

# College NEWS



**Autumn  
2010**

## Quality standards vary between eye drop devices and those classed as medicines

Due to changes in EC law, many products previously regulated by medicines legislation are now regulated under the medical devices directives. Ophthalmologists are advised to proceed with caution when prescribing artificial tears from this new class of products.

The range of prescribable eye drop devices listed in part IXA (Appliances) of the Drug Tariff includes artificial tears described as 'single dose units', an accurate description for the majority of this group but with two exceptions promoted as being safe to use for 12 hours after opening. Ophthalmologists prescribing artificial tears for use on compromised eyes, e.g. immediately post refractive surgery, should avoid products with this extended in-use shelf life and select unit dose eye drops labelled 'use once and discard remainder'.

The list of preserved multidose eye drop devices, while containing traditionally-preserved products allocated the standard in-use shelf life of 28 days, also includes multidose eye drops containing newer preservatives and allocated in-use shelf lives of up to six months. These preservatives e.g. stabilised oxychloro complex, sodium chlorite and polidronium chloride are not used in medicinal eye drops in the UK and are

not subject to the preservative efficacy tests of the European Pharmacopoeia but to the less stringent tests applied to contact lens care products.

The standard with which artificial tear eye drops classed as devices must comply, BS EN ISO 14730, 'Ophthalmic optics – Contact lens care products – Antimicrobial preservative efficacy testing and guidance on determining discard date' clearly states which eye preparations it is intended to cover:

*"There are differences between ophthalmic preparations and contact lens care products and some of these are significant in relation to preservative efficacy testing. Typically, ophthalmic preparations are packaged in small-volume containers and are for use for short periods on compromised eyes. Contact lens care products are distributed in larger volume containers and are used with contact lenses on a long term basis on healthy eyes".*

Patients with compromised eyes require ophthalmic preparations conforming to the higher standards required of eye drops classed as medicines.

**Lucy Titcomb, Lead Ophthalmic Pharmacist,  
Birmingham and Midland Eye Centre.**

Type of eye drop	Medicine or device	Product	In-use shelf life
Unit dose	Medicine	All products	Single use only
	Device	Clinitas, Ocusan	12 hours after opening
		All the other products	Single use only
Multidose preserved	Medicine	All products	28 Days after opening
	Device	Lumecare long lasting, Lumecare eye drops, PVA 1.4% Tubilux	28 Days after opening
		Blink Intensive Tears	45 Days after opening
		Oxyl	60 Days after opening
		Optive, Systane	6 Months after opening

Further reading: [www.pjonline.com/files/rps-pjonline/pdf/pj20100626\\_eye\\_drops-633.pdf](http://www.pjonline.com/files/rps-pjonline/pdf/pj20100626_eye_drops-633.pdf)

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Please contact [database@rcophth.ac.uk](mailto:database@rcophth.ac.uk) if you get a new email address so that we can keep in touch.

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### Copy deadlines

**Winter**  
**5 November 2010**

**Spring**  
**5 February 2011**

**Summer**  
**5 May 2011**

**Autumn**  
**5 August 2011**

# Establishing a good standard of psycho-social care in Ophthalmology

At the Annual Congress in May in Liverpool, Changing Faces was kindly invited by Mr John Lee, President, to launch our new guide for ophthalmology practitioners. This guide is designed to be read alongside our comprehensive booklet, "Face Equality for Patients with Disfiguring Conditions". These guides help to inform and raise awareness of the psychological and social issues difficulties that could arise with a patient's condition and any functional loss.

There are a variety of conditions that affect the eyes causing the patient to have a visible difference. Also termed a 'disfigurement', a patient's condition may cause additional psycho-social concerns such as lowered self-esteem, withdrawal and a lack of confidence. As a result, some struggle at work or school and find it difficult to start or maintain relationships. Psycho-social concerns do not affect every patient and, in fact, research repeatedly shows that the severity of the condition is not a reliable indicator of the severity of distress experienced by the patient. Therefore, some patients with a "minimal" visible difference may unexpectedly be experiencing a high level of psychological distress.

A self-help guide or some tips on dealing with unwanted comments or people staring can be useful. For patients who continue to struggle, referral to psychological services, or charities such as ours, can help a patient if they are experiencing high levels of anxiety and distress.

We provide publications and a range of courses for health professionals which help to address the issues raised above. If you would like a copy of our new booklet for ophthalmology professionals, other publications designed for patients, or would like to register for one of our training days, please contact Gemma Borwick, training adviser in health (0845 4500 275) [gemma@changingfaces.org.uk](mailto:gemma@changingfaces.org.uk).



## The centre for workforce intelligence (cfwi)

Was set up following the NHS workforce in 2006.

See [www.cfwi.org.uk](http://www.cfwi.org.uk) for more details

*Mr Winfried Amoaku, Chairman of the Scientific Committee, taking an uncharacteristic breather at the 2010 Congress. See page 9 for a full report*



## Charities join forces to appeal for ophthalmic equipment

CBM UK and Aid to Hospitals Worldwide (A2HW) are working in partnership to ship much needed medical equipment to the developing world.

CBM UK is one of the largest disability charities working in the developing world. It is working in conjunction with the International Agency for the Prevention of Blindness and The World Health Organisation in an initiative called 'Vision 2020' that aims to eliminate avoidable blindness in the developing world by 2020. CBM has over 800 projects in over 90 countries worldwide and gave care to over 23 million individuals in 2009 alone. For more information please see [www.cbmun.org.uk](http://www.cbmun.org.uk)

A newer charity, A2HW, is a six year-old social enterprise, partnering with CBM by supplying and shipping a full range of medical and surgical equipment to those on the frontline of overseas healthcare. Shipping everything from a bandage to a complete operating

theatre, A2HW has been commended by the NHS for its cost-saving waste management methodology. A2HW collects redundant but still useable NHS equipment, prepares it for shipment and donates it to charities and recognised organisations working in the poorest communities around the world. As a bonus, A2HW is able to save money for the NHS and relieve landfill demand by shipping more than 100 tonnes annually.

