QUARTERLY BULLETIN OF THE ROYAL COLLEGE OF OPHTHALMOLOGISTS

College NEWS

Spring
2012

National Recruitment 2012

There has been a huge drive from the Department of Health for all medical specialties to take part in national recruitment. This is partly driven by costs; estimates suggest that a national system would incur just 1/10th of the total cost of individual deaneries.

The College's Training Committee and Recruitment Subcommittee have been working tirelessly since 2010 to make national recruitment a reality for ophthalmology. The College has come a long way since suggesting interviews took place in several clusters throughout the country, which was piloted in 2011, to going live with national recruitment in one centre.

The College selected the Severn Deanery to co-ordinate 2012 recruitment into Ophthalmic Specialty Training for ST1. This took place on 1 – 3 February in Bristol and required close collaboration between the College and the Deanery. The College wish to thank the Severn Deanery for its excellent support and military-style organisation of the interviews.

A total of 287 candidates applied; 260 were long-listed, 198 were short-listed and 195 candidates were interviewed for a total of 89 ST1 posts. Consultants from all UK deaneries were involved. Interviews consisted of a 30-minute review of the applicant's portfolio by two consultants, a portfolio interview, critical appraisal of a scientific paper and three clinical scenarios that included a communication skills exercise.

The College would like to thank all those involved in the process including interviewers as well as the lay representatives. National recruitment was successful and will now be the norm in the future.

Alex Tytko
Head of the Education and Training Department

Annual Congress

Please visit the College website for up-to-the-minute information on this year's congress – it will be better than ever! 15 – 17 May 2012 Arena and Conference Centre, Liverpool *www.rcophth.ac.uk*

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database@rcophth.ac.uk

Articles and information to be considered for publication should be sent to:
kathy.evans@rcophth.ac.uk
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Copy deadlines

Summer
5 May 2012

Autumn
5 August 2012

Winter
5 November 2012

Spring
5 February 2013

New Ophthalmology Clinical Research Fellowship Scheme Opens for Applications Later this Year

A series of Clinical Research Training Fellowships, supported by the Medical Research Council (MRC), the Royal College of Ophthalmologists and Novartis Pharmaceuticals Ltd, focusing on ophthalmology research training within the United Kingdom will open for applications later this year.

Historically ophthalmology research has failed to attract sufficient numbers of competitive research training proposals. These fellowships are the first example of a prestigious research fellowship involving a royal college, an industry partner and the MRC. The aim is to foster a group of UK researchers dedicated to clinical ophthalmology, and whilst candidates from any area of ophthalmology can apply, applications in the areas of Glaucoma, Medical and Surgical Retina, Paediatric Ophthalmology and Stem Cells, will be particularly welcome as the scheme aims to encourage clinical research in these particular fields.

Up to two fellowships may be awarded per year and will be awarded by the MRC with input from the College. These prestigious three year research programme fellowships are open to all UK based ophthalmologists and will only be awarded to the highest quality science and research applications submitted. Applications for the scheme will open in summer 2012.

Further information will be available in the summer issue of College News and at the College's Annual Congress in May 2012.

From the Quality and Safety Sub Committee

Insertion of incorrect intraocular lens implant (IOL)
Cataract removal with IOL implantation is the most frequently undertaken elective surgical procedure performed in many developed economies. Although most cataract operations have a successful visual outcome, a small proportion continue to be marred by the preventable error of insertion of an IOL implant of a different power to the one intended.

The World Health Organisation's (WHO) 'Safe Surgery Saves Lives' (*www.who.int/patientsafety/safesurgery/en/index.html*) initiative aims to improve patient safety in surgical practice globally. The WHO programme involves, in part, the use of a surgical checklist. There were, however, a number of criticisms of the generic checklist when it was introduced into the NHS. Thus the College and the NPSA developed a bespoke checklist for cataract surgery.[1] An analysis of 'wrong IOL incidents' has been undertaken.[2] The College's cataract surgery checklist requires confirmation prior to surgery that the 'correct IOL' implant has been determined and is available. The checklist was subsequently highlighted by the WHO as an example of good practice. The American Academy of Ophthalmology has provided an educational resource on reducing wrong site/wrong IOL surgery.[3] The Department of Health considers insertion of a wrong implant a so-called 'never event'[4].

The College was informed in late 2011 that reports continue to be received by the NPSA via the National Reporting and Learning System (NRLS) concerning insertion of an incorrect or 'wrong' IOL despite these developments. Although it is disappointing that 'wrong IOL' patient safety incidents are still occurring there is also evidence from the recent reports of 'good practice' being implemented with near misses being identified before an incorrect IOL is implanted. Ophthalmologists are encouraged to use the cataract surgery checklist. It has also been proposed that on occasion the ophthalmologist might consider asking key members of surgical teams "How do you know I've selected the correct IOL for the correct eye?" Another suggestion is circling the IOL power selected on the biometry print out, or the use of highlighter felt tipped pens to draw attention to the IOL power selected.

