

College NEWS



Summer
2011

Red Nose Day

The Examination Department led by Emily Beet and George Hibdige organised Red Nose Day events to coincide with the March Council and raised £332. One of the highlights was a competition to find the most dextrous player of "Operation". Sophie Donovan, the Examinations Administrator, who is shortly to start maternity leave, was the winner. Special mentions go to Mr Jonathan Eason, Chairman of the SAS Group, and Mr Alex MacLeod, Council representative for Wessex.



Mr Jonathan Eason operates



The March Council

The new president

Professor Harinder Dua has been elected as President and will serve for three years from the May 2011 Annual General Meeting.



The Advisory Committee on Clinical Excellence Awards (ACCEA)

The ACCEA is currently under review by the Review Body on Doctors' and Dentists' Remuneration (DDRB), which is expected to report to Ministers in July 2011. ACCEA is currently working on the basis that the 2012 round for England will be proceeding as normal. Consultants wishing to apply for an award should visit the College website www.rcophth.ac.uk for updates and it is likely that forms will have to be submitted to the College by 3 October for scoring.

The MRC/RCOphth John Lee Fellowship

The fund currently stands at £72,000 and we need a further £50,000 to fund the first fellowship. Please donate at

www.justgiving.com/rcophth/donate

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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
robertsloan@virginmedia.com

Copy deadlines

Autumn
5 August 2011
Winter
5 November 2011
Spring
5 February 2012
Summer 2012
5 May 2012

Blind in Business (BIB)

This is a charity based in the City of London. It works with blind and visually impaired children aged 13-16 across the UK, to help them with career planning and confidence building. It informs children about the right assistive technology so they can cope within education, at home and, eventually, the workplace.

Each year it works with 400 children and 120 graduates. As teenagers progress through College and University they come back to BIB for support in finding their first job. The BIB Employment Service helps undergraduates and graduates into modern careers such as marketing, law, IT, teaching and accountancy - anything but driving a bus. The services are completely free and in a typical year 60-80 people are supported into good jobs throughout the country.

BIB also works with employers to raise their aspirations of what blind and visually impaired people can do and brings together employers and graduates for mock interview days.

The Charity is always looking to create new links with professionals who work in the field of visual impairment. If you come across anybody who can benefit from its services please ask them to get in-touch. www.blindinbusiness.org.uk; info@blindinbusiness.org.uk Phone: 0207 588 1885

RNIB RCOphth 'Understanding' series of leaflets

There are three new titles in the easy-to-read 'Understanding' series of leaflets on common eye conditions:

- Understanding Charles Bonnet syndrome
- Understanding dry eye
- Understanding posterior vitreous detachment.

These are in addition to existing guides which include glaucoma, age-related macular degeneration and cataracts. The guides cover causes, symptoms, treatments and coping mechanisms for each eye condition. Individual copies are available free of charge in print, audio and Braille formats and are downloadable from www.rnib.org.uk

Contact: the RNIB Helpline (0303 123 9999) or helpline@rnib.org.uk

Returning to work after surgery: new patient information

The Royal College of Surgeons (RCS) has recently updated its online patient information series 'Get Well Soon' which offers advice about getting back into everyday activity and work following common operations, including cataract procedures. The information is designed to be read by patients who know they are going to have surgery in preparation for a good, speedy recovery.

The online leaflets contain information about what to expect after an operation and a day-by-day recovery tracker focusing on what a patient can do safely after a routine procedure. The information has been produced by the RCS and speciality surgical associations with funding from the Department for Work and Pensions, and can be found at www.rcseng.ac.uk

British Council for Prevention of Blindness. Fellowship and Research Grant Programme

The aim of these grants is to fund research and training in prevention of blindness for high calibre clinicians and scientists from the UK and overseas.

BCPB
British Council
for Prevention
of Blindness

I. Fellowships worth up to £63,000 per year over two or three years. Fellowships are available to clinicians wishing to undertake a PhD or MD. In 2012, BCPB seeks to fund one Fellow from the UK and one Fellow from overseas (researchers from low income countries and sub-Saharan Africa in particular are encouraged to apply).

II. Research grants worth up to £63,000 in total over one, two or three years. Research grants are available to clinicians, scientists or epidemiologists:

- a) for 'pump-priming' to develop their research ideas and generate pilot data to facilitate a future application for a substantial grant; or
- b) to provide funding for a non-clinical PhD or DrPH studentship.

Projects must further the goals of 'VISION 2020: The Right to Sight' - the elimination of avoidable blindness - and priority will be given to projects which benefit low income countries. Grants will be awarded to UK research/training institutions. Applicants are advised to read the Information for Applicants.

Closing date: 11 October 2011. For more information visit: www.bcpb.org

The SAS Group vacancy

Dr Elizabeth Kaonga, the SAS representative for SE Thames is due to step down from the committee.

SAS members interested in representing the region should contact penny.jagger@rcophth.ac.uk

Members' News and Appointments

Consultant Appointments

We would like to thank those consultants who have attended Advisory Appointment Committees. We rely on medical personnel departments to confirm consultant appointments. Please contact aac@rcophth.ac.uk if you notice an error or omission.

