

# College NEWS



**Autumn  
2013**

## President's Election

Professor Harminder Dua's term as President will end in May 2014; the election process for his successor will be run by the Electoral Reform Society and, as far as possible, it will be conducted electronically. We therefore need the correct email for members eligible to vote. Please contact [database@rcophth.ac.uk](mailto:database@rcophth.ac.uk) if you need to change or verify your details held on the membership database.

### The key dates are:

9 September	Call for nominations from past and present Council members
8 October	Deadline for receiving nominations is 5pm.
10 October	Information sent to the Electoral Reform Society
28 October – 29 November	Election period

## Report on the 25<sup>th</sup> Anniversary Annual Congress 2013: 21–23 May, Liverpool

With the 25th Anniversary of the formation of the College, there was much anticipation at this year's Annual Congress. The opening double session was chaired by the President, Prof Harminder Dua, and a variety of opinion leaders spoke on 25 years of progress in ophthalmology. Prof David Spalton (London) reminded us of the transition from extra-capsular cataract surgery to phacoemulsification today. Prof Jon Gibson (Birmingham) outlined the huge progress in medical retina with the introduction of anti-VEGF therapy. Developments in other sub-specialty areas in ophthalmology were covered by Mr Bill Aylward (vitreo-retinal surgery), Mr Larry Benjamin (surgical training), Prof Peng Khaw (glaucoma), Prof Dimitri Azar (refractive surgery), Prof Andrew Dick (ocular inflammation) and Mr Geoff Rose (oculoplastics). Speakers reminded us of how things were done 25 years ago and how things are now!

As usual, the Congress was the College's opportunity to invite distinguished speakers from around the world to deliver its eponymous

lectures. Prof David Williams (New York, USA) delivered the Edridge Green Lecture, showing the advances in adaptive optics with its application to live imaging of single human cells in the eye. He showed a spectacular series of images revealing the living retinal microstructure.

Prof Phil Murray (Birmingham, UK) gave an entertaining Duke Elder lecture, sharing his research and clinical experience of uveitis. Uniquely, Prof Murray presented satirical video interviews of a fictitious patient attending his uveitis clinic over several years. Despite the vast improvements in the understanding of ocular immunology and therapy, we were shown how little has changed from a patient's perspective. However, Prof Murray did show a final video sketch of the same patient sometime in the future, suggesting clinician's sputum as a curative therapy!

The third eponymous lecture, the 'Optic UK Lecture', was presented by Dr Gerrit Melles (Rotterdam, Netherlands).

...continued page 2

<b>2</b>	Building report
<b>3</b>	Members' news and appointments
<b>5</b>	Focus
<b>7</b>	Museum Piece
<b>9</b>	Opinion Piece
<b>10</b>	Professional standards news
<b>12</b>	Awards and scholarships
<b>14</b>	Glaucoma day and Retina day
<b>16</b>	Diary

Eponymous Lectures from Congress will be available on the College website [www.rcophth.ac.uk](http://www.rcophth.ac.uk) from 2 September.

The 2014 Diary is enclosed. This has been supported by Altomed Limited,

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

### Copy deadlines

Winter	5 November 2013
Spring	5 February 2014
Summer	5 May 2014
Autumn	5 August 2014

Dr Melles described how his ground-breaking work in lamellar corneal transplant surgery has transformed the treatment of corneal endothelial disorders, which has changed from full thickness keratoplasty to transplantation of the posterior corneal layers. He showed how the technique has been further refined so that transplanting just the Endothelial-Descemet's layer (DMEK) can achieve outstanding visual outcomes.

The 25th Anniversary was celebrated by a special drinks reception held at the Museum of Liverpool, where delegates were able to mingle, catch up with gossip and view the attractive artwork on display.

Overall registrations were up from last year with around 1,300 delegate registrations. The largest increases were for consultant and specialty doctor registrations, as well as a large number of overseas delegates from 36 different countries. All 47 sessions were well attended with strong positive feedback.

The Congress received a total number of 509 abstract submissions for poster/paper/case report/DVDs sections but only 226 posters and 20 videos were accepted. Among the accepted poster abstracts, 22 were chosen for the rapid-fire sessions. The Trade Exhibition, organised by OPTIC UK, was well received with all commercial space taken and exhibitors reported a strong interest in their products from delegates.

The tremendous success of the 2013 Congress could not be achieved without the efforts of the scientific committee led by Prof Tony Moore and the College staff: Heidi Booth-Adams, Olivia Sibly and Alice Lancaster. Their detailed preparations and on-site management ensured that our 25th Congress remains one to remember!

Mr Parwez Hossain,  
Honorary Programme Secretary

## BUILDING REPORT No. 3



*Work begins on the ground floor*

Since the last building report (College News – Summer 2013), we have concluded the tender process and have chosen Cameron Black Ltd to refurbish and fit out 18 Stephenson Way. The company has completed a number of projects that can be seen on [www.cameronblack.com](http://www.cameronblack.com); recent clients include The Prince's Trust, The British Film Institute and Google.

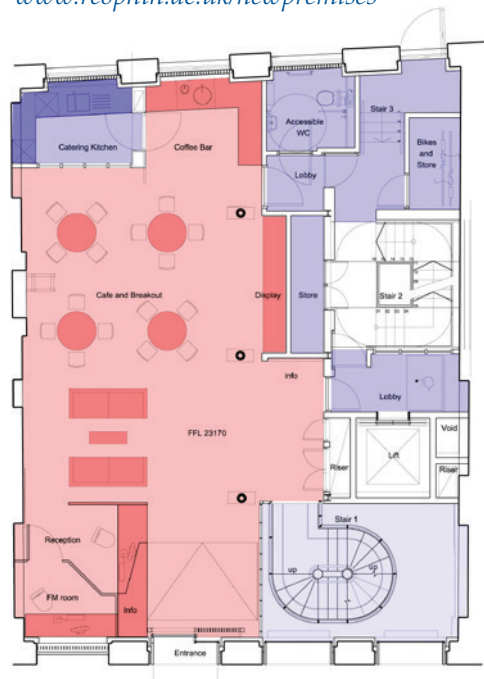
Cameron Black took possession of the building on 8 July 2013. It had already been substantially stripped out and the final asbestos tests revealed nothing untoward. The first tasks included creating temporary offices for the construction managers and welfare areas for the staff and removing the old lift. Underpinning work has started in the basement and there has been some grit blasting of external and internal walls to establish the colour and state of the brickwork. In the next few months, the new lift will be installed and the concrete base

for the feature staircase formed. The façade will be cleaned, redundant rainwater pipes removed and repairs carried out to the cills, brickwork and to the glazed tiles on the front elevation. Work on the shell for the additional storey will also start in earnest which will be very exciting.