The NPSA will cease to exist in March 2012 and the patient safety functions of the NPSA are due to transfer to the NHS National Commissioning Board. This change will mean that learning from patient safety incidents in the NHS in England and Wales will be different and may become more challenging despite quality and safety of care being a priority. The College has provided guidance on patient safety available within the hospital eye services folder on the College website. The College welcomes hearing from ophthalmologists on quality and safety matters.

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3. American Academy of Ophthalmology. Wrong Site/Wrong IOL Performance Improvement http://one.aao.org/ce/educationalcontent/performanceimprovementcme.aspx
4 Department of Health. The never events list. London 2012. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132355

The 2012 Ruskell Medal from the Worshipful Company of Spectacle Makers

The award of £750 is for those making their initial "first author" published contribution to the advancement of visual science, optometry or ophthalmology. Reviews and editorials will not be considered. Entrants must have obtained a first degree since 1 April 2009. Closing date 30 March 2012. Contact *clerk@spectaclemakers.com*

COLLEGE TRAVEL AWARDS AND FELLOWSHIPS

AWARD	AMOUNT	CLOSING DATE
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*

The National Ophthalmology Database (NOD)

The National Ophthalmology Database is a College facilitated project to collate pseudonymised data from electronic patient record systems for ophthalmology for the purpose of national audit, research and revalidation[1]. Encouraged by successful pilot extractions undertaken in 2006 through the Do Once and Share cataract project[2-4] this work has been extended to other clinical fields. Eye units from 30 NHS Trusts have so far joined this collaborative exercise with detailed information having to date been extracted on around 480,000 clinical episodes covering a range of topics including cataract surgery (240,000 operations), hospital diabetic eye care, AMD treatments and glaucoma surgery. The College is the official data controller with the governance and running of the project via a management board which reports to the College Revalidation, IT and Professional Standards Committees. Data which are compliant with nationally agreed data standards (e.g. the national cataract dataset) can be extracted and incorporated from any electronic patient record system thus allowing flexibility for current and future care record software.

Following appropriate local information governance permissions, data from electronically enabled units are remotely extracted to a secure server within the NHS firewall. Data are pseudonymised, checked for errors as far as possible and descriptive analyses produced. Summarised data are presented on the website such that contributors are able to view data from their own centre in the context of aggregated data from all centres. For certain items, such as cataract surgery, presentations take the form of funnel plots with individual surgeons able to view their own capsule rupture rate plotted according to their surgical volume alongside all other contributing surgeons. Contributors are able to use these data for personal audit with benefits in terms of appraisal and revalidation.

Access is available from any NHS N3 connected computer with initial registration requiring a valid NHS email address. Ophthalmologists from contributing centres enjoy the greatest functionality in terms of personal or unit based audits. Individuals from non-contributing centres are able to view aggregated data within which context they may manually add their own data point to printed graphs. Members are invited to visit the site at *www.nod.nhs.uk.*

Acknowledgement: Pump priming funding for NOD was received from the National Screening Programme for Diabetic Retinopathy.

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Mr John Sparrow and Mr Rob Johnston

Macular Disease Society 25th Anniversary Awards for Excellence

The Macular Disease Society's fourth Annual Awards for Excellence are now open for nominations. The awards include a Best Clinical Services category which recognises exceptional treatment and outstanding patient care. A poster was included in Society's research journal, Digest, which was circulated in February. You may want to encourage patients in your macular clinic to consider making a nomination! For further details go to: *www.maculardisease.org/awards* Closing date 31 May 2012

The Lay Advisory Group (LAG)

The College wishes to recruit new members to the LAG. Please bring this notice to the attention of friends and colleagues who are neither ophthalmologists nor optometrists. The LAG meets four times a year and members are expected to attend a standing committee in addition. The posts are for three years, renewable once; there is no remuneration but travel expenses are reimbursed. For more details contact *penny.jagger@rcophth.ac.uk*

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THE ROYAL COLLEGE OF OPHTHALMOLOGISTS

Focus

Spring
2012

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

A Jane Dickinson, Consultant Ophthalmologist, Royal Victoria Infirmary, Newcastle

Thyroid-associated Ophthalmopathy

Thyroid-associated Ophthalmopathy (TAO) is an immensely debilitating condition. Half of patients experience anxiety or depression, quality of life is impaired comparable to chronic diseases such as diabetes or some cancers[1], and the socio-economic impact is considerable. Research shows that the worldwide management of patients with TAO is currently suboptimal, including the UK[2] and so, in 2009, an important worldwide initiative was launched.