Dr Pankaj Kumar Agarwal	Princess Alexandra Eye Pavilion, Edinburgh
Mr Atul Bansal	University Hospital, Coventry
Miss Elizabeth Bristow	Cheltenham General Hospital, Cheltenham
Mr Barry Thomas Cartmill	Altnagelvin Area Hospital, Londonderry
Mr Cian Collins	Altnagelvin Area Hospital, Londonderry
Mr Vincent Dubois	University Hospital Aintree, Liverpool
Dr David Gilmour	Gartnavel General Hospital, Glasgow
Mr Rafik Girgis	Bristol Eye Hospital, Bristol
Miss Raina Goyal	Royal Glamorgan Hospital, Llantrisant
Mr Omar Hadid	Doncaster Royal Infirmary, Doncaster
Mr Nick Hawksworth	Abertawe Bro Morgannwg, Swansea
Mr Christopher Hemmerdinger	Warrington Hospital, Warrington
Dr Paul Johnstone	Ninewells Hospital, Dundee
Miss Emma Jones	Moorfields Eye Hospital, London
Mr Shahram Kashani	Eastbourne District General Hospital, Eastbourne
Mr Inayat Khan	Hinchingbrooke Hospital, Huntingdon
Mr Vasileios Kostakis	Ipswich Hospital, Ipswich
Dr Manjula Kumarasamy	Aberdeen Royal Infirmary, Aberdeen
Mr Stephen Lash	Southampton General Hospital, Southampton
Dr Elisabeth MacDonald	Gartnavel General Hospital, Glasgow
Mrs Karen Madill	Princess Alexandra Eye Pavilion, Edinburgh
Mr Nonavinakere Manjunatha	Doncaster Royal Infirmary, Doncaster
Miss Anna Mead	Stoke Mandeville Hospital, Aylesbury
Mr Simon Morgan	Westmorland General Hospital, Kendal
Mr Praveen Patel	Moorfields Eye Hospital, London
Mr Ashish Patwardhan	Royal Cornwall Hospital, Truro
Mr Atul Shah	Royal Cornwall Hospital, Truro
Mr Manickam Thiagarajan	Princess Royal University Hospital, Orpington
Mr Stephen Thomson	Raigmore Hospital, Inverness
Mr Ajay Tripathi	Russells Hall Hospital, Dudley
Dr James Vallance	Ninewells Hospital, Dundee

Regional Advisers

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

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

The table below shows those post holders who will shortly complete a three year term of office. Any person wishing to stand should contact esther.merrill@rcophth.ac.uk

RETIREMENT DATE	NAME	REGION	ELIGIBLE FOR RE-APPOINTMENT
Sept 2011	Mr Simon Hardman Lea	East Anglia	No
Sept 2011	Dr Chris Scott	Scotland North East (Aberdeen)	No

Membership information

Please contact database@rcophth.ac.uk if you get a new email address so that we can keep in touch with you. We are rolling out an events package so that payment for seminars and courses may be made electronically. It will be necessary for delegates to use the email address that the College holds on the membership system – and we can only hold one email address.

City Road reunion

A reunion for those who were appointed as residents or consultants to the City Road branch of Moorfields before 1990 will be held on Friday 28 October, 2011 at The Medical Society of London, Lettsom House, 11 Chandos Street, London, W1G 9EB.

The event will consist of a reception, lunch and a talk from Richard Keeler, on the history of Moorfields.

Numbers are limited, so that those who would like to participate should contact Tim ffytche as soon as possible at: t.ffytche@btinternet.com or by post to 1 Wellington Square, London, SW3 4NJ

The MRC and RCOphth Fellowship

Dr Michelle Chan has been awarded the Fellowship and will start autumn 2011.

Obituaries

We note with regret the death of:

Mr Jonathan David Griffiths of Bath, Somerset

Dr Abu Tayer M M Hossain of Kolkata, India

Dr Robert MacDonald of Rangina, New Zealand

Dr Thomas Edward Moore of San Francisco, USA

Dr Harish Prasad Tandon of Northwich, Cheshire

Mr Arumugam S Rubasingham of Mansfield, Nottinghamshire

Dr William Wilson of Glasgow, Lanarkshire



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Focus



Summer
2011

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

Small gauge vitrectomy

Evolving through the first 14-gauge instrument and the later 17-gauge single port device, perhaps the most important milestone in small gauge vitrectomy was the development of 20-gauge approach in 1974 by O'Malley et al. This technique involved the introduction of three ports through the sclera after a peritomy and suture closure of the sclerotomies and the conjunctiva.

The quest to improve surgical outcomes, decrease the operating time and minimize tissue trauma led on to the development of small gauge sutureless vitrectomy systems. The aim of this article is to review the technique, the instrumentation, advantages and disadvantages of the small gauge trans-conjunctival sutureless vitrectomy systems.

Although first described in the 1990s, the 25 gauge popularized by Fuji and colleagues in 2002 and the 23 gauge popularized by Eckardt et al in 2005 are the two main small gauge vitrectomy systems in current vitreo retinal practice.

Surgical technique

Wound construction

One of the most important steps in sutureless vitrectomy technique is the wound construction. The conjunctiva is displaced using a cotton applicator or forceps. Trocar-guided cannulas are passed through conjunctiva and sclera into the vitreous cavity. The angle of entry into the sclera influences the sealing of the sclerotomy after the removal of the cannulas. The more oblique the path through the sclera, the better the re-apposition of the edges after the removal of cannulas,

and lesser the leakage from sclerotomies.¹ Some favour a bi-planar scleral incision, with a more oblique initial and a more perpendicular final entry into the vitreous to create a two-step incision in cross section. (Figures 1a and b). The infusion is usually placed into the infero-temporal with the two other ports used for endoillumination and the active instrument. Newer entry systems have a blade-like configuration which allows improved wound configuration.

Fluid dynamics

The factors that influence the rate of vitreous removal are the infusion pressures, the aspiration pressures and the duty cycle of the vitrector. With higher cut rates of up to 5000 cpm on modern machines, the resulting 'bites' of vitreous are smaller, creating less shear forces and better flow rates.

Compared to the 20-gauge probe, where the infusion pressures vary between 30 to 40mmHg, vitrectomy with small gauge systems works at higher infusion pressures in the range of 50mmHg. Because of the smaller internal diameter of a tube, the flow rate is less with small gauge probes compared to the 20-gauge probes. Increasing the infusion pressure improves the vitreous removal rates in small gauge systems.