Away from the building site, we have begun work with the architects, Bennetts Associates, on furniture specifications so that the College will be a stylish, welcoming and comfortable place for members and guests, and a pleasant and functional workplace for staff. Aziz Rajab-Ali and Sara Davey are leading on the IT and audio-visual projects and College staff are generally sifting through and scanning records and correspondence kept in Cornwall Terrace to reduce the volume of paperwork to be transferred.

Our fundraising efforts have received a notable boost from the Oxford Ophthalmological Congress, which made a generous donation to enable the commission of a large cabinet to house College artefacts on the ground floor. We have also received a number of generous donations from Fellows and Members, patients and societies, which will all go to improve the technical infrastructure of the College. All donations of £2,000 and over from individuals will be recognised in a permanent form.

You can make a donation by visiting our Justgiving page [www.rcophth.ac.uk/newpremises](http://www.rcophth.ac.uk/newpremises)



*Plan for the ground floor*

### Turning a Blind Eye

To celebrate the College's 25th anniversary and to capture the advances in strabismus, Mr Hugh Williams has produced a DVD that is both informative and entertaining. The DVD was distributed to Congress delegates but we still have a few copies; please contact [reception@rcophth.ac.uk](mailto:reception@rcophth.ac.uk) if you would like to receive one.



# Members' News and Appointments

## Consultant appointments

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

Mr Mohammad Abbasi	Torbay Hospital, Torquay
Dr Deepa Anijeet	Stobhill Hospital, Glasgow
Mr Sudipto Farhan Bhatta	Hull Royal Infirmary, Kingston upon Hull
Mr Stephen Byard	The Queen Elizabeth Hospital, King's Lynn
Mr Paul Stephen Cannon	Stepping Hill Hospital, Stockport
Mr Vinoo Philip David	Royal Blackburn Hospital, Blackburn
Mr Ashraf Hassan	Westmorland General Hospital, Kendal
Miss Roxane Hillier	Royal Victoria Infirmary, Newcastle upon Tyne
Mr Zia Ur Rehman Khan	Rotherham District General Hospital, Rotherham
Mr Qasim Mansoor	The James Cook University Hospital, Middlesbrough
Miss Rashmi Mathew	Moorfields Eye Hospital, London
Mr Areeb Moosavi	Milton Keynes General Hospital, Milton Keynes
Ms Eleni Nikita	Manchester Royal Eye Hospital, Manchester
Mr Farhan Ahmed Qureshi	Royal Albert Edward Infirmary, Wigan
Mr Ernest Mark Talbot	Arrowe Park Hospital, Wirral

## Birthday Honours

Two College members were recognised in the 2013 Queen's Birthday honour; many congratulations to both of them

**Professor Peng Khaw** was awarded a knighthood for services to Ophthalmology

**Mr Alexander Daniel Holt-Wilson** was awarded an OBE for Ophthalmologist services to People in Ethiopia.

## Obituaries

We note with regret the death of:

**Dr Francis D McAuley**, Dublin Eire  
**Professor Ramesh C Tripathi**, Columbia, South Carolina USA

## Congress: Honorary Programme Secretary

After several successful years, Mr Parwez Hossain will make 2014 his last Congress as the Honorary Programme Secretary. We are looking for someone to shadow Parwez and then take on the role for 2015 – 2017. Enthusiasm, tact and an interest in organising a scientific programme to a high standard are the qualities required. Please contact [olivia.sibly@rcophth.ac.uk](mailto:olivia.sibly@rcophth.ac.uk) for more information

## The European Subcommittee

College members who have an interest in European ophthalmology and wish to join the relevant committee are asked to contact [penny.jagger@rcophth.ac.uk](mailto:penny.jagger@rcophth.ac.uk) for more information

Call for Certificate of Eligibility for Specialist Registration assessors

Consultants of three years standing interested in assessing CESR applications are asked to contact [alex.tytko@rcophth.ac.uk](mailto:alex.tytko@rcophth.ac.uk) for more information.

## 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 [training@rcophth.ac.uk](mailto:training@rcophth.ac.uk)

NAME	REGION	DATE OF APPOINTMENT	DATE OF REAPPOINTMENT	DATE OF RETIREMENT
Vacant position	Northern Ireland			
Vacant position	Scotland North East (Aberdeen)			
Miss Dilani Siriwardena	Moorfields	September 10		September 13
Mr Christopher Hammond	South East Thames	March 07	September 10	September 2013 (by special agreement)



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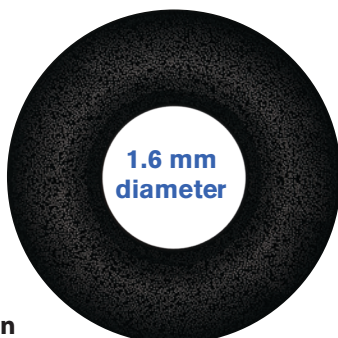
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# Focus



**Autumn  
2013**

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

*Stephen Tuft MChir MD FRCOphth  
Matthew Burton PhD FRCOphth  
Moorfields Eye Hospital NHS Foundation Trust*

## Microbial keratitis

Microbial keratitis is infection of the cornea that can be caused by a range of non-viral pathogens. The causative organisms include bacteria, protists (e.g. *acanthamoeba*), and fungi (yeasts, moulds and microsporidia). It is characterised by an acute or sub-acute onset of pain, conjunctival injection, and corneal ulceration with a stromal inflammatory infiltrate. Depending on the size and location of the ulcer, vision may be impaired.

### Epidemiology

There are large regional differences in the relative prevalence of each of these causative organisms determined by climate and socio-economic factors. In tropical countries fungal corneal infection, often associated with agricultural injury, is a major cause for preventable corneal blindness. In temperate countries, such as the UK, bacterial keratitis is the most common cause, although cases of *acanthamoeba*, fungus and microsporidium keratitis occur.<sup>1</sup> Mixed infections causing keratitis can confuse the clinical picture and make management more difficult. The majority of cases have a clearly identifiable risk factor for infection and in the UK contact lens wear is now the most important risk for all forms of microbial keratitis. Other important risk factors are ocular surface disease, trauma, surgery, and the use of topical steroid. Importantly, risk factors for infection change over time (e.g. increased popularity of contact lens wear and refractive surgery) and monitoring for changing patterns of disease and sensitivity profiles is essential. Guidelines for the management of microbial keratitis need to be informed by local patterns of infection and antimicrobial sensitivities. Although treatment guidelines are often based on laboratory sensitivity data the relevance of in vitro sensitivity disc diffusion results to clinical outcomes is uncertain.<sup>2</sup> Sensitivity testing for *acanthamoeba* is not generally available and fungal sensitivity testing is only performed in the National Fungal Reference Laboratory (Tel: 0117 9285030).