Working together, CBM and A2HW are in very short supply of a wide range of ophthalmic equipment to send to hospitals in the developing world. The equipment needed can be new or used, as long as it is serviceable. If you can help in any way, please contact the Gifts in Kind Department at CBM UK on 01223 484700 or [gifts@cbmun.org.uk](mailto:gifts@cbmun.org.uk)



# Members' News and Appointments

## Consultant Appointments

Mr Pammal Ashwin	Kettering General Hospital, Kettering
Miss Melanie Chak	Royal Berkshire Hospital, Reading
Miss Lucy Clarke	Royal Victoria Infirmary, Newcastle upon Tyne
Mr Molham Entabi	Lincoln County Hospital, Lincoln
Miss Charlotte Funnell	Sutton Hospital, Sutton
Dr Paul Johnstone	Ninewells Hospital, Dundee
Mr Aldrin Khan	Darlington Memorial Hospital, Darlington
Mrs Divya Mathews	HM Stanley Hospital, St Asaph
Mr Subhanjan Mukherji	James Paget University Hospital, Great Yarmouth
Miss Winifred Nolan	Moorfields Eye Hospital, London
Mr Himanshu Patel	Moorfields Eye Hospital, London
Mr Hamid Porooshani-Nia	Broomfield Hospital, Chelmsford
Miss Dhanesvari Thomas	Moorfields Eye Hospital, London

**Correction:** Mr Abdul J Khan has been appointed at the Lincoln County Hospital, Lincoln and not Essex County Hospital as reported in College News, Summer 2010

## New CPD Booklet

The new CPD booklet is in production and I would like to bring to your attention the category changes. The original old categories, A to D, will be replaced by the new CPD matrix:

	Internal	External	Self Accredited
<b>Clinical and Academic</b>	Local postgraduate meetings or teaching activities (A)	Regional/national/international external post-graduate academic activities/meetings (B)	Self-directed activities (C)
<b>Professional and Managerial</b>	Training in management/administration/teaching/information technology (D)		

The College will continue to audit only external, clinical and academic meetings (old category B). This category includes regional, national and international external postgraduate academic activities at meetings and research projects undertaken that result in publication. Please continue to keep evidence of attendance at live events, e.g. certificate of attendance, a receipt for the cost of the meeting, name badge, or similar.

The results of the 2010 audit undertaken over the summer will be presented at the next CPD Subcommittee in October 2010, the Professional Standards Committee and the College Council. The results will be published in a future issue of College News.

The launch of the enhanced on-line CPD system should come into effect towards the end of this year and further details will be communicated to members in due course.

On behalf of the College I would like to encourage all members to record CPD activities.

**Note:** The contribution of CPD is part of the essential step to revalidation. It is set out in the 'Chief Medical Officer's report' Medical revalidation – Principles and Next Steps. Department of Health, 27 July 2008. [www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_086430](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_086430)

Mr T K J Chan, Chairman of the CPD Committee

## Professorial appointments

**David Spalton** is now a Professor of Ophthalmology at King's College, London. He continues to be a consultant at St Thomas', London

## Obituaries:

We note with regret the death of:  
**Mr Michael James Arthur Britten**, Cheshire  
**Sir Randal Forbes Elliott**, Auckland, New Zealand  
**Miss Catherine Heatley**, London

## Clinical Excellence Awards 2011

Consultants should send their completed forms by email to the College at [accea@rcophth.ac.uk](mailto:accea@rcophth.ac.uk) by **9 a.m. Monday 4th October 2010.**

All application forms must be submitted to the College electronically to this mailbox (and not any other mailbox) and any applications arriving after this date will not be accepted under any circumstances.

Please note that these forms are purely for College use and must not be sent to the ACCEA. Applications to ACCEA can only be submitted online, by the applicant themselves and they cannot be accepted by any other route. However, the information can be copied and pasted into the online form. It is hoped that the ACCEA online application system will become available in early September so please keep checking the ACCEA website. We will announce it on our homepage when it becomes available.

In August 2010 the Secretary of State for Health, Andrew Lansley announced a UK-wide review of clinical excellence awards, with recommendations to be submitted to the UK Health Ministers by July 2011. The scheme was first introduced in 1948, and has remained largely unchanged.

## Travel expenses

Please book a train ticket in advance if you are attending College meetings to take advantage of cheaper fares





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# Focus



Autumn  
2010

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

## Refractive Surprise after Cataract Surgery

Milind Pande, Medical Director  
Vision Surgery & Research Centre, Hull.

The last decade has seen the emergence of refractive cataract surgery. This is defined as cataract surgery which not only restores the transparency of the ocular media but also attempts to correct any refractive aberrations of the eye, with the objective of achieving the best possible uncorrected visual acuity. This reduces the spectacle dependence of patients with consequent quality of life and economic benefits. Aspheric Monofocal, Toric, Multifocal and Accommodative IOLs provide good options to achieve reduced spectacle dependence. It is not unreasonable to expect almost all patients free of co-morbidity to achieve uncorrected vision equal to or better than the legal standard to drive a car with aspheric monofocal IOLs. Multifocal and Accommodative IOLs can in addition provide good intermediate and near vision without spectacles.

The success of refractive cataract surgery depends on achieving a predictable refractive outcome for defocus (spherical equivalent) and astigmatism. Refractive surprises can seriously compromise patient satisfaction and also give rise to potential problems of anisometropia, dominance switch in which the dominant eye ends up with the weaker uncorrected vision and, above all, give rise a sense of failure in patients expecting good uncorrected visual acuity. This article focuses on the prevention and management of refractive surprises in cataract surgery.

**Prevention:** Percival et al<sup>1</sup> using ultrasound measurements and customised lens constants reported 97% of eyes achieving a refractive outcome within 1 dioptre of target. Gale et al<sup>2</sup> suggest a benchmark for NHS cataract surgery is to achieve 85% within 1 dioptre. These figures have to be viewed within the perspective of the normal distribution of refractive error in the population with 66% of eyes within 1 dioptre of emmetropia. It follows that if one is to use a standard power IOL within the population without any biometry, 66% of eyes would fall within 1 dioptre of target. It is interesting to look at the causes of refractive surprise after

cataract surgery. In 1992 prior to the advent of optical biometry, Olsen<sup>3</sup> reported that 54% of refractive surprises were due to errors in axial length measurement, 38% were due to errors in predicting the post operative IOL position and 8% were due to errors in keratometry measurements. The advent of optical biometry improved the accuracy and consistency of axial length measurements to such a degree that a similar study by Norrby<sup>4</sup> in 2008 showed that the commonest source of error is in the prediction of post operative IOL position (36%), followed by errors in post operative refraction (27%), axial length measurement (17%), keratometry (10%), pupil size (8%), variation in refraction across the pupil and IOL power 1%. Optical biometry is an essential tool for improving the accuracy of IOL power calculation. In patients with dense cataract where optical biometry is not feasible, immersion ultrasound biometry provides similar levels of accuracy.

There are various protocols available to improve the accuracy of measurements and all of them are based on rechecking the measurements when the probability of these occurring in the population is very low. These protocols are implemented within the newer versions of software for optical biometry machines. Although these protocols alert the operator to unusual measurements they do not identify errors, which do not appear to be unusual in patients with unusual eyes. It is thus critical to not only use these protocols but to supplement them with a strategy of reconciling the IOL power measurements with the patient's refractive history prior to the development of cataracts. A crude rule of thumb is to expect a difference of 3 dioptres in the IOL power between eyes with a difference in pre-cataract refraction of 2 dioptres. Reducing the risk of refractive surprise requires a consistent approach to measuring eyes, reconciling the measurements with the patient's refractive history, using a modern theoretical formula like the SRK-T, Haigis or the Holladay 2 and

customising formula constants for surgeons as well as different lenses.

