QUARTERLY BULLETIN OF THE ROYAL COLLEGE OF OPHTHALMOLOGISTS

College NEWS

Winter
2011

The MRC and RCOphth John Lee Fellowship

So far we have raised approximately £95,000 but more funds are needed. Donations warmly welcomed at: *www.rcophth.ac.uk/jlfellowship*

The Rotterdam Eye Hospital has five mobile eye clinics, which are based in white Mercedes vans that travel to less agile patients. The first 'Oogbus' (eye-bus) was named after Professor Donders, then after Professors Snellen and Henkes and then in honour of Dr Binkhorst. The newest mobile eye clinic has been named 'Dr John Lee'.

News from The Scientific Department

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

For the latest announcements please see the College website *www.rcophth.ac.uk*

Join us in Liverpool for Congress 2012

Retina Day – 14 May, Main Congress – 15 - 17 May

Join world-renowned experts for sessions on all eye conditions at the largest ophthalmic meeting and exhibition in the UK. Hear the latest translational research, late breaking news and updates in your specialty, learn new skills, network with colleagues and view new products and equipment. Registration opens on 13 February 2012. Remember that as a member you will benefit from a reduced rate. Visit the website for the latest news and programme *www.rcophth.ac.uk/annualcongress*

Eponymous Lectures

The Ashton Lecture	Prof Bertil Damato	Liverpool. UK
The Bowman Lecture	Prof John Forrester	Aberdeen, UK
The Edridge Green Lecture	Prof Wolfgang Drexler	Vienna, Austria
The Optic UK Lecture	Prof Paul Mitchell	Sydney, Australia

RCOphth goes international

The College hosted a joint session with the American Academy of Ophthalmology. Organised by members Geoffrey Rose and David Verity, the lively session was a great success and enjoyed by delegates. Topics included the lumpy lid, mucky eye, bulgy eye and the troublesome socket.

RCOphth takes on the World

The World Ophthalmology Congress (WOC) was last held in the UK in 1950. The College has submitted a bid to host the 2018 WOC at London's ExCel and we will keep you updated.

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

Spring
5 February 2012

Summer
5 May 2012

Autumn
5 August 2012

Winter
5 November 2012

Latest figures on visual impairment registrations

The NHS Information Centre for Health and Social Care has released its figures on the numbers registered and newly registered as visually impaired with councils across England.[1] These figures show that there has been a fall in the number of individuals newly registered in the year ending 31 March 2011 as compared with their last look at the data in 2008. There has been a fall of 11% in new registrations for severe sight impairment (blindness) and a fall of 10% in new registrations for sight impairment (partial sight). A fall of 7% was seen for blind registrations in Scotland when comparing figures for 2010 with 2009 but a 9% increase in partial sight registrations was observed over the same time period.[2]

Whilst figures may reflect improvements in our efforts at reducing visual impairment, there is concern that they might also indicate an increase in the number of subjects who are eligible for certification but not being certified. It is important to note that these figures may be used by policy makers deciding where scarce resources are best spent. Certification in many cases serves as the trigger for support from social services for visually impaired patients and we would encourage all College members to offer certification where appropriate.

1. Registered Blind and Partially Sighted People Year ending 31 March 2011 England. The Information Centre for Health and Social Care.
2. Registered Blind and Partially Sighted Persons, Scotland 2010. A National Statistics Publication for Scotland.

Dr Catey Bunce
CVI Project Lead

Revalidation update

The best piece of advice the College can give to members is that they should gather supporting information in order to be prepared for their next appraisal.

Please look at two documents recently published on the website: *www.rcophth.ac.uk/page.asp?section=449&sectionTitle=Revalidation+%26+Appraisal*

- Preparing for Revalidation as an Ophthalmologist
- Guidance on Supporting Information for Revalidation in Ophthalmology.

These provide practical advice and links to resources to assist ophthalmologists preparing for appraisal and revalidation and they will be updated as required in the future.

New career guidance

The Academic Group has produced Academic Ophthalmology as a Career as a companion piece to Ophthalmology as a Career. Both are intended to help undergraduates and foundation trainees plan their futures and they appear on the College website: *www.rcophth.ac.uk/undergraduate*

The Medicines and Healthcare products Regulatory Agency (MHRA) The MHRA has launched a discussion forum for Good Clinical Practice (GCP). It is designed to help those involved in clinical trials to implement quality procedures that can ensure compliance with relevant legislation and GCP requirements.

It will facilitate communication between researchers and allow users to put forward their comments and get 'real-life' examples. *www.mhra.gov.uk/Howweregulate/Medicines/Medicinesregulatorynews/CON134711*

Commissioning guidance for eyecare

The College has joined forces with the College of Optometrists (COptoms) to produce commissioning guidance in anticipation of the changes to follow the likely implementation of the Heath and Social Care Bill. The working party is jointly chaired by Mr Richard Smith, Chairman of the College's Quality Standards Subcommittee and Dr Cindy Tromans, President of COptoms. The aim is to help commissioners understand how to use resources across primary and secondary care to design health services for each of the major eye conditions, including glaucoma, urgent eye care, low vision and children's eye services. It continues to receive strong support from Sir Muir Gray, the NHS Chief Knowledge Officer.

Sir Muir, Cindy and Richard in the Spectacle Gallery at the College of Optometrists

Jackie Trevena, Head of the Operational Support Department, retired in November, after 20 years of dedicated service. Aziz Rajab Ali has been appointed as her successor.

