diplopia may be caused by direct involvement of extraocular muscles in the inflammatory process in the orbit or may be central in origin. Ischaemic cranial nerve palsies may have variable presentation and may include medical 3rd nerve palsy – partial or complete, 4th nerve palsy and/or 6th nerve palsy. Multiple cranial neuropathies in presence of other recognised systemic symptoms should be considered to be due to GCA unless proven otherwise.

Diagnosis:

Clinicians should consider GCA as a possible diagnosis in patients presenting with ischaemic complications in ophthalmic practice. Finding of an ischaemic sign(s) in

presence of classic systemic features adds weight to the clinical diagnosis of GCA.

To confirm diagnosis, urgent blood tests should be requested that include full blood count, ESR and C–reactive protein (CRP). These may show anaemia and /or throbocytosis, however raised ESR and raised CRP are commonly used markers for GCA disease activity. Both these tests are useful in monitoring disease activity and response, and may help adjustment of steroid treatment. Combination of these two tests offers better indication than the tests on individual basis. A small minority of patients would have normal ESR and/or CRP.

The conclusive confirmation of diagnosis can only be made by the 'gold standard' temporal artery biopsy. Where possible, a temporal artery biopsy should be performed as soon as possible and within two weeks of initiation of steroid treatment. Histological examination of biopsy specimen typically shows pan-arteritis with round cell infiltration affecting all layers and can lead to occlusion of the lumen. Multinucleated giant cells are often found in the specimen but are not necessary for the diagnosis. Healed arteritis and skip lesions may be responsible for a false negative biopsy result and hence a long biopsy specimen (>2cm). A second artery biopsy may be considered, however in presence of typical clinical features of GCA, steroid treatment should not be discontinued. The American College of Rheumatology criteria (1990) for clinical diagnosis of temporal arteritis requires at least 3 of the following 5 criteria to be present (sensitivity 93.5%, specificity 91.2%) :

1. Age of onset older than 50 years
2. New-onset headache or localized head pain
3. Temporal artery tenderness to palpation or reduced pulsation
4. Erythrocyte sedimentation rate (ESR) greater than 50 mm/h
5. Abnormal arterial biopsy (necrotizing vasculitis with granulomatous proliferation and infiltration)

There is emerging evidence that non-invasive imaging such as Colour Doppler, MRI or fluorine-18-fluorodeoxyglucose positron emission tomography (FDG-PET) may aid the diagnosis . Finding of choroidal ischaemia / shut down on fundus fluorescein angiogram in presence of aAION or CRA occlusion can support the diagnosis of GCA.

Management:

In patients, presenting with visual loss due to aAION, or retinal artery occlusion, high dose systemic steroids, typically 1-2mg/kg/day is used. It should be emphasised that the treatment is to prevent further complications of arteritis as reversal of ischaemic complication is very unusual, especially recovery of vision. In cases of visual loss e.g. with aAION or ischaemic neurological deficits, patient should be admitted for high dose steroids and close monitoring . Initial treatment in such cases can be with intravenous steroids (methylprednisolone 0.5 -1g/day for up to 3 days). Apart from anti-inflammatory- immunosuppressive effect, it may also help with chemical decompression of optic disc oedema in cases of AION. Intravenous treatment should be followed by high dose oral steroids (Prednisolone 1-2mg/kg/day).The oral steroids need to be continued up to 2 years and in some cases indefinitely. The dose reduction needs to be gradual and titrated against clinical response as well as ESR and CRP levels. Along with steroids, protection for gastric mucosa (H2 blocker) and against osteoporosis (calcium supplements, bisphosphonates) should be considered. Usual precautions should be taken regards to pre-existing systemic infections prior to commencing steroids. Maintenance dose (5-10mg) of systemic steroids is usually required for up to 2 years for the majority of the patients. Relapses are rare with adequate treatment but need to be identified and treated promptly by adjusting to a higher steroid dose.

Some patients need second line treatment to reduce steroid dose and to control disease activity. Steroid sparing agents like azathioprine, methotraxate, cyclosporine, infliximab etc can be used however it is advisable that such patients are co-managed with rheumatologists.