Higher aspiration pressures are used in small gauge systems to achieve a reasonable rate of vitreous removal. The maximum aspiration varies between 400 to 600mmHg compared to 150mmHg in 20-gauge systems.

The duty cycle is the length of time the vitrector port is

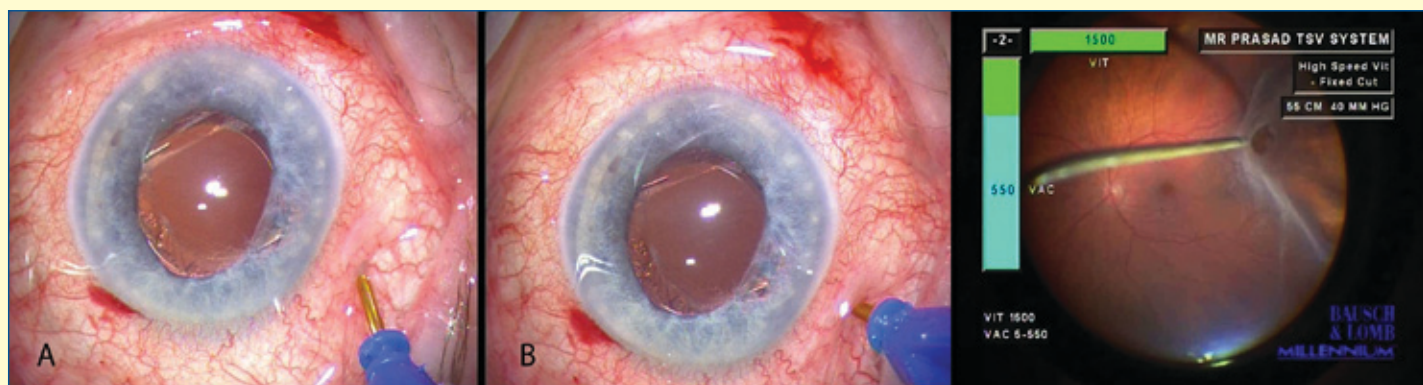


Figure 1a, b: Photograph showing the bi-planar entry used in small gauge vitrectomy (oblique and perpendicular steps) 1c: Photograph showing the wide field illumination with a Chandelier light along with indentation.

open compared to the time it is closed. Duty cycles with a longer port opening time results in higher flow rates thus compensating for the decreased flow in the smaller diameter instruments.

Illumination systems

Evolving from an external slit illuminator outside the eye, refinement and minification of the instruments have created small-diameter endoillumination probes to allow a panoramic view of the posterior segment. Of the recent systems, the fibre-optic illumination pipe which remains fixed to the cannula without the need for suture placement (a chandelier type illumination) has enabled the execution of bi-manual surgery and provides wide illumination of the vitreous cavity (Figure 1c).

Completion of surgery

The cannulas are removed and the conjunctiva is displaced over the sclerotomies with a cotton tip applicator and no sutures are needed. Some surgeons advocate the use of an air bubble of about 15% in the eye even if gas is not needed and posture the patient supine for 24 hours. This places the air bubble in apposition to the sclerotomies and helps to keep them closed in the first day postoperatively thereby decreasing the chances of hypotony.²

While leakage from sclerotomy wound is not a common problem, patients who have had previous vitrectomy and conjunctival scarring, eyes with thin sclera and those of young children appear to be at a higher risk of leak and have to be carefully assessed after removal of the cannulas.³

Complications

Intraoperative complications

During the surgery, increased intraocular pressure during the placement of trocar cannulas can put undue stress on prior corneal or limbal wounds such as in eyes that have had sutureless cataract surgery or recent corneal transplants. Suture closure of any recent corneal and scleral wounds before trocars are inserted may be desirable.

Secondly, spontaneous dislocation of the cannula can occur during the exchange of instruments between the ports and also more importantly, the cannula attached to the infusion line can dislocate during scleral depression causing intraoperative loss of volume. Re-positioning of the cannula should repressurize the eye.

Thirdly, the incidence of iatrogenic breaks have been reported with a wide variation with some studies finding relatively higher incidence with 25 gauge (15.8%),⁴ while other studies found lesser incidence compared to 20 gauge.⁵

Postoperative

Reports have shown the prevalence of up to 20% of post-surgical hypotony using 25 gauge in earlier series. In most cases IOP values normalized within a few days with no residual problems. The only factor that has been found to be significant in the formation of hypotony with sutureless vitrectomy has been young age of the patient.³ Better wound construction has now minimized this problem.

Postoperative endophthalmitis was initially suspected to occur more frequently after sutureless vitrectomies. Earlier series reported rates ranging from 0.04% to 0.84%. More recently published large retrospective studies do not indicate that sutureless small gauge vitrectomy is as-

sociated with higher rates of endophthalmitis than in 20 gauge.^{6,7} We are currently conducting a prospective BOSU study on this topic and hope to throw some more light on this issue.

Advantages of small gauge systems

The most obvious advantage is the ability for direct insertion through the conjunctiva and sclera and removal without need for any sutures. Shorter surgical times, rapid postoperative and visual recoveries are also very attractive advantages of the sutureless vitrectomy systems.

The smaller port size of the instruments increases the ability to remove vitreous with very little traction or to remove epiretinal membranes without risking incarceration of retina in the port.

Many of the studies with small gauge vitrectomy have found decreased inflammation and pain postoperatively and improved patient comfort. Also, astigmatism following 23- and 25-gauge vitrectomy has been shown to be less than 20 gauge resulting in rapid visual recovery.

Disadvantages

Creation of a PVD with suction alone could theoretically be more difficult with the smaller vitrectomy probes.