### Diagnosis

A careful history should be taken to identify potential risk factors for infection, particularly a history of recent contact lens wear or foreign travel. Poor lens hygiene, swimming, showering and face washing in contact lenses, or corneal trauma involving contaminated water or soil are especial

risks for *acanthamoeba* infection. Clinical signs do not reliably distinguish different organisms. Some features such as a gradual onset of symptoms may raise the suspicion of an atypical cause, while perineural infiltrates are a frequent feature of early *acanthamoeba* infection, and raised slough and serrated infiltrate margins suggest fungal disease.

Wherever possible, the nature of the causative organism should be investigated by the collection of samples for microscopy, culture and sensitivity testing using a validated protocol. It is not necessary to stop antibiotics prior to taking samples for culture. Multiple samples should be taken from the edges of the ulcer using a disposable needle or blade following the instillation of a non-preserved topical anaesthetic. As a minimum, samples should be placed on a glass slide for gram stain examination and also plated directly onto blood agar and a nutrient broth for bacteria. The use of transport media is not recommended. The laboratory should be asked to give antibiotic sensitivities to agents that are available for topical ophthalmic use.

If *acanthamoeba* infection is suspected an epithelial biopsy should be plated directly onto non-nutrient agar and an additional sample sent in formalin for histopathology. Yeasts and filamentary fungi will grow slowly on blood agar, however, isolation is enhanced if additional samples are plated directly onto Sabouraud dextrose agar. If contact lenses and lens care solutions are available they should also be sent for culture.

Confocal microscopy of the cornea is an important diagnostic aid to help make a rapid diagnosis of *acanthamoeba* or fungus infection. Bacteria and microsporidium are too small to be resolved by this technique. Polymerase chain reaction (PCR) to detect *acanthamoeba* and fungal DNA is not yet generally available in the UK, although this also promises to be useful (see [www.micropathology.com](http://www.micropathology.com)).

### Management of Microbial Keratitis:

Approximately 5% of new cases of microbial keratitis in the UK are caused by fungus or *acanthamoeba* and priority should be given to identifying these cases early. Cases with a history or signs suggestive of *acanthamoeba* or fungus

infection should have smears and cultures, and preferably be referred to a unit where confocal microscopy is available. Appropriate treatment for these pathogens should be started immediately. Topical steroid should not be used until the nature of the infection is confirmed, and then only in conjunction with an effective antimicrobial.

**Bacterial keratitis:** Initial treatment should be with a broad-spectrum antibiotic to cover both Gram-positive and Gram-negative pathogens. Topical fluoroquinolones (e.g. ofloxacin, levofloxacin or moxifloxacin) are well tolerated and effective in the UK. Dual therapy with fortified 5% cefuroxime and 1.5% gentamicin is also effective but less well tolerated. Prolonged use of a fortified aminoglycoside such as gentamicin is toxic and may delay epithelial recovery or cause epithelial necrosis. The topical therapy may subsequently be modified according to the results of in-vitro bacterial sensitivity. Treatment needs to be intensive for the first few days to achieve therapeutic tissue concentrations and rapid control of the infection, with the frequency being reduced in line with the clinical response. Oral antibiotic is not indicated unless there is a risk of endophthalmitis or bacterial scleritis. Topical steroid is not usually part of an initial treatment regimen.<sup>3</sup>

**Acanthamoeba keratitis:** Treatment is directed at killing the amoebic cysts as opposed to the more sensitive trophozoites. Biguanides are the treatment of choice because they have the best cysticidal effect of the available agents. There is no proven benefit of the use of Polyhexanide (PHMB) 0.02% over chlorhexidine 0.02%, and although dual therapy with a second agent such as hexamidine or brolene is common, there is no published trial data to support this strategy. If there is a poor initial response higher concentrations of both PHMB (0.06%) and chlorhexidine (0.2%) are available. The host response is thought to be important in elimination of acanthamoeba infection and the early use of topical steroid may delay recovery and adversely affect outcome. Topical steroid may be indicated later if there is progressive vascularisation, stromal melt, scleritis or marked anterior uveitis. Oral non-steroidal agents (e.g. flurbiprofen 50mg TDS) can help control pain and immunosuppression should be considered if there is an associated scleritis.<sup>5</sup>

**Fungal keratitis:** Evidence from a large randomised controlled trial supports the initial use of topical natamycin 5% for suspected filamentary fungal infections.<sup>4</sup>

Alternatives if this is not available are topical chlorhexidine 0.2% or topical voriconazole 0.1%. If yeast is identified treatment should include topical amphotericin 0.015%. Although the use of an intrastromal injection of voriconazole has been suggested as a means of achieving high tissue concentrations this may increase the risk of perforation. The addition of oral antifungal treatment with voriconazole or Itraconazole is indicated if there is evidence of deep corneal invasion or intraocular spread, or if there is spread of the infection to the limbus. Topical steroid should not be used during treatment of fungal infection. Excisional keratoplasty has an important role for control of progressive filamentary fungal keratitis, aiming for an excision into 2mm of clear tissue. Topical ciclosporin or systemic immunosuppression may be required to control severe inflammation after keratoplasty.

**Microsporidium keratitis:** This is rare but may be seen in patients who have acquired their disease overseas, particularly following visits to Hong Kong, Singapore and other South-East Asian areas. The organism does not grow in culture and the diagnosis is confirmed by histological

examination of an epithelial biopsy. In the majority of cases disease is limited to the epithelium where the appearance can mimic acanthamoeba infection. Epithelial disease is managed by epithelial debridement and the use of a topical fluoroquinolone.

**Progressive disease:** Microbial keratitis may pose a significant therapeutic challenge, particularly if initial cultures are negative. Even in specialist units cultures are negative in 30 to 40% of cases of acanthamoeba despite the presence of clinically characteristic appearances. Filamentary fungi spread deep within the cornea and superficial biopsies may be negative. Suspect unusual pathogens (e.g. Mycobacterium, Nocardia), particularly if there has been laser refractive surgery or foreign travel. Re-culture onto selective media such as Lowenstein Jensen medium, Sabouraud agar and non-nutrient agar. A corneal biopsy (for culture and histopathology) may be necessary, particularly in cases where the infection is focused in the deeper part of the cornea. Confocal microscopy examination or tissue for PCR examination may also prove informative. Strategies for the culture of unusual pathogens, as well as treatment, should be discussed with a microbiologist.

Unfortunately, even with early diagnosis and apparently appropriate therapy a proportion of cases with acanthamoeba or fungal infection will inexorably deteriorate. The reasons why some cases do not respond to therapy despite in vitro susceptibility of the pathogen to treatment are unclear. Better therapeutic agents are required.