Small hyperopic eyes, large myopic eyes, eyes with very steep or flat corneas, shallow anterior chamber depths, prior history of refractive surgery, vitrectomy, corneal ectasia, peripheral corneal melt syndromes and contact lens use (when measured without an adequate contact lens holiday) are at significant risk of refractive surprises. It is important to warn these patients of the increased risk of refractive surprise as part of the informed consent process and prepare the patients for a second stage enhancement procedure.

**Clinical Assessment of Refractive Surprise:** A methodical approach is critical in identifying the cause of a refractive surprise. This consists of the following:

1. Refraction: Inaccurate refraction<sup>4</sup> is the second most common cause of refractive surprise after cataract surgery. An accurate subjective refraction is essential. Auto-refractor measurements while repeatable are not consistent with subjective assessments. A repeatable consistent strategy to refract postoperative patients is essential in order to reduce errors as well customise lens constants. The post-operative refraction also forms the basis for calculating the correction needed in a secondary enhancement procedure.
2. Repeat Biometry Measurements: Optical biometry makes it easy to measure the axial length and keratometry in pseudophakic eyes. This will identify any measurement errors in the original biometry.
3. Calculating IOL power with the new measurements allows for a comparison with the previous calculation. The difference in IOL power between the original and recalculation should be consistent with the magnitude of the refractive surprise. If the full magnitude of the refractive surprise cannot be explained by the difference between the original and recalculated IOL power other factors apart from measurement error like prediction of postoperative IOL position or a lens power error may be significant contributors to the refractive surprise. The cause of a refractive surprise can influence the method chosen to correct the refractive surprise.

An example case workup is shown in the box below.

<u>Illustrative Case Workup</u>			
75 year Male had R eye Phacoemulsification with a 21D Monofocal IOL with a Plano refractive target. Post Operative refraction achieved was -5 /-0.75 D axis 95. The preoperative measurements and analysis are given below			
eye	R eye	L	Analysis: The IOL power difference between eyes is 0.5D, which is equivalent to a refraction difference of 0.625 D. However the actual difference in refraction between the eyes is 2.75D. One would expect an IOL power difference of 4 D with this refraction difference. The measurements are thus inconsistent with the pre-op refraction status.
Ref	-3.5/-1.5 x 85	-1.5	
K's	44.5/45 @ 176	44/44.5 @ 170	
AvgK	44.75	44.25	
AxL	23.06	23.40	
IOL Power d for emmetropia	21 d	20.5	
The patient was re-measured and the results are below			
R eye Measurements			Analysis: The re-measured IOL power is 7 dioptres less than the originally measured IOL power. This translates to a spectacle refraction difference of -4.86 dioptres almost the entire refractive surprise. This value is determined by looking
Original	Re-measured		
Ref	-3.5/-1.5 x 85	-5/+0.5 x 95	
K's	44.5/45 @ 176	44.5/45.49 @ 170	

**Correction of Refractive Surprise:** Identifying the cause of a refractive surprise is critical in picking the correct refractive enhancement procedure to correct the surprise. Not all surprises need to be corrected. Prior to any such enhancement it is important to identify and demonstrate the benefits as well as the potential risks a patient may expect from an enhancement procedure. It is important to keep in mind the trade-offs a patient may have to accept by carrying out an enhancement procedure. Patients who end up myopic in their non-dominant eye may well prefer the accidental monovision. Similarly patients with multifocal lenses may well prefer a longer working distance attained by a small hyperopic surprise.

Laser vision correction, Secondary Piggyback IOLs and IOL Exchange are the common methods for correcting refractive surprises. It is important to demonstrate a stable refraction before attempting a correction.

Laser vision correction using either LASIK or LASEK will give the most predictable refractive outcome. A completely new type of procedure with considerable cost can create significant anxiety especially in elderly cataract patients.

Secondary Piggyback IOLs placed in the ciliary sulcus is a simple procedure within the comfort zone of most cataract surgeons. The trauma and risks of removing an IOL is avoided and piggybacking covers for an IOL power error. Spherical errors are relatively easy to correct but sphero-cylindrical errors can also be treated with Toric piggyback lenses. The calculations for choosing the power of these lenses is based on the refraction using a vertexing formula like the Refractive Vergence formula<sup>5</sup>.

**IOL Exchange:** This is a method of last resort when all other corrective options have been considered and discarded. Removing an IOL from an eye can be a technical challenge depending on the lens design and the time period the lens has been in the eye. Removing lenses months or years after primary surgery can be fraught with the danger of rupturing the capsule. The replacement IOL calculations use the same method as used for the primary IOL. IOL exchange is not a good method to correct refractive surprise due to an error in predicting the postoperative IOL position or an error in the actual IOL power.

**Summary:** Refractive surprises after cataract surgery are a common cause of patient dissatisfaction. Prevention requires a consistent method of biometry. A methodical assessment with repeat measurement is needed to identify the cause. A risk benefit assessment is critical to establish the need for a refractive enhancement. Laser vision correction and secondary piggyback IOLs carry lower risk and are more predictable methods for correcting refractive surprises.

#### References:

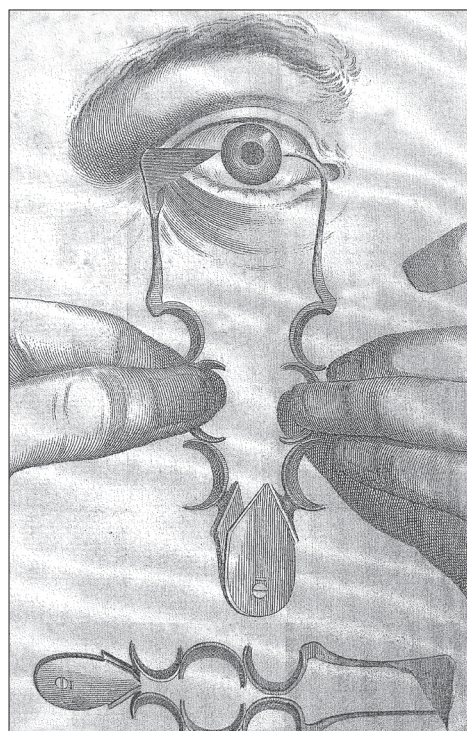
1. Percival SP, Vyas AV, Setty SS, Manvikar S. The influence of implant design on accuracy of postoperative refraction. Eye 2002; 16(3): 309-315.
2. Gale RP, Saldana M, Johnston RL, Zuberhuhler B, McKibbin M. Benchmark standards for refractive outcomes after NHS cataract surgery. Eye 2009 23, 149-152
3. Olsen T. Sources of error in intraocular lens power calculation. J Cataract Refract Surg. 1992 Mar;18(2):125-9.
4. Norrby S. Sources of error in intraocular lens power calculation. J Cataract Refract Surg. 2008 Mar;34(3):368-76.
5. Holladay JT. Refractive Power Calculations for Intraocular Lenses in the Phakic Eye. AJO 1993; 116: 63-66



# Early cataract knives

In 1747 a Frenchman, Jacques Daviel, performed the first extraction of a lens with cataract. Hitherto, couching was the preferred method used to relieve patients of this form of blindness. Entry into the eye for the couching operation was with a thin arrow-shaped knife which created a small self closing wound. Daviel's operation required a much larger section to allow removal of the lens through it.