One of the main issues with the small gauge vitrectomy systems have been the increased flexibility of the instruments. This could cause difficulty with dissection of peripheral membranes in proliferative vitreoretinopathies. The use of oblique incisions to achieve water-tight closure exacerbates this problem as torsion on the probe is required to hold the instruments perpendicular to the sclera when removing the vitreous. Different approaches to circumvent this problem include the use of bi-planar incision which has a perpendicular final entry, thereby negating the problem. The development of newer probes which are stiffer and have a wider internal diameter has helped to improve flow rates and also provide better access to the peripheral vitreous. Also the ability to do bimanual surgery and perform scleral indentation during vitrectomy thereby bringing peripheral vitreous centrally has helped in reducing problems with instrument flexion.

Conclusions

Development of small gauge vitrectomy systems has definitely expanded the treatment options available to patients and surgeons. A variety of conditions can now be treated with less inflammation, less patient discomfort and faster recovery. Rates of retinal tears and retinal detachment are low and consistent with available evidence. Modifications in instrumentation, case selection and surgical technique have considerably reduced the incidence of various complications including hypotony. The concern regarding increased risk of endophthalmitis stands unsupported as various studies have shown this risk to be comparable to 20-gauge cases. We hope that the current prospective BOSU study with consistent selection criteria, standardized outcome measures and long-term follow up will inform us of long-term visual results and adverse events as well as recommend ways to reduce complications and optimize outcomes. Clearly, exciting times are ahead for the vitreo retinal surgeons.

*Balasubramanian Ramasamy MS, FRCOphth
Som Prasad MS, FRCSEd, FRCOphth, FACS*

Museum piece



An almost great ophthalmologist John Zachariah Laurence (1828-1870)

The first binocular ophthalmoscope was invented by the French ophthalmologist F. Giraud-Teulon in 1861. A year later, an Englishman, John Zachariah Laurence (pictured left), constructed a much superior instrument. This was only one of a number of significant introductions and inventions made during a short life.

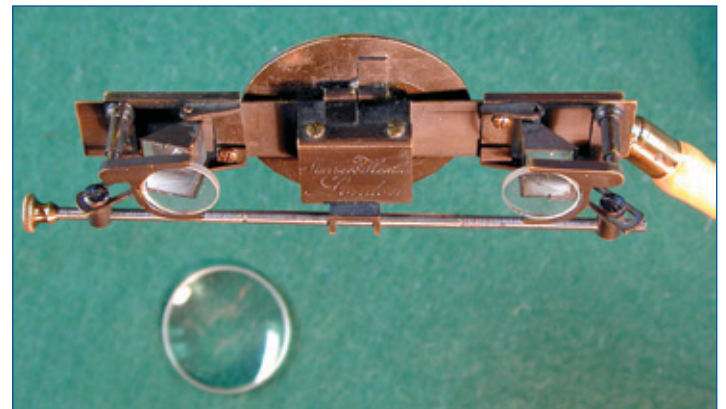
Little is known of Laurence's early education except that he enrolled in the Faculty of Arts session 1847-8 at University College, London at the age of 19. In 1850 he joined the Faculty of Medicine where he was to study for four years. He must have been an outstanding pupil judging by the number of gold and silver medals he was awarded. He obtained his MRCS in 1854 and less than a year later a FRCS and an MB in 1857.

Also in 1857, at the age of 29, he opened the South London Ophthalmic Hospital at St George's Circus, South London. This was ultimately to become the Royal Eye Hospital. Although the hospital had just two beds Laurence enlisted another ophthalmic surgeon, Carsten Holthouse, consultant at the Westminster Hospital, to help him. The hospital was to change its name three times while Laurence was in charge. In 1860 it became the Surrey Ophthalmic Hospital, then the Ophthalmic Hospital, Southwark in 1865 and, finally, in 1869 the Royal South London Hospital.

Laurence studied refraction under Frans Donders in Utrecht for several months; Donders having just published in his 1862 classic work 'On Anomalies of Accommodation and Refraction of the Eye'. Laurence was to use his new knowledge to give a series of lectures at his hospital which were subsequently published in the Medical Times and Gazette. The lectures formed the basis of his 1865 book on refraction entitled 'The Optical Defects of the Eye' which was also translated into German. In the following year, 1866, in conjunction with his house surgeon, Robert C Moon, he published 'A Handy-Book of Ophthalmic Surgery for use of Practitioners'.



Laurence's grave



Laurence and Heisch Binocular Ophthalmoscope 1862

In 1864 he started publication, with Thomas Windsor from Manchester, of the first English ophthalmic journal called the Ophthalmic Review. Although this only lasted for three editions it was highly regarded and Laurence was a major contributor. It was in the second volume, published in 1866, that he wrote a paper detailing a condition that was to become known as the Laurence-Moon-Bardet-Biedel Syndrome.

Laurence was among the original 81 members of the German Ophthalmological Society later known as the Heidelberg Society. He was also a member of the Society of Practical Medicine of Paris. He was a frequent contributor to journals on a wide variety of subjects. These included the BMJ, Lancet, Medical and Chirurgical Journal, Transactions of the Glasgow Medical, the RLOH reports and the aforementioned Medical Times and Gazette.

Apart from being a fine linguist and scholarly writer, he enjoyed music, singing, drawing and fishing. He is buried next to his wife, Miriam, in the Jewish cemetery of the West London Synagogue.

It is tempting to speculate that if Laurence had not died at the young age of 42 he could well have become one of the outstanding ophthalmologists of his generation.