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 David Assheton	St Helens Hospital, St Helens
Miss Seema Arora	Hull Royal Infirmary, Hull
Mr Ahmad Dabbagh	Kingston Hospital, Kingston upon Thames
Miss Annegret Dahlmann-Noor	Moorfields Eye Hospital, London
Mr Raja Das-Bhaumik	Moorfields Eye Hospital, London
Mr Alastair Denniston	Queen Elizabeth Hospital, Birmingham
Mr Jasvir Grewal	Kingston Hospital, Kingston upon Thames
Mr Ahmad Khalil	Blackpool Victoria Hospital, Blackpool
Miss Sarah Meredith	Queen Alexandra Hospital, Portsmouth
Miss Susan Mollan	Selly Oak Hospital, Birmingham
Mr Harish Navak	Alder Hey Hospital, Liverpool
Mr Dan Nguyen	Leighton Hospital, Crewe
Mr Nishal Patel	William Harvey Hospital, Ashford
Mr Simon Rogers	Queen Alexandra Hospital, Portsmouth
Mr Tarek Saleh	Blackpool Victoria Hospital, Blackpool
Mr Jagadish Sardar	Royal Shrewsbury Hospital, Shrewsbury
Mr Ijaz Sheikh	East Surrey Hospital, Redhill

Honorary Treasurer

Any Member or Fellow wishing to nominate should send a 400 word statement and photograph to the Honorary Secretary *hon.sec@rcophth.ac.uk* by 20 January 2012. The job description is available: *www.rcophth.ac.uk/appointments*

Retirement Date	Name	Eligible for re-election
May 2012	Mr Peter McDonnell	Yes

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.

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
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
Interim placement	Mr Christopher Scott	North East	No

Professorial appointments

Marcela Votruba has been appointed Professor of Ophthalmology at the School of Optometry and Vision Sciences, Cardiff University.

Awards

Mr Peter Watson FRCOphth (Hon) has been awarded the Jose Rizal International Medal by the Asia Pacific Academy of Ophthalmology, the highest award of the Academy.

Mr Winfried Amoaku has won the Judges Special Award in the Macular Disease Society's annual awards.

The Eye Have it

The royalties from the above book by **Mr Christopher Liu** will go to support Sussex Eye Hospital. The foreword is written by Professor Roger Buckley, the afterword by the President, Professor Harminder Dua. The publication date is 27 January 2012 but the book will be available before Christmas. *www.bookguild.co.uk*

A musical treat

Mr Jay Menon, Consultant at the Royal Glamorgan Hospital, specialises in the management of glaucoma and serves as the Programme Director for the All Wales Postgraduate Ophthalmology Training Programme. He has produced an album of 12 soft rock and love songs, entitled Through My Eyes. All the funds raised from sales of this album will go towards Professor Ted Garway-Heath's research at Moorfields Eye Hospital. The CD is available at: *www.amazon.co.uk*, *www.hmv.com* and at the website of the International Glaucoma Association *www.glaucoma-association.com*

Obituaries

We note with regret the death of:

Dr Peter Gormley, Belfast, Northern Ireland

Dr Abdul Latif Khan, Swansea, Glamorgan

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THE ROYAL COLLEGE OF OPHTHALMOLOGISTS

Focus

Winter
2011

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

Carole A Jones

Periocular Basal Cell Carcinoma

Basal cell carcinoma (BCC) is the most common form of skin cancer in Europe, Australia and the US, representing 90% of all eyelid malignancies[1]. As a result of inconsistent reporting, the exact incidence in the UK is unknown but estimates suggest that 53,000 new cases are diagnosed in the country each year[2].

The causal link between sun exposure and all skin cancers is well described [3]. BCCs are most common in people over 50 years, but an increasing number of younger adults are developing this form of skin cancer because of prolonged sun exposure and the use of sunbeds. BCCs may also develop in scars or sebaceous naevi, and are associated with several genetic syndromes, including basal cell naevus (Gorlin's) syndrome, xeroderma pigmentosa, Bazex syndrome and albinism.

Effective in reducing the incidence of these tumours are sunscreens, particularly those with protection against UVA and UVB[4]. In order to be effective, sunscreens need to contain both a physical blocker (eg zinc oxide) and a chemical blocker (eg avobenzone). However, the difficulties of applying sunscreen to the lids often mean that this part of the face is neglected. The photoprotective power of sunglasses is dependent on the quality of the glasses, their size and the position on the face (displacement of sunglasses a few mm down the nose results in a significant increase in the amount of UV light reaching the eye[5].

The location of periocular tumours follows a consistent pattern; with the most common site being the lower lid followed by the medial canthus, eyebrow and upper lid and finally ateral canthus. It has been recorded that in men these tumours are more likely to occur on the right side of the face, this is probably related to differential sun exposure[6].

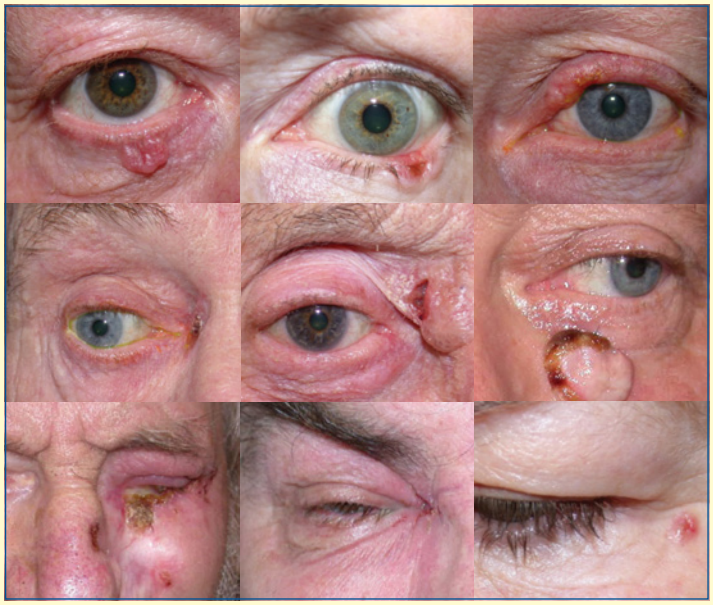
There is a wide variation in the clinical appearances and morphology of basal cell carcinomas. Clinically the lesions may be nodular, cystic, superficial, morphoeic (sclerosing), keratotic and pigmented variants. Common histological subtypes include nodular, superficial and pigmented forms, in addition to morphoeic, micronodular, infiltrative and basosquamous variants which are particularly associated with aggressive tissue invasion and destruction[7].