## Recommendations

- There should be improved efforts to educate the public of the infection risks associated with cosmetic contact lens wear.
- Acanthamoeba infection should be considered in ALL cases of epithelial or anterior stromal keratitis in patients who have worn cosmetic contact lenses. Do NOT make a diagnosis of herpes simplex infection in a contact lens wearer until acanthamoeba infection has been excluded.
- Do not treat contact lens associated keratitis with topical chloramphenicol. The most common bacterial pathogen for contact lens associated keratitis is Pseudomonas aeruginosa, which is resistant to chloramphenicol.<sup>6</sup>
- Referral pathways for obtaining a confocal microscopic examination should be identified, with prompt referral.
- PCR should be introduced as a diagnostic aid for suspected acanthamoeba or fungal infections.

## Figure

Severe microbial keratitis in a soft contact lens wearer. Early isolation of the pathogen and effective treatment are essential.

## Table

Suggested primary topical treatments for microbial keratitis

Pathogen	Primary treatment	Alternative
Bacteria	Fluoroquinolone e.g. moxifloxacin	Cefuroxime 5% and Gentamicin 1.5%
Acanthamoeba	Polyhexanide 0.02% or Chlorhexidine 0.02%	Hexamidine Brolene
Fungi	Natamycin 5%	Chlorhexidine 0.2% Voriconazole 1%

For references see Collge website



# ARTHUR MacCALLAN (1872 - 1955)

## Trachoma King of Egypt

At the beginning of the 20th century ophthalmia (trachoma) was rampant in Egypt, then in effect a British Protectorate. In 1903 Dr EC Fischer, Professor of Ophthalmology in Egypt, approached the Royal London Ophthalmic Hospital (Moorfields) for help; Arthur Ferguson MacCallan, a 31 year old ophthalmologist, was put forward.



Arthur MacCallan

MacCallan was an unpaid chief clinical assistant and had received no income that year except £10 for a squint operation done privately. He had tried, unsuccessfully, to obtain the post of pathologist at the RLOH and ophthalmic surgeon at St Mary's Hospital and so accepted the post, and its salary of £500 plus expenses, with alacrity.

Writing home, MacCallan recorded that he had to contend with the problem of heat, flies, 'innumerable fleas', and 'mosquitoes as big as sparrows, very bony and strong.' However that was nothing compared to the necessity to adapt to the local culture and practices, learn Arabic and improve his French.

He was to manage the first Travelling Ophthalmic Hospital (TOH) and to teach the local medical staff ophthalmic surgery. Accordingly, he needed to gain the confidence of the locals, medical doctors and dignitaries and to find suitable places to set up the TOHs.

Early on he met Sir Ernest Cassel who had financed the building of the Aswan (Low) Dam. During its construction Cassel, shocked to observe the effect and extent of ophthalmia on the local population, had set up a Trust Fund of E£40,000 in an attempt to alleviate the suffering the disease caused. MacCallan's role was to implement the objectives of the Trust which he did to great effect over the next 20 years.

Professor Ernest Fuchs of Vienna, later a close friend, observed in an article titled 'Egyptian Eye Diseases' that there were only 4 eye hospitals in the country when MacCallan arrived. There were eye specialists in the large towns but in the provinces operations were performed by barber surgeons, much like in England in the 18th century. Dr Max Meyerhof, called the Trachoma 'the twelfth plague of Egypt'.

The trustees of the Cassel Trust Fund decided to use the interest of E£2,000 pa. to establish temporary ophthalmic hospitals (TOH) under canvas. These were to be set up near towns for six months before moving on. The TOH was considered cynically by some of the Egyptian medical profession as being "looked upon by the fellahin as a device by the Christians to destroy the Muslims".

The first TOH camp, set up at Menouf, a town of 23,000 equidistant between Cairo and Alexandria, consisted of ten tents, the kitchen and stores housed in mud brick

buildings. It was a great success, treating 6,157 patients and undertaking 615 operations in just three months and a second TOH was quickly established at Fayum.

However a far greater project was in train: to build a permanent eye hospital in the capital town of every province. Eight hospitals, all designed by MacCallan, were built by 1912 and paid for from public subscriptions and private benefactors. MacCallan also supervised the teaching and training of local Egyptian medical officers

Whilst Kitchener was British Consul (1911-14), he directed MacCallan to personally undertake research into ankylostomiasis and bilharziosis, MacCallan responded by setting up 5 TOHs devoted to these infections.

At the outbreak of World War I, Lord Kitchener was recalled to England to join the cabinet as the War Minister. He ordered MacCallan, then on leave in England, to return to Egypt to be seconded to the RAMC with the rank of Major. He was required to convert a number of the TOHs to military hospitals under canvas for the sick and wounded from various campaigns: the Suez Canal, Gallipoli and Salonica. Surgeon-General Ford stated "Major MacCallan's hospital has been, in my opinion, a model of what a war hospital under canvas should be". MacCallan's reputation spread and after the capture of Jerusalem in 1917, Field Marshall Viscount Allenby



Travelling Ophthalmic Hospital, Luxor 1910.



Travelling hospital for ankylostomiasis

asked him to advise on the ophthalmic hospital.

In 1924 he left Egypt for the last time; his achievements over 21 years, against the odds, were outstanding and included the establishment of 20 permanent hospitals. Before he left he put in motion the building of the Memorial Ophthalmic Laboratory at Giza. A bust of Arthur MacCallan now stands within the building in recognition of his service.



Memorial Ophthalmic Laboratory at Giza

*Light out of Deep Darkness* by MacCallan's grandson, Michael, [mmacallan@yahoo.co.uk](mailto:mmacallan@yahoo.co.uk) is a detailed account of Arthur's years in Egypt. A copy may be borrowed from the joint library of Moorfields / Institute of Ophthalmology and the College.

Richard Keeler, Museum Curator, [rkeeler@blueyonder.co.uk](mailto:rkeeler@blueyonder.co.uk)

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# Independent Sector Provision of NHS Eye Care: A Personal View

The College has strict guidelines within its' Royal Charter preventing it from engaging in commercial activities. However, College members may benefit from understanding how the rapid increase in independent sector provision of NHS eye care may affect the way ophthalmologists work in the years ahead.

In 2012 the Coalition government passed the Health and Social Care Act which opened NHS services to competition from the private sector and 14 eye care services were put out to tender in that calendar year.

There are now a number of companies operating NHS eye care services, both within hospitals and in the community. These include Care UK, Circle Health, Aspen Healthcare/Midland Eye, The Practice PLC and CESP/Newmedica.

Many College members will view the arrival of competition within the NHS with dismay. However, if members do not engage with the tender process the likelihood is that established departments will lose work.

Those College members who do engage in the process will find it complex and time consuming: tenders are usually advertised in specialist media and doctors may not even know that their local services are being outsourced. Moreover, a typical tender document may run to several hundred pages and require specialist writing skills. Figure 1 illustrates the eight stages involved in winning a tender.