The 'Amsterdam Declaration', as it is known[3], aims to raise awareness of TAO, improve the experience of patients undergoing treatment and improve outcomes. TEAMeD (Thyroid Eye disease AMsterdam Declaration) Implementation Group UK is a multidisciplinary initiative supported by the RCOphth, BOPSS and other UK professional and patient led organisations, which is driving the Amsterdam Declaration in the UK. TEAMeD is currently preparing national guidelines on referral pathways and will soon launch a national audit.

Although much of TAO is not yet preventable, the hope is that earlier recognition and appropriate referral will help patients to access optimal management. Through optimal early management, the worst sequelae will be prevented; through optimal later treatment, appearance and visual functioning will be normalised as much as possible. The aim of this review is to highlight aspects of TAO that may help ophthalmologists to achieve the goals of the Amsterdam Declaration.

Objectives: For newly presenting patients, there are three mandatory objectives: the diagnosis of TAO must be securely established; the phase of the disease must be identified; and disease severity must be assessed. While severity will indicate whom to treat and how quickly, disease phase determines therapeutic options i.e. how to treat. In addition, for all patients with TAO at any stage of their disease, euthyroidism must be rapidly achieved then maintained, and smoking cessation measures implemented where applicable.

Diagnostic signs and pitfalls: Patients presenting with bilateral signs comprising upper eyelid retraction, soft tissue swelling and inflammation, proptosis and muscle restriction in the context of abnormal thyroid regulation need no further investigations for a secure diagnosis of TAO. Rarely, TAO presents with no detectable thyroid abnormality, no upper lid retraction, divergent strabismus or purely unilateral signs. The diagnosis of TAO is then not secure and needs further investigation. Note that misdiagnosis of TAO as allergy is common; however, TAO does not itch.

Disease phase: TAO is partially self-limiting: active (inflammatory) phases of progression, plateau and regression lasting six to 18 months are followed by inactivity – the 'burnt-out' phase, where abnormalities often persist. Determining phase is important, as disease-modifying treatment is only appropriate during active TAO, while surgical rehabilitation must await the inactive phase. Active disease is usually highly symptomatic. Apart from recent change in appearance or visual function, aching and surface irritation are common. Early muscle restriction provokes diplopia on waking. Active TAO usually shows signs of inflammation, with swelling and redness of eyelids and conjunctivae viewed as surrogates for orbital inflammation. The clinical activity score (CAS)[4], although not infallible helps identify active TAO and predict treatment response. Clinical assessment plus duration of TAO will determine phase in most patients[5]. Occasionally alternative strategies are needed for moderately severe disease with low CAS. These include re-assessment over time, trial of medical therapy or further investigations e.g. quantitative MRI.

Severity: Severity refers to the degree of deficit in any feature of TAO. 'NOSPECS' provides a good aide memoire, however, a stricter measurement protocol e.g. *www.eugogo.eu* helps future comparison. It is worthwhile noting that Hess charts are poor for assessing TAO unless strictly unilateral, and late change is difficult to interpret as it does not necessarily denote relapse. Uniocular excursions and binocular fields are far more helpful. Management decisions are simplified by grouping patients into three categories of severity[6]: sight-threatening; moderately severe but not sight-threatening; and mild. Apart from the rare situation of subluxation, all patients with new sight threatening disease are active, whereas lesser degrees of severity can apply equally to inactive patients or those where phase is uncertain. Alternatively, the VISA system[7] uses a slightly different protocol and provides a useful proforma and management paradigm, although the principles of treatment remain the same.

Sight-threatening TAO: All patients with active TAO should have dysthyroid optic neuropathy (DON) positively excluded as its signs may be subtle. Older male diabetic smokers are at greater risk. As proptosis signifies self-decompression then those with muscle restriction but minimal proptosis (tight orbits) are at highest risk. Visual acuity and field loss may be mild, but are usually preceded by loss of colour appreciation, plus an afferent pupil defect if DON asymmetrical (60%). Imaging can suggest risk of DON, but the diagnosis is purely clinical. It relies on detecting either a swollen disc or at least two of the four features above. The risk of lagophthalmos and corneal ulceration relates principally to poor levator function (rather than upper lid retraction per se), in the context of a tight inferior rectus and poor Bells'. It may be further aggravated by proptosis. Corneal exposure is an emergency.

Moderately severe but not sight-threatening TAO

If motility restriction, appearance or aching impact significantly on daily life, then TAO may be severe enough to justify disease modulation if active, or surgery if inactive. This decision rests on balancing anticipated benefits against side effects of treatment[6,8], so assessing quality of life can help[9].

Mild TAO: If the risks of disease modulation or major surgical treatment are not justified by the benefits then TAO is mild. However, these are not absolute categories and lid surgery may still be indicated once inactive.

Management of active TAO: All patients should have optimal thyroid control and be helped to stop smoking as both measures reduce the risk of worsening disease and show a significant benefit on outcomes[10,11]. Both gel and nocturnal ointment lubricants are a major help, and fresnel prisms may be indicated.