From this first operation, for the next 100 years, many designs of knives were invented. The word "invention" is perhaps an over-statement as the difference in design between some of the knives was very slight. According to Hirschberg, the historian, "every reputable cataract surgeon invented his own knife and preferred it to any other."



*Guerin's cataract knife 1769*

Daviel's incision was in the middle of the lower half of the eye with a side cutting knife and then scissors were used to enlarge the section to nearly 180 degrees.

Arguments and debates raged, books were written putting forward solutions to the best site of entry, the best shape of knife, the size of section, the method of cutting the tissue, the entry of instruments and the extraction of the cataract.

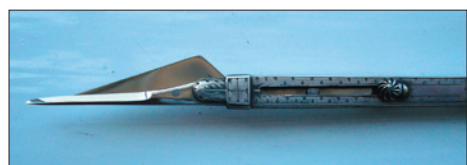
Stabilisation of the eye was always a problem on the incision of the knife and during the cutting procedure. One commentator referred to the cause of the problem as "general unsteadiness of the globe, from the influence of the mind on the organ about to be injured". He went on to comment that, "Nothing would be more easy if the eye could be held steady". There was no anaesthesia until Koller's introduction of cocaine in 1884 and

the patient's stoic cooperation was needed. The eyelid speculum was used not only to draw the eyelids apart but to stabilise the eye. Before the speculum the surgeon relied on an assistant holding the patient's head in a kind of headlock while at the same time holding the lids open.

The College has recently acquired a rare spring-loaded cataract knife invented by Pierre Guerin of Lyons in 1786. His previous attempt in 1769 to design a knife for cataract is shown in the illustration. (Note the stepped stop near the point of the right stabilising arm preventing penetration of the cornea). The knife is used by placing the ring firmly on the eye allowing the cornea to protrude and at the same time hold the eye in position. The keratome-shaped knife when released moves across the cornea in a fraction of a second cutting a large section in the cornea. The instrument did not prove popular!

Various double blade knives also had limitations. These consisted of one blade on top of the other whereby one blade was used to enter the eye and stabilise it and the other slid over it to enlarge the section. Beer's knife and its many imitations were designed not only to penetrate the eye but cut a section with the sharp angled side using the instrument in one sweeping movement.

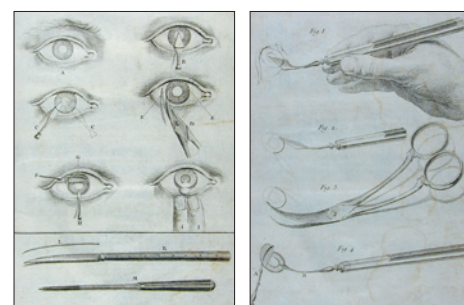
In 1865 Albrecht von Graefe introduced a new knife and method of forming a section. His thin bladed knife with a sharp point and one cutting edge entered the eye at the equator on one side of the sclera and emerged on the other.



*Double knife with sliding mechanism*

With a gentle sawing action the section was formed from the inside of the anterior chamber outwards to the exterior.

The designers of early cataract knives all faced the same challenge, namely to make them of a sharpness and shape to cut a section in the eye large enough to remove the cataract swiftly without the use of anaesthesia. From the hundreds of designs and methods used it was evidently a problem not easily solved. The handles were usually made of ivory which gave a fine balance and grip.



*Daviel's cataract operation. Published 1753*



*Guerin's spring loaded cataract knife. 1786*



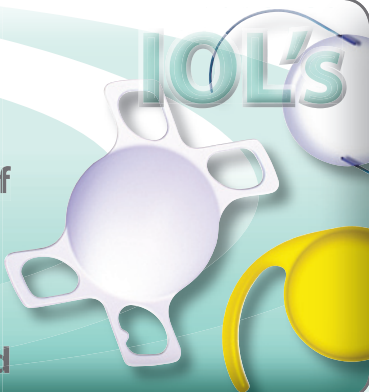
*Guerin's knife "loaded"*

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# REPORT ON ANNUAL CONGRESS 2010

Welcome additions to the programme this year included the Late Breaking News Lecture detailing the DRCRN study evaluating laser and adjunct therapies in diabetic macular oedema given by Professor Susan Bressler.

Another highlight was the successful introduction of the retinal subspecialty day. Attended by more than four hundred ophthalmologists, the action packed day covered key updates in medical and surgical retina. They had two keynote speakers and a debate over transconjunctival sutureless vitrectomy.

## EPONYMOUS LECTURES

Professor Allen Foster delivered the inaugural Barrie Jones Lecture: "Blinding Eye Infections", a unique insight to tackling Trachoma. He also detailed the progress made towards Vision 2020 aims and the key issues remaining.

The Edridge Green Lecture was delivered by Professor Graham Holder. In "Flecks, Dots and Spots" he revisited basic electrophysiology and showed its clinical importance in everyday ophthalmology.

In the Duke Elder Oration Lecture Professor Mohammad Daud Khan outlined the daunting task of establishing eye care for the ordinary people of Pakistan, the help from UK and worldwide ophthalmologists and the achievements made.

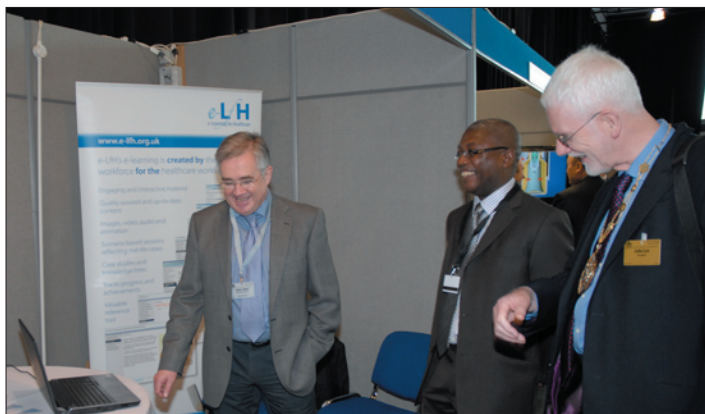
The Bowman Lecture by Professor Brenda Gallie, "Sustainable globally accessible care for retinoblastoma families", was an excellent opportunity to understand the clinical, emotional and economic importance of timely molecular diagnosis of RB1 mutations.