Conclusion:

A high index of suspicion is needed for identifying GCA in patients presenting with visual disturbance suggestive of vascular origin. Clinical spectrum of GCA is varied but careful and systematic clinical evaluation supported by ancillary test can help to establish accurate diagnosis. Prompt treatment with high doses systemic steroids should be initiated, pending confirmation of diagnosis especially in cases of visual loss. Steroid treatment needs to be continued for long term and anticipated side effects of treatment should be discussed with the patient and appropriate preventive treatment should be offered.

Box 1: Clinical pearls

Clinical assessment: pointers to GCA
Systemic symptoms – Jaw claudication, Temporal artery abnormality
Severe vision loss
Chalky white disc
Other circulatory disturbance – e.g. diplopia/CRA occlusion
Investigations:
ESR/ CRP level – usually high but beware 'normal ESR GCA'
FFA – choroidal ischaemia in presence of AION or CRAO
TA biopsy – earlier the better, use Doppler to mark the course of artery.
Treatment:
Treat early treat hard- consider IV steroids when presenting symptoms are severe
Protection for gastric mucosa, bones
Collaborate with Rheumatologists
Second line agent
Long term care

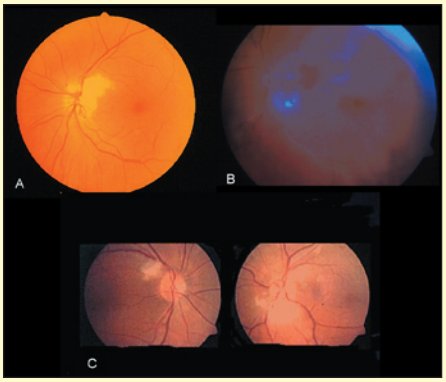

Fig.1. Ophthalmic complications of GCA

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Bradford Teaching Hospitals
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Portraits on the move

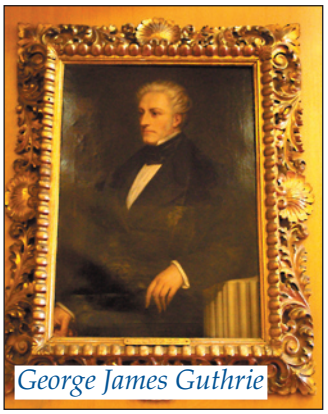
Eminent ophthalmologists of the past often had their portraits painted by famous artists. Such was the case with surgeons associated with Moorfields Eye Hospital and the Institute of Ophthalmology. With the conversion of the old Moorfields boardroom for clinical use at the turn of this year an opportunity was taken to move five of the portraits to hang on the walls at the College on an on-loan basis.

The oldest of these portraits is of **John Cunningham Saunders** (1773–1810) who was the founder of The London Dispensary for the Relief of the Poor afflicted with Eye and Ear Diseases, in 1805, now mercifully known simply as 'Moorfields'. This first eye hospital in the world was opened to cater for the high number of soldiers returning from the Napoleonic Wars infected with what was termed 'Egyptian ophthalmia'. Saunders trained as an anatomist before becoming an ophthalmologist. He died, five years after opening the hospital, at the young age of 47. The portrait shown here is by Arthur Devis.

John Cunningham Saunders next to the bust of Mr Robert Doyne

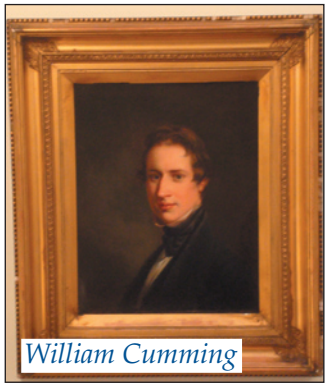
John Farre

Dr John Farre (1775–1862) was a pathological anatomist and ophthalmologist and financial supporter of the hospital. He was editor of the Journal of Morbid Anatomy and completed Dr Saunders' book on Eye Diseases. This fine painting by Thomas Phillips would seem to be only a part of a much bigger portrait.