Whilst these tumours very rarely metastasise (a reported incidence of less than 0.1%), they can be locally destructive. Perivascular or perineural invasion are features associated with the most aggressive tumours[8]. In the recent NICE guidelines, all BCCs above the clavicle are identified as high risk lesions and need to be managed by specialists as part of a multidisciplinary cancer team[8].

As clinical presentation can be very variable, biopsy is recommended for all suspicious lesions and, in particular, if the tumour is large and reconstruction is needed. A simple punch biopsy is a reliable technique and can be performed easily in outpatients.

Several treatment modalities are available to the clinician including surgical excision, Mohs' micrographic surgery, topical Imiquimod, 5-fluorouracil, photodynamic therapy and radiotherapy. To date, few high quality studies compare the different treatment modalities for facial BCCs[9]. Of all the treatment techniques available, surgical excision with monitoring of excision margins has the highest cure rate and generally is the treatment of choice; a number of articles discuss treatment options and recommendations[1,10].

Medical management: Imiquimod is an immune response modifier that is a Toll-like receptor 7 agonist. It induces interferon and other cytokines, and stimulates cell-mediated immunity through T cells and stimulation of apoptosis in BCC cells. It has been shown to be effective as a topical treatment



for superficial basal cell carcinoma, achieving histological clearance rates of 82-90% using a treatment regime of 5x/week Imiquimod for six weeks[11]. Detailed patient counselling on the use and side effects of this medication is essential prior to treatment.

It has been reported that 5% 5-fluorouracil is 90% effective in treating BCCs following a 12-week course, although there were lesions on the trunk. Its use is only recommended in low-risk sites so it should not be used to treat periocular BCCs.

Photodynamic therapy (PDT) involves the destruction of sensitised cells by an irradiating light source. A prodrug, either 5-aminolaevulinic acid (ALA) or methyl aminolaevulinic (MAL), is applied to the skin prior to treatment. Superficial BCCs have been shown to achieve 87% clearance. The five-year recurrence rate in nodular BCCs is higher, 14%, if treated with PDT as compared with standard surgical excision, 4%. A multicentre study, of 'difficult-to-treat' facial BCCs suggests that MAL-PDT may be an option for high-risk disease when other more effective treatments are contraindicated. Nevertheless as the clearance rates are lower than for surgical treatments, PDT is not generally recommended for management of nodular BCCs on the head or neck[1,10].

Surgical management: The surgical excision of periocular BCCs involves removing the lesion with a predetermined margin of 3-4mm around the macroscopic tumour margin, and is regarded as standard treatment. The use of smaller margins has been reported although the presence of residual tumour tissue requires re-excision. It has been demonstrated that when excision of facial BCCs is undertaken with narrower margins, histological clearance is not reliably achieved. Morphoeic and large BCCs required wider surgical margins in order to maximise the chance of complete excision.

Basal cell carcinoma on the face, and particularly on the eyelid, appears to have a higher degree of subclinical spread than tumours arising elsewhere. Tumour recurrence where complete tumour clearance is reported is recorded as between <2% and 4%[12]. It is recognised that incomplete excision leads to a higher recurrence rate; studies with a five-year follow up have reported recurrence rates of 21-41% for patients following previous incomplete excisions[13].

When incomplete excision occurs on the face there is good evidence to support the need for re-excision. Boulinguez et al report a 24% chance of incompletely excised BCCs becoming more aggressive when they recur[14].

The use of staged tumour resections first pioneered (as chemosurgery) by Frederic Mohs in the 1940s[15], which was later refined as Mohs' micrographic surgery (MMS), is well described. MMS results in extremely high cure rates for both primary and recurrent tumours, together with maximal preservation of normal tissues[16]. Modifying standard ways of examining convention histopathological specimens may simulate MMS and improve tumour clearance whilst minimising normal tissue loss.

Whilst it is a more time-consuming technique, requiring a range of specialists, a recent study comparing Mohs' surgery to standard excision for facial and auricular non-melanoma skin cancer found MMS to be more cost effective than standard surgical excision. However, a Cochrane review compared MMS to surgical excision and stated that no reliable conclusions could be reached regarding which method of treatment resulted in a lower recurrence or complication rate for periocular BCC, and no studies were found comparing the cost of either method directly[17].

Radiotherapy: May be considered in those patients not suitable for surgical excision, the cure rates are reported as over 90% for most skin lesions. Tumours of the lower eyelid, inner canthus, lip, nose and ear are amenable to radiotherapy. However, the upper eyelid is not an appropriate site for radiotherapy due to keratinisation of the conjunctiva and damage to the tarsal plate and the eye.

Radiotherapy may be a good option for elderly patients, with very large BCCs of the scalp, but it is not appropriate for recurrent BCCs or patients with Gorlin's syndrome[10]. Treatment in fractions over several visits may produce better cosmetic outcomes than a single fraction treatment. A randomised trial recorded a higher recurrence rate in those undergoing radiotherapy for small facial BCC when compared with surgical excision; 7.3% and 0.7%, respectively[18]. The cosmetic outcome of radiotherapy is reported to be worse than that achieved by surgical excision.

In addition, radiotherapy tends to be more expensive than any other form of treatment. A recent prospective study by Lear et al in Canada looked at the cost of MMS and radiotherapy for 49 BCCs. The authors found the cost of radiotherapy to be significantly greater at approximately four times the cost of MMS[19].

Conclusion: The indolent nature and lack of metastatic spread has led to irregular reporting, and thus an underestimation of the true incidence of BCCs in the UK. At present the standard surgical excision is the treatment of choice for periocular BCCs, although the advantages of Mohs' excision should not be understated in this area where tissue loss is often difficult to reconstruct.

