

College NEWS



Autumn
2011

Anti-VEGF agents in age-related macular degeneration (AMD)

In the UK, ranibizumab (Lucentis) is licensed for the treatment of the neovascular form of AMD and has NICE approval for use in the NHS, where it is routinely prescribed. Bevacizumab (Avastin) has a very similar mode of action but is not licensed for AMD treatment, though it is widely used in many countries. Experience from clinical practice suggests that the drugs may have similar safety profiles; the CATT study results have demonstrated the non-inferiority of bevacizumab when compared to ranibizumab.

Current College advice is to follow the NICE guidelines and to use ranibizumab, the licensed treatment. However, several PCTs have been in discussion with ophthalmologists about using bevacizumab, which is significantly cheaper, in preference to ranibizumab. This raises important and complex issues that warrant review.

If bevacizumab has equal efficacy and there are no major safety issues what is holding back its use within the NHS? There are a number of key concerns:

- What is the legal position of an ophthalmologist who uses a non-licensed drug where a licensed drug is available for the same disorder?
- What is the position on informed consent – should individual patients be asked to give consent to be treated with a cheaper non-licensed drug where there is an alternative licensed drug?
- Are there any differences in the safety profiles of the two drugs?

- Will the cost of ranibizumab lead to restrictions in other areas of ophthalmology?
- The use of cheaper, non-licensed drugs will reduce the financial returns to pharmaceutical companies who have, at great expense, developed drugs that have been through all the regulatory hurdles. Will this limit future research into new treatments?

The College is tackling this issue in a number of different ways which may result in revised guidance:

- The President has written to the General Medical Council for its view on the use of cheaper non-licensed drugs where an alternative licensed drug exists for the same indication.
- College officers have an autumn meeting scheduled with Sir Michael Rawlings, Chairman of NICE.
- A small group of senior medical retina experts will review the published evidence on the relative efficacy and safety of the treatments.
- The College will urgently press the NHS Executive to commission a review by NICE and the MHRA so that a consistent policy can be adopted by the NHS.

Professor Tony Moore
Chairman of the Scientific Committee

The College launched an appeal against the NICE decision to stop ranibizumab for the treatment of diabetic macular oedema. It will be heard in October 2011.

THE ADVISORY COMMITTEE ON CLINICAL EXCELLENCE AWARDS (ACCEA)

The Review Body on Doctors' and Dentists' Remuneration reported on ACCEA in July 2011 but its fate remains unknown.

The College is working on the basis that the 2012 round for England will proceed as normal. Consultants wishing to apply for an award should visit www.rcophth.ac.uk for updates. It is likely that forms will have to be submitted to the College by 3 October 2011 for scoring.

3	Members' News and Appointments
5	Focus
7	Museum Piece
9	Patients with Learning Disabilities
11	Bird Shot Day
12	Orbis
13	Congress reports
16	Education, Training and BOSU
18	Diary

Please tell us if you move
database@rcophth.ac.uk

Articles and information to be considered for publication should be sent to:
kathy.evans@rcophth.ac.uk
and advertising queries should be directed to:
Robert Sloan 020 8882 7199
robertsloan@virginmedia.com

Copy deadlines

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

New Vice President, Chairman of the Training Committee

Mr Mike Hayward will succeed the outgoing chairman, Miss Carole Jones, with effect from 12 September 2011. Miss Jones muses on her change of career below:

Renew, retread, retire?

The concept of change for change's sake is a dangerous one but the one certainty in life is that we will not be here forever. Medicine has a long training course, and it is an absorbing career, but what of the things we left to one side, the hobbies we left for our studies and the skills we never fully honed?

In the spirit of this, and after a few life events which reminded me that I was far from immortal, I decided to return to an earlier passion, the stage. At the age of 15, I made the mistake of netting a clutch of good GCE grades and from then on it seemed foolish not to pursue a sensible and rewarding career. But how to change, and what of my present career?

The NHS is, in many respects, a generous employer. There are three options once you reach 50: retire and take a pension, albeit reduced; defer your pension until later; or take a career break. The latter is available to all employees who have worked at least two years, and allows up to five years away from work. The condition is that the employee does not earn during their career break, but it allows the luxury of a fallback position.

So beginning on the first day of the next academic term, and after the repeated ritual humiliation of auditions, I start an MA in drama. Will I be any good? Will I survive? Will I miss the leading role I already have? Time will tell.

I recommend this course of action to those who need time to exhale and explore.

My role in the College has been taken over by Mike Hayward, so I know the organisation is in excellent hands. And I will be watching with great interest from the wings.

Miss Carole Jones

EYE: Your journal needs you!

Eye is the official journal of The Royal College of Ophthalmologists and is committed to publishing high quality, independently peer-reviewed research and review material. It aims to provide the practising ophthalmologist with information on the latest clinical and laboratory-based research. Whilst principally aimed at the practising clinician, the journal contains material of interest to a wider readership including optometrists, orthoptists, other healthcare professionals and research workers in all aspects of the field of visual science.

Manuscripts submitted to Eye are peer-reviewed by experts from all over the world who volunteer their time to help ensure every issue is filled with high quality articles. In 2010, reviewers completed an average of 1.6 reviews each.

Eye is looking to expand its current database of reviewers and would very much like to hear from anyone who could lend a little of their time and expertise to help Eye remain one of the UK's leading ophthalmic journals.

To sign up, please contact: eye@rcophth.ac.uk.

PS: We are finalising a way of thanking reviewers. The details are still being thrashed out but reviewers who complete a certain number of reviews in a year will be offered a free one-year online subscription to Nature.

EYE: The Digitization Project

The College joined forces with Nature Publishing Group (NPG) in 2002. NPG has generously funded the digitization of EYE journals 1987-2001 and the results are on the website.

Focus correction

There was an error in the Spring 2011 issue on The surgical management of infantile cataract. The article should read:

"In contrast, Birch et al. found a bilinear relationship of visual acuity with age at surgery, with a breakpoint of around 14 weeks. In their series of 37 patients treated for dense bilateral cataracts he estimated that there would be a one-line decrease in the final LogMAR acuity for every three weeks that surgery is delayed in the first 14 weeks." (not: "every week" as erroneously printed).

The Wales eye patient advocacy service – three-year project

RNIB Cymru has been awarded £362,504 from the Big Lottery Fund Board to fund the expansion of the hospital eye clinic liaison service. Working in seven new hospitals across South, West and North Wales, it will help and support people to come to terms with sight loss.

Changing Faces seeks ophthalmologist for advisory committee

This UK charity, based in London, gives support and information to people with disfigurements to the face, hands or body, and to their families. It wants to provide more psychosocial care for people who look visibly different following surgery for head and neck cancer. suec@changingfaces.org.uk

Members' News and Appointments

Consultant Appointments

We rely on medical personnel departments to confirm consultant appointments. Please contact aac@rcophth.ac.uk if you notice an error or omission.