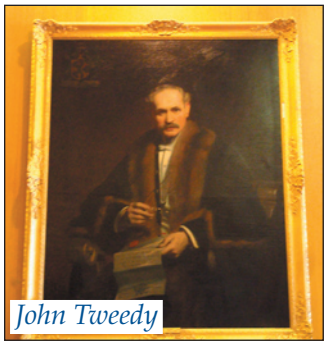
George James Guthrie

Mr George James Guthrie FRS (1785–1856) was the most outstanding military surgeon and ophthalmologist of his generation. He served in many overseas campaigns over 14 years and was greatly admired by the Duke of Wellington. He later opened The Royal Westminster Ophthalmic Hospital in 1816 which was subsequently amalgamated with Moorfields. Three times President of the Royal College of Surgeons, he was the first to give a series of lectures on the specialty of ophthalmology. The portrait was painted by Claudius Jacquand of Paris.



William Cumming

William Cumming (1822–1855) was a 24-year-old ophthalmologist at Moorfields when he wrote a paper in 1846 entitled *On a luminous appearance of the Human Eye and its application to the detection of disease of the retina and the posterior part of the Eye.* He was the first to describe how it was possible to observe the fundus in a living person, five years before the invention of the ophthalmoscope. He died at the tragically young age of 33.



John Tweedy

Sir John Tweedy (1849-1924) was a major supporter of the hospital both as a long serving ophthalmologist for 22 years, and as a fundraiser. This portrait by an unknown artist shows him in his robes as President of The Royal College of Surgeons, 1903–06 during which time he also served as President of the Ophthalmological Society of the United Kingdom.

Other portraits on the move to the College, this time from storage rooms at the Institute of Ophthalmology, are ones of Sir John Herbert Parsons and Sir Stewart Duke-Elder.

The College wishes to acknowledge and thank the administrators of Moorfields and the Institute for their agreement to loan these pictures which will be greatly appreciated by a wide audience.

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

Successful implementation of corneal epithelial stem cell therapy for patients with total limbal stem cell deficiency

Significant loss or damage to limbal stem cells (LSCs) leads to limbal stem cell deficiency (LSCD) characterised by breakdown of the epithelium and conjunctivalisation of the ocular surface, which eventually leads to significant ocular pain and blindness. The standard treatment of LSCD involves transplanting large whole tissue limbal grafts from the patient's healthy fellow eye (putting that eye at potential risk of developing LSCD) or from living or cadaveric donors (requiring high dose systemic immunosuppression with its associated health risks).

Recently, successful treatment of this condition has been achieved, while avoiding those risks mentioned, by the transplantation of ex vivo expanded LSCs taken from a small autologous limbal biopsy. These stem cell therapies are relatively new and as such, specific protocols and guidance are not yet in place. Our group has sought to minimise any risk to the patient by developing a technique that removes all non-human animal products from the LSC expansion process and ensuring all aspects of the culture process are carried out under Good Manufacturing Practice conditions.

This prospectively designed clinical translation study was carried out in a strictly defined uniform group of patients with total unilateral LSCD and no other significant co-existing ocular pathology so that success or failure of reversal of total LSCD could be attributed solely to the LSC therapy. Eight eyes of eight consecutive patients with unilateral total LSCD were treated with ex vivo expanded autologous LSCs on human amniotic membrane (HAM) with a mean follow-up of 19 months. Postoperatively, clinical and histological reversal of LSCD with the establishment of stable corneal epithelium was obtained in all eyes (100%) with significant improvements in both vision impairment and pain scores.

This study demonstrates that transplantation of autologous limbal epithelial stem cells cultured on HAM without the use of non-human animal cells or products, is a safe and effective method of successfully treating patients with total LSCD. The full study has been recently published in the journal Stem Cells (In press).

Sai Kolli [1,2,3], Sajjad Ahmad [1,2,3*], Majlinda Lako [1,2], and Francisco Figueiredo [1,2,3]*

*[1]North East Institute for Stem Cell Research; [2]Institute of Human Genetics, International Centre for Life, & [3]Department of Ophthalmology, Royal Victoria Infirmary, Newcastle University, UK. (*first equal co-authors)*

Interested in helping the GMC develop new ophthalmology assessments?