The recent development of medical treatments, and in particular Imiquimod, offers other treatment options. With increasing experience of this medication, future ophthalmologists may find that time-consuming and unpleasant surgery is replaced, at least in part, by medical treatment for periocular BCCs.

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CHAVASSE

"From the outset we learn to think binocularly"

Francis Bernard Chavasse 1889 - 1941

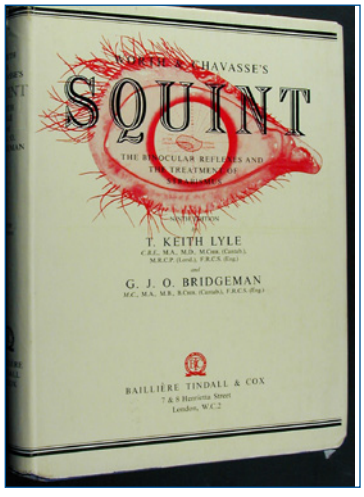
(Francis) Bernard Chavasse was born in 1889, the fifth of six children. Four of his siblings were twins. The family will always be remembered for their outstanding valour in the First World War. In less than two months the parents of Chavasse (his father was Bishop of Liverpool), saw two of their sons killed, two Military Crosses awarded and the only Victoria Cross with Bar of the Great War awarded posthumously to Noel Chavasse. (a VC with Bar signifies that the recipient has been decorated with the Victoria Cross twice, the highest award for gallantry that a British and Commonwealth serviceman can achieve). Indeed Bernard, whose Military Cross was awarded for outstanding bravery, was originally cited for a VC.

He was educated at Balliol College, Oxford where he took a first in Natural Sciences. From university he joined the Royal Army Medical Corps and then the First Kings Liverpool Regiment to serve as a medical officer in Egypt, Gallipoli and the Western Front.

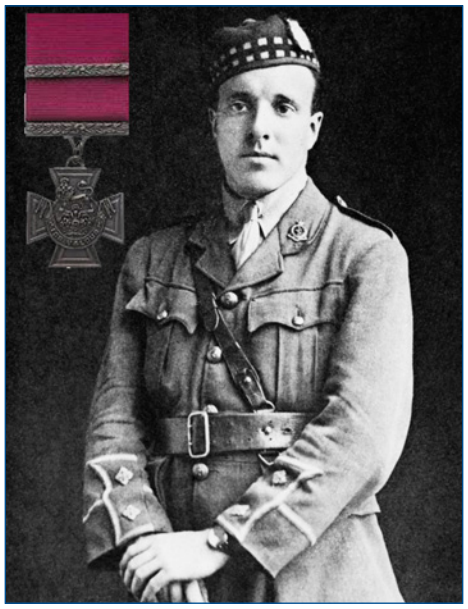
After the war Chavasse took up the study of ophthalmology in his native city of Liverpool. He had an outstanding career in ophthalmology, making a major contribution with papers at the Ophthalmological Society of the United Kingdom and at the Northern and Oxford Congresses. Worth's Squint was already a classic. After the sixth edition, Chavasse completely revised it, bringing it up-to-date and adding his own ideas on physiology and pathology. He was an excellent surgeon and he described several of his procedures in the book.

In addition to his writing, Chavasse should be recognised for the invention of a number of surgical instruments, among them: fixation forceps, a strabismus hook and a marginal myotomy retractor. He also was a strong supporter of orthoptic training, not so much on the treatment methods but as a help in diagnosis.

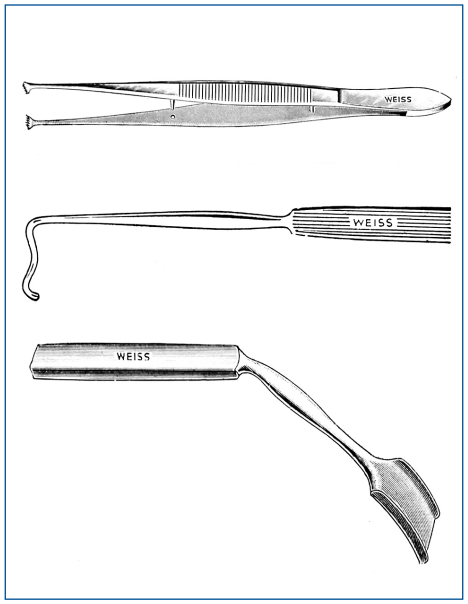
Chavasse spent a considerable amount of time and energy on the welfare and development of the Liverpool Eye and Ear Infirmary. His devotion was reciprocated by his colleagues and friends who greatly mourned his untimely death. Having survived the war, Chavasse lost his life in a car accident in 1941 at the age of 52.