Mr Romesh Angunawela	Moorfields at St George's, London
Mr Sanjay Choudhary	Glan Clwyd Hospital and Wrexham Maelor Hospital, Wrexham and Rhyl
Mr Jonathan Clarke	Moorfields Eye Hospital, London
Mr Amir Hamid	North East London NHS Treatment Centre, Ilford
Miss Amanda Lewis	Sussex Eye Hospital, Brighton
Ms Sarah Mackenzie	Harrogate District General Hospital, Harrogate
Miss Margaret Minasian	Hillingdon Hospital, Uxbridge
Miss Rachel Pilling	Bradford Royal Infirmary, Bradford
Mr Ahmed Sallam	Cheltenham General Hospital, Cheltenham
Mr Saanan Umeed	Ysbyty Gwynedd Hospital, Bangor

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
December 2011	Mr Tin Chan	South Yorkshire & South Humberside	No
December 2011	Mr Mark Watts	Mersey	No
March 2012	Mrs Veronica Ferguson	North West Thames	Yes
March 2012	Mr Nabil Habib	South Western (Peninsular)	Yes
March 2012	Mr Jeremy Diamond	South Western (Severn)	Yes
March 2012	Mr Gerard McGinnity	Northern Ireland	No
March 2012	Miss Caroline Cobb	Scotland East (Dundee)	Yes

City Road reunion.

Friday 28th October 2011 at the Medical Society of London. There are still places available for the reunion lunch for those appointed as residents or consultants to the City Road Branch of Moorfields before 1990. Please contact Tim ffytche at: t.ffytche@btinternet.com or by post to 1 Wellington Square, London, SW3 4NJ

Possible photographic club

Lt Col Ravi Goel was recently awarded Licentiate status by The Royal Photographic Society. Any members interested in forming an ophthalmic photographic club should contact him directly: ravigoel.t21@btinternet.com

Professorial appointments

James Bainbridge has been appointed to the Chair of Retinal Studies at UCL Institute of Ophthalmology and Moorfields Eye Hospital London. As a surgeon-scientist, he uses a broad translational approach to develop novel interventions for a range of retinal disorders, including inherited diseases, diabetes and AMD. He has established a programme of research that extends from laboratory investigation, through preclinical development of therapies, to clinical trials of new medical and surgical interventions.

Caroline (Carrie) MacEwen has been appointed Honorary Professor of Ophthalmology at The University of Dundee. She is currently Senior Vice President of the College and chairs the Examinations Committee.

Marcela Votruba has been appointed Honorary Professor at the School of Optometry and Vision Science at Cardiff University.

Obituaries

We note with regret the death of:
Mr Thankarajah Arulampalam
Mansfield, Nottinghamshire
Dr Dennis Roux McCartney
Umhlanga Rocks, South Africa

The MRC/RCOphth John Lee Fellowship

We have successfully raised over £83,000 in eight months. We have formed a small committee to develop a long-term fundraising strategy for this most worthy aim and seek an ophthalmologist to join. For further details, please contact penny.jagger@rcophth.ac.uk Donations can be made at www.justgiving.com/rcophth/donate

Mardeno's Ophthalmology Atlas

This guide is designed to help clinicians explain conditions to patients. The company is looking for an ophthalmologist to help with the editorial process. grainger@mardeno.co.uk



HS JOHN WEISS
INTERNATIONAL

EVER INCREASING CIRCLES

Innovative additions
to the Weiss range of
capsulorhexis forceps:



Gutierrez-C Combi Microforceps-Scissors

Grasp and cut in one manoeuvre through a
sub 1mm incision.

"Extra Fine" Capsulorhexis Forceps

Round or Flat Handle, for 2.0mm incisions.



JOHN WEISS

Ophthalmic Surgical Instruments

John Weiss & Son Ltd.

89 Alston Drive, Bradwell Abbey, Milton Keynes, MK13 9HF, United Kingdom
Tel: +44 (0)1908 318 017 Fax: +44 (0)1908 318 708 Web: www.johnweiss.com

Focus



**Autumn
2011**

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

Pterygium Surgery

*Mr Parwez Hossain PhD FRCOphth FRCS (Ed)
Southampton General Hospital,
Southampton*

Pterygium is a relatively frequent condition where a wing-shaped fold of conjunctiva with fibrovascular tissue invades the superficial cornea. The condition is often preceded with degenerative changes occurring in the interpalpebral bulbar conjunctiva such as pingueculum.

The prevalence of pterygium varies from 1 to 15% depending on the geographical location of the population under analysis¹. The main risk factors are the total exposure to ultra-violet (UV) light and increasing age¹. One plausible hypothesis for its pathogenesis is that the effects of UV radiation causes actinic change in the conjunctiva layers, resulting in abnormal growth². This growth may be exacerbated by hot, dry or windy environmental conditions. Those patients with lifestyles that have greater exposure to these conditions e.g. outdoor pursuits and residence in sunny environments, have a greater risk of developing pterygia^{1,2}.

The main clinical considerations are the effect of the pterygium on the patient's vision, the possibility of malignant change, the presence of ocular irritation and cosmetic appearance to the patient. These factors will determine whether surgery is justified.

Malignant change: If a patient presents with a 'pterygium' and the lesion affects the temporal limbal margin or has gelatinous appearance, or the head is surrounded by translucent/frosted-appearing epithelium with suggestion of pagetoid spread, then exclusion of an underlying diagnosis of carcinoma in situ (Bowen's Disease) is necessary. As it can be difficult to determine such changes by direct clinical examination (especially in redo surgery), it is vital that all pterygium excision samples are sent for histopathological diagnosis for exclusion of malignant change. One report suggested about 10% of pterygium show changes consistent with ocular surface squamous epithelial neoplasia³. Thus for patients with recognisable malignant changes prior to surgery, the clinician should consider referral to an ocular surface neoplasia specialist for further management.

Prevention?: So far there is no proven method of prevention of pterygium, but limiting exposure to UV light, to dry and dusty environments could help progression. Protection from these factors can be achieved by wearing protective eyewear that has good ultraviolet blockage. Close-fitting wraparound sunglasses can help for these purposes as they protect the eyes from both radiation and air borne particulate matter.

When to operate?: Surgery was not undertaken until absolutely necessary in the past, due to the high recurrence rates, up to 40%, in particular with recurrent pterygia⁴.

Over past decade significant improvements in outcomes from pterygium surgery have been made. This is largely related to the widespread adoption of conjunctival auto-grafting, reducing the rate of recurrence to <10%^{5,6}.

As a pterygium progresses it approaches the visual axis and may lead to a reduction in visual acuity as it may cross the centre of the cornea. The progression may be very slow over several years or rapid over several months. An advanced pterygium, which involves the visual axis, is associated with a poorer visual and cosmetic outcome with higher rates of recurrence.

Because of the reduction in recurrence rates, the threshold for surgery has reduced and earlier surgery using the latest techniques should be considered. However, patient's expectations have been replaced with concerns of post-operative scarring, comfort and final cosmetic outcome. These factors should be discussed with the patient prior to any surgical intervention.

If the pterygium causes symptoms of ocular irritation or appears unsightly then it is reasonable to consider surgery irrespective of its size. It may be better to operate earlier.