Sight-threatening TAO: Treatment is mandatory and evidence suggests that intravenous methylprednisolone (IVMP) is optimal first line treatment[12]. There is no evidence-based protocol, however, 500mg–1g daily for three days before assessing response is commonly used. Patients who fail to respond adequately require prompt surgical decompression. Radiotherapy is inappropriate as sole therapy as its time course for response is too long, however, it may be useful adjunctive therapy. The place of other agents in DON is less clear.

Moderately severe but not sight-threatening TAO: For active patients of this severity, the first line treatment is generally corticosteroids. IVMP has greater efficacy and fewer side effects than oral steroids[6,13], with a mean of 79% patients responding to IVMP monotherapy versus 56% for oral regimes. Additionally, any response is seen early so non responding patients can quickly be withdrawn and offered alternatives. When radiotherapy is combined with IVMP 88% of patients respond, and it may have a more lasting benefit, particularly on motility. Radiotherapy should be avoided in diabetic patients or those under 35 years of age. Oral prednisolone plus radiotherapy is less efficacious than IVMP, and similar to oral prednisolone plus cyclosporine, although the latter has more side effects[13]. Of prime importance is the avoidance of prolonged oral prednisolone. This increases the likelihood of cushingoid change, which has a major negative impact on patients. Additionally, fatty change in the orbit can increase venous congestion making it difficult to differentiate from active disease, although imaging and intraocular pressure can help. The place of azathioprine in combination is yet to be proven, however, a trial is in progress.

Mild TAO: In addition to supportive measures, oral selenium 200 µcg daily for six months improves TAO outcomes[14].

Post treatment relapse: Some relapse after 12 weeks of steroids and radiotherapy is common but, unless the patient returns to a severity warranting treatment, this period can usually be weathered. Few patients require other therapy, but cyclosporine can be effective.

Management of inactive TAO: Surgical rehabilitation follows a logical sequence based on anticipated side effects: namely decompression precedes strabismus surgery, which precedes eyelid lengthening and finally debulking. As patients with significant TAO rarely return to normal appearance and function, such surgery offers the chance to transform patients and help restore quality of life. Orbital decompression is immensely valuable, with low morbidity in experienced hands. However, a recent study has shown that decompression rates vary widely across the UK, dropping off significantly with increasing distance from the few major centres[15]. Proptosis readings do not have to be above an arbitrary cut-off before offering orbital decompression; premorbid appearance and quality of life assessment[9] can help select suitable patients. Hence it behoves us all to appreciate the scope of current surgical rehabilitation; to develop it or refer as necessary for optimal care. Close Liaison with the endocrinologist to optimise thyroid treatment is so crucial in TAO that multidisciplinary clinics have developed in many areas. Their advantages include patient convenience, shared expertise in difficult decisions and ease of flow of information between clinicians. Additionally, patients being considered for radio-iodine can have eye assessment to ensure they do not have active TAO, which may worsen unless steps are taken.

Current theories of pathogenesis and novel therapies: TAO is an autoimmune process where the main target is the orbital fibroblast. Fibroblasts are stimulated by cytokines and induced to interact with immune cells. This results in excessive glycosaminoglycans (with fluid accumulation and swelling of muscles), further cytokines and chemo attractant production, and also their differentiation into adipocytes thereby increasing the fat of the orbit[16]. Increasing understanding of these processes suggests potential roles for new agents, some of which are starting to be tested. One such agent is rituximab. This is currently undergoing randomised trials; however, until results are available it is inappropriate for this expensive agent to be used outside of specialist centres.

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Acknowledgements: I am grateful to Dr Petros Perros for his comments on this manuscript.

18th century quacks - part 1

In the 18th century, England was regarded as the paradise of quacks. Ophthalmology attracted three of the most famous and outrageous. This issue will describe two of them and the third will feature in the Summer 2012 issue.

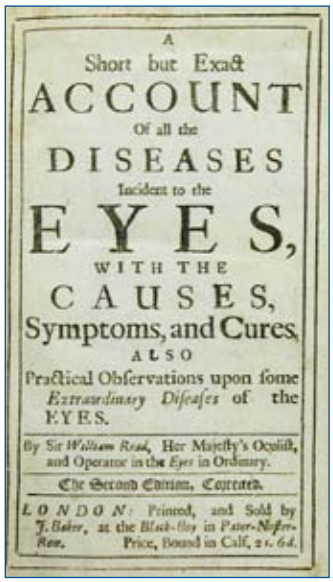
WILLIAM READ

There is no birth date for William Read but by the time he died in 1715 he was famous. Read was an itinerant and highly successful oculist whose flamboyant advertising of his medical and surgical skills came to the attention of Her Majesty, Queen Anne whose Oculist in Ordinary he became. She subsequently knighted him for treating seamen and soldiers gratis. This high honour attracted considerable lampooning.