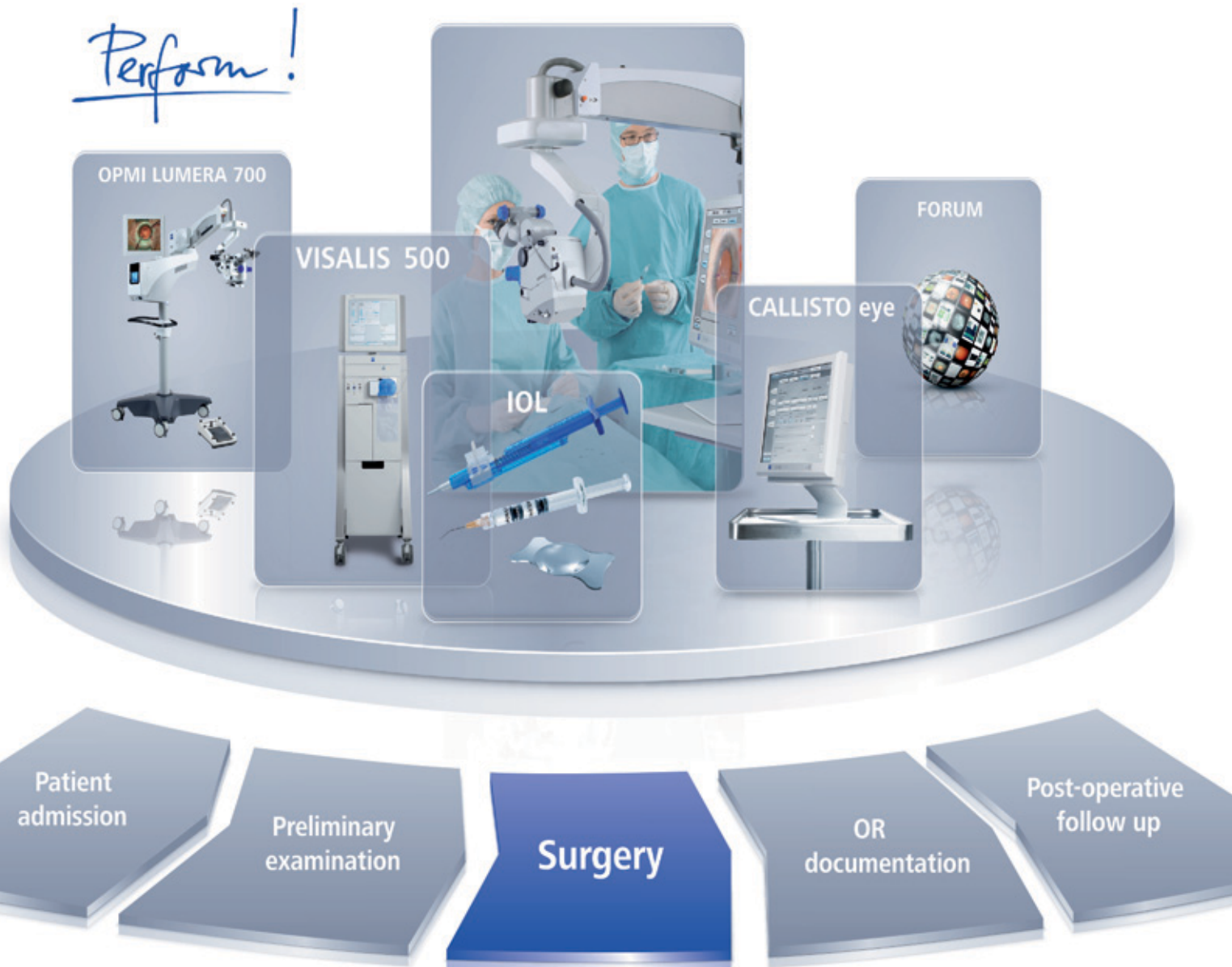
*Richard Keeler, Museum Curator
rkeeler@blueyonder.co.uk*

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We make it visible.

From the Academic group

Clinical Research networks

The National Institute of Health Research (NIHR) was established by the Department of Health (DH) to deliver the UK government's Research and Development Strategy 'Best Research for Best Health'. The NIHR manages its activities through four main strands:

- NIHR faculty – supports individuals in England
- NIHR research – commissions and funds research UK wide
- NIHR systems – creates unified streamlined knowledge management systems
- NIHR infrastructure – provides facilities for research in the form of clinical research networks.

The UK Clinical Research Network was established in 2005 to provide the infrastructure for supporting research that would benefit the NHS and in England consists of six topic-specific clinical research networks covering the six priority areas of cancer, dementia, diabetes, mental health, medicines for children and stroke and primary care. This scope has been widened to include the full spectrum of disease and clinical need through the creation of the comprehensive Clinical Research Network (CCRN). The CCRN consists of 25 comprehensive Local Research Networks in England (CLRN's) and, along with the networks established in Scotland, Wales and Northern Ireland, has the remit to deliver a comprehensive infrastructure that will support research throughout the UK. A total of 26 areas of need were identified in 2008 and ophthalmology constitutes one of these disease-specific specialty areas.

The ophthalmology specialty group (OSG) brings together topic-specific expertise and members are drawn from across the four devolved nations. Members of the group are nominated by each of the CLRN's and include multi-professional representation drawn from medical and optometric fields and patient support organisations. Representation from other allied fields such as visual rehabilitation is currently being sought. The functions of the group are to contribute to the activities of the CCRN through providing an understanding of ongoing research activities in this topic area and manage the portfolio of adopted trials and studies within ophthalmology. These latter duties include:

- Provision of advice on suitability of studies for adoption for both investigator-led and industry-led studies
- Assess feasibility/do-ability of potential studies
- Monitor accrual and retention statistics in adopted studies and work with investigators to institute measures to improve recruitment
- Provide oversight of ongoing research outside the portfolio to reduce duplication
- Ensure equitable access to CCRN resources for adopted studies

- Share expertise and strategic support to investigators of studies included in the portfolio.

The OSG has a remit statement which is available on the NIHR portal. The portfolio includes some 80 adopted clinical trials and studies with the vast majority adopted solely by the OSG and some 10% co-adopted with other specialty groups (children's, diabetes, endocrine, musculoskeletal etc). Several examples exist of studies where initial poor enrolment was considerably improved and successful attainment of the recruitment target was achieved following adoption into the portfolio. Adoption into the OSG portfolio is therefore strongly encouraged as this will provide seamless access to CLRN resources and to expertise for help with strategies to improve recruitment and retention into trials and studies.