The Second Optic UK Lecture given by Professor Robert N Frank entitled "Bench-to-beside adventures of a diabetic researcher: Results past, results present", was a heart warming view of the progress that has been made in the understanding and treatment of diabetic retinopathy.

## 2010 PRIZE WINNERS

**The Foulds Trophy for the best basic science oral presentation: Miss S Zahra**

*"Prolongation of mouse corneal allograft survival following systematic and topical 3-hydroxykynurenine administration."* Indoleamine 2,3-dioxygenase (IDO) has previously been shown to prolong corneal graft survival. This work presents data showing that it is the production of kynurenines that is a mechanism by which IDO prolongs corneal graft survival. It is possible that these molecules could be used in the future to prevent allograft rejection.



*The President, Mr John Lee, and Mr Winfried Amoaku with Mr Jim Innes, the e-LH Lead.*



*Miss Clare Bailey with David Allen of RNIB*

**The Advanced Medical Optics (AMO) prize: Dr M Moosajee**  
Her research used a novel plasmid vector to deliver a specific DNA complex to Choroideraemia mouse retina. Results showed a 4-month persistence of episomal transgene expression which has implications for Choroideraemia, and the use of non-viral gene vectors in other retinal diseases.

**The Societas Ophthalmologica Europaea (SOE) prize: Dr K Wong**

*"Semi-automated digital image analysis of retina in preterm infants with and without retinopathy of prematurity: a comparison of different vessel selection methods"*. Computer-assisted image analysis, developed at City University London, has been validated to assist in the screening of retinopathy of prematurity (ROP) for plus disease. This further work has concluded that measuring the four largest vessels is as effective at detecting ROP as previous methods.

**The Treacher Collins prize award for the best DVD: Mr. K Waddell**

Health care workers often perform surgery for trachoma in remote areas. This DVD showcased an innovative engineered clamp to hold the lid correctly during surgery, instead of using two artery forceps. The clamp is designed to simplify the surgery and aid haemostasis.

**The Royal Eye Hospital (London) prize. A poster presented by Dr Z Carrim**

This detailed experiences of 37 patients referred with retinoblastoma (RB). Results of outcomes following chemotherapy for ocular and orbital RB were reported.

**The Royal Eye Hospital (Manchester) poster prize: Dr D Nguyen**

This study of SERVQUAL, a quality measurement tool, was used in a sample of glaucoma outpatient patients. It identified quality gaps, highlighting interpersonal aspects of care and time spent waiting. Examining patient priorities, expectations and perceptions will help improve service provision.

**The BINOC (British Isles Neuro-ophthalmology Club) Ivor Levy poster prize: Dr D Mansfield**

*"Delayed diagnosis of oculopharyngeal muscular dystrophy (OPMD) in Scotland."* showed an Inverclyde Royal Hospital team review of 17 patients with genetically proven OPMD. It concluded that a high index of suspicion in patients who present with a positive family history and ptosis is helpful, and genetic testing is simple to confirm the diagnosis.

We encourage you to watch the members' area of the College website, as the eponymous lectures from 2010 will be shared with all members. (See [www.rcophth.ac.uk](http://www.rcophth.ac.uk)).

*Miss Susan Mollan, Scientific Committee*

# What does “quality” mean?

For the last three years, almost every official document on health policy has contained the word “quality”; Lord Darzi’s 2008 review of the NHS was entitled “High Quality Health for All”. The word has a “feel good” factor – but what does it mean, and does it mean the same thing to clinicians, patients, commissioners and politicians? In the context of health-care, it should have a universal meaning – doing the right thing, at the right time, for the right reasons to obtain the best achievable health outcomes.

A simple and inexpensive way of measuring the quality of a clinical service is to use a self-assessment questionnaire. Self-declarations form an important part of reviews of healthcare organisations by regulatory bodies and honest self-appraisal is incentivised by the possibility that responses may be verified by external inspection.

The College’s Quality Standards Group has produced a draft suite of simple self-assessment tools for the following clinical services: cataract, glaucoma, diabetic retinopathy, age-related macular degeneration (AMD) and vitreoretinal surgery. Available from the College website they do not attempt to assess every aspect of the service in detail, but focus on areas where problems are likely to show where the service is under stress. Very few clinical services will achieve a perfect score, so the questionnaires can be used as quality improvement tools.

[www.rcophth.ac.uk/standards/quality\\_standards\\_development](http://www.rcophth.ac.uk/standards/quality_standards_development)[www.rcophth.ac.uk](http://www.rcophth.ac.uk)

We invite departments to make use of these questionnaires as audit tools and we seek feedback on the following:

1. Are these valid measures of quality of clinical care?
2. How easy or difficult is it to get the information needed to answer the questions accurately?

Please send comments to Beth Barnes, Head of Professional Standards ([beth.barnes@rcophth.ac.uk](mailto:beth.barnes@rcophth.ac.uk)) by 31 December 2010. A questionnaire on children’s eye services is under development by the Paediatric Subcommittee and a draft version is available on request from Beth.

*Mr Richard Smith  
Chairman, Quality Standards Group*

## Training Opportunities at Optimax

Optimax, one of the largest national providers of Laser Refractive Surgery, also offers intraocular refractive surgery for patients who are not suitable for Laser Vision Correction (LVC).

For several years, the company has trained ophthalmic surgeons to perform LASIK and LASEK and a number of Optimax trained surgeons now perform this type of surgery in the NHS, ophthalmic institutions and other independent companies. We have an excellent in-house training programme, offering regular academic meetings, seminars, on-line discussion forums and clinical audits. In addition, Optimax offers a variety of training packages for external surgeons wishing to learn laser refractive surgery. We run a one year fellowship programme, covering training in preoperative evaluation, corneal topography, pachymetry and aberrometry, the use of Excimer and Femtosecond lasers, surgical techniques including LASIK and LASEK, and post operative management of laser refractive surgery patients.

Laser refractive surgery is highly technological and innovation-heavy and there are very limited training opportunities within the NHS for ophthalmologists interested in the discipline. We are therefore offering short term (one, three and six months) training programmes to NHS ophthalmic surgeons.

We also welcome ophthalmic surgeons for informal visits to our clinics ranging from one to seven days to observe laser refractive surgery. These visits can be arranged by contacting our general manager, Mrs Beata McManus; for further information on training programmes please contact me.

