Policy versus needs

Dr Eric Midwinter, until recently Director of the Centre for Policy on Ageing, brought the day to its climax with a witty and perceptive presentation of the views of older people. All too often the services provided for them do more to salve the social conscience of the providers than to meet the needs of the recipients. In part this is due to the voice of older people not being heard, but it is also due to the fact that older people do not raise their voices enough. In future the focus needs to be on the rights of older people as citizens, not on their rights when (and only when) they become social casualties. Dr Midwinter prophesied a change when new cohorts of people with greater social awareness become old. He painted an amusing picture of future street riots in which old age pensioners over-turn meals-on-wheels vans in protest against late or irregular delivery; the rioters, however, would be unlikely to set fire to the vans since the vegetables they contained would probably already be over-cooked.

The message

The final discussion drew together some of the themes of the day. While the ‘demographic breathing space’ could give us time to think and plan more rationally, it might also be a time in which worsening deficiencies of provision could pass unnoticed.

Training in the care of elderly people for the medical profession seems less adapted to current needs and less able to adapt to future needs of the public than that for the social work and nursing professions.

The lack of sophistication of the elderly public allows them to be ‘fobbed off’ with less than optimum care. In the United States conscious efforts are made to educate older people to be more perceptive and more demanding about the care they receive from health and social service professionals.

In the last analysis, the public will get the services it demands. Politicians need to be reminded that people aged over 65 constitute 20% of the electorate.

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General medicine and ophthalmology: common interests

A conference entitled ‘General Medicine and Ophthalmology’ was held at the Royal College of Physicians on 1 June, 1992.

Eye diseases are frequently a manifestation of systemic conditions; it is therefore in the patient’s best interest for ophthalmologists and physicians to co-operate in their management. Without such co-operation there is the risk that patients fall between stools and neither condition is adequately treated. Medical specialties in which eye conditions are particularly prominent include dermatology, endocrinology, neurology, rheumatology, and cardiovascular diseases.

The advantages of joint clinics in medicine and ophthalmology were demonstrated by Professors Alex Crombie and Pat Kendall-Taylor for Graves’ disease, by Mr Philip Murray and Dr David Young for uveitis, and by Professor Eva Kohner for diabetes. These included more expert assessments of patients leading to quicker and more complete diagnoses, earlier recognition of complications, and access to a wider range of investigations and treatments, opportunities for collaborative research, improved education for patients and doctors, increased patient convenience, and a stimulus for better control of factors which can worsen the disease.

Thyroid-associated eye disease

Professor A L Crombie (Newcastle upon Tyne) pointed out that visual loss in thyroid-associated eye disease (TAED) is often missed. Its causes include corneal ulceration, papilloedema, optic atrophy, macular oedema, choroidal folds, and most commonly acquired hypermetropia which only needs refraction correction. The ‘differential intraocular pressure’, which is defined as the difference in intraocular pressure with the eye in the axial position and looking as far up as possible, may be an important clinical indicator of the severity of thyroid eye disease. The physician’s specific contribution is the treatment of the dysthyroid state.

Rapporteurs:
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(65% of cases) with either anti-thyroid drugs and/or thyroid ablation with radioactive iodine. The ophthalmologist is able to intervene, as appropriate, with lubricating eye drops, tarsorrhaphy, squint surgery, retrobulbar steroids, irradiation, or surgical decompression of the orbital contents.

Professor P Kendall-Taylor (Newcastle upon Tyne) found many advantages in having a combined medical/ophthalmological clinic. In Newcastle they had developed an ‘ophthalmopathy index’ to assess the severity of the eye disease and its response to treatment. Although the prevalence of TAED is 8-10 times greater in women, the disease is more severe in men, as shown by the index. The ophthalmopathy index is the sum of seven measurements of thyroid eye disease, graded according to severity, and includes soft tissue swelling, proptosis, differential intraocular pressure, diplopia, corneal lesions, and optic neuropathy; in addition it is becoming possible to quantify the bulk volume of the ocular muscles on CT scanning, though this is not yet widely available.

The use of steroids in the management of thyroid-associated eye disease remains controversial. One should not hesitate to use steroids if the deterioration in vision is greater than two lines on the Snellen chart over a few days. The decline can be measured objectively by visual-evoked potentials and assessing the enlargement of orbital muscles on CT scanning. In those who do respond well to steroids an improvement in the ‘ophthalmopathy index’ may occur within a week of starting treatment with methylprednisolone. Those who do not improve in the first week are unlikely to benefit from longer-term use of steroids. Some advocate radiotherapy under steroid cover, but the advantage of this over steroids alone is not clear. The roles of octreotide, a long-acting somatostatin analogue, and of plasmapheresis remain experimental.