In tacit acknowledgement of the difficulties involved, the College recently wrote to lead clinicians encouraging them to consider working with LOCSU (Local Optical Committee Support Unit) to provide medical cover for

community eye care services run by optometrists within local optician shops. However, before choosing to work in conjunction with LOCSU (or any other commercial organization), College members should be aware that two of the organizations they may wish to work with have significant management input provided by College members (Circle and Aspen/Midland Eye), while CESP/Newmedica is majority-owned by over 250 College members and already operates 13 NHS services (some jointly with hospital eye departments).

Thus, College members considering working in joint ventures with the independent sector have a number of options available.

*Mr Jeremy Diamond FRCOphth  
Medical Director at Newmedica  
Bristol Eye Hospital*

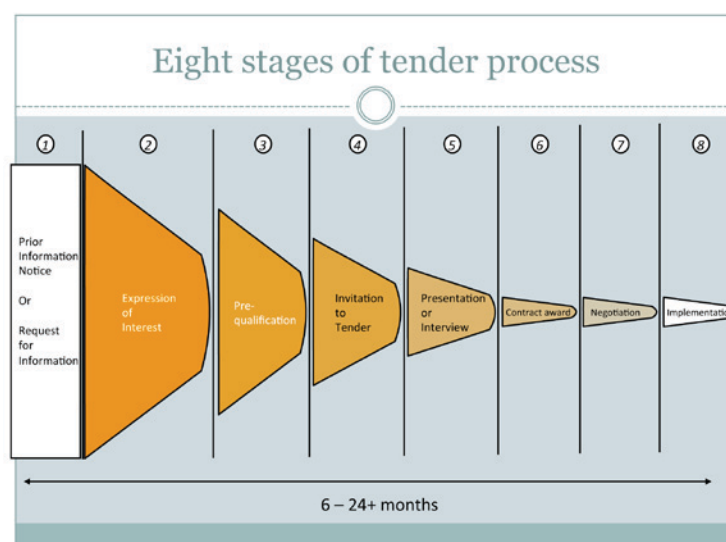


Figure 1

## Certificate of Fitness for Honorary Practice

NHS Employers and the Academy of Medical Royal Colleges have agreed a means by which consultants can carry out short-term, ad hoc or urgent activity in another organisation, without the need for an honorary contract of employment. Current practice for the short-term visit of a consultant involves obtaining a full honorary contract and verifying the necessary employment checks, such as occupational health and Criminal Record Bureau (CRB) checks. This often takes several weeks, by which time the opportunity to visit is lost. The certificate is not intended to remove the need for honorary contracts of engagement between organisations, but aims to support trusts by covering absences and responding to emergencies where there is no time to carry out employment checks. It will also allow consultants to provide training or maintain

their own skills by visiting another hospital's patients.

For further information visit NHS Employers website [www.nhsemployers.org/PlanningYourWorkforce/MedicalWorkforce/CertificateofFitnessforHonoraryPractice/Pages/CertificateofFitnessforHonoraryPractice.aspx](http://www.nhsemployers.org/PlanningYourWorkforce/MedicalWorkforce/CertificateofFitnessforHonoraryPractice/Pages/CertificateofFitnessforHonoraryPractice.aspx)

The certificate may be requested at appraisal by the consultant and contains all relevant information to show that a consultant is fit to carry out clinical work on a short-term basis. The certificate is then held on the consultant's file, to be produced when invited to assist in patient care at another organisation. A record of attendance would be completed by the host organisation, to record the honorary practice carried out.

## Revalidation portfolio launched for College members

On 5 September 2013 the College launches the new revalidation portfolio which is free to members. The portfolio, which is confidential and easy to use, has been developed with Equiniti 360° Clinical, with support and financial backing from the Academy of Medical Royal Colleges (AoMRC).

The portfolio is accessible online over the internet, and is only for you and those to whom you give permission. It minimises the need for duplication by interfacing and communicating with existing systems and applications, and provides intuitive assistance in gathering the supporting information for appraisal and revalidation. Many College members will already be using an electronic portfolio provided by their employer to store supporting information for appraisal, and ophthalmologists in training already use the College's specialty training portfolio. However, a recent survey of members suggests that significant numbers of ophthalmologists do not currently have access to an electronic portfolio, and the Revalidation Portfolio aims to meet this need in particular.

As trainees are revalidated via the Annual Review of Competence Progression process there is no need for trainees to keep a separate revalidation portfolio via this new online system. Registration and information:

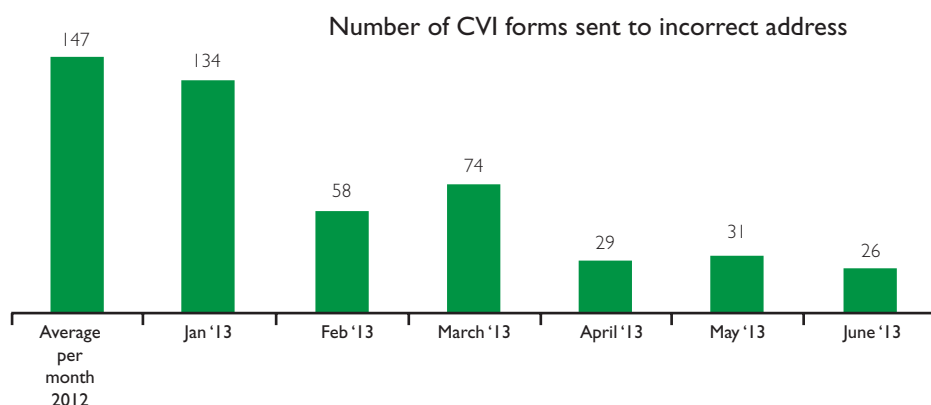
[www.rcophth.ac.uk/revalidation/](http://www.rcophth.ac.uk/revalidation/)

## The Correct address for Certificate of Vision Impairment (CVI) Forms

– *please do not put confidential data at risk!*

Ophthalmic clinics send one copy of the CVI form to the Certifications Office, Moorfields Eye Hospital (MEH), London, for epidemiological analysis on behalf of the College. This provides data for the Public Health Outcomes Framework 2013-2016 new preventable sight loss indicator.