*Mr Malcolm Samuel, FRCOphth  
Medical Director, Optimax, [malcolm.samuel@optimax.co.uk](mailto:malcolm.samuel@optimax.co.uk)*

## Academic Clinician Scientist sessions at Congress 2011

The recently convened academic group is developing a proposal to run a forum for academic trainees, as well as all College members, to promote and present current research.

The aim is to broadcast the possibilities of research and academic training. It is important to generate the critical mass to make our specialty competitive and recognised in academic medicine.

For further information please contact Professor Andrew Dick [a.dick@bristol.ac.uk](mailto:a.dick@bristol.ac.uk).

## Call for College Reps

The College is seeking representatives for the following technical committees of the British Standards Institute:

- CH/172/3 Spectacles
- CH/172/6 Ophthalmic Instruments.

[www.bsigroup.com](http://www.bsigroup.com)

If you are interested please contact [beth.barnes@rcophth.ac.uk](mailto:beth.barnes@rcophth.ac.uk)

## College Website – Members’ Area

‘Genetic Testing and Counselling in Inherited Eye Disease’ by Ms Susan Downes, Professor Andrew Lotery, Professor Graeme Black & Mr Aris Konstantopoulos, explores the genetic basis of eye diseases and referral to genetics services. Genetic testing should be undertaken in specialist ophthalmic genetics services. Many are expensive to perform and the implications of test results must be discussed accurately and sensitively with patients and families. [www.rcophth.ac.uk/finance-membership/members/genetic\\_testing](http://www.rcophth.ac.uk/finance-membership/members/genetic_testing)

## Moorfield courses

See [www.moorfields.nhs.uk/healthprofessionals](http://www.moorfields.nhs.uk/healthprofessionals) for a list of courses



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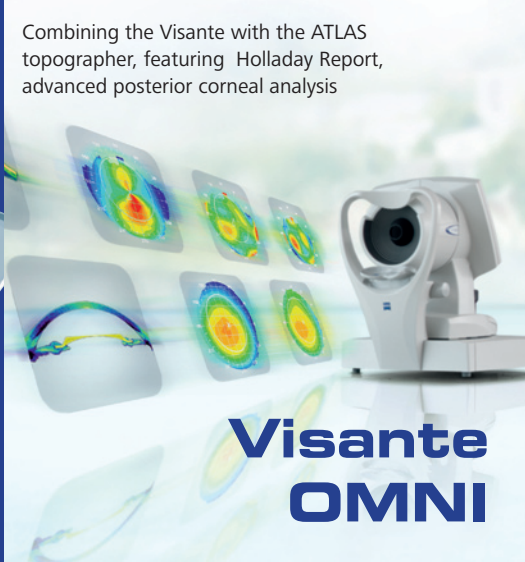
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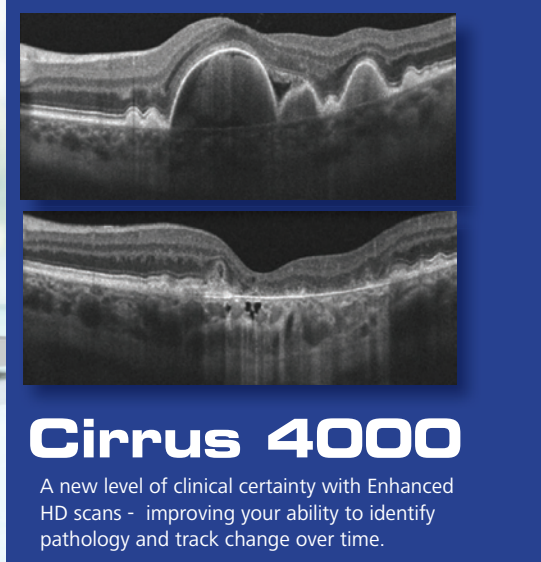


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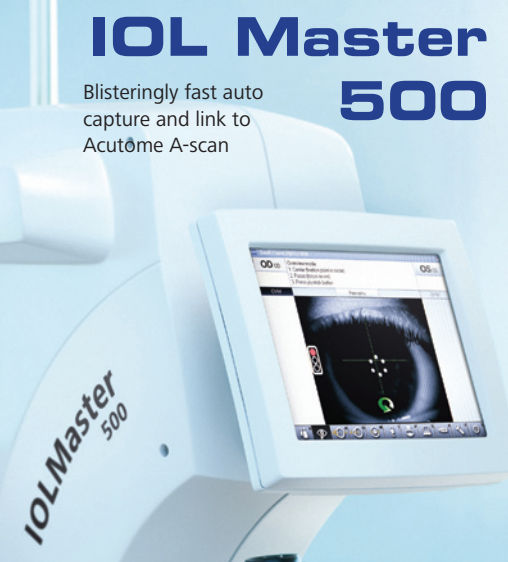


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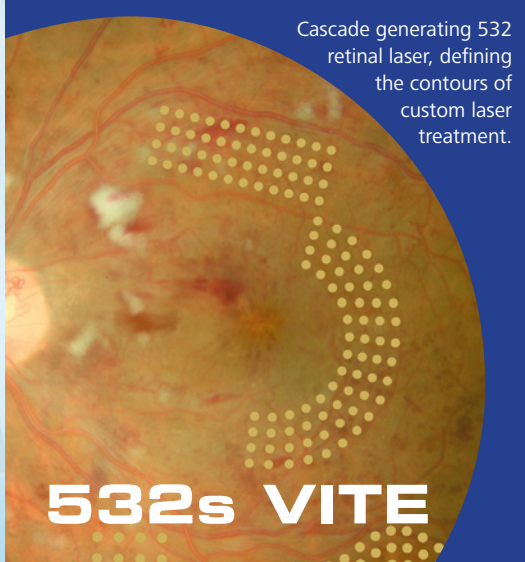
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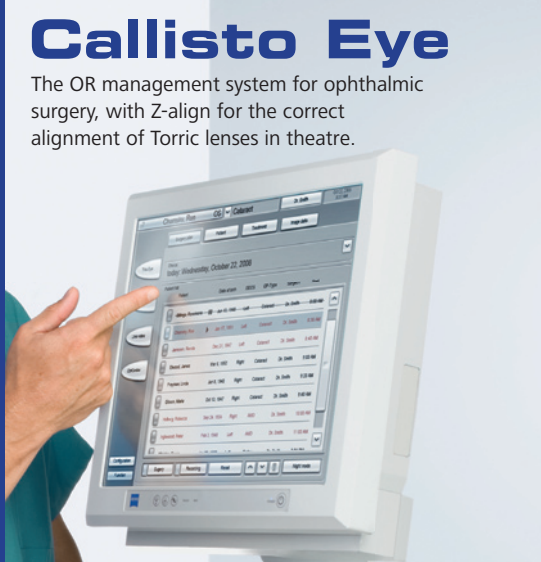
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# AWARDS AND FELLOWSHIPS

## Notice of College Travel Awards and Fellowships

AWARD	AMOUNT	CLOSING DATE
The Dorey Bequest and Sir William Lister Travel Award 2010	C. two awards £400-£600 each	8 October 2010
The Ethicon Foundation Fund Travel Award	Four to six awards of c. £400-£1,000 each	5 November 2010

Information and application forms for all awards are available on the College website: [www.rcophth.ac.uk/education/travelawards](http://www.rcophth.ac.uk/education/travelawards)

## THE BRITISH OPHTHALMOLOGICAL SURVEILLANCE UNIT

### The Fight for Sight Surveillance Study Bursary 2010



Thanks to the kind support from Fight for Sight, the BOSU is again able to offer a research bursary award of £6,000 to support an ophthalmologist in training to undertake an epidemiological study of a rare eye condition. Applications will be assessed upon their suitability for nationwide surveillance, public health and/or scientific importance and the achievability of the research questions.