Edition of Worth and Chavasse's Squint



Captain Noel Chavasse VC with bar



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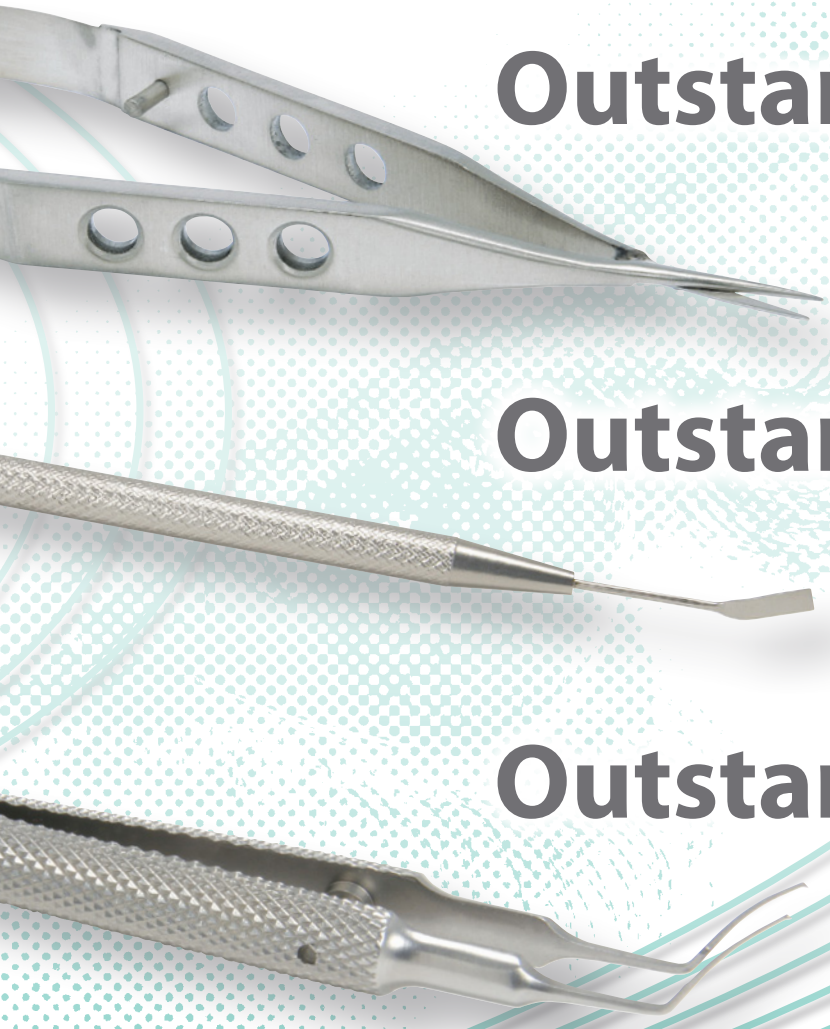

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International links

Mike Burdon, Consultant Ophthalmologist from Birmingham, and I were invited to run a workshop with the Eastern Africa College of Ophthalmology (EACO) in Addis Ababa, Ethiopia during the Annual Congress of the Ophthalmological Society of East Africa in October 2011. EACO is a relatively new organisation with a mission to increase the quantity of ophthalmologists and improve the quality of eye care in the region.

Our brief was to help facilitate discussions on the development of an EACO Continuing Professional Development programme. Mike provided a personal view on his career development since taking up his consultant post and the importance of CPD to himself and we discussed the various components that can be part of a CPD programme. The board then debated how it might build an EACO CPD programme, noting the role of regulatory bodies in promoting CPD. EACO reported on our work to its AGM the next day and will work on a plan of action for a CPD programme over the next year. The visit strengthened the relationship between the College and EACO and gave us the opportunity to promote the offer of affiliate membership to EACO members.

We also attended the two day OSEA Congress and the gala dinner complete with traditional dancers providing a dizzying display of skill and stamina. Our hosts were extremely welcoming and the visit was successful on a number of levels. We hope to hear of future EACO CPD developments.

Another team from the College will be visiting EACO in Kenya in November to help with EACO examinations and curriculum development.

For more information about EACO and its work and links with the College, visit *www.eacokut.org*

Beth Barnes
Head of the Professional Standards Department

New specialty interest group on bio-data

With support from the Department of Health, the Scottish Executive and leading medical research charities, the UK Biobank project aims to improve the prevention, diagnosis and treatment of a range of diseases. The project has reached its initial goal of recruiting 500,000 UK adults, aged between 40 and 69 years. All the participants have provided demographic and lifestyle data, medical history, biometry data and tissue samples. Ophthalmic data has been collected from approximately 80,000 participants. This includes visual acuity, refraction, corneal hysteresis, IOP, fundus photography and spectral domain OCT.

A number of specialty interest groups are coming together to try to agree research proposals and access to the UK Biobank resource. A second meeting for ophthalmologists and scientists interested in the ophthalmic data and eye disease is planned for spring 2012. If you already have an interest in the resource or are keen to be kept informed of this and future meetings, please email: *martin.mckibbin@leedsth.nhs.uk*

TWITTER

The College will be starting a Twitter feed from 1 December. To follow us on Twitter, just add @RCOphth

TRAVEL AWARDS AND FELLOWSHIPS

AWARD	AMOUNT	CLOSING DATE
International Glaucoma Association Research Awards 2012	Two awards of up to £50,000	Tuesday 31 January 2012
Pfizer Ophthalmic Fellowship 2012	One award of up to £35,000	Friday 24 February 2012
Keeler Scholarship 2012	One award of £30,000	Friday 24 February 2012
Fight for Sight Award 2012	One award of £5,000	Friday 30 March 2012
Patrick Trevor Roper Undergraduate Travel Award 2012	Two awards of £550	Friday 1 June 2012

(Please note that these closing dates may be subject to minor amendment. Please check the website for the confirmed date) Information and application forms for all awards are available on the College website: *www.rcophth.ac.uk/awardsandprizes*