Pterygium surgery techniques: The main problems with pterygium surgery are the problems with post-operative recurrence and scarring. There are also risks from surgically induced astigmatism and the consequent effect on uncorrected vision.

The aim for the surgery is remove the pterygium in such a way that regrowth does not occur. The key objectives of surgery are to:

1. Remove the pterygium completely and ensure histological diagnosis.
2. Reduce the risk of corneal scarring.
3. Reduce the effects on astigmatism.
4. Achieve rapid post-operative corneal epithelial healing.
5. Reduce the chances of recurrence.
6. Reduce the chances of post-operative scarring.
7. Achieve a comfortable post-operative recovery period with minimal levels of inflammatory activity.

Simple excision with direct closure and bare sclera technique Simple excision and direct closure of the conjunctiva carries a high risk of recurrence. Although the rate of recurrence will

depend on the size of the lesion, the rate of recurrence can be as high as 90%⁶. In the bare sclera technique, an exposed area of sclera is left and allowed to fill the bare area by scarring, which in turn acts as a barrier to pterygium regrowth, while allowing the cornea to re-epithelialise before any regrowth reaches the limbal area. Despite the theoretical advantages of this procedure and the potential of combining adjunctive therapy such as beta irradiation, mitomycin C and human amniotic membrane grafting, the method is associated with recurrence rates as high as 40%⁶.

Primary pterygium excision with conjunctival autografting using fibrin glue: The main developments in pterygium surgery in the last ten years have been the widespread use of auto conjunctival grafting, especially of limbal autoconjunctival grafting and the use fibrin tissue adhesives⁴⁻⁶. When these are combined, the recurrence rates can fall to below 10% with additional reductions in post-operative scarring and improvements in patient comfort⁶.

Cases are performed under local anaesthetic (using peribulbar or retrobulbar anaesthesia). However, in younger/nervous patients, general anaesthesia is used.

Surgically, the pterygium base, limbal margins are first marked. The area within the marks is injected with local anaesthetic containing adrenaline under the conjunctiva. This injection allows the pterygium to 'balloon-off' the ocular surface. The pterygium covering the corneal area is separated from the corneal tissue using a lamellar corneal blade, aiming to leave the remaining anterior corneal surface as smooth as possible. Blunt dissection is then used to lift the pathological area over the sclera. Minimal cautery is applied to any bleeder vessels. The total amount of cautery is kept to a minimum; in order to reduce cautery associated scarring. Only the fibrovascular tissue within the pterygium is excised, keeping any Tenon's and caruncle tissue that is left undisturbed.

The dimensions of the deficit in the conjunctival limbal area and bulbar areas are measured and a similar size of limbal conjunctival autograft is measured. The typical harvest site is the superior bulbar conjunctiva. A distinctive marking system is used to allow the surgeon to distinguish between the epithelial and stromal surface of the graft as well as the limbal posterior margins of the graft.

A 27-gauge needle attached to a small syringe containing local anaesthetic with adrenaline is inserted outside the area to be harvested with needle placed just below the conjunctival surface. The anaesthetic is then injected so the potential graft tissue 'balloons-up'. The graft tissue is gently dissected so that a thin, even layer of conjunctival graft tissue is removed. The limbal area of the graft up to clear cornea is dissected off the cornea limbus, taking care not to buttonhole the conjunctiva or go too deeply into the corneal limbus.

Use of fibrin glue: Fibrin glue was shown to reduce recurrence rates, post-operative discomfort and surgical time. Fibrin glue is a blood-derived product that consists of two components: fibrinogen and thrombin. When the two components are mixed, fibrinogen is activated by the thrombin and converted to fibrin, which acts as the tissue adhesive. In addition to the adhesive effect, fibrin also reduces intraoperative bleeding and post-operative inflammation. With the significant reduction in the operating time, this can easily offset the cost of the glue.

Technique to apply the glue: The glue is mixed as separate components and kept at 37°C until use. Each component is drawn up separately in labelled 1ml syringes just before use (attached with 27G needle). Thrombin is applied to the exposed area of sclera/subtenon's tissue from excised pterygium. The auto-conjunctival graft is then positioned 'sunny side down' over the cornea (i.e. with epithelial side down), taking care to flatten it out as single untwisted layer of tissue. Fibrinogen glue

(one drop) is applied to the graft, where the drop will spread evenly over its stromal surface. The whole graft is picked up with non-toothed corneal forceps and then positioned and 'ironed out' over the exposed sclera, ensuring the correct orientation of the graft tissue, making sure it is epithelial side-up, limbal areas of the graft appose the limbal recipient site etc. It takes approximately 10 seconds before the glue sticks, so this manipulation has to be done in this time i.e. before the glue sets! After the graft is stuck, then to the non-limbal edges of the graft, single drops of fibrinogen are placed between the graft-recipient junctions to seal the graft host junction.

What happens if the glue is set and the graft not in an optimal position?: If the graft is misplaced and glued in the wrong position or orientation, then the graft can be 'peeled off' and glue over the host site removed. The process of applying the glue in two components is redone until a satisfactory surgical result is achieved.

The optimal temperature for glue setting is 37°C; if the ambient temperature is lower or the glue components are cooler, it will take longer for the glue to set.

Application of adjunctive therapy - Mitomycin C: This is used for patients at high risk of recurrence or scarring, including under 40 years of age, previous surgery, long-term use of eyedrops, double pterygium, and patients with high risk of keloid. Mitomycin C 0.04mg/ml is applied to the exposed sub-tenon's layer and the sub-conjunctival area with at least 2mm surrounding the area of the original pterygium. This is applied using 1mm X 1mm surgical sponge pieces, which are placed over this area. Counts should be made of the number of sponges placed, so that none are retained in the eye post-operatively.

At the end of the procedure, topical antibiotic and steroid ointment is applied with an eye pad. The patient is given a course of topical antibiotic and steroid ointment for approximately one month. Clinical follow-up is made at one month post-operatively, ensuring the histopathological results are at hand. Patients are advised to take three days off work to allow for post-operative pain and discomfort.

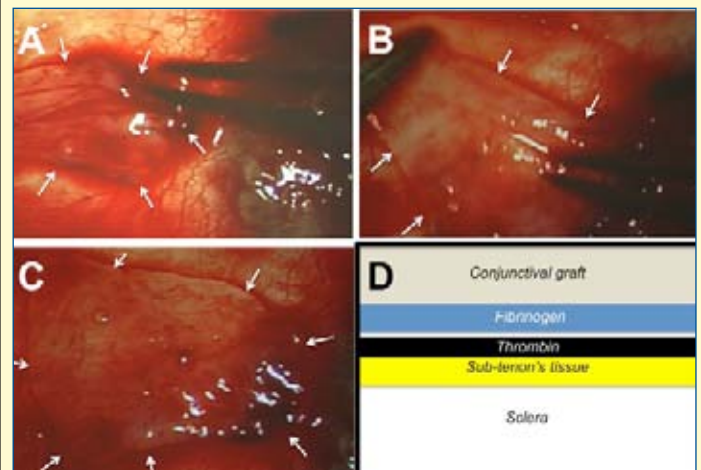


Figure 4. Adhesion of autograft to recipient site. A) Autograft is turned with epithelial side-up and orientated so that limbal area of donor area (purple mark on photo) is placed in a similar location to the recipient site (white arrows edges of conjunctival auto-graft). B) The autograft is then 'ironed-out' so that it covers the maximal area in the recipient site., this should be done within 10 seconds C) The edges of the graft are apposed to the host margins and spots of fibrinogen components are applied to seal the edges. D) Autograft Glue Sandwich: Layer arrangement of tissue and fibrin glue components, thrombin should ideally placed first on the base and fibrinogen on top, this allows more controlled glue adhesion.

