

CORRESPONDENCE

Circannually herpetic eye attacks: questionable significant rhythmicities

EDITOR,—Gamus *et al*¹ have reported significant circannual rhythms of epithelial herpetic keratitis in males, especially in the age groups 6–10 years and 45 years and older. No such rhythms were found in females. If the authors of the paper had made additional subdivisions, again according to age, sex, and clinical signs they probably would have found further interesting circannual rhythms – for instance, in patients with blue eyes, but not brown or green eyes, and only in females 15–29 years of age.

Although the problem of multiple choices and multiple studies on a subject is not mentioned in the statistical guidelines published in the *BMJ* and recommended in the instructions for authors in the *BJO*, it is of utmost importance. Instructive in this connection is the witty story told in a recent issue of the *Scientific American*,² which emphasises the risk that some of the one in 20 chances may lead to believing in a mirage.

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- 1 Gamus D, Romano A, Sucher E, Ashkenazi IE. Herpetic eye attacks: variability of circannual rhythms. *Br J Ophthalmol* 1995; 79: 50–3.
- 2 McClosky DN. The insignificance of significance. *Sci Am* 1995; 272: 20–1.

Reply

EDITOR,—I assume that Dr Cohen's comments stem in part from viewing our results as numerical entities rather than biological events. Consequently, he refers to the distribution patterns as (possible) random and suggests the use of oversophisticated analytical methods which, in our view, are obsolete for analysing the straightforward observations of the present study.

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Modulation of amblyopia therapy

EDITOR,—It is with great interest that I read the paper by Lloyd *et al* in the September issue of the *BJO*.¹

There is no doubt that surgery of the monocular cataract and removal of the opaque lens is only one step in the treatment of this challenging condition. The resulting monocular aphakia (if no IOL is implanted) is a problem which can be best handled and overcome by the use of contact lenses. However, the experience in most centres of paediatric ophthalmology around the world has led to the realisation that full compliance with contact lens wear and occlusion therapy against amblyopia have been very difficult to achieve in most of these cases. Furthermore, unavoidable contact lens loss and intermittent periods of lens induced ocular irritations have precluded a constant and undisturbed aphakic correction.² Therefore, the final visual

outcome in children with monocular congenital cataract has been unanimously very poor despite the fact that during the preverbal period these children had a good optokinetic (OKN) response with the amblyopic eye fixating and behaved 'normally' with the sound eye patched. Because of these results, I advocated the use of intraocular lenses in these cases and published the initial observations in a selected group of children in 1983.³ Outstanding in their achievement of excellent visual results were the small number of unilateral aphakic eyes following congenital cataract reported by Beller *et al*⁴ and the ones studied in the present papers by Lloyd *et al*.¹ In both of these reports, the visual acuity of the aphakic eyes has been mostly based on extrapolation of the visual evoked potential amplitude⁴ or by the preferential looking technique.¹ To my knowledge, Beller *et al* have never published the real visual acuities of their group of children after a longer follow up when the special conditions of the study and the occlusion therapy were terminated. In the paper by Lloyd *et al* two of the patients (cases 1 and 2) were more than 3½ years old at the time of writing the paper. Today these children are more than 4 years old and it would be most interesting for all of us if these authors could let us know whether the 'normal' preferential looking pattern in these children is translating now into a 20/20 visual acuity or it is hardly a 20/80 or less visual acuity. This information is, in my opinion, crucial and of utmost importance to all paediatric ophthalmologists facing the dilemma of choosing the best aphakic correction for their little patients suffering from unilateral congenital cataracts.

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- 1 Lloyd IC, Dowler JGF, Kriss A, Speedwell L, Thompson DA, Russell-Eggitt I, *et al*. Modulation of amblyopia therapy following early surgery for unilateral congenital cataracts. *Br J Ophthalmol* 1995; 79: 802–6.
- 2 BenEzra D, Paez JH, Frucht J. Monocular and binocular congenital cataract. *Ophthalmic Paed Gen* 1983; 2: 123–8.
- 3 BenEzra D, Paez JH. Congenital cataract and intraocular lenses. *Am J Ophthalmol* 1983; 96: 311–4.
- 4 Beller R, Hoyt CS, Marg E, Odom JV. Good visual function after neonatal surgery for congenital monocular cataract. *Am J Ophthalmol* 1981; 91: 559–65.

Reply

EDITOR,—We thank Dr BenEzra for his interest in our paper. We agree that cataract removal is only a small part of the complex and prolonged management of unilateral congenital cataract. Accurate aphakic correction (usually via contact lens fitting) and regular optometric follow up are also necessary, combined with rigorous amblyopia treatment. Good long term compliance with contact lens wear has been shown to be achievable in a high proportion of aphakic infants¹ and we thus disagree with the statement that final visual outcome in monocular congenital cataract managed with contact lenses is invariably poor. Since the early paper by Beller *et al*,² other major centres have reported good recognition acuity results using similar methods to our own^{3–5} and indeed achieved some degree of binocularity in a few children.⁵

The two children in our study who were more than 3 years old at the end of the study had single Sheridan Gardner optotype acuities of 6/9 part phakic and 6/12 part aphakic (case 1) and 6/5 phakic and 6/9

aphakic (case 2). These children, together with the others reported in our paper, are part of an ongoing study and will be the subject of a follow up paper. Their recognition acuities so far appear comparable with other similar studies.^{3–5}

The use of intraocular lenses in infancy is probably the way forward but has until recently been fraught with surgical and refractive difficulties.⁶ Ongoing primate work may, in the long run, provide us with a better idea of optimal implantation protocols in infancy⁷ and perhaps allow us to move away from the long term use of contact lenses.

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- 1 Amaya LG, Speedwell L, Taylor D. Contact lenses for infant aphakia. *Br J Ophthalmol* 1990; 74: 150–4.
- 2 Beller R, Hoyt CS, Marg E, Odom JV. Good visual function after neonatal surgery for congenital monocular cataract. *Am J Ophthalmol* 1981; 91: 559–65.
- 3 Robb RM, Mayer DL, Moore BD. Results of early treatment of unilateral congenital cataracts. *J Pediatr Ophthalmol Strabismus* 1987; 24: 178–91.
- 4 Pratt-Johnson JA, Tillson G. Unilateral congenital cataract; binocular status after treatment. *J Pediatr Ophthalmol Strabismus* 1989; 26: 72–5.
- 5 Birch EE, Swanson WH, Stager DR, Woody M, Everett M. Outcome after very early treatment of dense congenital unilateral cataract. *Invest Ophthalmol Vis Sci* 1993; 34: 3687–99.
- 6 Markham RHC, Bloom PA, Chandna A, Newcomb EH. Results of intraocular lens implantation in paediatric aphakia. *Eye* 1992; 6: 493–8.
- 7 Lambert SR, Fernandes A, Grossniklaus G, Drews-Botsch C, Eggers H, Boothe RG. Neonatal lensectomy and intraocular lens implantation: effects in rhesus monkeys. *Invest Ophthalmol Vis Sci* 1995; 36: 300–10.

NOTICES

Royal Society of Medicine, Section of Ophthalmology

The following meeting (beginning at 5 pm) is open to RSM members and their guests only.

NEW HORIZONS IN THERAPEUTICS, 9 May 1996

The identification of human tumour antigens: a strategy for developing tumour vaccines; New developments in the management of CMV retinitis; The development of ophthalmic drugs; The challenge of gene therapy in the context of eye diseases.

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