Sir William Read was illiterate and could not sign his name and yet he published a book in 1706 titled "A short but exact account of all Diseases incident to the Eye". In fact the first part was a faithful lift from Richard Banister's "Breviary" of 1622 citing cases as though they were his own. However, he omitted the chapter titled "Of proud quacksalving montebanks that would undertake all cures and perform few"!

The second part is a direct copy of the

William Read



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Read's book

English translation of Jacques Guillemeau's book of 1585. The third part is his own, written by an amanuensis, boasting of his surgical dexterity and promoting his styptic water apparently a cure for all ailments. Sir William Read's rare book was recently acquired for the College library.

ROGER GRANT

There is no birth date for Roger Grant; he was also illiterate and could not sign his name.

His early career was as a cobbler though some referred to him as a tinker. He was also an Anabaptist claiming the power of healing with semi miraculous cures. In 1710 he became sworn oculist and operator in ordinary to Queen Anne and then later to George I. He lost an eye in the Emperor's service in the continental wars, a fact on which he traded as giving him special insight into those who were blind. A full account of many of his operations was advertised twice weekly in the British Apollo, an 18th century periodical, and these contained glowing accounts of sight repaired. He was in the habit of giving his friends and acquaintances engraved portraits of himself.

He died about 1724

This poem sums him up admirably:

"A tinker first his scene of life began;
That falling, he set up for cunning man,
But wanting luck, puts on a new disguise,
And now pretends that he can mend your eyes;
But this expect, that, like a tinker true,
Where he repairs one eye he puts out two."

Roger Grant

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

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Members' News and Appointments

The Annual General Meeting

The 2012 AGM will take place at 4.00 pm on Wednesday, 16 May and all members are eligible to attend. Those members who are not registered for Congress but wish to attend the AGM only must present themselves at the registration desk at 3.15 – 3.45 pm so that a security pass can be made. The agenda and proposed subscriptions for 2013 have been included as an insert in this issue of College News. The papers can also be downloaded from the members' area of the website: *www.rcophth.ac.uk*

Staff and Associate Specialists' Forum

Tuesday 15 May 2012 at 5.30 pm

OTG Forum

Wednesday 16 May 2012 at 5.30 pm

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 Faisal Ahmed	Western Eye Hospital, London
Dr Suheb Ahmed	Forth Valley Royal Hospital, Larbert
Mr Amer Awan	Ayr Hospital, Ayr
Mrs Antonella Berry-Brincat	Lincoln County Hospital, Lincoln
Mr Howard Bunting	Queen Mary's Hospital, Sidcup
Mr Maged Habib	Sunderland Eye Infirmary, Sunderland
Mr Kim Son Lett	Birmingham and Midland Eye Centre, Birmingham
Mr Asif Orakzai	Altnagelvin Hospital, Londonderry
Miss Poornima Rai	Moorfields Eye Hospital, London
Mr Dinesh Rathod	Glangwili General Hospital, Carmarthen
Miss Alison Rowlands	Arrowe Park Hospital, Wirral
Mr Sachin Salvi	Royal Hallamshire Hospital, Sheffield
Mr Mahmoud Sarhan	Calderdale Royal Hospital, Halifax
Miss Elisabettamaria Scoppettuolo	Altnagelvin Hospital, Londonderry
Mr Anil Singh	Lister Hospital, Stevenage
Miss Vasuki Sivagnanavel	Kingston Hospital, Kingston upon Thames
Mr Nicholas Strouthidis	Moorfields Eye Hospital, London
Mr Simon Taylor	Imperial College London and Royal Surrey County Hospital, London/Guildford
Dr Catherine Wheeldon	Stirling Royal Infirmary, Stirling
Mr Roger Wong	St Thomas' Hospital, London
Miss Rahila Zakir	Western Eye Hospital, London
Mr Gamal Zohdy	Glangwili General Hospital, Carmarthen

Obituaries

We note with regret the death of:

Professor Eric Arnott, Bordon, Hampshire. A memorial service will be held on Thursday, 29 March at 11am at St. George's Church, Hanover Square, London WIS IFX.

Dr B Bhattacharya, Torquay, Devon

Mr Peter Fenton, Fareham, Hampshire A memorial service will be held on Thursday, 12 April 2012 at St Margaret Lothbury, Lothbury, London, EC2R 7HH

Mr John C Gwasaze, Kampala, Uganda

Dr Abdul Latif Khan, Swansea

Mr Denis Wilson, Cork, Eire

Mr Redmond Smith, Ealing, London. Mr Smith was awarded an Honorary Fellowship in June 2009 and a brief obituary appears on page 12.

CHANGING OF THE EXAMINATIONS GUARD

Professor Carrie MacEwen term as Senior Vice President and Head of the Examinations Committee will come to an end at the May AGM. Four years of hard work and dedication were celebrated with a spectacular cake at the morning coffee break at the February Examination Committee meeting. Mr Peter Tiffin is her successor.