Contact Barny Foot ([BOSU@rcophth.ac.uk](mailto:BOSU@rcophth.ac.uk) or 07808 581659) for an informal discussion and to request application guidelines. Below is general advice on setting up a BOSU project which also applies to the Fight for Sight Bursary and is a companion piece to the article that appeared in College News (Summer 2010, page 1).

#### How to set up a surveillance project.

The suitability of a condition is considered according to three criteria:

- **Rarity:** All suggested conditions should have an expected population incidence of less than 300 cases per annum.
- **Case identification:** The condition must be clearly described so that all ophthalmologists will be able to identify it in a clinical setting.
- **High public health, or scientific importance or an implication for future service provision.**

**Closing date: 15 October 2010**

#### Potential applicants should contact the unit for a brief initial discussion and the next steps are:

Write a short outline proposal (up to two sides of A4), to summarise the aims and objectives of the study, the case definition (this can be refined later) and some background detail on the condition's suitability for surveillance.

## 2010 Awards made to date:

#### The Fight for Sight Award

Dr Rizwan Malik

#### The Keeler Scholarship

Mr Robert Henderson

#### The Pfizer Ophthalmic Fellowship

Mr Romesh Angunawela

#### The Patrick Trevor-Roper

Dr Safa Elhassan and Dr Adeel Iqbal

#### Undergraduate Travel Awards

##### IGA Research Grants

Professor James Morgan,

Dr Ameet Shah and Dr Sumit Dhingra

### Sir Edward Lewis Foundation Bursaries

Members of the Moorfields Alumni Association (MAA) may apply for one of three bursaries up to £1,000 for teaching/training visits to be undertaken in Central or Eastern Europe in 2011. (Albania • Armenia • Azerbaijan • Belarus • Bosnia and Herzegovina • Bulgaria • Georgia • Kosovo • Macedonia • Moldova • Montenegro • Romania • Serbia • Ukraine).

Programmes should be based mainly on **VISION 2020** subjects\* and applicants must have confirmation of provisional acceptance from the post-graduate centre to be visited.

The successful recipients must produce a report for the and for the MAA website.

Please send applications (quoting MAA number) and a short CV in Word format to [Europe@v2020.org](mailto:Europe@v2020.org)

#### Closing Date: 1 December 2010

\* **VISION 2020** subjects include diabetic eye disease, retinal vascular disease, glaucoma, paediatric ophthalmology, cataract surgery, age-related macular disease and the management of low vision. Additional subjects such as retinal detachment, corneal disease, trauma, ophthalmoplastics, uveitis and neuro ophthalmology will also be considered.





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# UK Vision Strategy



The College is a member of VISION 2020 and actively supports the UK Vision Strategy. The 2010 Vision Strategy Conference held in Birmingham on 15 June had over 350 delegates and 200 people listening to the conference via a live web stream. It successfully brought professionals together, raising the profile of eye health and sight loss issues nationwide.

During the day an important new initiative 'You and your vision: a charter for eye care and sight loss services' was launched by Rt Hon David Blunkett MP.

'You and your vision' outlines, in clear and jargon-free terms, what people should expect on their eye care journey, reinforcing the drive for seamless health and social care services. The charter starts with the sight test, then looks at the point of diagnosis for those who have an eye condition, and goes on to cover issues such as the need for emotional support and referral to specialist services. There is space on the back page for eye clinics to include their own details so that local people know exactly where to go for support.

It can be downloaded from the UK Vision Strategy website [www.vision2020uk.org.uk/UKVisionstrategy](http://www.vision2020uk.org.uk/UKVisionstrategy) and copies in print and other formats can be obtained by calling 0303 123 9999.

Recordings of the plenary sessions can be heard at [www.vision2020uk.org.uk](http://www.vision2020uk.org.uk)

One of the most interesting sessions of the conference was co-presented by Dr Roshini Saunders and a report appears below:

## Electronic optometric referral with digital images to the hospital eye services (HES)

A pilot study was designed in Fife between 2005 – 2006 where 350 patients were consecutively referred from community optometry to HES using NHS mail with attached digital images, when appropriate. The traditional paper referral form was redesigned as a new electronic form to include more patient clinical detail and information on previous HES attendance. Simultaneously the optometrist electronically notified the GP who sent the patient medical history electronically via Sci Gateway. The referral was acknowledged electronically within 24 hours with optometry feedback and appointment allocation or not. All digital images were viewed by the consultant who decided on appropriate management.

The pilot study was found to be safe, speedy, clinically effective and approximately 30% of referrals did not require an HES appointment as an accurate consultant e-diagnosis was possible. Concurrently urgent macula and glaucoma cases were identified early and patients were better triaged

to attend the most appropriate specialist clinic at first visit resulting in a more one-stop service. Patient satisfaction for the service was 97% (EYE 2009;23:1134 – 1140)

Following the pilot success the service was rolled out to the entire region. Since implementation in 2007, waiting times have been reduced from several months to a few weeks. Approximately 18% of new patients receive e-diagnosis, eliminating the need for an HES appointment. These are mainly patients with dry macular degeneration, glaucoma suspects, longstanding retinal lesions and patients who have already attended HES with same diagnosis. Emergency attendances and "did not arrive" attendances have reduced by 10 – 15%.

NHS mail however is not robust enough for national roll out. The Scottish Executive is currently considering a business case to connect all optometrists to the HES using an N3/Internet/SciGateway connection to harness the benefits of this scheme throughout Scotland.

Dr Roshini Saunders

## Low Vision England seeks College representation

Although the majority of patients attending an eye clinic can receive treatment to prevent sight loss, there will always be a small percentage for whom this is not the case. These patients need to be able to access good low vision services.

Since 1998, the national Low Vision Services Group (LVSG) has worked to champion greater awareness of the benefits of providing appropriate low vision equipment and training to partially sighted people to help them maintain their independence and avoid depression. This group is now part of VISION 2020 UK and contributes to achieving the outcomes of the UK Vision Strategy.

