reported.[8] In one of these reported patients, who were positive for both ANA and HLA-B27, hypopyon had been described in association with the recurrent episodes of AAU that developed during adulthood. The hypopyon described in that case occurred in the context of HLA-B27 associated AAU in an adult, distinct from and temporally following, clinical features of childhood ANA positive CAU.[8] In contrast, our reported patient developed recurrent spontaneous hypopyon (at the age of 5) in the context of the typical, insidious CAU without any clinical features of HLA-B27 associated AAU.

It remains unclear whether the presence of HLA-B27 antigen in our patient is a coincidence or whether it is of pathogenic significance. HLA-B27 antigen may represent a risk factor for the development of hypopyon in anterior uveitis, even in those that do not display the typical phenotype of HLA-B27 associated AAU. It would be of interest to follow the clinical course of our patient into her adulthood to determine whether she later develops ocular or systemic features of HLA-B27 associated AAU. Further studies of a cohort of ANA and HLA-B27 positive children with uveitis are indicated to investigate their clinical phenotype and the potential interaction between ANA and HLA-B27.

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A simple model for teaching indirect ophthalmoscopy

Indirect ophthalmoscopy is a useful technique to allow a wide angle view of the fundus, to screen for retinal disease, and to examine the peripheral retina. It provides a better view of the fundus in patients with lens opacities than is allowed by direct ophthalmoscopy. As the threshold at which cataracts are operated in developing countries is changing we have found it important that junior doctors and other eye health workers who select cataract patients for operation can use the instrument.

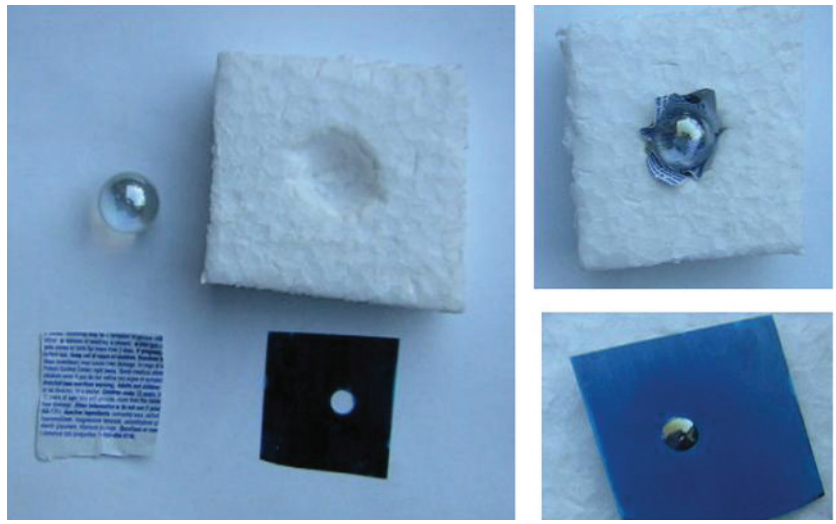

Figure 1 Model for practising indirect ophthalmoscopy.

We use a simple model to teach the technique of indirect ophthalmoscopy. An hour or two with this model gets the beginner ''over the hump'' of learning how to position and move the light and lens. When the first real patient is examined, the learner can immediately concentrate on the fundus, minimising frustration and time spent shining an annoying light into a patient's eye.

The model is shown in the figure 1. The ''eyeball'' is a clear glass marble, set into anything that will keep it from rolling, such as a small bottle cap or a hole made in a piece of Styrofoam. Behind the marble, moulded around it, a piece of paper is placed with the smallest print available—the package inserts from prescription medicines work well. Finally, a hole is punched in a scrap of paper to use as a pupil. The optics of the system are excellent for practising indirect ophthalmoscopy and the student can be tested by how many words, letters, or lines he can see compared to the instructor.

Other models have been described before, which are more sophisticated or allow for scleral indentation but the materials may be hard to obtain.[1–3] A model equally simple to make as that described here has been proposed[4]; it does not require a glass marble and is good for helping the beginner get oriented, but the marble model provides more of a challenge at learning to view the retina outside the posterior pole.

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In vivo measurement of opacified H60M intraocular lenses using Scheimpflug photography

The Scheimpflug videophotographic camera is a modified slit lamp camera that uses a narrow slit beam and Scheimpflug optics to increase apparent depth of field (enabling simultaneous focusing of the entire anterior segment). Area densitometry measurement of scattered light intensity gives a cross sectional image of the anterior segment. In 1995, Lasa *et al* demonstrated the use of Scheimpflug photography[1] to assess posterior capsular opacification (PCO). Subsequent studies have correlated the values obtained with visual acuity.[2 3] The system is efficient and reliable for PCO evaluation with good intraobserver and interobserver reproducibility.[4 5] This has been verified by comparison with histological findings.[6] Delayed opacification of Hydroview (H60M) intraocular implant lenses (Bausch & Lomb, Rochester, New York, USA) has been reported.[7] In our patient series we find this to give rise to progressive visual loss and symptoms of glare.

We demonstrate the use of Scheimpflug video-photography (Pentacam, Oculus) for assessment of three cases of opacified H60M intraocular lenses (IOLs). All had uncomplicated cataract surgery with insertion of Hydroview R hydrogel lenses.

Case 1

An 89 year old woman had a +21.50 dioptre IOL in January 2001, for nuclear sclerotic cataract giving Snellen visual acuity of 6/18.