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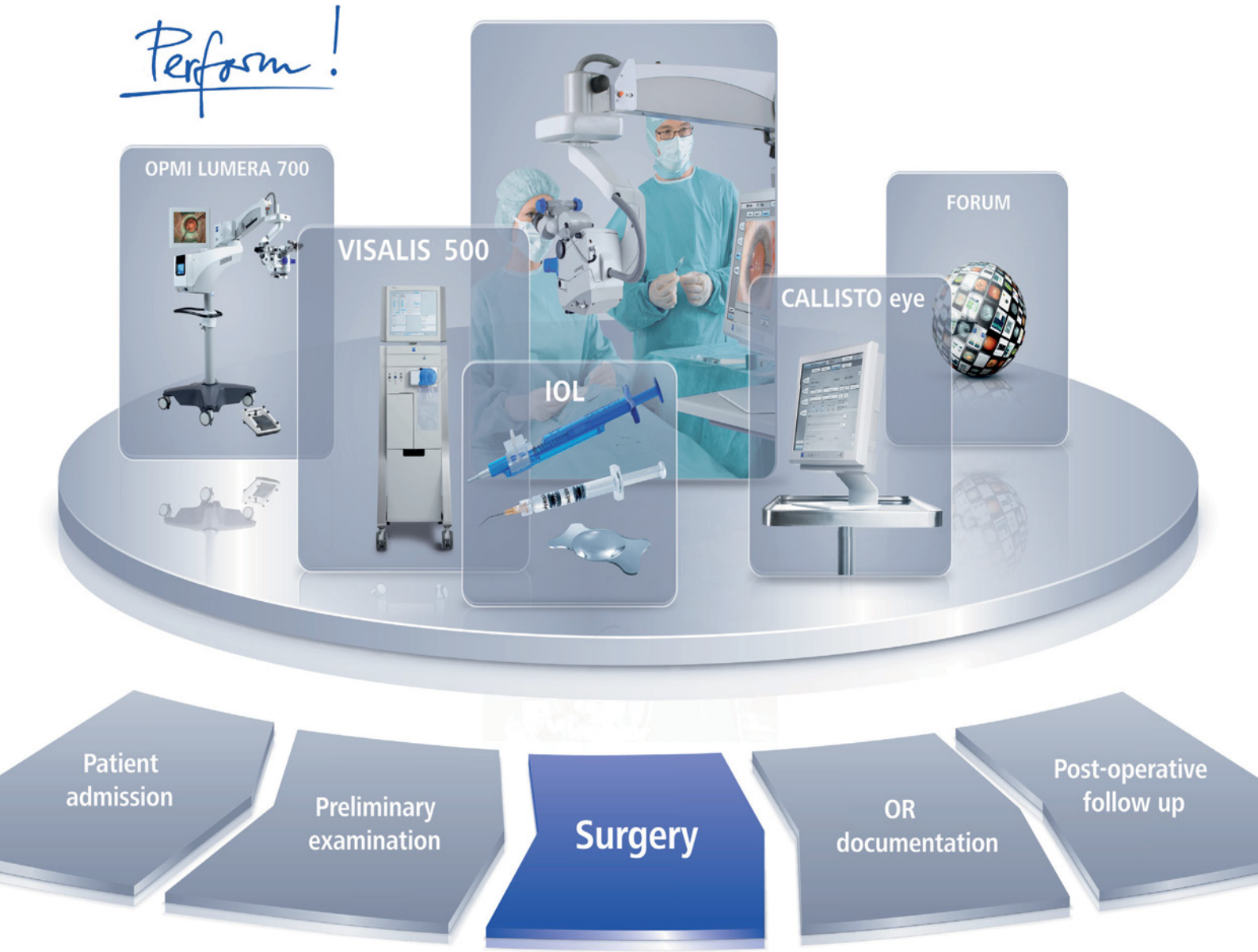

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The Staff and Associate Specialists' group

From autumn 2006 to summer 2011, I had the privilege of representing Oxford region SAS ophthalmologists at the College SAS committee and, as an extension of this role, I also attended the CPD subcommittee meetings.

Making my way to the first meeting I really had no idea what to expect, but I remember leaving the meeting feeling energised. At the inaugural meeting we were informed that Council had, as part of a strategic review of activities, identified that SAS ophthalmologists were less engaged with the College than other member groups. Armed with lots of news and ideas, I organised my first meeting with regional SAS colleagues. This was well attended but then attendance dwindled to the point that I simply communicated with them by email.

I was totally unprepared for this lack of enthusiasm and this recurring theme was echoed by other regional representatives. Elsewhere, in the October 2011 issue of the National Association of Clinical Tutors newsletter, a report on the SAS Tutors Development Day states, 'the main challenge was to motivate SAS doctors'. By contrast officers of the College have been refreshingly welcoming and open to ideas from the group.

On a personal level I learned to appreciate all the good stuff happening in my trust and raise my personal bar having heard about some of the achievements of other SAS ophthalmologists. I have formed some long-lasting friendships with College officials and with other SAS representatives. As a group we are now part of the College establishment and active in all College matters through our representation at committees.

One of the deciding factors in my stepping down was that every SAS doctor should have the opportunity of holding such a position. I would urge you all to become involved because we have shown that we do have a voice, the College does listen and we can make a difference through our direct involvement in College work. Please urge your non-member colleagues to join up and find out for themselves what the College has to offer SAS ophthalmologists.

Dr Suri Dhanoa

NB: We will participate in the second joint College SAS Conference to be held at the RCP London on 7 January 2012.

Patient consent

Obtaining consent is often a time-consuming process. The consenting procedure requires an explanation of why a procedure is necessary, the nature of the procedure and the risks and benefits. In addition the post-procedure processes and expectations the patient should have in terms of comfort, success and timelines for these, if possible, should be explained. It is also necessary to explain the alternative options for treatment with the patient. Once all this has been achieved, the patient will often have additional questions which make the length of the consenting process unpredictable.

Obtaining consent is required for practical reasons, as informing a patient of the treatment options and explaining the risks and benefits of these options is likely to give the patient more involvement and ownership of the decisions made and strengthens the relationship with the patient. In addition, ethical reasons relating to the principle of autonomy dictate that every individual has the right to bodily integrity and there are also legal reasons, which are a defensive process to avoid subsequent accusations of unlawful assault by the clinician.

Informed consent, or 'patient-centred' consent as it is described in the National Health Service Plan for England, is a basic doctrine in modern healthcare law. The Department of Health in England and Wales requires the NHS to adopt model forms and information leaflets to ensure good practice in seeking consent.

EIDO healthcare provides a series of patient information leaflets for common ophthalmic procedures. These are composed by ophthalmologists and updated annually to ensure all new information relevant to the consenting process for that procedure is included. These leaflets are peer reviewed and tested for comprehensibility before being approved for use. The College understands the usefulness of patient information leaflets and endorses the leaflets developed by EIDO. Each leaflet is reviewed by two College officers and the Lay Advisory Group – an activity consistent with the charter objective of educating the public. The College receives a modest royalty for this service. EIDO encourages feedback from clinicians and patient users of the leaflets to further develop a patient-focused information leaflet. *www.eidohealthcare.com*

Mr Anthony King, EIDO Author

Eye Journal – Thank You

We would like to thank all those who responded to our recent request for volunteers to review manuscripts for Eye. If you would like to lend a little of your expertise and add your details to our database, please contact the Editorial Office at *eye@rcophth.ac.uk*.