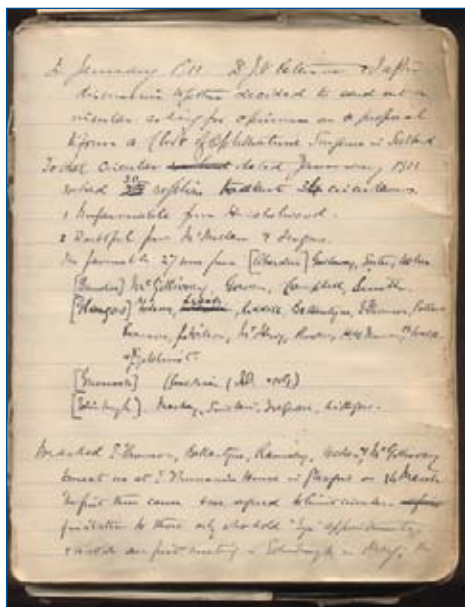
References:

1. Saw SM, Tan D. Pterygium: prevalence, demography and risk factors. *Ophthalmic Epidemiology* 6(3):219-28, 1999
2. Coroneo MT, Di Girolamo N, Wakefield D. The pathogenesis of pterygia. *Current Opinion in Ophthalmology* 10(4):282-8, 1999
3. Hirst LW, Axelsen RA, Schwab I. Pterygium and associated ocular surface squamous neoplasia. *Archives of Ophthalmology* 127(1):31-2, 2009
4. Ratnalingam V, Eu AL, Ng GL, Taharin R, John E. Fibrin adhesive is better than sutures in pterygium surgery. *Cornea*. 29(5):485-9, 2010
5. Koranyi G, Seregard S, Kopp ED. Cut and paste: a no suture, small incision approach to pterygium surgery. *British Journal of Ophthalmology* 88(7):911-4, 2004
6. Pan HW, Zhong JX, Jing CX. Comparison of Fibrin Glue versus Suture for Conjunctival Autografting in Pterygium Surgery: A Meta-Analysis. *Ophthalmology* 118(6):1049-54, 2011

The Scottish Ophthalmological Club's centenary



William G Sym, co-founder



Original written note of Club



James V Paterson, co-founder



Programme of first meeting

outstanding international reputation in ophthalmology with people such as William Porterfield, James Wardrop, William Walker, William Mackenzie, George Monteath and Douglas Argyll Robertson all at the forefront of their profession.

A few Scottish ophthalmologists had travelled south to attend the Ophthalmological Society of the United Kingdom which was formed in 1880 and two, Argyll Robertson and George (later Sir George) Berry, had achieved the highest office of president. After the formation of the Club, Scotland produced further presidents with Maitland Ramsay (1922), Usher (1927), Sinclair (1931), Traquair (1943), Ballantyne (1946) and Scott (1970). Wallace Foulds (1981) went on in 1988 to become the first president of the newly formed College of Ophthalmologists. Jeffrey Jay (1997) was the first Scottish president to be elected after the College received Royal assent.

In 1911, however, it was felt that the new knowledge in ophthalmology arising from the 1851 invention of the ophthalmoscope should be more widely propagated in Scotland through its own organisation.

William G Sym and James V Paterson convened the first meeting of the Club on 26 May 1911 in the eye department of the Royal Infirmary, Edinburgh. There were 35 items on the agenda and the presenters were chosen by ballot. Among them Dr George MacKay, Chairman for the session, gave a paper on trephining for the relief of glaucoma, Dr HM Traquair exhibited an apparatus for iontophoresis and AHH Sinclair demonstrated the new tonometer as invented by Schiotz.

Dinner for the 16 of the initial 18 members was held at the Caledonian Station Hotel, Edinburgh (6/- and morning dress!) and, as prescribed, there were no speeches excepting a toast to the King and the Club. The same hotel will host the centenary dinner for the Club. Unlike the first meeting when informality was taken seriously with no president or constitution, the Club today has a president, Carrie MacEwen, a constitution and there will be speeches.

From its commencement, the Club has held two meetings a year generally alternating between Edinburgh and Glasgow but occasionally going to Paisley, Aberdeen and Dundee.

The 100th SOC Meeting was held at the Royal College of Surgeons, Edinburgh on 3 June 1967 and was very well attended.

In this centenary year, the RCS(Ed) will hold a public exhibition, "Sight for Scotland", which is curated by Dr Geoffrey Millar and Chris Henry.

The main celebrations will take place at the Edinburgh International Conference Centre on 8 and 9 September with the first day mainly devoted to a symposium, "The First Hundred Years and Beyond", to honour the contribution of past Scottish ophthalmologists. While the founding members of the Club might mourn the lack of informality at the centenary, they would be amazed at the incredible advances in their profession over the last 100 years. Above all they would be very proud to have been part of these developments by founding the Scottish Ophthalmological Club.

A full history of the Scottish Ophthalmological Club, "A Centenary History" has been edited by GT Millar and is available from Professor MacEwen for £15 plus postage and packing. Please contact c.j.macewen@dundee.ac.uk

One hundred years ago, in 1911, a club was formed in Edinburgh which was to meet twice a year for the main purpose of the demonstration and discussion of ophthalmological cases. It also provided an opportunity for members to present new instruments and methods in ophthalmic practice. It was called the Scottish Ophthalmological Club.

It set out to be an informal gathering of members, with strong emphasis on the social side. Scotland already enjoyed an

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

New

VISALIS® 500

**There are
solutions ...
then there
is the Zeiss
solution ...**



- Modular phaco and vitrectomy system for anterior and posterior procedures.
- Captivating design with exceptional ergonomics
- Flexible and efficient performance technologies
- Excellent integration into the surgical workplace



Carl Zeiss Ltd
Medical Division

www.zeiss.co.uk

PO Box 78, Woodfield Road
Welwyn Garden City Herts AL7 1LU
Tel: 01707 871250 Fax: 01707 871366
E-mail: so-admin@zeiss.co.uk



We make it visible.

Managing eye care in people with learning disability (PWLD)*

Looking after the health needs of people with learning disability (PWLD) is challenging for the patient, their carers and the healthcare team. There is a paucity of training and experience at all levels and most clinicians are unaware of the resources available to support them.