*Professor Usha Chakravarthy
Chair, The Ophthalmology Specialty Group*

Clinical Valuation of Indicators

Clinical valuation of indicators published on NHS Choices Sir Bruce Keogh (Medical Director of the NHS) has been developing quality indicators based on data routinely collected in hospitals. While the vast majority of these are not relevant to ophthalmology, there are some (for example, waiting times and re-admission rate) which are. These indicators are now published on the NHS choices website, accessible to the public at www.nhs.uk/hospitals. Trust medical directors have been invited to get involved in scrutinising their own data before it is submitted, so there is an opportunity to correct factual errors. The College recommends that department leads check their unit's figures on the website and inform their medical director of any errors.

*Mr Bill Aylward
Chairman, IT Subcommittee*

Vacancy: The College is seeking a representative for the British Standards Institute (BSI) Intraocular Lens Committee of the Optical group.

The BSI (www.bsigroup.com) works with the International Organization for Standardization to set standards for the manufacture of intraocular lenses. The BSI Intraocular Lens Committee is responsible for appointing members to ISO/TC 172/SC 7/WG 7 and relevant CEN/TC 170 working groups; briefing UK delegates ahead of European and international meetings and determining the UK response to documents in consultation. There are usually about three to four meetings per year.

The College seeks a consultant ophthalmologist member with a working knowledge of IOL technology to represent it and provide relevant feedback.
Contact: beth.barnes@rcophth.ac.uk

Stickler syndrome

The Advisory Group for National Specialised Services (www.specialisedservices.nhs.uk) and the Department of Health have commissioned the Vitreoretinal Service at Cambridge University NHS Foundation Trust to provide a national diagnostic service for Stickler syndrome with effect from April 2011. The objectives of this new service are:

1. To provide accurate clinical and molecular genetic diagnosis and sub-classification of Stickler syndrome for patients and families in England
2. To develop a central patient registry and repository of data for longitudinal outcomes of all patients with Stickler syndrome in England.

Prior to commissioning, a limited service was offered to patients on a voluntary basis by research laboratory staff funded by research grants but this has been overburdened by the national demand and this newly commissioned service is expected to eradicate inequity by ensuring that all patients in England are able to access prompt and accurate diagnosis and multidisciplinary team (MDT) advice.

Patients suitable for referral will be individuals with congenital vitreous abnormality typically (but not exclusively) from the following four groups:

- (i) Neonates with Pierre-Robin/cleft and myopia
- (ii) Infants with spondyloepiphyseal dysplasia associated with myopia or deafness
- (iii) Patients with a family history of retinal detachment

with associated joint hypermobility, midline clefting, or deafness

- (iv) Sporadic cases of retinal detachment associated with joint hypermobility, midline clefting, or deafness

All patients will be assessed in a MDT clinic to assign phenotype which assists substantially in directing and optimising subsequent molecular genetic analysis. The service is for diagnosis only and all day-to-day ongoing medical care will continue with local or regional providers.

DNA samples from patients unable to attend the clinic for MDT phenotyping may be analysed directly, but clinicians and patients need to be aware that without prior phenotyping, turnaround and accuracy of the molecular genetic analysis is likely to be far less predictable. This strategy should be reserved for exceptional circumstances only.

Under current health service arrangements for the UK, AGNSS provision covers patients in England. Provision for patients from Wales, Scotland and Northern Ireland can be requested, commissioned and provided via approval and authorisation from the appropriate local healthcare commissioning body.

All referrals should be made to: Mr MP Snead, Stickler Syndrome Diagnostic Service, Vitreoretinal Service, BOX 41, Cambridge University NHS Foundation Trust, Hills Road, Cambridge CB2 0QQ.

Proposed new training programme for ophthalmic practitioners to start in October 2011

A new education and training programme for ophthalmic photographic, technical and scientific support staff is proposed. The Foundation Degree in Ophthalmic Science and Technology, begun in 2006, has been very well received by both students and the workplace, but will soon be superseded by a new BSc Honours, under the aegis of the Department of Health's Modernising Scientific Careers initiative.

The proposed course will be offered as a specific pathway of BSc. Healthcare Science (Neurosensory Sciences) by De Montfort University, Leicester, subject to validation and accreditation by Medical Education England. The first year will be full time, but students with a healthcare qualification and/or experience can be exempted from up to half of the first year and would attend lectures for two modules only. Most of years two and three would be ophthalmic-specific delivered as part-time distance learning, and students will only need to attend De Montfort for lectures for two modules at the beginning of the second year. It is probable that students who complete years one and two will be granted a Foundation Degree if they do not wish to continue for a further year and attain the BSc Honours.

Departments sending students on the programme must provide work-based training and allow students time

for study and course work. Students will be sent course materials and will have contact with a tutor. There will be face-to-face teaching about one Saturday per month. Depending on student numbers, this can be provided in several locations across the UK.

Students able to enroll in October this year will be subject to the full time fees of £3,375 per academic year for the duration of the course. In the first year this fee may be less if students are able to use accredited prior learning towards some modules. In subsequent years students would be expected to undertake each academic year on a part-time basis, with part-time fees. It would, of course, be up to employers to decide how much they could contribute. We strongly recommend that completion of the course is linked to pay scales so that students feel they are investing in their own future.