By expanding our reviewer database we aim to reduce the submission-to-decision time for new papers as well as maintain a high standard of published articles.

Eyes Elsewhere diary

February 2010: We are pleased! Very pleased indeed: we have completed a cataract surgery initiative in a remote rural area in mid-Myanmar and had no cases of endophthalmitis. The visiting ophthalmologist doing the same in a neighbouring district was not so fortunate and over half of his cases came down with an E. coli infection. It was suggested that our infection-free success was due to my insistence that all patients shower (paying particular attention to hair, hands, and fingernails) before surgery, but I am positive that the credit must go to the 'steam cooker', a floor-standing steam sterilizer that we brought with us. In fact we brought all required equipment with us in two lorries, which took two days from Yangon by road and ferry. The equipment available locally consisted of a desktop autoclave, a wonky slit lamp and a broken scanoptics microscope (which our engineers were able to fix). We had been invited by a senior local politician and through his intervention we had a generator, extra water supply and were extremely well looked after.

As many as 95% of the 230 patients we operated had visual acuities of count fingers or less due to dense lens opacities. All had extra-capsular lens extractions with lens implants. And, yes, there were peri-operative complications, but no worse than the National Cataract Survey figures in the UK for the same procedure.

'We' are a non-governmental team, consisting of two consultant ophthalmic surgeons, four local qualified doctors (ophthalmology trainees), two nurses, two opticians and our driver-cum-porter. On this occasion, we were supported by two engineers/hand holders and the Alcon appointed technician, who excelled at biometry. Two local ophthalmologists helped with the surgery. From them I learned that after four years of specialist training in larger units one may be volunteered for a rural posting for an unspecified time period. One may be single handed for a population of 300,000 people, without days off or annual leave entitlement for a monthly salary of about 100 pounds. I am full of admiration – and dismay.

The benevolent eye service trust

August 2010: A review – over 50% of patients showed they achieved a visual acuity of 6/12 or better (with pinhole). Unfortunately there was a high rate of posterior capsular opacification with no Yag laser in sight.

December 2010: The Benevolent Eye Service Trust (BEST) was registered with the charity commission in the UK.

BEST logo

April 2011: We have moved to better premises at Pun Hlaing Hospital in Yangon and hold weekly clinic sessions for non-paying patients.

October 2011: We have had 605 outpatient consultations, have performed 83 surgeries and given 16 laser treatments. The service is financed by donations and private income; privately owned equipment is shared. There is a place for a continuous non-profit service, giving additional experience and opportunities to local healthcare professionals.

Our four trainees are supervised at all times. We favour good patient care, accurate note keeping and evidence-based practice rather than numbers. We insist on audit and they have the unique opportunity to learn English from a German. My Myanmar vocabulary, however, remains very limited. But there is one phrase I recognise, 'kha na lay'… wait a moment!

I would love to know who financed that cataract surgery initiative – we have a surgical waiting list and need more instruments….please. And the senior local politician – he was gratefully re-elected.

For more information please visit our web site *www.theeyetrust.org*

Miss Therese Worstmann

Eye Journal - Fast Track

If a paper is of high importance or particularly novel, authors have the option of requesting that it be Fast Track reviewed. If agreed, the Editorial Board will aim to review the paper and return a decision within two weeks. This service can be requested in the author's cover letter.

For more information about becoming a reviewer, the Fast Track service or anything to do with submitting a paper to Eye, please contact the Editorial Office (*eye@rcophth.ac.uk*) or visit the website (*http://nature.com/eye*).

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HONORARY FELLOWS

At the Admissions Ceremony in September 2011, an Honorary Fellowship was awarded to Mr Mike Brace. This is an edited version of the citation given in his honour.

President, members of council, ladies and gentlemen, it is a privilege to present this citation on behalf of Mike Brace, an exceptional man, who through his own insight, courage, motivation and example, has done more to help blind and partially sighted people than almost anyone I know.

Mike was born in Hackney in 1950, but at the age of ten, he innocently picked up a black medicine bottle in which was hidden a firework that exploded in his face. Over the next year his sight gradually faded until it was finally expunged by sympathetic ophthalmitis. Life was not easy growing up in Hackney as a blind child, but Mike recalls that he accepted his condition without ever feeling bitter or resentful. At Linden Lodge School he learnt to expertly type, read Braille and enjoy music and drama. He recounts the travails of coping with blindness including numerous faux pas such as scaring old ladies by undressing with the curtains open and sitting on people's laps on the tube. Mike's sense of humour generally prevailed, except when strangers really did ask his mother 'does he take sugar?'

Mr Nick Astbury with Mike Brace FRCOphth (Hon) and the President

There were depressive low times, but liberation as well through music and folk singing and a social life that led in 1972 to a long and happy marriage with Maureen.

Since 1976 he has had two careers. One has been as a social worker, team manager and ultimately Assistant Director for Social Services in Kensington and Chelsea, before taking up his current post as Chief Executive of VISION 2020 UK.

The other has been as a sportsman and sports manager. Sport has played a major role in Mike's life. He co-founded the METRO sports club for the blind and has undertaken over 50 different sports himself, including football, cricket, skiing, ice-skating, bowls, judo, fencing, sailing and surfing. He was National Champion at race walking and still holds many of the records for a totally blind walker. He has completed two London marathons, two ski marathons and the gruelling 125-mile Devizes to Westminster Canoe Marathon.

He represented Britain at cross-country skiing in the first Winter Paralympics in 1976 and then again in three World Championships, six Paralympics and two European Championships. He has managed the British Cross Country Ski Team, and athletics teams in European and World Championships and was the manager for the first England Blind Cricket Team, which participated in the inaugural World Cup of blind cricket in India.