The General Medical Council (GMC), the independent regulator of doctors in the UK, protects, promotes and maintains the health and safety of the public by ensuring proper standards in the practice of medicine. The Medical Act 1983 gives the GMC the power to place restrictions on a doctor's practice if his or her fitness to practise is impaired and since 1997 it has been able to use performance assessment as part of its Fitness to Practise procedures.

Tests of Competence are assessments of knowledge and clinical skills, comprising a knowledge test and an objective structured clinical examination (OSCE). Each test is tailored to the level of training of the doctor under investigation and based on both general and specialist ophthalmic knowledge and skills.

To develop new knowledge test questions and OSCE stations, the Academic Centre for Medical Education (ACME) at UCL is working with the GMC. They are looking for ophthalmologists of all grades from around the UK to contribute to the development and piloting of new material. Volunteers will take a written test and a 12 station OSCE. You will be asked for feedback on the material, and you will receive an honorarium and expenses, and CPD points. Volunteers are needed from ALL grades, ALL specialties (generalist and sub-specialist), from FY2 to consultant. You just need to have worked in ophthalmology for at least four months within the last year.

The initial question writing day: Wednesday 9 June 2010 The General Medical Council, Euston, London.

The evaluation day (OSCE and knowledge test) will be held on 26 July 2010 near City Road, London. Further information is also regularly updated on our website *http://www.ucl.ac.uk/dome/gmc*.
Contact: *t.acme@medsch.ucl.ac.uk*

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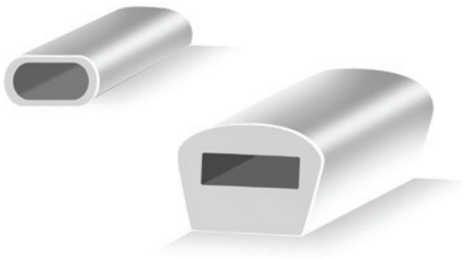
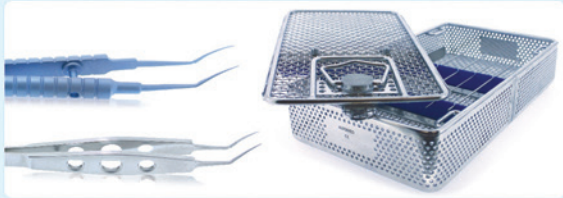


Post-vitrectomy wide bands can now be secured better with flatter oval sleeves. The new Wong Buckling Sleeve is also now available. Use a sleeve to buckle.

Bodkins are back

New improved DCR Bodkins are now available from Altomed. They feature slimmer and more malleable probes, to facilitate smoother insertion. Strength has also been maintained for problem-free 'pull through'.



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A shot in the arm for VISION 2020 Links Programme and the reduction of avoidable blindness in Africa

The VISION 2020 Links Programme received a fantastic boost in February when it was announced that various funding applications to the International Health Links Funding Scheme (IHLFS) had been successful. This will enable, among other things, a partnership between the Eastern Africa College of Ophthalmologists (EACO) and the Royal College of Ophthalmologists who, together with four training institution links, will receive £180,000 over three years to specifically increase the quality and quantity of eye care training in Eastern Africa. The funding will enable the links to flourish and much-needed subspecialty training to be delivered over the next three years.

The RCOphth link with EACO will play a key role in establishing the framework for specialist Fellowship training in the region and appropriate assessment of competencies, quality assurance and Continuing Professional Development. Each institution-institution link will be strengthened by its association with EACO and the RCOphth link to provide a quality-assured structure for examinations, training assessment and governance whilst practical training takes place through the individual links activities.

In Eastern Africa there are an estimated 5m blind and partially sighted people, the majority of whom are treatable but there is only one ophthalmologist per million people. This funding will provide the opportunity for ophthalmologists and their staff in both link institutions to help address the VISION 2020 goals.

Mr Nick Astbury
Chairman of the International Committee

A group from the Western Trust, Northern Ireland on a Needs Assessment visit to the ECWA eye hospital, Kano, Nigeria to help improve the paediatric eye service

ORBIS

ORBIS is a unique international sight-saving charity which partners with local hospitals and trains eye care teams where the need is greatest.
Training rural medical professionals in the treatment of the most common eye conditions means that treatable conditions need not cause life-long blindness. This hands-on training is carried out by the ORBIS volunteer medical faculty; highly experienced in their field, they share knowledge and understanding, leaving skills in the hands of those who can do so much.