For further information about the programme and how to apply see: www.ahpo.org More about the Modernising Careers programme can be found at:

www.dh.gov.uk/en/Aboutus/Chiefprofessionalofficers/Chiefscientificofficer/DH_086661

Miss Rosalind Harrison



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Takagi AT1 Slit Lamp
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Tonometer Prisms



Canon Non-Contact
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TRAVEL AWARDS AND FELLOWSHIPS

AWARD	AMOUNT	CLOSING DATE
Dorey Bequest and Sir William Lister Travel Award 2011	c. two awards £400-£600 each	7 October 2011
Ethicon Foundation Fund Travel Award	Four to six awards of £400-£1000 each	4 November 2011

Information and application forms for all awards are available on the College website:

www.rcophth.ac.uk/awardsandprizes

The Royal College of Ophthalmologists Prize for Innovation 2011

Heeding the call last year by Sir Bruce Keogh for cost savings in the NHS, the College introduced a competition for innovations in eye units that saved money whilst maintaining or enhancing the quality of patient care. We received 10 excellent entries. The 1st prize of £250 and a certificate will be presented at Congress 2011 to Dr Shyamanga Borooah and Dr Roshini Sanders: a Centralised Ophthalmic Electronic Referral System in Scotland. www.rcophth.ac.uk/page.asp?section=588§ionTitle=Innovation+Prize

Certificates have been awarded to two highly commended entries:

- Professor Paul Dodson: Ophthalmic Photographic Diabetic Review (OPDR); a virtual clinic approach for management of referable diabetic maculopathy (M1)
- Professor Bertil Damato and Dr Sarah Coupland:

Selective screening for metastasis from uveal melanoma
It was such a success that we are running the competition again.

- Any member may enter
- Entries limited to two sides of A4
- Maximum 2 authors
- Previous entrants not placed may resubmit their entry, updated with new data
- The innovation should have been trialled and demonstrate savings
- Winners may be asked to make a short presentation at Congress

Closing date: **7 September 2011.**

Contact : beth.barnes@rcophth.ac.uk

www.rcophth.ac.uk/awardsandprizes



Leading science for better health



The MRC and RCOphth John Lee Fellowship

One clinical research training fellowship, set up to advance the science and practice of ophthalmology, will be awarded jointly by the MRC and The Royal College of Ophthalmologists. It will be named after the late President, Mr John Lee, to honour his outstanding contribution to ophthalmology.

Applicants must be a member of the College, a UK trainee ophthalmologist and want to work towards a doctoral degree. The fellowship will provide an opportunity for someone who aspires to a career as a clinician scientist or who wishes to strengthen their future clinical practice to undertake a period of clinical, epidemiological or laboratory based research related to eye disorders. For further details see www.rcophth.ac.uk Closing date: **15 September 2011**



MRC/Ulverscroft Vision

Research Group are funding the first Clinical Research Training Fellowship specifically in the area of paediatric

ophthalmology / visual sciences. The UVRG is an interdisciplinary research grouping at the Institute of Child Health, UCL and Great Ormond Street Hospital. It aims to strengthen research that improves understanding, prevention or

management of eye disease and visual impairment in children and to build capacity in academic paediatric ophthalmology. The Fellowship may be held at any institution in the UK (with standard terms and conditions for an MRC CRTF).

The Fellowship will be included in the autumn 2011 round with a likely submission deadline of September 2011

www.mrc.ac.uk/index.htm

For further information contact: Professor Jugnoo Rahi
j.rahi@ich.ucl.ac.uk

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HONORARY FELLOWS

At the Admissions Ceremony in September 2010, an Honorary Fellowship was awarded to Mr John Scott. This is an edited version of the citation given in his honour.

John Scott started his ophthalmic training in June 1961 at the Western Ophthalmic Hospital. There he met Gregory Keith, a Senior Registrar interested in retinal detachment surgery, who had been to Düsseldorf to visit Ernest Custodis, a 1950s pioneer of non-drainage surgery and the use of external episcleral plombs. Gregory Keith was determined to use this technique in preference to the current methods which included scleral resection and intrascleral silicone rubber. Gregory taught John Scott how to use the indirect ophthalmoscope, then a new instrument.

Two early moments sparked John's interest in retinal detachment surgery. The first was when he found a retinal tear in a patient with retinal detachment that Gregory had not been able to find. The other incident concerned a patient with a retinal detachment in an only seeing eye who went blind as a result of complications from scleral resection.

John got on the House at Moorfields Eye Hospital in 1964 where he worked with Lorimer Fison and pursued his interest in retinal detachment surgery. He saw a patient who had been referred with bilateral giant retinal tears, the treatment of which was considered to be hopeless. John Scott had read Paul Cibis' book on vitreoretinal surgery which described silicone oil as a treatment method. Together with Mr Rolf Blach, a Fellow in the retinal service, he got hold of some silicone oil and was successful in treating one eye but unsuccessful in treating the eye which had a much larger tear.

In 1967, at the age of 30, Mr Scott was appointed as Consultant Ophthalmic Surgeon at Addenbrooke's Hospital to develop a retinal detachment service for East Anglia. It was a condition of the appointment that he visit the USA to study their techniques for retinal detachments.

Paul Cibis had worked in St Louis but had died two years before. His colleague, Ed Okun, introduced Cibis' patients and John was so impressed with the results that he decided to continue his work using silicone oil to treat complex retinal detachments. Ed Okun gave him the silicone oil that Dr Cibis had not used and the blueprint for the silicone oil syringe.

John Scott returned to Cambridge where he ensured that the staff were trained to use the binocular indirect ophthalmoscope and to draw accurate, detailed diagrams of the detached retina. He decided to treat retinal detachment cases with what is now conventional surgery but at that time was regarded as revolutionary. This included direct observation of the retina with the indirect ophthalmoscope while performing the non-drainage surgery.

Local patients with complex retinal detachments, patients with failed retinal detachment surgery and diabetics with



The 2010 Honorary fellows and their supporters with the late President. Mr John Scott is seated, to the far left.

late complications of retinopathy were referred. The Addenbrooke's instrument workshop made a silicone oil syringe from Cibis' blueprint but John modified Cibis' technique and used the silicone oil to achieve the separation of the proliferating membranes. Soon he was receiving national and international referrals.