- The Certifications Office used to be based at Empire House, 133-144 City Road, London EC1V 2QN. In August 2007 it moved to main building of MEH. The 2007 CVI form was updated with new address, however several eye clinics and ophthalmologists use the older versions of the CVI (2003, 2005) which has the incorrect address.
- Since 2007 the Royal Mail has provided a safeguard automatic redirection which ensures that confidential information does not reach non-NHS premises, the cost has been borne by charitable sources. The service will cease in March 2014 and there is no scope for further extension.
- Please ensure that your hospital is sending forms to:  
**The Royal College of Ophthalmologists, c/o Certifications Office  
Moorfields Eye Hospital, City Road, London EC1V 2PD**
- The CVI form, with correct address, is downloadable from  
<http://ecvi.moorfields.nhs.uk/resouces.aspx>



## Specialised services commissioning

– *stakeholder registration*

Stakeholder registration is now open for all stakeholders: patients, carers, service users, members of the public, clinical staff, provider organisations working in specialised services and voluntary sector partners. On registration you will be asked to self-categorise the level of engagement you would like to register for with a Clinical Reference Group (CRG). The categories range from being kept informed of the work of a CRG, notified when there is opportunity for you to engage more directly through either focus groups during the year to formal consultation on the commissioning tools (service specifications or clinical commissioning policies). If at the time of completing the form you are not sure which category to select, registration will still ensure you are at least kept informed and you will still be notified of all work and opportunities of engagement being undertaken by the CRG this year. It will be possible for you to change your registration category at a later stage.

The CRG for ophthalmology covers specialised services for both adult and paediatric ophthalmology services.

The 'Manual' contains details of all services which have been defined as truly 'specialised'.

You can register using the online registration form at [www.engage.england.nhs.uk/consultation/crg-stakeholder](http://www.engage.england.nhs.uk/consultation/crg-stakeholder)

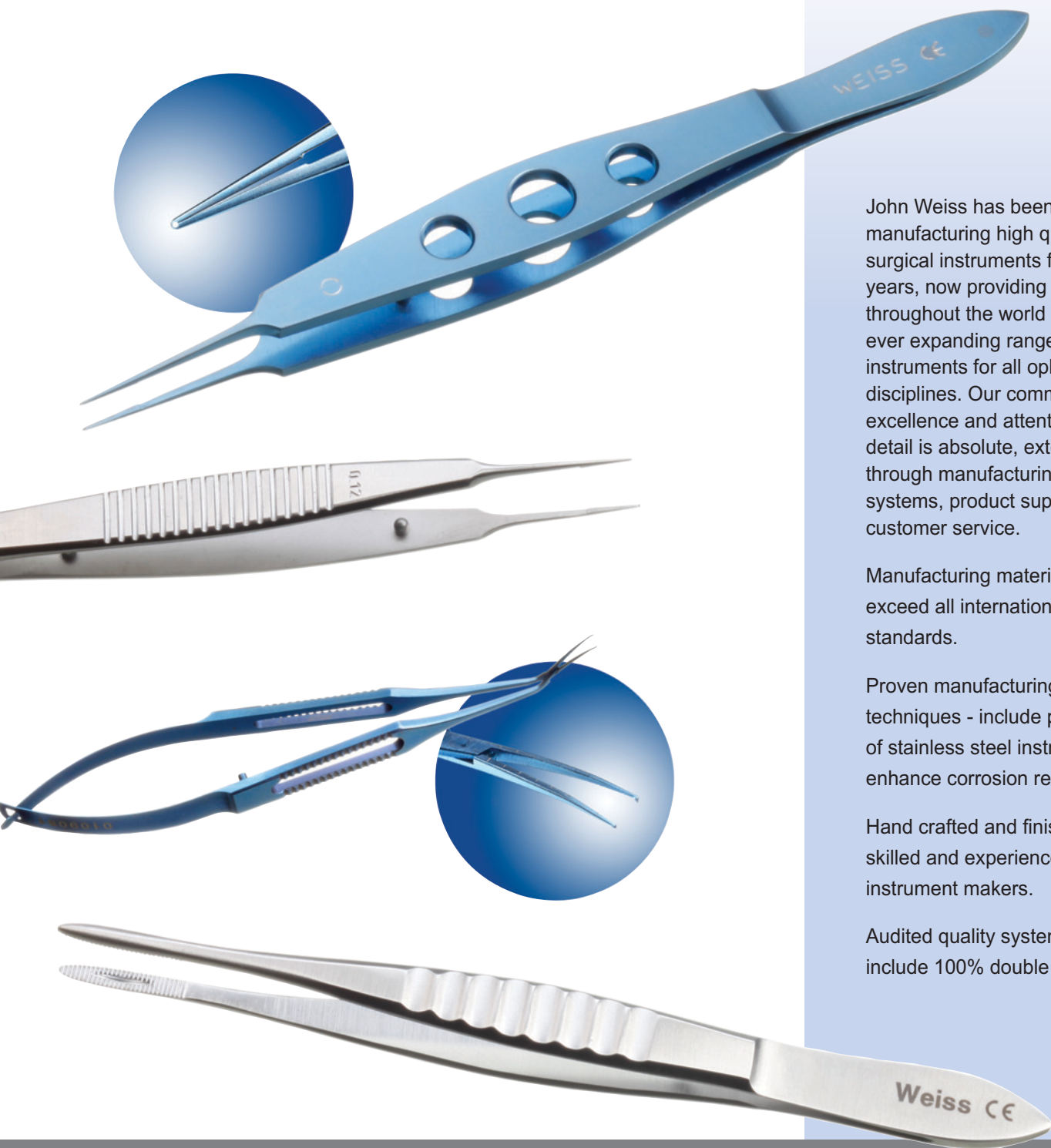
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# COLLEGE TRAVEL AWARDS AND FELLOWSHIPS

AWARD	CLOSING DATE
Dorey Bequest & Sir William Lister Travel Awards Multiple awards of £300 - £600	Wednesday 25 September 2013
Ethicon Foundation Fund Multiple awards of £300 - £600	Wednesday 30 October 2013
MRC/RCOphth/Novartis Clinical Research Fellowship	Wednesday 15 January 2014



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](http://www.rcophth.ac.uk/awardsandprizes)

## Running a surveillance project

*Jon Park writes about the experience and benefits of being awarded a BOSU Research Bursary*

In November 2009 I had the pleasure of being awarded a BOSU research bursary to study Endophthalmitis following Vitrectomy. This has proved to be a very rewarding experience both personally and professionally.

The initial stages helped me to improve my understanding of planning a major research project and gave an insight into the roles of various members involved in research ranging from clinicians, statisticians, administrative staff, fund holders and those involved with the ethics committee. It was useful to have the support of the BOSU to help design the study methodology and assist with our application to the R&D dept.

After six months of planning, two years of nationwide data collection followed and this provided a logistical challenge that gave further experience into how hospital trusts can be engaged in research and development.

Finally the study is now complete, and it has been most enjoyable to analyse our results as a team and prepare three articles for publication in peer-reviewed journals. Knowing that our work will inform other clinicians and improve patient care is very fulfilling. The research skills that I have developed will provide a strong foundation for tackling further research projects in the future.

This project has also provided opportunities to gain in-depth knowledge relating to a subspecialty that is of interest (vitreo-retinal surgery). I have had the opportunity to present our findings at national and international meetings, which has allowed me to meet other surgeons in the field and to gain their advice on fellowship training, which has been beneficial with respect to career progression.