There are about 1 million PWLD adults in the UK and:

- The estimated prevalence of certifiable visual impairment is 9.3%.
- PWLD are 10 times more likely to have serious sight problems than other people.
- PWLD or their carers may not know they have a sight problem or be able to articulate their frustration due to failing sight.
- PWLD need to have a sight test at least every two years.

PWLD have the same rights of access to NHS ophthalmic services as everyone else and legislation requires that reasonable adjustments be made to meet their needs. Ophthalmic assessment is often most successful when care staff have been trained to support people having eye tests, clinic appointments and surgery. Non-clinicians and family carers supporting the patient need to anticipate potential difficulties and work with eye care professionals to ensure the patient's understanding and co-operation.

The College has recently published guidance on the subject. www.rcophth.ac.uk/core/core_picker/download.asp?id=944&filetitle=The+management+of+visual+problems+in+people+with+learning+disabilities

The guidance contains many examples of the reasonable adjustments that ophthalmologists can promote.

Here are just a few:

Be proactive in identifying PWLD – working with GPs to ensure a patient's learning disability is flagged so that measures can be put in place to facilitate clinic visits

Be aware that PWLD may have a written health record – this will help the team understand how the patient communicates, their likes and dislikes, such as a fear of dark rooms

Work closely with carers to accommodate each patient's individual requirements – to help make the most of each appointment and plan future care effectively

Resist departmental protocols which routinely discharge patients who do not attend – residential or day care staff may be unaware of an appointment or inadequately staffed to allow patients to attend clinic

Act as advocates for PWLD, highlight areas of inequality and work with commissioners to enable access to services – to include provision of suitable information and access to screening services

Be aware of local services which support PWLD to gain access to eye tests – liaison with optometrists is essential to develop pathways for referral and management in secondary care. It is an ideal opportunity for promoting pre-appointment information and familiarisation visits.

The impact of improving vision on quality of life in this population cannot be overestimated. Caring for PWLD cannot fall to a few doctors with a special interest: improving ophthalmic care relies upon very small changes in practice by the profession as a whole.

Miss Rachel Pilling, Consultant Ophthalmologist

Eye care for adults with learning disabilities – a personal perspective

Nothing could ever have prepared me for the heart-breaking enquiries I received during my 21 years at RNIB and SeeAbility's Look Up information services. I was frequently shocked by the neglect of the eye care needs of adult PWLD and the prejudice voiced by some professionals to support staff and parents.

- Many never had an eye test. Visual impairment was often not identified until middle age. The oldest was 84 years old, "newly identified as being born with a visual impairment".
- Lives were spoiled by uncorrected refractive errors. An elderly "blind man" taken for an eye test was actually myopic. Once his refractive error was corrected, he urgently wanted to learn to read but was concerned that time was running out! A "severely disabled man" in his mid 30s immediately became continent when he could see his way to the toilet wearing his new glasses.
- Changes in behaviour would be misinterpreted. "Challenging behaviour" would be attributed to a learning disability, dementia or even abuse – but in fact the person was upset by deterioration in their vision. Sight loss is a frightening experience, especially for those who do not understand why their world has changed and cannot communicate their anxiety to others.

Progress in eye care for PWLD since the 1995 Disability Discrimination Act

Progress has been considerable yet there is a mass of evidence that PWLD continue to receive poor health care that does not acknowledge their individual needs.

Two quotes from support staff will remain with me:

"The first ophthalmologist took the view that Jodie was too disabled for surgery. The second said Jodie needed his sight as much as anyone else and happily did the operation".

"I had expected a battle to get him an operation. But the doctors all took the view that he would be devastated if he went blind. The hospital staff were brilliant – they made 'reasonable adjustments' and we had a wonderful outcome".

PWLD have equal rights of access to NHS ophthalmic care services. They may need special support to benefit from treatments and this must be made available; ophthalmologists are uniquely placed to make the changes needed.

Gill Levy, Member of the Lay Advisory Group

* with apologies for the abbreviation but space is at a premium

SD HEALTHCARE

Specialists in
Single-use procedures

High Quality Instrumentation • Flexible on Quantities • Professional Service

Brand New Every Time

Quality Single-use
Sterile Ophthalmic
and Refractive
Instruments

I/A's

Individual Instruments

Complete Packs

surgitrac
instruments

First-ever UK birdshot patient day

Birdshot chorioretinopathy is a rare, poorly understood chronic, bilateral form of posterior uveitis that affects individuals of all ages and can lead to irreversible visual loss.

The Birdshot Uveitis Society (BUS) joined forces with medical professionals from Moorfields Eye Hospital NHSFT, Guys and St Thomas' NHSFT and Pitie-Salpetriere University Hospital, Paris, to cover topics such as: what is birdshot; symptoms, diagnosis and prognosis; tests and monitoring; current treatments; and latest information on birdshot, new trials, and research. The afternoon sessions were more patient focused, with Mike Brace CBE, Chief Executive of VISION 2020 (UK) speaking about how he coped with blindness and Phil Hibbert talking about how he came to set up the Uveitis Information Group, after he was diagnosed with uveitis.

A total of 126 people attended the day which was a huge success (as evidenced by the six-month evaluation) because it:

- Allowed learning across patients and professionals
- Informed about latest treatments and thinking
- Addressed patients' concerns through questions and answers
- Allowed networking, experimenting with low vision aids and learning about other services
- Expressing how it feels to have birdshot through art
- Established a large cohort of patients who gave their

views on research priorities, enabling a research network (BRN) to go forward and flourish

- Raised the profile of the disease.

Rea Mattocks of BUS said: "Feedback from patients showed an overwhelming view that it had reduced their sense of isolation and given them renewed hope for their futures."

A DVD of the day has been produced and has been distributed to eye departments across the UK. If you have not received your copy, please contact: birdshot@uveitis.net. A 5-minute DVD is available at: <http://birdshot.org.uk/6670>

The next birdshot day will take place in March 2012.

Details will be posted on <http://birdshot.org.uk/patientday>. UK consultants interested in being a part of the Birdshot Research Network (BRN) are welcome to join the existing members of the BRN at 11am on Tuesday 18 October 2011 at Birmingham and Midland Eye Hospital (Organiser Prof Murray). Contact BUS at birdshot@uveitis.net for further details.

The next patient engagement day to be organised by the PPI team at Moorfields and NIHR-BRC is focused on glaucoma. The patient day will take place on 1 October 2011 at the Central Hall Westminster. Further information will be available from the "Events" section of the BRC website, www.brcophthalmology.org/events. All patients and healthcare professionals are welcome.

Miss Narciss Okhravi

Seniors' day

The College held a very successful and enjoy Seniors' Day on 30 June. Mrs Denise Mabey, Mr Rob Scott, Miss Clare Davy and the College Curator, Richard Keeler, all gave well received talks.



The British Ophthalmologists Golf Society (BOGS)

Feeling stressed and overworked? Dust off those golf clubs and join BOGS now!

BOGS has been meeting for over 60 years and would like to encourage new members to join the society. All we ask is that you have an official handicap (you don't have to be a member of a golf club). We meet twice a year, with opportunities to play with and compete against our trade colleagues and others from the profession. The spring meeting is at Woodhall Spa, Lincoln – a fabulous venue with one of the best golf courses in the country. The autumn meeting replaces the Oxford meeting and the venue will change each year.