Children are at the forefront of ORBIS's work because of the number of years they will live without seeing and the detrimental effect blindness has on schooling and employment.

The Chairman of the Education Committee and Vice President, Mr Larry Benjamin, is an ORBIS volunteer and says "ORBIS programmes provide a solution to eliminate treatable and preventable blinding conditions. Not only are we able to teach new techniques to the local eye surgeons, but we can help to improve the overall system for getting children through the clinic, making eye care more efficient. It can be hard and sometimes heartbreaking but is ultimately very rewarding work".
ORBIS would welcome dedicated paediatric ophthalmology specialists to its volunteer faculty. If you have a minimum of five years experience at consultant level and a significant amount of experience in teaching and training others, please do get in touch.

Contact: Nina Begum, ORBIS Volunteer Faculty Coordinator, on 020 7608 7281 or email *nbegum@orbis.org.uk*

The American Journal of Ophthalmology

The AJO has a article that has not had the coverage it warrants - it has an interesting public health message:

Am J Ophthalmol. 2010;149:160-169. The Association of Smoking and Alcohol Use with Age-related Macular Degeneration in the Oldest Old:
The Study of Osteoporotic Fractures

European Board of Ophthalmology

I would like to encourage Ophthalmologists in the UK to join the European 'Club'. Decisions made by politicians are having an inevitable and increasingly significant impact on medical training and practice in the UK. This should not be seen as a threat but an opportunity to ensure that the British wealth of experience in training and examination has a positive influence, shaping our speciality in Europe.

1. The Residency Review Committee (RRC):

The RRC aim is to promote, encourage and recognise high standards of education, training and research in ophthalmology. This is an integral part of the EBO's role to harmonise training across Europe. The RRC should be seen as a source of guidance and support to Units aspiring to reach the standards required. Departments that fulfil the criteria are awarded a Certificate and it is hoped that many units in each European state will be eligible. This process should encourage exchanges and collaboration between departments of equally high calibre.

2. The European Board of Ophthalmology Residency Exchange Programme:

The EBO aims to promote the highest standards of ophthalmic care in European Union countries by ensuring that the training of ophthalmologists is raised to the highest possible level. As a practical effort towards that aim, EBO has an Exchange Program for residents, teachers and chairmen/programme directors to visit EBO-approved teaching centres. The programme is open for 40 residents, 10 teachers (staff members) and 10 chairmen/programme directors to visit one of the EBO-certified institutions. The period of exchange is one month for residents, two weeks for teachers and 3-4 days for chairmen/programme directors. The successful residents will receive an honorarium of 1,000 euros, and the teachers/chairmen/programme directors will receive 500 euros.

3. EBO Diploma examination:

This exam is held in Paris in May. The diploma is granted to doctors who pass the exam AND are either recognised Specialists in ophthalmology in a European country OR are in formal training in Europe. The requirements for UK trainees were recently changed and those who have completed four years in a formal training program are now eligible to sit the exam.

For more information and application forms please visit: www.ebo-online.org

Mr Wagih Aclimandos, EBO President-elect, Chairman RRC
waclimandos@nhs.net

The Amsterdam Declaration

Graves' Orbitopathy: Improving Outcomes for Thyroid Eye Disease

The College has signed the Amsterdam Declaration which is about improving care for people with thyroid eye disease, focusing on early diagnosis and intervention, collaborative research and education. To date 68 cosignatories (14 international professional societies, 43, national professional societies, 11 patient-led organisations) have supported it.

Graves' orbitopathy affects hundreds of thousands of people in the world every year. It causes pain, discomfort, double vision, disfigurement and sometimes blindness. People suffering with Graves' orbitopathy have a poor quality of life and long-term psychosocial morbidity. The quality of care received by the majority of people affected by this condition can be improved. Conventional treatments are effective when used appropriately and by centres with expertise. Not all patients are offered effective treatments either because most are not referred early or not at all. People at high risk of developing Graves' orbitopathy can be identified and effective risk management can potentially lessen the severity of the disease.