John tried to persuade his colleagues that some of the conditions then regarded untreatable could be treated successfully using the right technique. His use of liquid silicone in posterior segment surgery generated much criticism and John had to defend his views in many quarters worldwide in sometimes quite hostile environments. Uncontrolled studies into the effect of intravitreal liquid silicone on the rabbit retina had shown it to be toxic but controlled studies showed that liquid silicone oil had no toxic effect on the function of retina.

Amazingly, John Scott carried out all his surgery on the retina using the indirect ophthalmoscope holding the silicone syringe in one hand and the indirect lens in the other hand. A local firm of metal workers forged an operating table for treating giant retinal tears in which the patient was suspended upside down (underneath the table) while the surgeon operated from beneath, sometimes lying down on the floor on his back.

I had the privilege of working with John as his Senior House Officer and Registrar for over two years. He has the exceptional gift of being ambidextrous and I marvelled the results that he was able to achieve with nothing other than the tip of a needle at the end of the silicone oil syringe.

John Scott retired about 10 years ago but his pioneering contribution to the treatment of retinal detachment will be remembered forever by the profession. It is a great pleasure and an honour to present John Scott, a worthy recipient of an honorary fellowship of the Royal College of Ophthalmologists.

*Mr Liaquat Amanat
Council representative for East Anglia
2008-2011*

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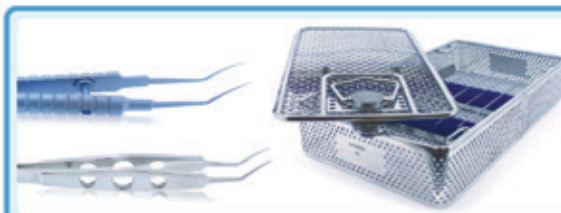


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College Seminar Programme 2011

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

29 June

Focus on DMO Regional Symposia
Chaired by: Professor Yit Yang & Mr Salman Mirza
Birmingham

7 – 8 July

Retinal Imaging Seminar

Chaired by: Mr Heinrich Heinmann & Professor Yit Yang
The Institute of Physics, 76 Portland Place, London

6 September

The Future Management of Glaucoma: Virtual Clinics, Electronic Patient Records and Shared Care

Chaired by: Professor James Morgan

15 September

Paediatric Amblyopia and Strabismus

Chaired by: Mr Mike Clarke and Mr Robert Taylor

13 October

Medico-legal Seminar
Chaired by Professor Charles Clark and Mr Graham Kyle

15 November

Revalidation in Ophthalmology

Chaired by: Mr Richard Smith

18 November

Elizabeth Thomas Seminar

Chaired by: Mr Winfried Amoaku
The East Midlands Conference Centre, Nottingham

Please visit

www.rcophth.ac.uk/seminars
for further details.

College Skills Centre Programme 2011

Details are on the website at
www.rcophth.ac.uk/bmscourse

Training the Trainers

20 September Day 1

What to teach and How to teach

14 October Day 2

Appraisal and How to teach practical skills

3 November Day 3

Assessment

21 November Day 4

Trainees in difficulty

Please visit

www.rcophth.ac.uk/trainingthetrainers
for further details.

SAS National Eye Day

21 October

Manchester Novotel
penny.jagger@rcophth.ac.uk

Ophthalmic Trainees' Group

19 November

The East Midlands Conference Centre, Nottingham

Open to those with an interest in ophthalmic training: ophthalmic trainees, SAS doctors, junior doctors interested in a career in ophthalmology and medical students.

It is a relaxed, informal day meeting, with highly-regarded speakers giving talks on real-world aspects of ophthalmology. Topics include: passing the new Part Two FRCOphth, using technology to enhance training, working internationally (especially in less-developed countries), along with pearls from life as an ophthalmologist from a panel of consultants. Registration is £45

www.rcophth.ac.uk/otgsymposium

Other Events 2011

7 – 8 July

Cornea and Oculoplastics Course

Unit, Queen Victoria Hospital, East Grinstead
cpcourse@qvh.nhs.uk
www.corneaoculoplasticscourse.org

7 – 9 September

41st Cambridge Ophthalmological Symposium

St. John's College, Cambridge
Chairman: John Dart
bm.ashworth@tiscalli.co.uk

15 – 17 September

The Banff Translational Glaucoma Meeting

Banff, Alberta, Canada
trottier@ualberta.ca
<https://uofa-cs.gobigevent.com/btgm2011>

1 October

OCULUS – Practical OSCE and viva revision for Part 2 Fellowship

Course Chair – Professor Phil Murray
Birmingham & Midlands Eye Centre
lisa.ford4@nhs.net
www.oculus-course.com

13 – 14 October

UKISCRS 35th Annual Meeting

Convention Centre, Southport
ukiscrs@ukiscrs.org.uk
www.ukiscrs.org.uk

28 October

City Road Reunion

The Medical Society of London, London
t.fytche@btinternet.com

18 November

MCLOSA (Medical Contact Lens and Ocular Surface Society) 18th Annual Scientific Meeting

One Great George Street, Westminster, London.
chemmendinger@google.mail

Other Events 2012

22 February–5 March 2012 Ophthalmology Study Tour to Cuba

Cuba's healthcare system is a fascinating model for the rest of the world, and now there is an opportunity to examine it in the context of the ophthalmology profession. The tour, led by Professor Christopher Liu, visits Havana, the lovely Vinales Valley, the Sierra Escambray Mountains and the beautiful baroque city of Trinidad. It combines talks from local speakers with professional visits, meetings and a full range of cultural tours. Extended time in Havana or on a Caribbean Beach is optional. Contact Jon Baines Tours on 0207 223 9485 or email on info@jonbainestours.co.uk

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