We hope you will join us for good friendly company, a little relaxation and the mutual enjoyment of golf. Future meetings: 25–26 September 2011 and 14–15 May 2012. Neither meeting is sponsored. Contact Karen Goodall to join the mailing list: bogs.golf@yahoo.co.uk.

Would you like to be a volunteer associate ophthalmologist with ORBIS?

The UK is a privileged part of the world with an excellent health service delivering good medical care, free at the point of delivery. If you have an eye problem you can get help, if you have a cataract your vision can be quickly restored, if you have glaucoma, treatment is readily available and you are very unlikely to go blind.

This is not the case in the majority of countries in the world and particularly in the poor countries where ORBIS, the international sight-saving charity, works. If you have cataracts and live in the deep south of Ethiopia you will gradually go blind, if you have diabetes mellitus in the rural areas of Bangladesh no-one will screen your retina, if you are a premature baby in Peru there is no treatment for retinopathy of prematurity and you are likely to be blind for life. All of these conditions and many, many more will not cause blindness and /or disability if the dedicated and skilled ORBIS staff and volunteers can reach those people in need either by helping them directly or by providing the training, facilities and support to local doctors, nurses, biomedical engineers and administrators in those countries to provide a local service to their population in need. There are nearly 40 million people in the world who are blind and 80% do not need to be. In the world today, one child goes blind every minute and the children most at risk are under five years old. Up to 60% of those children die within one year of becoming blind and those that survive can expect to spend on average 40 years without sight. None of this is necessary!

Would you like to help these people in need and gain an insight into the world of overseas medicine? If so, you might consider becoming an ORBIS associate ophthalmologist. This is a volunteer position for one to four weeks working with the Flying Eye Hospital team.

ORBIS is famed for its Flying Eye Hospital; a DC-10 aeroplane which has been converted to hold a teaching eye hospital. It travels to developing countries to train local eye care teams and to provide high-quality care to those who need it most. As with all ORBIS programmes, medical volunteers with teaching experience, donate their time and expertise to improve eye care provision in our partner hospitals. ORBIS also has country offices in six developing countries providing long-term sight saving programs on the ground.

We ask a lot of our volunteers, both in experience and while on mission, but the personal reward is great. So much so that we wanted to open it up to junior ophthalmologists. As part of ORBIS' commitment to cultivating the next generation of ophthalmologists' interest in global blindness prevention, we have introduced an associate ophthalmologist role aboard the ORBIS Flying Eye Hospital. This role offers a structured environment for motivated ophthalmologists-in-training interested in international ophthalmology and public health.

ORBIS associate ophthalmologists serve as volunteer members of our medical team, gaining the opportunity to screen and care for patients' pre- and post-operatively as

well as facilitate training sessions. In a year, the Flying Eye Hospital typically conducts six to eight, two to three week programmes in countries across the world and we accommodate one associate ophthalmologist per programme week with a maximum involvement of three weeks.

This is a great way of experiencing a new dimension of ophthalmology, in new surroundings, treating different conditions, with international colleagues. It is a truly unique opportunity.

Pravin Pandey was an associate ophthalmologist onboard the Flying Eye Hospital in Uganda, last year, he says: "The experience was like no other. It added an exciting aspect to my training and I felt part of a great cause. I would encourage all higher specialist trainees to become an ORBIS volunteer and expand your horizons!"

The application process

- Candidates should be in their third or fourth year of Higher Specialist Training and hold a valid passport.
- Write to Nina Begum, ORBIS, Fergusson House (4th Floor), 124-128 City Road, London EC1V 2NJ for an application form.
- Submit an application form, letter of recommendation from their consultant, copy of Medical School Diploma, current GMC and C.V.
- Applications will be considered by the Flying Eye Hospital Medical Director on a rolling first come/first served availability basis.
- The role of associate ophthalmologist is self funded. Candidates will be expected to fund their own airfare, visa, meals and other incidental expenses. ORBIS will provide transfers and accommodation at the same hotel as the ORBIS staff team. ORBIS will assist in organising travel itineraries and visas.

Remember, you can help by donating too. For more information about ORBIS and our work worldwide visit www.orbis.org.uk.

*Mr Robert F Walters FRCS, FCRS(Ed), FRCOphth.
Chairman ORBIS International*



Parvin Pandey examining patients in Uganda. ©ORBIS

The Royal College of Ophthalmologists' retina day – 23 May 2011

The retina day was compact yet comprehensive, mixing updates of current retinal practice with clinical tips.

The Age-related macular degeneration (AMD): now and the future session started with capacity issues in the "intravitreal era" and "monthly treatment sub-era". Mr R Gale (York Hospital) delivered a lecture many specialists could relate to. He had also brought with him the mobile community eye care trailers, nicknamed "Liberty Plus". The mobile units have been helping deal with the fundamental issues of geography, capacity and space in York.

Prof N Bressler (Wilmer Eye Institute) highlighted strategies for treatment of geographic atrophy (GA). He stressed the importance of ruling out the differential diagnoses and reminded us that there was no correlation in the size of the GA compared to the visual loss. Treatment currently under scrutiny included targeting the complement cascade, preventing oxidative stress, modulating the visual cycle and neuroprotective agents.

In epimacular brachytherapy, Dr P Dugel (Doheny Eye Institute) outlined the promising results from the MERTIAGE study: 18% of the cohort were anti-VEGF injection free after brachytherapy. There was a documented reduction in size of the choroidal neovascular membrane (CNVM) in many and in 67% of this hard to treat cohort, the CNVM had disappeared. Updates in diabetic vitrectomy, treatment of vein occlusions and classification of peripheral fundus vascular disease were discussed in the mid morning session.

In the morning keynote address Prof Susan Bressler (Wilmer Eye Institute) outlined the results from the DRCR.net trial. The main findings were that ranibizumab with prompt or deferred laser was more effective than laser monotherapy and triamcinolone (Trivaris) for diabetic macular oedema at one year. There was an average of eight to nine injections in the first year and two to three injections in the second year.

Mr Steel (Sunderland Eye Infirmary) and Mr McKibbin (St. James' University Hospital) conducted an excellent session, on "What to do next?" The audience and the panel interacted and shared their opinion on a number of interesting case studies.

Surgical retina was the topic for discussion in the next session. This included the indications and potential for enzymatic vitreolysis with Ocriplasmin (microplasmin); the importance of global terminology in eye trauma; and advances in paediatric surgical retinal practice. Later Prof S Lightman (Institute of Ophthalmology) discussed local versus systemic treatment for sight-threatening uveitis.

In the great debate, Prof S Bressler looked like she was going to have no problems convincing the 34% of the audience who voted against the axiom: "Anti-VEGF monotherapy will remain the mainstay for treatment of wet AMD for the next five years". However, Dr P Dugel gave a light-hearted debate (the turkey, butcher and reporter scientist), which was also scientifically compelling and swung the house to reject the motion (29% in favour and 71% against).