Professor Alistair Fielder has given many years of valuable ophthalmic input to the Low Vision Services Group and now, as he retires from the Group, we would like to publicly record our thanks. We are also seeking a new representative. Although the task is not onerous time-wise, key to success is the cross-sector approach and linkage back to the professional bodies. The cross sector approach enables the Group to have influence both at national and local levels.

For further information about the group and the role contact: Lance Clarke (01372 37701) [lclarke@sa-vi.org.uk](mailto:lclarke@sa-vi.org.uk)

## New member for VISION 2000

The Uveitis Group is among the latest organisations to join, bringing the total number to 49. The race is now on to see who will be the 50th member.



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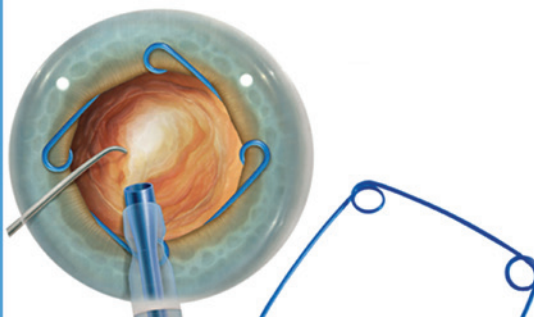
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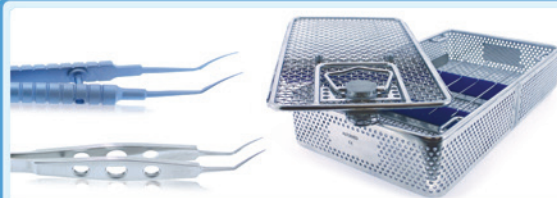


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## Important Congress dates

### Abstract submission website opens

14 September 2010

### Abstract submission closes

16 November 2010

### Abstract results published

18 January 2011

### Registration website opens

15 February 2011

### Congress

24 - 26 May 2011, Birmingham

## College Seminar Programme 2010

All College seminars and events take place at 17 Cornwall Terrace, unless otherwise stated.

### 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

### 9 November

#### Benchside Spectrum of Translational Research in Ophthalmology

UCL Institute of Ophthalmology, London  
Chaired by: Professor Andrew Dick & Professor Andrew Lotery

### 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

#### Revalidation in Ophthalmology

Chaired by: Mr Richard Smith

Please visit [www.rcophth.ac.uk/scientific/seminars](http://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 2 9 November

Please visit [www.rcophth.ac.uk/education/traintrainers](http://www.rcophth.ac.uk/education/traintrainers) for further details.

## College Tutor Induction Days

### 12 October

## SAS Conference

### 22 October

Jury's Inn, Birmingham  
[penny.jagger@rcophth.ac.uk](mailto:penny.jagger@rcophth.ac.uk)

## The Ophthalmic Training Club (OTC)

### 20 November

The Royal Society of Medicine, London  
[www.rcophth.ac.uk](http://www.rcophth.ac.uk)

## College Skills Centre Programme 2010

Details of the Basic Microsurgical Skills courses are on the website at [www.rcophth.ac.uk/skillscentre](http://www.rcophth.ac.uk/skillscentre)  
Additional courses are listed below which take place at the College and more are planned.

### 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/Ms S Downes

### 23 November

#### Oculoplastics Course

Miss S Webber/Miss R Manners

### 6 December

#### Paediatric Course

Mr K Nischal/Mr C Bentley

## Other events 2010

### 1 - 2 October

#### 3rd Newcastle Peri-ocular Tumour

Civic Centre, Newcastle upon Tyne  
[cythirlaway@nuth.nhs.uk](mailto:cythirlaway@nuth.nhs.uk)

### 2 October

#### OCULUS - Practical OSCE and viva revision for Part 2 Fellowship

Course Chair - Prof P Murray  
Birmingham & Midlands Eye Centre  
[s.n.patwary@gmail.com](mailto:s.n.patwary@gmail.com)  
[www.oculus-course.com](http://www.oculus-course.com)

### 29 October

#### High Holborn Reunion

The Medical Society of London, London  
[t.fytche@btinternet.com](mailto:t.fytche@btinternet.com)

### 10 - 11 November

#### Facial Plastic Surgery Dissection

Anatomy Dept. Guys' Hospital, London  
[ruth.underhay@gstt.nhs.uk](mailto:ruth.underhay@gstt.nhs.uk)

### 19 November

#### MCLOSA 17th Annual Scientific Meeting

The Royal Society, 6-9 Carlton House Terrace, London  
[secretary@mclosa.org.uk](mailto:secretary@mclosa.org.uk)

### 25 - 26 November BEAVRS

The Celtic Manor Resort, Coldra Woods Newport, South Wales  
[www.beavrs.org](http://www.beavrs.org)  
[beavrs2010@googlemail.com](mailto:beavrs2010@googlemail.com)

### 3 December

#### UK & Eire Glaucoma Society Annual Meeting

Church House, Westminster, London  
[marketing@iga.org.uk](mailto:marketing@iga.org.uk)

### 10 December

#### 4th Amsterdam Retina Debate

Academic Medical Center, Amsterdam  
[www.amc.nl/retinadebate](http://www.amc.nl/retinadebate)

### 10 - 11 December

#### 7th Retinal Imaging Interpretation

Clinical Sciences Centre, Aintree Hospitals, Liverpool  
[richard.hancock@aintree.nhs.uk](mailto:richard.hancock@aintree.nhs.uk)

## Other events 2011

### 8 January

#### Ophthalmology Interview Skills Course

London, exact venue TBC  
[ophthalmologycourse@yahoo.co.uk](mailto:ophthalmologycourse@yahoo.co.uk)  
<http://ophthcourse.webs.com>

### 3 - 4 February

#### The Annual St Thomas' Hospital Trends in Ophthalmology

The Royal Society, London,  
[www.trendsinophthalmology.com](http://www.trendsinophthalmology.com)  
[Info@trendsinophthalmology.com](mailto:Info@trendsinophthalmology.com)

### 5 February

#### Refractive Conference

The Royal Society of Medicine, London  
[janice.ireland@optimax.co.uk](mailto:janice.ireland@optimax.co.uk)

### 25 February

#### VR in a Day

St Thomas' Hospital, London  
[www.eyehope.co.uk](http://www.eyehope.co.uk); [vrinaday@googlemail.com](mailto:vrinaday@googlemail.com)

### 3 - 6 July

#### Oxford Ophthalmological Congress

Call for papers - send abstracts by 11 January  
[www.oxford-ophthalmological-congress.org.uk](http://www.oxford-ophthalmological-congress.org.uk)  
[o\\_o\\_c@btinternet.com](mailto:o_o_c@btinternet.com)

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