I would recommend applying for a BOSU research bursary as an excellent way to take on a national research project.

## BOSU Research Bursary Awards 2013

The \*BOSU is requesting applications for three research bursaries of £6,000

1. The RED Trust Surveillance Bursary- for an ophthalmologist in training
  2. The Ross Foundation BOSU bursary for an ophthalmologist training in Scotland
  3. The Ross Foundation SOSU study bursary for an ophthalmologist Training in Scotland
    - Suitable conditions for BOSU studies are a predicted annual incidence of less than 5 per million (300 cases per annum in the UK)
    - Suitable conditions for \*SOSU studies are a predicted annual incidence of less than 30 per million (150 cases per annum in Scotland)
- (NB Eligible ophthalmologists may submit the same application for consideration for both awards.)

Assistance with preparation of applications is available from the BOSU and applicants are advised to initially contact Barny Foot ([barny.foot@rcophth.ac.uk](mailto:barny.foot@rcophth.ac.uk) or 07808 581659) for an informal discussion and to request application guidelines. Closing date for applications for all bursaries is **18 October 2013**

\*BOSU - British Ophthalmological Surveillance Unit

\*SOSU - Scottish Ophthalmological Surveillance Unit

## The 2014 Retina Case Awards

– sponsored by Novartis

UK specialist registrars (ST3 and above) are invited to submit a retina case study.

Entries will be judged by an independent panel of leading UK retinal specialists. Chosen finalists will present their cases to the panel and have their case studies published in a supplement in Eye News.\*

The two best retina case reports will receive an educational travel grant.

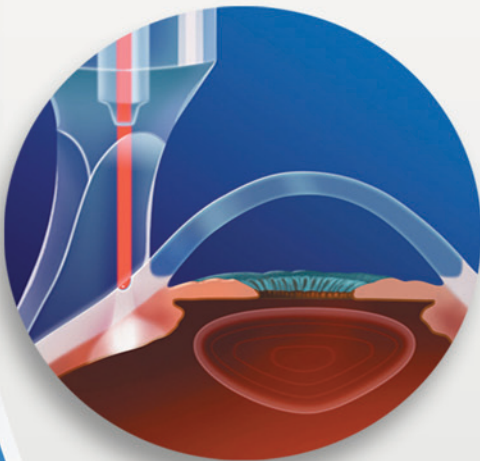
Closing date: 25 October 2013.

[retinacase.phgbfr@novartis.com](mailto:retinacase.phgbfr@novartis.com)

\*Subject to editorial approval.

# Control Uncontrolled Glaucoma

**G-PROBE GLAUCOMA DEVICE OFFERS A  
NON-INVASIVE SURGICAL DAYCASE SOLUTION**




Transscleral cyclophotocoagulation (TSCPC) using the G-Probe device is a long-term, effective IOL lowering procedure.<sup>1</sup>

TSCPC has been proven effective with many types of glaucoma patients, including those with good vision.<sup>1-3</sup>



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1. Wilensky JT, Kammer J. Long-term visual outcome of transscleral laser cyclotherapy in eyes with ambulatory vision. *Ophthalmology*. 2004;111(7):1389-1392.
2. Egbert PR, Fiadoyor S, Budenz DL, et al. Diode laser transscleral photocoagulation as a primary surgical treatment for primary open angle glaucoma. *Arch Ophthalmol*. 2001;119:345-350.
3. Roatford AP, Jayasawi R, Madhusudan S, et al. Transscleral diode laser cycloablation in patients with good vision. *Br J Ophthalmol*. 2010;94(9):1130-1183.

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## Here are reports of the events held at the Arena and Convention Centre, Liverpool on Monday 20th May 2013

### RCOphth Glaucoma Day 2013

The first Glaucoma Day was organised by Peter Shah and Fiona Spencer to appeal to everyone managing glaucoma, from glaucoma subspecialists to trainees and other health professionals.

The programme, delivered by internationally distinguished and UK speakers, was broken up into four main topics. During 'Improving the management of Angle Closure Glaucoma' we heard why good clinical assessment of the angle by gonioscopy is so important, when and how imaging can help, tips on performing iridotomy and iridoplasty, the role of cataract and glaucoma drainage surgery in angle closure. Careful examination, planning and preparation were emphasised by the panel.

The 'Problem with Normal Tension Glaucoma' session looked at what makes us worry, practicalities of IOP phasing, reducing errors in IOP testing and what changes happen at night in NTG. Clear guidelines for the neuro-ophthalmic assessment and imaging of the 'glaucoma' patient were discussed so that we don't miss other masquerading conditions or delay diagnosis.

'The role of New Technologies and Surgical Techniques'

aimed to help the audience decide whether they may like to expand their portfolio. Trabectome, trabecular meshwork stents, HIFU, non-penetrating surgery and canaloplasty were covered, which patients may be suitable and the learning curve.

The final session looked at optimising the ocular surface in glaucoma and the problems we can create. Pearls for cataract surgery in glaucoma for us to be aware of including potential problems in brittle angles, in post trabeculectomy eyes as well as PXF; a systematic approach in primary angle closure were presented, finishing with how to manage severe post-op IOP spikes.

Interactive handsets and questions for the audience as well as the panel encouraged audience participation throughout. Where the aim had been for the talks to include practical tips that could be easily adopted or lead to a change in practice the success was confirmed by the excellent feedback! 187 people had registered for the day and 92% said they enjoyed it enough to return next year when we hope you will also join us!

*Fiona Spencer,  
Manchester Royal Eye Hospital*

### RCOphth Retina Day 2013

The Retina Day was convened by Winfried Amoaku and Som Prasad and over 450 delegates enjoyed a packed programme.

Mr Tim Jackson from King's College spoke on radiotherapy for Age-Related Macular Degeneration (AMD), comparing the results with the ranibizumab (Lucentis) treatment. Prof Darius Moshfegi from Stanford University discussed Aflibercept as the first line treatment for AMD for some practices in the United States. Dr John Kitchens from Kentucky talked about 'non-responders' to anti-VEGF treatments. Prof Paul Bernstein presented results from the AREDS 2 Study which showed that the addition of lutein and zeaxanthin into the new formulation gave added benefit in delaying progression of AMD.

Mr CK Patel from Oxford talked on the different imaging available in paediatric retinopathies. Prof Paulo Stanga from Manchester gave an overview of the development of wide angle imaging of the posterior segment, in particular, swept source OCT. Prof Magdy Moussa from Tanta University, Egypt spoke on enhanced depth imaging (EDI) OCT for visualisation of choroid diseases. Dr Pravin Dugel from Doheny Eye Institute showed the newer non-invasive multi spectral imaging

especially for dry ARMD. Prof Heimann from Liverpool presented results from the Ocriplasmin study with encouraging results for small macular holes.