Dr Dugel then delivered his keynote lecture: Novel drug delivery systems for retinal disease. From aptamers to biodegradable microspheres, the newer drug delivery technology on the horizon will likely make treatments for chronic retinal disease less intensive for specialists and patients alike.

Dr C Awh (Tennessee Retina) summarised some of the main successes in modern vitreo-retinal surgery: high-cut rates, improved fluidics and enhanced viewing systems with alternative light sources. His opinion was that better understanding of the ageing vitreous, and how to manipulate it, would shift treatment towards prophylaxis.

The maths-in-medicine eye study group

The week following what was an excellent Oxford Congress, another three day meeting took place which one would be forgiven for overlooking. It was the first ever Maths-in-Medicine Study group devoted entirely to the eye. Organised by Professor Helen Byrne and Dr Chris Breward from Oxford University, and myself, and hosted by OCCAM (Oxford Centre for Collaborative and Applied Mathematics), it proved an engaging and productive affair with nearly 40 delegates spanning the disciplines of ophthalmology, pathology, engineering and mathematics and there was no shortage of studies.

Problems were first presented on topics covering such as the causes of glaucoma, the mechanism of progression in retinitis pigmentosa, explanation for increased incidence of myopia in young children and the use of visual field data to predict likely burden from glaucoma in an ageing population. Then the participants split up into self-selected separate groups to work on them (some choosing to move between rooms to

work on more than one). The informal atmosphere stimulated in-depth discussion and the cross disciplinary nature engendered lively and informed debate combined with perceptive and penetrating analyses. With catered rooms in St Hughes allowing the delegates to be resident, work continued long after the timetabled sessions officially ended. At least one paper table cloth, over supper, got covered in equations.

At the end of three days, it was clear that several collaborations had been kicked off and talk has already turned to repeating it next year. If so, it is an event that would be well worth attending. We have entered the age of cheap computing and the need to establish collaborations between doctors, mathematicians and computer scientists is pressing. So it is very encouraging to see Oxford University taking the lead in this, and the active support of the College. It is just possible that those present have been privileged to witness the birth of something quite remarkable.

Mr Alexander Foss

The Royal College of Ophthalmologists' Annual Congress

24–26 May 2011

Over 240 abstracts were presented as rapid-fire papers, videos and posters at this year's Congress. Highlights of the scientific programme included three eponymous lectures, two new courses, a choice of eight breakfast meetings and the re-introduction of the allied professionals day.

Symposia

The ocular toxicity symposium highlighted the importance of the "yellow card system" for reporting suspected drug ocular side effects. There was a pragmatic approach to screening, investigating and follow-up. Both the paediatric and adult population at risk were discussed, as was the possibility of genetic predisposition.

Success with presbyopic intraocular lenses (IOLs) was a new course which dealt with detailed management of patient expectations within the limits of this technology. Monovision, multifocal and accommodative IOLs were scrutinized for their advantages and disadvantages. Understanding the patient's visual requirements, matching this to the choice of IOL, and then thorough discussion to explain achievable outcomes were the underpinning messages.

Ophthalmic emergencies was an excellent session with clear illustrations of how to approach lid lacerations, expanding orbital haematomas, orbital infections, corneal emergencies and vascular visual loss.

An approach to occult visual loss was an effective symposium. It balanced over investigation with careful exclusion of the differential diagnosis. It gave a strategy for dealing with these complex patients. Cognitive behavioral therapy is emerging as a treatment for functional vision loss; future studies will determine whether this is beneficial and cost-effective.

FFA Grand Rounds was an interesting session with cases presented from around the UK. Most cases were rare and posed either diagnostic or management dilemmas. These included proliferative diabetic retinopathy in retinitis

pigmentosa, acute lymphoblastic leukaemia and central serous retinopathy.

Eponymous lectures

Professor Eberhart Zrenner delivered the Edridge Green Lecture. He has been key in the development of subretinal active microphotodiode arrays to replace degenerative photoreceptors. In his lecture he shared the journey from conception to clinical science. His videos illustrated the benefit that these retinitis pigmentosa patients have gained following implantation.

Professor Graeme Black delivered the Duke Elder Lecture. His main areas of interest are translational research in genetic disorders that affect vision. At the NIHR Manchester Biomedical Research Centre they are improving access to UK-wide genetic diagnostic services, mainly by professional awareness of the patient's needs.

The Optic UK Lecture was delivered by Professor Stanley Chang. He outlined his collaboration with the Bristol scientists in the development of perfluorocarbons that have revolutionized the success of retinal detachment surgery. His lecture focused on how ocular coherence tomography has assisted in the understanding of retinal detachments associated with optic disc anomalies.

Late breaking news

Professor Paul Mitchell (University of Sydney) summarized the most recent medical retina studies. He condensed the safety data studies that are referred to for anti-VEGF treatments. He then focused on diabetic macular oedema: the use of fenofibrate in reducing the requirement for laser and the anti-VEGF studies for diabetic maculopathy.

We encourage you to watch the members area of the College website, as the eponymous lectures from 2011 will be shared with all members.

Miss Susan Mollan

Congress 2012

We are pleased to announce the eponymous lecturers:

The Ashton Lecture: Professor Bertil Damato, Liverpool, UK

The Bowman Lecture: Professor John Forrester, Aberdeen, UK

The Optic UK Lecture: Professor Paul Mitchell, Westmead, Australia

The Edridge Green Lecture: Professor Wolfgang Drexler, Vienna, Austria

Seasonal Flu Immunisation Programme 2011/12

The Chief Medical Officer has written to the President to ask him to encourage the College members to be vaccinated against influenza.

In 2010/11 the update of 'flu jabs among frontline healthcare professionals was only 37.5%.

There will not be a national advertising campaign for seasonable flu immunisation this winter and members are also asked to encourage their eligible patients to be vaccinated.



Carleton

Making light work



And we are just getting started...

- ✓ CR2 Non-Mydriatic Retinal Camera
- ✓ Copernicus + Spectral Domain OCT
- ✓ TX-20P Non-Contact Tonometer/
- ✓ Pachymeter
- ✓ PCT-200 Corneal Topographer
- ✓ PTS-1000 Visual Fields

Canon. A brand both you and your patients can trust.

Canon

 **OPTOPOL**
technology



TRAVEL AWARDS AND FELLOWSHIPS

AWARD	AMOUNT	CLOSING DATE
Dorey Bequest and Sir William Lister Travel Awards 2011	C. two awards £400-£600 each	7 October 2011
Ethicon Foundation Fund Travel Award	Four to six awards of £400-£1,000 each	4 November 2011

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



The British Ophthalmological Surveillance Unit (BOSU) Research Bursary Awards 2011

Each award is for £6,000 and will facilitate an epidemiological study of a rare eye condition through BOSU or its Scottish Counterpart, SOSU,

The Fight for Sight BOSU Study Bursary

This will support an ophthalmology trainee in the UK.
 Closing date: 14 October 2011.

The Ross Foundation BOSU Study Bursary

This will support an ophthalmology trainee in Scotland.
 Closing date: 14 October 2011.