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
June 2012	Mr Harry Bennet	Scotland South East (Edinburgh)	Yes
June 2012	Mr Chris Blyth	Wales	No
December 2012	Miss Susan Downes	Oxford	No
Interim placement	Mr Christopher Scott	North East	No

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College Open Afternoons

– *a request for help*

To celebrate the Olympic Games being held in London, the College has teamed up with our two neighbouring Colleges in the Regent's Park area: the Royal College of Physicians and the Royal College of Obstetricians and Gynaecologists, to host a series of open afternoons during the period of the Olympic Games.

The College hopes that this will help to raise the profile of the College with the general public and it will give members of the College an opportunity to engage with people with an interest in matters relating to eye health and the importance of research. The Museum Curator and Miss Wendy Franks have agreed to show instruments from the College collection and to mount an exhibition of watercolours. We hope to complement the exhibition with a demonstration of the EyeSi simulator to show the difference in procedures then and now. We might also screen showings of The Olympian Ophthalmologist and clips of operation videos.

Unfortunately, the College is not able to reimburse hotel expenses and has only a limited travel budget, but if you live or work within easy travelling distance of the College – or happen to be in London anyway – please do consider whether you might be able to volunteer for an afternoon or two. This is an opportunity for every member from new trainee to senior member to get involved with outreach and to greet visitors from the UK and overseas to London and the success of the venture will depend on you, the members. Finally, although the afternoons will be free of charge to the public, any donations will go to the John Lee Fellowship Fund. Please contact *penny.jagger@rcophth.ac.uk*

Certificate of Eligibility for Specialist Registration (CESR) – an opportunity to be involved

The College wishes to recruit consultants to assess applicants who seek entry to the Specialist Register via the Equivalence route (formerly known as the Article 14 route). This involves reviewing applications from doctors both from the UK and abroad to determine whether their training and subsequent experience is equivalent to that of a recently successful CCT candidate.

This standard is set in law by order of parliament to ensure the highest standard of patient care and safety. The CESR panel will then make a recommendation to the General Medical Council as to the suitability of the applicant being placed on the Specialist Register.

Training in the assessment process will be given by the College with a graded involvement in performing the assessment (i.e. consultants will start as an observer, then become a non-lead assessor and finally, when sufficient experience has been gained, take on the responsibility of a lead assessor).

This stimulating and rewarding work is open to substantive NHS consultants in the UK of at least five years' standing who have recently been involved in the training process. They must also be current members of the College, registered for continuing professional development (CPD) and the appointment will be for three years (renewable once).

The job description and application form is available on the members section of the website under the appointments and opportunities section: *www.rcophth.ac.uk/appointments.*

Please send a CV and the completed application form to: *alex.tytko@rcophth.ac.uk* by Thursday 12 April 2012. A training day for assessors is planned for Tuesday 4 September 2012 at the College.

Mr Peter Simcock
Chairman – Equivalence of Training Subcommittee

College representative needed for primary care group

The College is seeking a representative to sit on the Vision 2020 UK Primary Care Group and report to the Professional Standards Committee (PSC). The Group exists to provide a multidisciplinary forum for advocacy and guidance for the provision of primary eye care health in England. Specific responsibilities will include leading on the Map of Medicine clinical pathways for ophthalmology for the Group and the College. The Group meets twice a year and the PSC meets four times a year.

Please contact (*beth.barnes@rcophth.ac.uk*) or see the information on the Appointments page (membership area) on the College website. Closing date for nominations 27 March 2012. The PSC will review any nominees at the next meeting on 20 April 2012.

OBITUARY: Redmond John Hamilton Smith

MS, DO, FRCS FRCOphth (Hon)

Consultant Ophthalmic Surgeon, Moorfields Eye Hospital and St Mary's (the Western Ophthalmic)

Redmond was educated at the Oratory School and then at St Mary's Medical School, where he was secretary of the Students Union and played for the rugby and cricket first teams. He qualified in 1946 and his introduction to ophthalmology was as house surgeon to the Eye Department at St Mary's. After service in the RAMC he became a resident at Moorfields Eye Hospital, City Road, and later worked part-time in the Institute of Ophthalmology. He was appointed consultant to the Royal Northern Hospital in 1954 and three years later to St Mary's Eye Department, which moved to the Western Ophthalmic. In 1960 he was appointed at Moorfields Eye Hospital, City Road.

Redmond was an outstanding general ophthalmologist with a special interest in glaucoma and he ran a dedicated clinic at Moorfields for many years. He was an innovative surgeon and introduced some novel operative procedures, such as the injection of supra-choroidal air into the eye in retinal detachment surgery, and the operation of trabeculotomy by means of a nylon suture first passed along the canal of schlemm and then 'bowstringed' into the anterior chamber (being one of the earliest to use an operating microscope).