For further information contact Dr Petros Perros *petros.perros@nuth.nhs.uk*.

eyessee appeal for Sri Lanka

Our charity eyessee is proud to announce its official opening of the new eye clinic and day surgery centre at Samanala Valley in Sri Lanka. From our previous appeal last year we managed to equip two OPD rooms with slit lamps and various diagnostic equipment. We have managed to equip one operating theatre with a Phacomachine and an operating microscope and we have carried out our first pilot camp in October 2009 where we screened over 500 patients and operated on 24 patients. We would like to equip the second operating theatre but we are short of some vital pieces of equipment and we would dearly like:

An Operating Microscope
Phacomachine
Ultrasound A scan
Ultrasound B scan
Autorefractor
Prism Bars
Various Fundus lenses.

We will arrange collection and shipping. Please contact the eyessee charity on 01903 500345 or me

Mr Sal Rassam
salrassam@hotmail.com.

eyesee in Sri Lanka

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
International Glaucoma Association Research Award 2010	2 Awards of up to £50,000	16 April 2010
Patrick Trevor Roper Undergraduate Travel Award 2010	2 Awards of £550	4 June 2010
Dorey Bequest and Sir William Lister Travel Awards 2010	c. two awards £400 - £600 each	8 October 2010
Ethicon Foundation Fund Travel Award 2010	Four to six awards of c. £400 - £1,000 each	5 November 2010

Consultant time:
Professional leave survey

238 consultants responded to the email survey sent out in January

Impressionistic analysis of free text comments

- Respondents who had experienced no or few difficulties frequently cited the importance of having a sympathetic medical director in post.
- A notice period of 6 weeks (sometimes 8 weeks) strictly enforced
- Some respondents had faced an explicit ban on professional leave and 7.8% of respondents had been refused leave.
- Some consultants had received implicit messages that professional leave should not be applied for
- One trust had a policy of refusing any sort of external duties within normal working hours unless it was paid for it
- The distinction between professional and study leave increasingly blurred as more NHS Trusts amalgamate professional and study leave to offer a maximum of 30 days to be taken over 3 years.
- Foundation Trusts appear more likely to require consultants to make up lost time.
- There was a theme that the College could alleviate the problem by sharing out the work.

44 % of Consultant Members participate in College activities

Following on from the survey, we carried out an exercise to list all consultants involved in College activities. We listed members of College committees, the Examiners panel, the Advisory Appointment Panel, Regional Advisers, College Tutors, Skills Faculty and chairmen of Congress sessions and Seminars. The list covered 44% of consultant members .

Further work for the College

- Explain the benefit of College participation to the wider NHS
- Encourage/enable more members to participate
- Use time more effectively
- Develop a system to recognise the contribution of members

THANK YOU, TO ALL PARTICIPANTS

The Medical Research Society

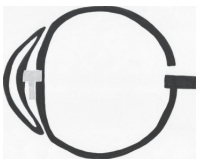
The Medical Research Society promotes translational and basic science research and organises an annual Clinical Scientists in Training meeting.

Please visit *www.medres.org.uk* to see the opportunities it can bring for our profile and our academic and research trainees. At the 2010 meeting there was only one ophthalmology presentation out of 100+ presentations and posters. So plenty of scope to get in there and improve the 2011 stats!

Abstracts can be accepted from 1 August 2010.

Professor Andrew Dick

The Ophthalmic Trainees Group presents the inaugural meeting of The Ophthalmic Training Club



To enjoy, to learn, to inspire

Saturday 15 May 2010 at the Royal Society of Medicine, London, Approx. 8.30 -17.30

Educational Event 'A Thousand Years of Wisdom' to include:

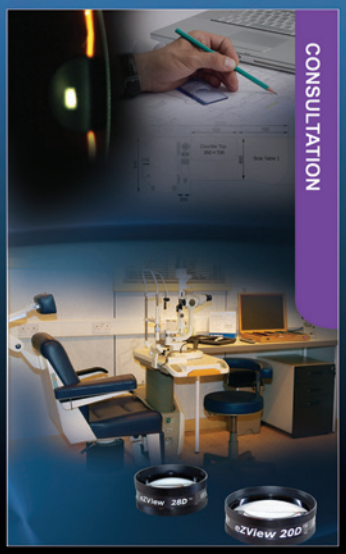
- E-Portfolio/Curriculum
- Organising Fellowships in the UK and abroad
- Medico-legal issues
- Tips on preparing for your Fellowship Assessment
- Tips on preparing for Article 14/CESR
- Consultants representing different Ophthalmic Subspecialties talking on a range of topics

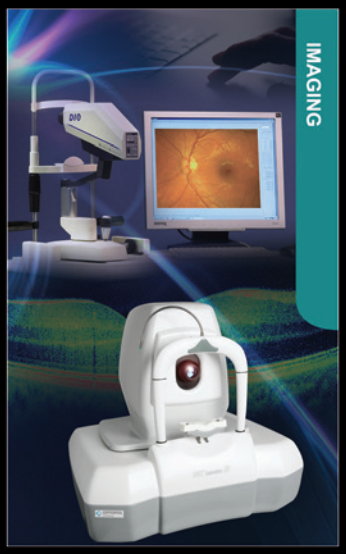
The educational event is supported by an educational grant from MSD.

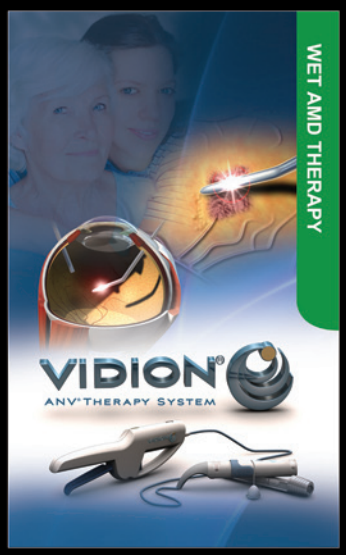
Social Programme from18.30 to 20.30 open to family members; a tour of major London sites a private capsule ride on the London Eye (60 places only). There is no sponsorship for the social event. For further details please visit the College website *www.rcophth.ac.uk*

Carleton

Making light work







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Honorary Fellows

At the Admissions Ceremony in June 2009, an Honorary Fellowship was awarded to Mr John Wright. *This is an edited version of the citation given in his honour*

Mr President, my Collegiate Members and Fellows, Ladies and Gentlemen,

There are a few occasions when one is called upon to give a summary of a person's life and it is a particular delight when it is a chance to distil the essence – to draw a cameo – of a person with whom one has had the privilege to work especially closely during one's career.

Being a serious and diligent student, Wright graduated MB ChB from Liverpool Medical School in 1956; perhaps more telling of the diligence would be the recognition that John made a legendary name for himself as Captain of the University Golf Club!

After graduating MD, he started ophthalmic training in the legendary St Paul's Eye unit in Liverpool and then moved to London to "break into" the ophthalmic world in the great Metropolis. John Wright clearly had the Gods on his side, his becoming Resident Officer at Moorfields in 1965 after a brief period of research with Professor Perkins in the Institute of Ophthalmology; within 3 years he was Lecturer at the Institute and appointed Consultant Surgeon to St Mary's Hospital in 1969, during which time he held an honorary Consultant post at Moorfields and, with the encouragement of the inspirational Professor Barry Jones, started the Orbital Clinic in the same year.

John Wright was appointed as full consultant to Moorfields Eye Hospital in 1973 and remained a highly influential colleague until retirement in 1996: to say John was "influential" might be regarded as an understatement by many! He was a legend; a man who believed in truth and fairness; a teacher and leader who believed in setting an example, and who would not tolerate second-best if due to laziness, rather than genuine difficulty; a colleague who cared about all aspects of his staff and patients – both their professional matters and also a fatherly concern for their family or other worries.