Dr Rick Spaide from New York spoke on the imaging of the vitreomacular interface. This was followed by the presentation of memorable cases by the different consultants with participation from the delegates on different treatment options.

Results of the BOSU study on endophthalmitis after vitrectomy were presented by Mr Jon Park and Mr Ramasamy. Mr Malhar Soni from London discussed the changes in the management of endophthalmitis over two decades. Mr Riaz Asaria from Royal Free Hospital, London, showed surgical videos on the management of dropped nucleus and the use of heavy liquid. Mr Ian Pearce from Royal Liverpool Hospital presented the RELIGHT study on Ranibizumab for diabetic macular oedema. Miss Claire Bailey from Bristol Eye Hospital held a debate with Dr Daniel Martin from Cole Eye Institute on whether Laser treatment is obsolete in the treatment of diabetic maculopathy involving the fovea. Dr Martin also spoke on the CATT study 3 years on. Prof Michael Ip from the University of Wisconsin presented data on the different management strategies of diabetic macular oedema.

*YC Yap, University Hospital Aintree, Liverpool  
Parwez Hossain, University of Southampton,*

### AMO Prize is awarded

The AMO Prize is awarded to one of the top two abstracts and the 2013 winner was the paper 'Time trends over five decades, and recent geographical variation, in rates of childhood squint surgery in England', Dr Munazzah Chou is seen here with Prof Tony Moore and Chris Farmer of AMO.





# delivering surgical innovation

## The new name in VR surgery from Germany

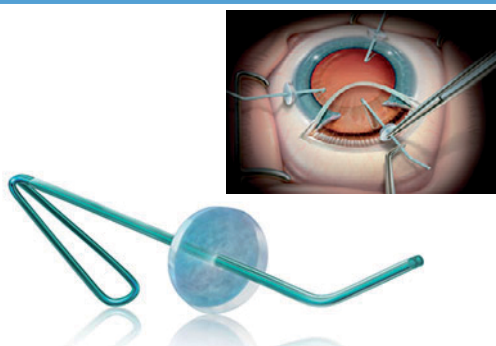


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## College 2013 Seminar Programme

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

**16 September**

### **New Frontiers in the Management of Glaucoma**

Venue: Institute of Physics, 76 Portland Place, London

Chair: Professor Keith Martin

**18 September**

### **Frontline Neuro-Ophthalmology**

Venue: Institute of Physics, 76 Portland Place, London

Chair: Mr Mike Burdon & Miss Susie Mollan

**23 September**

### **Management of Incomitant Strabismus**

Venue: Centre for Comparative and Clinical Anatomy, University of Bristol

Chair: Mr John Ferris

**7 October**

### **Getting Research into Practice – Evidence-based Ophthalmology, Systematic Reviews and Guidelines**

Chair: Mr Richard Wormald

**17 October**

### **The Management of Corneal Infections**

Chair: Mr Parwez Hossain

**11 November**

### **Revalidation**

Chair: Mr Richard Smith

**6 December**

### **The Elizabeth Thomas Seminar**

Venue: East Midlands Conference Centre, Nottingham

Chair: Mr Winifred Amoaku

The Macular Society is offering 30 bursaries to cover registration costs for this seminar - available to any registered eye health professional on a first come, first served basis. To claim register at: [www.rcophth.ac.uk/elizabeththomas2013](http://www.rcophth.ac.uk/elizabeththomas2013) and email [events@rcophth.ac.uk](mailto:events@rcophth.ac.uk) to confirm you have registered and would like to claim reimbursement.

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

## The Annual Congress

22–24 May 2014

International Conference Centre (ICC), Birmingham

There is a new sponsorship scheme for overseas delegates. Please contact [olivia.sibly@rcophth.ac.uk](mailto:olivia.sibly@rcophth.ac.uk)

## The Skills Centre

### Programme 2013

#### Curriculum-Based Courses:

- Neuro-ophthalmology – 2 December
- Oculoplastics Curriculum Based Course – 11 December

[www.rcophth.ac.uk/page.asp?section=315&sectionTitle=Curriculum+Based+Courses](http://www.rcophth.ac.uk/page.asp?section=315&sectionTitle=Curriculum+Based+Courses)

#### Phacoemulsification Courses

[www.rcophth.ac.uk/page.asp?section=314&sectionTitle=Phacoemulsification+Courses](http://www.rcophth.ac.uk/page.asp?section=314&sectionTitle=Phacoemulsification+Courses)

## The Training the Trainers

**14 October**

Assessment

**18 November**

Appraisal and how to teach practical skills

**26 November**

Problem solving and the trainee in difficulty  
[www.rcophth.ac.uk/page.asp?section=434&sectionTitle=Training+the+Trainer+Courses](http://www.rcophth.ac.uk/page.asp?section=434&sectionTitle=Training+the+Trainer+Courses)

## SAS Day National Eye Day 2013

**18 October**

Burlington Hotel, Birmingham  
[penny.jagger@rcophth.ac.uk](mailto:penny.jagger@rcophth.ac.uk)

## Ophthalmic Trainees' Annual Symposium

**Saturday 23 November 2013**

Manchester Conference Centre  
[www.rcophth.ac.uk/otgsymposium](http://www.rcophth.ac.uk/otgsymposium)

## Other events 2013

**3 October**

### **The Expert Witness Institute Annual Conference**

Westminster, London  
[dabellj@ewi.org.uk](mailto:dabellj@ewi.org.uk)  
[www.ewi.org.uk](http://www.ewi.org.uk)

**25 October**

### **City Road Reunion Lunch 2013 Held by the Moorfields Alumni Association for consultants and residents working at City Road before 1995**

The Medical Society of London, 11 Chandos Street, W1G 9EB  
[t.ffytc@btinternet.com](mailto:t.ffytc@btinternet.com)  
1 Wellington Square, London, SW3 4NJ

## Other events 2014

**17 January**

### **Southern Ophthalmological Society Meeting**

Southampton Eye Unit  
[susan.cousens@uhs.nhs.uk](mailto:susan.cousens@uhs.nhs.uk)

**12 March**

### **UK Neuro-Ophthalmology Special Interest Group 6th Annual Meeting**

St Thomas' Hospital, London,  
Guest Speaker Prof Andy Lee, Texas, USA  
[www.uknosig.com](http://www.uknosig.com)

## For sale

IOL Master XP, 2007. This machine was bought for a peripheral eye clinic where we hoped to start pre-assessments, but has sadly not been used due to competing eye facilities in the vicinity. I would very much like to return at least some of the investment which the local League of Friends made on our behalf. Please contact Roger Gray on 01823 342950 - all reasonable offers considered

## Membership information

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

## The Royal College of Ophthalmologists

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