Please contact Barny Foot (BOSU@rcophth.ac.uk or 07808 581659) for help with applications.

The Ross Foundation Scottish Ophthalmological Surveillance Unit

This will support an ophthalmologist or other interested researcher to undertake a suitable study through the SOSU.
 Closing date: 23 September 2011.

National recruitment for ophthalmic specialty training (OST)

The College has been working with all deaneries in the United Kingdom and will coordinate national recruitment for ophthalmology in 2012, supported by the Severn deanery, as the lead deanery for recruitment.

Those applying for OST1 will submit a single application form via the College website, listing deaneries in preference order. The long and short-listing will be run against a standard scoring matrix and those invited for interview will attend a single national interview early in 2012.

The frustration, waste and duplication of effort inherent in the present system, where candidates make separate applications to individual deaneries, should be reduced and the participation of all deaneries will maintain local involvement in recruitment.

ONE Network Quarterly Update

2,537 College members have been assigned access keys to this resource supported by the American Academy of Ophthalmologists. Two new interactive cases in retina and uveitis subspecialties have been added and there are now 270 videos in the Media Library from past AAO Annual Meetings. Contact Jane Aguirre oneintl@aao.org with any questions or concerns.

New College e-logbook

The Education Committee is pleased to announce the launch of the new e-logbook, originally created by Dr Andy Simpson, a trainee in the London Deanery. It is an on-line surgical logbook for ophthalmologists, designed for the entry and analysis of ophthalmic surgical data from any computer with a connection to the internet. Information is displayed in both tabular and graphical forms to allow the easy analysis of data for training progress, audit and revalidation purposes. Dr Simpson will work closely with the College on the maintenance and development of the e-logbook. All members will be able to access the e-logbook through their College e-portfolio/CPD account and its use will be compulsory for trainees who start training on or after 3 August 2011. For further information please see www.rcophth.ac.uk/logbook



Macular Disease Society

The Macular Disease Society, the UK charity dedicated to supporting people affected by macular disease, is pleased to announce that its 2012 call for research grants is now open. Applications for research grants are invited from individual academics or clinicians or research teams attached to recognised academic or medical institutions. We will consider applications for grants up to £100,000 for clinical research projects including genetics and medical, surgical or quality of life interventions. Projects must be able to demonstrate potential benefit to people with macular disease. Closing date: 2 December 2011. The Macular Disease Society is a NIHR non-commercial portfolio partner. www.maculardisease.org/research or email deborah@maculardisease.org.

delivering surgical innovation

Mani, Consistently Sharp



Not only have many ophthalmologists commented on the unique sharpness of Mani knives, but many also identify consistency of excellent sharpness, over time and batches. Self sealing incisions can be performed with precision and peace of mind.

Altomed not only brings to you its own extensive instrument range, we also deliver to you leading world ophthalmic brands such as Sterimedix, Volk, Labtician and Mani.

Ask for a copy of our free colour catalogue and helpful price list.

Volk High Resolution Wide Field Lens



A new extremely compact lens, short in length designed specifically for ultra wide field examination and pan-retinal photocoagulation (PRP) of the retina.

New Lower Price Siluron 2000



Announcing a price reduction for the clever silicone oil from Fluoron. Siluron 2000 exhibits the increased integrity of oils with higher viscosities, but it is easier to handle and deliver into the eye even through 23G ports.



Reusable. Efficiently using resources and funds.

Using modern automated decontamination methods and the latest generation of trays such as Altomed Microwash, reusable instruments can be safely cleaned and sterilised without damage.



2 Witney Way, Boldon Business Park, Tyne & Wear, NE35 9PE. England
Tel: +44 (0)191 519 0111 Fax: +44 (0)191 519 0283
Email: admin@altomed.com Website: www.altomed.com

Annual Congress

15-17 May 2012

Arena and Conference Centre,
Liverpool

Important dates for your diary:

12 September 2011

Abstract submission opens

14 November 2011

Abstract submission closes

16 January 2012

Results published

13 February 2012

Registration opens

College Seminar Programme 2010

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

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 Tutor Induction Days

11 November

College Skills Centre Programme 2011

Details are on the website at

www.rcophth.ac.uk/bmscourse

SAS National Day

21 October

Manchester Novotel

penny.jagger@rcophth.ac.uk

Training the Trainers

20 September:

Day 1, What to teach and what 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

RCOphth/AAO joint meeting

24 October

Orlando, Florida, USA

Chaired by: Mr Geoffrey Rose and
Mr David Verity.

It will cover orbital, lacrimal and
oculoplastic diagnosis and surgery

[www.aao.org/meetings/annual_meeting/
program/index.cfm](http://www.aao.org/meetings/annual_meeting/program/index.cfm)

Ophthalmic Trainees' Group

19 November

The East Midlands Conference Centre,
Nottingham

This is open to those with an interest
in ophthalmic training.

Topics include passing the new Part 2
FRCOphth and the Refraction Certificate.

www.rcophth.ac.uk/otgsymposium

Other Events 2011

25 – 26 September

**The British Ophthalmologists Golf
Society (BOGS)**

Stapleford Park, Leicestershire

bogs.golf@yahoo.co.uk

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

1 October

Glaucoma Patient Day

Central Hall, Westminster, London

www.brcophthmology.org/GlaucomaPatientDay

12 – 14 October

**British Isles Paediatric
Ophthalmology and Strabismus
Association (BIPOSA)**

The Royal College of Physicians, London

[www.eazybook.com/inanyevent/
registration/eb-event-1a.php?eventid=230](http://www.eazybook.com/inanyevent/registration/eb-event-1a.php?eventid=230)

13 – 14 October

UKISCRS 35th Annual Meeting

Convention Centre, Southport

www.ukiscrs.org.uk

ukiscrs@ukiscrs.org.uk

28 October

City Road Reunion

The Medical Society of London, London

t.fytche@btinternet.com

9 November

**The Birmingham Neuro-
Ophthalmology Course**

Retinal Imaging Course

Aintree University Hospital

richard.hancock@aintree.nhs.uk

1 – 2 December

**UK and Eire Glaucoma Society
Meeting**

Museum of Science and Industry, Manchester

www.glaucoma-societyuke.org

10 December

**The Birmingham Ophthalmic
Laser Symposium**

Post Graduate Centre, City Hospital,

Birmingham

angela.swainsbury@nhs.net

1 – 4 July 2012

Oxford Ophthalmological Congress

Oxford Playhouse Theatre, Oxford

O_0_C@btinternet.com

CALL FOR PAPERS

Deadline 9 January

[www.oxford-ophthalmological-
congress.org.uk](http://www.oxford-ophthalmological-congress.org.uk)

APPOINTMENTS AND OPPORTUNITIES

The College has a number of internal
vacancies. It is also approached by
external bodies seeking ophthalmic
input. These openings will appear in the
members' section of the website.

The Royal College of Ophthalmologists

17 Cornwall Terrace, London NW1 4QW, Tel. 020 7935 0702 Fax. 020 7935 9838

www.rcophth.ac.uk **Editor of Focus: Professor Victor Chong**