exclusion and typically occurs in middle-aged men. The pathogenesis remains controversial and is thought to be related to abnormalities in the sclera resulting in albumin accumulation.[3] To our knowledge unilateral pseudophakic acute angle closure secondary to IUES has not been reported. Pseudophakic angle closure is rare and can be caused by a variety of different mechanisms.[4] Careful assessment of peripheral iris configuration and symmetry of anterior chamber depth point to the diagnosis.

Conflict of interest
The authors declare no conflict of interest.

References

1 Uyama M, Takahashi K, Kozaki J, Tagami N, Takada Y, Ohkuma H *et al*. Uveal effusion syndrome: clinical features, surgical treatment, histologic examination of the sclera, and pathophysiology. *Ophthalmology* 2000; **107**: 441–449.
2 Craig JE, Ong TJ, Louis DL, Wells JM. Mechanism of topiramate-induced acute-onset myopia and angle closure glaucoma. *Am J Ophthalmol* 2004; **137**: 193–195.
3 Elagouz M, Stanescu-Segall D, Jackson TL. Uveal effusion syndrome. *Surv Ophthalmol* 2010; **55**: 134–145.
4 Rauscher FM, Parrish RK. Atypical angle closures. *Curr Opin Ophthalmol* 2008; **19**: 107–114.

M Bhogal[1], D Mitry[1], M Restori[2] and I Subak-Sharpe[1]

[1]Eye Treatment Centre, Whipps Cross Hospital, London, UK
[2]Moorfields Eye Hospital, London, UK
E-mail: mitryd@gmail.com

Eye (2011) **25,** 1236–1238; doi:10.1038/eye.2011.108; published online 6 May 2011

Sir,
Association between intraocular pressure and adherence: is there one?

The paper by Ajit *et al*[1] that was recently published in *Eye* described a new methodology of graphically presenting adherence data, using an electronic dosing monitor. The concept of using such a device to provide meaningful, graphical information is potentially favourable to the clinician in identifying patterns of adherence. However, the idea of collecting this information for all patients is probably unrealistic and unlikely to be cost-effective.

Lowering intraocular pressure (IOP) to reduce or halt the progression of visual field loss is the only currently available intervention for patients with glaucoma. Measuring IOP to assess efficacy has been standard practice ever since topical anti-glaucoma therapy was commenced. If a therapeutic regimen is adhered to, a reduction in IOP would be expected on repeat measurement *a priori*. Theoretically, therapeutic outcome would be both an objective and a practical measure of adherence. However, to date there is no consistent evidence of a relationship between adherence and IOP.[2] Failure to identify such a relationship could be explained by the lack of a quantified correlation, or could be attributed to the methodological quality of the studies examining such a correlation being poor. However, it is more likely that the complexities of assessing the level of IOP due to individual differences (types of glaucoma and diurnal variance), together with regression to the mean, lead to 'noisy data'.

The methodology used by Ajit *et al*[1] stated that 100 patients at their initial interview had their IOP recorded. However, no further discussion of the IOP data was done in the paper. Assuming that Ajit *et al* had the intention of collecting IOP data to study any relationship between IOP and adherence, it would be interesting if their findings could be published, particularly given the potential value to the glaucoma clinician of learning how IOP measures might correlate with adherence.

Conflict of interest
The authors declare no conflict of interest.

References

1 Ajit RR, Fenerty CH, Henson DB. Patterns and rate of adherence to glaucoma therapy using an electronic dosing aid. *Eye* 2010; **24**: 1338–1343.
2 Olthoff CM, Schouten JS, van de Borne BW, Webers CA. Noncompliance with ocular hypotensive treatment in patients with glaucoma or ocular hypertension an evidence-based review. *Ophthalmology* 2005; **112**: 953–961.

H Cate and DC Broadway

Norfolk & Norwich University Hospital, Norwich, UK
E-mail: heidi.cate@nnuh.nhs.uk

Eye (2011) **25,** 1238; doi:10.1038/eye.2011.111; published online 20 May 2011

Sir,
Response to Cate and Broadway

We thank you for providing us an opportunity to respond to the letter by Cate and Broadway[1] concerning our paper on patterns of adherence to hypotensive therapy that was recently published in *Eye*.[2] Our paper tried to address the issue of adherence in a way that was clinically more meaningful than simple percentage figures that are commonly reproduced in the literature. As part of this project we also collected pre- and post-treatment IOPs although we did not report on them within the *Eye* paper.

In their letter Cate and Broadway highlight that the routine use of an electronic dosing monitor is unrealistic (especially so now that Alcon has discontinued the supply of such aids) and asks whether a measure of IOP reduction can be used as a surrogate measure for adherence. We have now undertaken an analysis of pre- and post-treatment IOPs and can report that there is