He carried out research into a number of subjects, including diabetic retinopathy (with Harry Keen), the minute anatomy of the canal of schlemm (under the guidance of Norman Ashton) and the natural history of neovascularisation of the iris following occlusion of the central retinal vein. He was the first to show that the earliest appearance of the new vessels is on the trabecular meshwork and that these vessels can be made to regress by ablation of the anterior part of the retina.

Most of his publications (including a textbook) were on glaucoma but in 1984 he became editor of the British Journal of Ophthalmology and authored editorial notes on a variety of subjects.

He was an inspirational teacher who followed the technique of Sir George Pickering, questioning dogma and ideas not based on sound logic. He also taught a multitude of other things based on his numerous hobbies. His placid temperament and modesty, amongst many other virtues, were a great example to junior staff and colleagues. Redmond is survived by his devoted wife Stella and a loving family. He will be greatly missed.

RJM

Membership by election

This College wishes to recognise the contribution of long-serving staff grade and associate specialists (SAS) ophthalmologists to patient care in the NHS as well as their past and continuous support to teaching and College activities.

In December 2011, Council members unanimously voted for the creation of a new category of membership: membership by election, which confers with it the use of the post nominals MRCOphth and voting rights.

Newly appointed consultants in the NHS can also apply if not already a member or Fellow of the College by examination.

It is hoped that this step for a more inclusive membership will enrich the College. Please spread the word to your friends and colleagues who are not yet members.

Visit the College website to view the eligibility criteria and access the application forms:
www.rcophth.ac.uk/page

Mr Bernard Chang,
Honorary Secretary

Senior NHS officials & GMC support doctors' professional leave

Sir Harry Burns (CMO, Scotland), Dame Sally Davies (CMO, UK Government), Dr Tony Jewell (CMO, Wales), Sir Bruce Keogh (Medical Director, NHS England), Dr Michael McBride (CMO, Northern Ireland) and Sir Peter Rubin (Chairman, GMC) have written to every employer in the NHS to support the need for doctors to undertake national work of benefit to healthcare systems across the UK. They point out that organisations such as the College rely heavily on senior members of the profession for their expertise and experience in a whole variety of roles. We hope that letter of support will help members seeking leave to undertake College activities.
www.rcophth.ac.uk/professionalleave

The World Ophthalmology Congress 2018

The College presented its bid to host the WOC in London in 2018. We gave it our best shot but Barcelona was selected at the host city,

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HONORARY FELLOWS

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

In order to recognize Piers' achievements we need to go back in history. When I started ophthalmic training 28 years ago I was taught the intracapsular technique where intraocular lenses were inserted under a bubble of air to protect the corneal endothelium. However, 7 years previously, the switch to extracapsular surgery was already being led, not from teaching hospital units, but from Scarborough and Bromsgrove and Piers continued to influence the switch through a series of surgical demonstrations, lectures and publications. He introduced viscoelastics into Scarborough and the UK in 1980 and researched and demonstrated their use, including filming eyes from the side to show how space could be maintained. In 1984 Piers reported on his 4 year clinical trial and by 1987 sodium hyaluronate had become universally accepted as a tool for maintaining space and preventing damage to the corneal endothelium. In the days when most of us were still using superior scleral tunnel incisions Piers was again leading the way with sutureless temporal clear corneal incisions – commenced in Scarborough in 1993. And on December 15th 1987 he implanted the first diffractive multifocal lens in Europe.

In those days audit hardly existed and some lens implanting surgeons were, on occasions, somewhat economical with the truth when it came to their results. In contrast Piers was always very open about his results and on one occasion was rapidly dropped as a lens company speaker for being, in their opinion, too candid. Such honesty is as important for patient safety today as it was then, as the recent problems with the de Puy hip implant exemplify.

Piers can be justifiably proud of his enthusiasm for sharing knowledge and expertise. He brought the congress of the European Intraocular Lens Implant Society meeting to Harrogate in 1984 and was determined to give those in the UK the benefit of American and European experience. In the dark ages, before the dawn of the internet, Piers organized 7 international teaching symposia at Scarborough from 1979 to 2000. This stretched the workings of the Scarborough Postgraduate Medical Centre and its staff to their limit. In the days before health and safety dominated our lives, not only were the seats in the lecture theatre full but most of the stairway and aisles too. It was a golden opportunity for those of us who were having to learn phaco, without the benefit of either surge control or consultant supervisors in theatre, to come and listen to the likes of Howard Fine and Richard Lindstrom. And the sun always shone in Scarborough as his wife Mary, who we are delighted to see here with us today, entertained delegates and their spouses.

Piers shared his knowledge and expertise on the international stage and did not hold the then current opinion that implants should not be used in the third world. As well as trips with ORBIS, in 1989 he led a UKIIS initiative team to work in rural Mindanao in the Philippines. Clinics were held outside under a huge umbrella at Dapitan – where no previous ophthalmologist had worked since the exiled Jose Rizal was executed in 1896. After two weeks of demonstrating implant surgery, the team were ready to leave, but then came a coup. Land routes were closed by bandits and there was no possibility of moving by sea because of pirates. It took four hours to telephone the consul in Manila using one of the two public telephones shared by ¾ million people.