Mike has been Chairman of British Blind Sport and was elected Chairman of Paralympics GB from 2001 to 2008, and was a member of the Board of the successful 2012 Bid Team and the London Organising Committee. He is a trustee or Board member of many organisations including the Disability Sports Development Trust and the British Judo Foundation.

Mike was awarded the OBE for Services to Disabled Sport in 2005 and the CBE in 2009.

I have known Mike as the chief executive of VISION 2020 UK, a post that he has held since 2001. He has served on our College Lay Advisory Group since 2002. In this, and all his other roles, he has shown himself to be totally dedicated to helping other people through raising awareness by public speaking or through quiet personal advocacy. Mike has brought to the role his own experience of sight loss and of battling his way through the obstacles that society has thrown in his and others' way. He can chair a meeting more effectively than his sighted peers and he has guided me through King's Cross station!

Mike is a communicator and over the years has created countless new and positive connections in the sector and encouraged trust between eye health professionals, social service officers and charity workers in a way that 10 years ago would have been unthinkable. For instance, 60,000 people have downloaded his blog, in which he documents his life with Izzie, his new guide dog.

Mr President, it is with great pleasure that I present Mr Mike Brace for the award of honorary fellowship of the Royal College of Ophthalmologists.

Mr Nick Astbury

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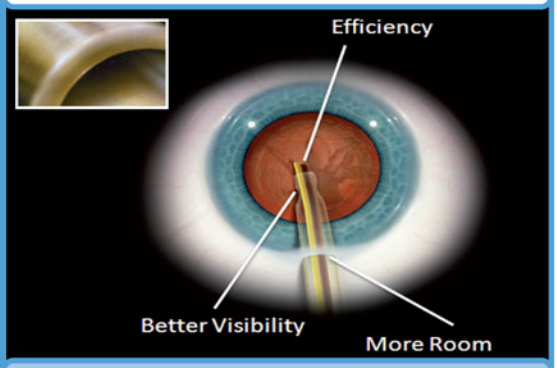

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Annual Congress

14-17 May 2012
Arena and Conference Centre, Liverpool

Important dates for your diary:

13 February 2012
Registration opens

College Seminar Programme

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

17 February
Managing a Diabetic Eye Service
Chaired by: Miss Clare Bailey, Bristol
The Institute of Physics, London

19 March
Post-keratoplasty Nightmares
Chaired by: Mr Jeremy Prydal, Leicester

12 – 13 July
Skills in Retinal Imaging, Diagnosis & Therapy
Chaired by: Professor Heinrich Heimann, Liverpool & Professor Yit Yang, Wolverhampton
The Institute of Physics, London

14 September
Glaucoma, Suspects & Ocular Hypertension
Chaired by: Mr John Sparrow, Bristol
The Institute of Physics, London

19 September
Investigation & Management of Inflammatory Eye Disease
Chaired by: Miss Elizabeth Graham, London & Professor Miles Stanford, London

11 October
What's New in Corneal Disease?
Chaired by: Mr Bruce Allan, London

18 October
The Management of Child/Adult Strabismus
Chaired by: Miss Louise Allen, Cambridge & Mr Tony Vivian, Suffolk

9 November
Screening & Management of Diabetic Eye Disease
Chaired by: Dr Noemi Lois, Aberdeen
Surgeon's Hall, Edinburgh

14 November
Appropriate Management of Neuro-ophthalmology Cases in Casualty
Chaired by: Mr Mike Burdon, Birmingham

30 November
The Elizabeth Thomas Seminar
Chaired by Mr Winfried Amoaku, Nottingham
East Midlands Conference Centre, Nottingham

www.rcophth.ac.uk/seminars

College Tutor Induction Days

9 February
11 June
15 November

College Skills Centre Programme 2011

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

Training the Trainers

6 February
What to teach and How to teach
29 February
Assessment – selection and interviewing, WpBAs, ARCPs, examining.
8 May
Trainees in Difficulty

Clinical Leads Forum 16 March

Chaired by Mr Richard Harrad
beth.barnes@rcophth.ac.uk

Seniors' Day 5 July

penny.jagger@rcophth.ac.uk

Other events 2012

14 January
Ophthalmology ST Interview Skills Course London
ophthalmologycourse@yahoo.co.uk
http://ophthcourse.webs.com

20 January
Southern Ophthalmological Society Meeting
Audrey Emerton Building, Sussex Eye Hospital
lisa.stanton@bsuh.nhs.uk

20 January
Inaugural Sussex Eye Foundation Charity Dinner
Banqueting Room, The Royal Pavilion, Brighton
lisa.stanton@bsuh.nhs.uk

27 January
Joint College SAS Conference
Royal College of Physicians, London
conferences@rcplondon.ac.uk
www.rcplondon.ac.uk/events

22 February – 5 March
Ophthalmology in Cuba
Jon Baines Tours
info@jonbainestours.co.uk

15 March
14th Annual Conference of the Medical Ophthalmological Society UK
St Thomas' Hospital, London
Topics: Uveitis, diabetes update, vein occlusion
lindy.gee@mosuk.co.uk

24 May
The British Contact Lens Association (BCLA)
Therapeutics Academy and Training Day for Medics
ICC Birmingham.
events@bcla.org.uk

1 – 4 July
Oxford Ophthalmological Congress
Oxford Playhouse Theatre, Beaumont Street, Oxford
o_o_c@btinternet.com
CALL FOR PAPERS: Abstracts should be received on-line by the Editor,
Prof A D Dick, Deadline **9 January 2012.**
www.oxford-ophthalmological-congress.org.uk

12 – 14 September
42nd Cambridge Ophthalmological Symposium
St John's College Cambridge
Cancer and the Eye
Chairman: Professor Bertil Damato
Academic Organisers: Mr Keith Martin & Mr Martin Snead
bm.ashworth@tiscali.co.uk
www.cambridge-symposium.org

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