Wright was appointed to Moorfields at a time when specialist clinics were being established and he established the Orbital Clinic - which was the first of its kind, gaining a national and international reputation for clinical excellence. The early days were pioneering and Wright took an international lead in this work: Investigations changed from the primitive plain X-ray (which told you almost nothing about orbits), through to the development of Ultrasonography; through the use of venography - with injections of dye into the forehead; the cumbersome polytomography; and finally the advent of computerised X-ray tomography – the CT which is now known everywhere. John Wright provided the first orbital patients for examination on the "top secret" EMI scanner which was hidden under great security at the Atkinson Morley Hospital – and these images, crude as they were, provided a whole new world of detail. Very exciting times and lead by an enthusiastic clinician and teacher.

It is probably fair to say that he brought orbital surgery out of the dark ages – the time when general surgeons or neurosurgeons were called in to remove half the head to reach the orbit – and Wright developed many new techniques within the speciality. The continued development of ever more refined techniques is a tribute to John Wright's broad shoulders, upon which we have been able to build.

John Wright has always believed in teaching at National and International level – having trained over thirty fellows from throughout the world and presented hundreds of lectures, many eponymous and highly prestigious. This pioneering spirit led to Wright being a founder member of both the European Society of Ophthalmic Plastic and Reconstructive Surgery and the Orbital Society.

His outstanding leadership has been recognised throughout his career – with Presidency of the European Society, the International Orbital Society and the deputy Master of Oxford Congress. It is, therefore, with greatest pleasure – Mr President - that I present my esteemed friend and colleague for the greatly-deserved accolade of Honorary Fellow to The Royal College of Ophthalmologists.

Mr Geoffrey Rose

Elaine Hudson EYE Editorial Secretary retired in February after 14 years of excellent service. The College wishes her many happy years of retirement.

The Clinical Leaders Network (CLN)

Consultant Ophthalmologists in England are encouraged to join the CLN and to be involved in regional NHS Leadership. *www.CLN.nhs.uk*

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Annual Congress 2010

Arena & Convention Centre, Liverpool
25-27 May

SAS Forum

Tuesday 25 May, 5.30pm
Email questions by 1 May to sas@rcophth.ac.uk

OTG Forum

Wednesday 26 May, 5.30pm
Email questions by 2 May to otg@rcophth.ac.uk

College Seminar Programme 2010

All seminars take place at the College, unless otherwise stated

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 6 half-day modules to be run over 3 days and is particularly useful for Programme Directors, College Tutors and educational supervisors.

Day 1	**20 September**
Day 2	**4 May**
	9 November
Day 3	**21 June**

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

College Tutor Induction Days

11 May
12 October

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.

7 May
Vitroeretinal
Mr Paul Sullivan

30 June
Oculoplastics Course
Ms S Webber/Mr H Maclean

1 October
Cornea Course
Professor H Dua

11 October 2010
Glaucoma Course
Professor P Bloom/Mr J Diamond/ Mr D Broadway

4 November
Medical Retina Course
Mr L Benjamin/Miss S Mitchell/Miss S Downes

23 November
Oculoplastics Course
Miss S Webber/Miss R Manners

6 December
Paediatric Course
Mr K Nischal/Mr C Bentley

The Royal Society of Medicine

Good News for Trainees - You can now attend the RSM Ophthalmology meetings free of charge

13 May – 6.00 pm
Is smaller better? The move to MICS
Chaired by: Mr Richard Packard

10 June – 4.00 pm
Trainees' prize meeting

1 Wimpole Street, London
ophthalmology@rsm.ac.uk

Other events 2010

3–4 June
British Ophthalmic Anaesthesia Society (BOAS)
Annual Scientific Meeting
The Royal College of Anaesthetists
www.rcoa.acuk
andrew.presland@moorfields.nhs.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.

2 July
Contact Lens Basics & Laser Refractive Surgery Complications
Audrey Emerton Building, Brighton
Rapid advances in technology and lack of exposure to laser refractive surgery can result in failure to recognise resulting complications presenting the HES
richard.lee@bsuh.nhs.uk

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

8–9 July
Cornea and Oculoplastics course
Queen Victoria Hospital,
East Grinstead
Didactic and clinical sessions with an opportunity to examine patients with 'textbook' examples of relevant disorders and diseases
cpcourse@qvh.nhs.uk

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

1–3 September
40th Cambridge Ophthalmological Symposium
Imaging the Visual System
St John's College, Cambridge
bm.ashworth@tiscali.co.uk

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