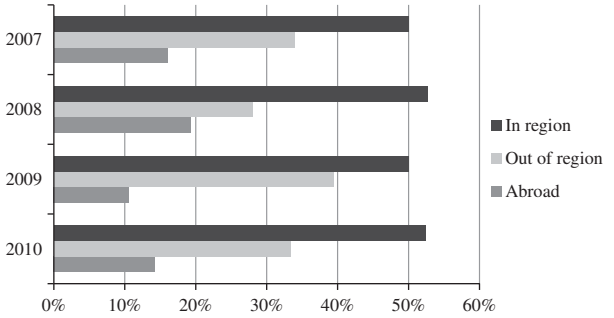

Figure 5 Trends in consultant appointments by region 2007–2010.

This cohort of CCT holders started their training before the introduction of run-through OST in 2007.[2] The first cohort of trainees in the new system is only just starting to emerge. In the next few years, we will have a better idea of how the new OST system has affected the outcome of CCT holders.

Conflict of interest

The authors declare no conflict of interest.

Full list of OTG Members at the time of project completion:

Will Dean (Chairman), Alan Connor (Deputy Chairman), John Bladen, Oliver Bowes, Anand Chawla, Samir Dowlut, Abdul-Jabbar Ghauri, Megan Johnson, Karinya Lewis, Lik Thai Lim, Murtuza Mookhtiar, Archana Pradeep, Mario Saldanha, Richard Symes.

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Sir,
A different approach for manual foldable IOL injection for keeping wound size and integrity

We have read the article by Khokhar S *et al*[1] with a great interest. The authors have rightly compared two techniques in terms of wound enlargement, wound integrity, and incidence of Descemet's membrane detachment. The authors state that manual injection of IOL with the compatible injector–cartridge system causes more enlargement on the final wound size and less posterior wound integrity when compared with motorized injector system.

We just wanted to share our practical approach during the manual foldable IOL injection. In our approach, even though we use compatible injector–cartridge system with microincision, we prefer to take help of wound assistance to keep wound size, integrity, and posterior Descemet's membrane during foldable IOL injection. However, the injection of IOL by wound assistance requires excess use of OVD to provide adequate globe tonus. To minimize the amount of OVD used, irrigation solution is supposed to be used for adequate globe tonus. On the basis of this reasoning, we use hydro-visco-implantation technique,[2] which is a modified technique of both classic and hydroimplantation techniques[3] for IOL injection by the wound assistance during microincisional cataract surgery. We generally place the tip of the cartridge into the wound edges without entering the anterior chamber.

In this technique, the capsular bag is filled approximately up to half with OVD and the anterior chamber is formed by bimanual irrigation cannula with continuous irrigation mode from the side port. After providing adequate tonus, the continuous mode could be put off to reduce the wash effect on OVD during the injection of IOL. After the injection of foldable IOL with the support of wound edges is completed, firm downward pressure could be applied with the tip of the aspiration cannula to the posterior lip of main incision and dynamic outflow could be created, and then the viscoelastic material could be removed from the eye without the necessity of using aspiration cannula.

As a result, during the procedure the injector does not exceed the cornea in full thickness, and it may provide not to enlarge the incision size, better wound integrity, and protection of the posterior Descemet's membrane integrity.

Conflict of interest

The authors declare no conflict of interest.

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Sir,
Response to: 'A different approach for manual foldable IOL injection for keeping wound size and integrity'

Many thanks to Özyol and Özyol[1] for their interest in our article.

Intraocular lens implantation is facilitated by the use of ophthalmic viscosurgical devices (OVDs) that possess moderate viscosity at medium shear rate.[2] We agree that the use of OVDs can be associated with complications if proper removal is not done; however, their use during implantation of intraocular lens (IOL) makes the process smooth and safe.

'Hydro-visco-implantation technique' may be a good approach to maintain the wound integrity and size after IOL implantation as suggested by the authors.[3] Presence of both OVD and balanced saline solution in anterior chamber produces a duality in the chamber that can result in poor visibility and shallowing of anterior chamber during IOL insertion. Irrigation can also lead to wash out of the OVDs as stated by Özyol and Özyol in their study, which can cause anterior chamber instability.[3]

It would have been really nice if Özyol and Özyol had done measurement of incision size and size of side port before and after IOL implantation. Anterior segment optical coherence tomography (ASOCT) study in such patients would really tell about the wound integrity and changes that occur both at the main incision site as well as the side ports where irrigation cannula is placed.

Hence we suggest the use of ASOCT to study the wound architecture after the technique described by Özyol and Özyol, which would further certify the safety of the technique.

Conflict of interest

The authors declare no conflict of interest.

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Sir,
Comment on 'The incidence of serious eye injury in Scotland: a prospective study'

We read with interest the paper by Morris *et al*[1] regarding 1-year incidence of serious eye injury in Scotland. The authors conclude that the incidence of serious ocular trauma requiring hospital admission for observation or treatment had decreased fourfold, from 8.14 per 100 000 in 1992 to 1.96 per 100 000 in 2009.[1] They postulate that under-reporting may account for a portion of this difference, noting a discrepancy between the Scottish Morbidity Records (SMR01) admission data and those reported through the British Ophthalmic Surveillance Unit.

We would like to report the annual incidence of serious eye injuries in our tertiary unit in Scotland at a similar time. Our stand-alone unit receives all serious ocular trauma in Edinburgh and the Lothians. Patients were identified from the ward admission logbook and cross-checked with theatre logbooks to ensure consistency. We identified 71 cases of ocular trauma requiring hospital admission in Edinburgh between January 2005 and December 2008 inclusive. This gives an annual incidence of 2.17 per 100 000 of population.[2]

Table 1 Visual outcomes 12 months after injury

OTS category	*NPL*	*PL to HMs*	*CFs to 6/60*	*>6/60 to 6/18*	*6/12 Or better*
1	4 (40%)	6 (60%)	0 (0%)	0 (0%)	0 (0%)
2	3 (23%)	6 (46%)	2 (15%)	1 (8%)	1 (8%)
3	0 (0%)	2 (14%)	0 (0%)	5 (36%)	7 (50%)
4	0 (0%)	0 (0%)	0 (0%)	2 (22%)	7 (78%)
5	0 (0%)	0 (0%)	0 (0%)	0 (0%)	3 (100%)

Abbreviations: CFs, counting fingers at 1 m; HMs, hand movements at 1 m; NPL, no perception of light; OTS, ocular trauma score; PL, perception of light.
This table shows the visual outcomes from our group of patients, broken down into numbers and percentages for each category.