Mr Hayward, Mr Percival and the President

In the midst of his national and international responsibilities Piers did not neglect his own department and was keen that those who worked in it had every training opportunity. One of the reasons for his notable production of papers is that from the start he kept a proforma for every implant patient and encouraged those in the department to get involved with clinical research. It was no surprise that, when others were struggling with Article 14 applications, the Associate Specialist at Scarborough was one of the first to gain entry to the specialist register by the CESR route. When we expanded the Yorkshire rotation Piers took on the responsibility of registrar training. The commute was long but our registrars relished the opportunity of surgical training that they experienced.

Piers, your name, along with Mr Michael Roper-Hall, shows that Ophthalmology between Watford Gap and the Scottish Borders is alive and kicking. We pay tribute to a surgeon who led modern cataract surgery, and in particular intraocular lens implantation. Cataract surgery is still an important part of what we do. To the surgeon it may be just another cataract on the list; to the patient it is a very important day. Piers, you illustrate that no matter where you work, in a department however small and without the advantage of wall to wall registrars, you can still make, and be recognised for, a significant contribution to your patients and your specialty.

Mr Mike Hayward
the European Intraocular Lens Implant Society

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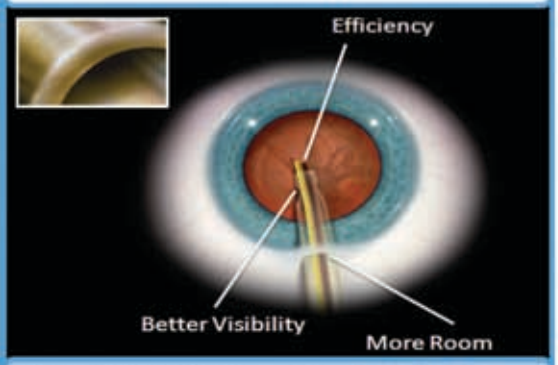

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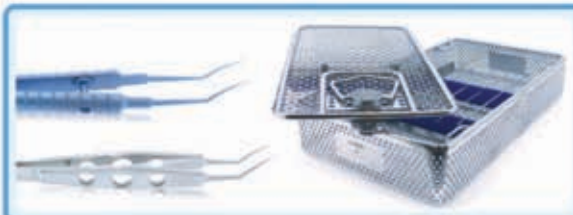

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Annual Congress

14-17 May 2012
Arena and Conference Centre, Liverpool

College Seminar Programme

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

Seminar Calendar 2012

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
Mr Winfried Amoaku, Nottingham
East Midlands Conference Centre, Nottingham

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

College Tutor Induction Days

11 June
15 November
education@rcophth.ac.uk

College Skills Centre Programme 2012

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

The Training the Trainers

8 May
Trainees in Difficulty

21 June
Appraisal/How to teach practical skills
education@rcophth.ac.uk

Senior's Day 2012

5 July
penny.jagger@rcophth.ac.uk

Macular Disease 'Top Doctors' seminars

The College is delighted to be working with the Macular Disease Society as part of their 25th Anniversary celebrations to present a series of 'Top Doctors' seminars across the UK. The eight seminars, aimed at patients with macular degeneration, run from May through July. Members of the College will give talks covering the latest information on macular treatments, services and research.

Edinburgh	14 May	Prof Baljean Dhillon
Belfast	15 May	Prof Usha Chakravarthy
Manchester	24 May	Prof Paul Bishop Prof Christine Dickinson
Newcastle	14 June	Mr James Talks Dr Patrick Degenaar
Inverness	19 June	Dr Simon Hewick
Bristol	28 June	Ms Clare Bailey Dr Denize Atan
Birmingham	17 July	Prof Jon Gibson Dr Hannah Bartlett
London	19 July	Prof Harminder Dua Prof James Bainbridge

www.maculardisease.org

Other events 2012

24 – 27 May
The British Contact Lens Association (BCLA)

24 May
Therapeutics Academy and Training Day for Medics
ICC Birmingham.

1 – 4 July
Oxford Ophthalmological Congress
Oxford Playhouse Theatre, Beaumont Street, Oxford
o_o_c@btinternet.com
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
bm.ashworth@tiscali.co.uk
www.cambridge-symposium.org

18-21 September
EVER European Association for Vision and Eye Research
Nice
www.ever.be

College open afternoons

2-4pm
Tuesdays & Thursdays
31 July - 23 August 2012
penny.jagger@rcophth.ac.uk

Membership information

Please contact:
database@rcophth.ac.uk
if you get a new email address so that we can keep in touch with you. This is particularly important if your NHS trust changes its name.

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