Uveitis

The protean nature of the causes of uveitis was pointed out by Dr David Young and Mr Philip Murray (Birmingham). They showed how the many causes of uveitis can be divided into reasonably well-defined groups according to the anatomical type of uveitis and its time course. This grouping then suggests the most appropriate investigations by the physician and the ophthalmologist.

Retinal vein occlusion

Miss Erna Kritzinger (Birmingham) talked about the combined ophthalmic and medical management of retinal vein occlusion (RVO). The non-ischaemic form of central retinal vein occlusion (CRVO) has a benign prognosis and predominantly affects younger age groups. In older age groups RVO is often a manifestation of systemic vascular disease, most commonly atherosclerosis. The management of its risk factors, principally hypertension and hyperlipidaemia, has reduced the recurrence rate of branch venous occlusions from 15% to 1%. RVO can lead to neovascularisation, rubeotic glaucoma, and blindness. In most ischaemic cases it is important to consider pan-retinal photocoagulation as prophylaxis against the development of neovascularisation.

Retinal artery disease

Professor C H Warlow (Edinburgh) reported a clinical study of 469 patients with transient monocular blindness due to retinal artery occlusion. The most significant risk factors were older age, smoking, atrial fibrillation, and a haematocrit greater than 49%. The risk of permanent blindness is rare, but these patients have an 8.6% per year risk of death from cerebrovascular accident or myocardial infarction. In 98 cases of retinal infarction, 74% were related to atheromatous disease, 17% to cardiogenic emboli, and the remainder to both. Hypertension, hypercholesterolaemia, and smoking were significantly related to the prevalence of retinal infarction. Carotid artery disease was present in 60% of patients with transient monocular blindness. The role of carotid surgery remains in dispute although the results of the European carotid surgery trials are encouraging. The risk of suffering a major cerebrovascular accident over a three-year period was 12.3% in patients who had carotid endarterectomy, and 21.9% in those who did not. Warfarin is less widely used than before. Medical management consists of treatment with aspirin and reducing the known risk factors.

It is generally agreed that steroids should be started immediately when giant cell arteritis (GCA) is suspected as the cause of retinal infarction. Miss Kritzinger mentioned two patients with GCA who lost the sight of the second eye within an hour of becoming blind in the first.

Diabetic retinopathy

Professor Eva Kohner (London) gave two main reasons for having a combined clinic of physicians and ophthalmologists for the care of the diabetic patient with retinopathy. They are the need for less-frequent clinic appointments for the patient, and the opportunity to deal with the medical factors that influence the progression of diabetic retinopathy. There was some doubt about the effect of diabetic control on the progression of diabetic retinopathy. Several trials in which glycaemic control was good showed an initial deterioration in the retinopathy. However, longer-term follow-up studies have shown that good diabetic control does reduce the incidence of retinopathy. A 2% drop in the abnormally high glycated haemoglobin level halves the incidence of proliferative retinopathy. Hypertension is significantly linked to both the prevalence and progression of diabetic retinopathy.
Although the criteria for treating proliferative diabetic retinopathy are known, this is still not the case for diabetic maculopathy. Clear guidelines on this do exist and need to be followed since diabetic maculopathy is a more common cause of blindness than proliferative disease.

Dr R E J Ryder (Birmingham) considered the problem of how best to screen for diabetic retinopathy. Since there are approximately 1-million diabetic patients in the UK (only half of them under diabetic clinic supervision), it is clearly impracticable for ophthalmologists to screen all people with diabetes for retinopathy. Some 76% of cases of diabetic retinopathy were missed when the fundus was examined through undilated pupils, and 56% when viewed through dilated ones. Use of a non-mydriatic camera is also associated with a significant error rate. The best method of screening for diabetic retinopathy is to use a combination of direct ophthalmoscopy and retinal photography.

Sickle cell disease

Dr Sally Davies (London) reviewed sickle cell disease and retinopathy. At present there are 5,000 patients in the UK with sickle cell disease. It is more correctly described as a family of diseases, with the characteristic feature of sickling of the red cell under conditions of relative hypoxia. The responsible gene originated in two populations: one around the Mediterranean, the other along the East coast of Africa. The ocular manifestations of sickle cell disease include central retinal artery occlusion, retinal haemorrhage, proliferative retinopathy, glaucoma secondary to hyphaema, iris atrophy, and angioid streaks. The prevalence of blindness is actually quite rare: among Dr Davies’s 600 patients who attend her sickle cell disease clinic, only two are blind as an aftermath of proliferative retinopathy.

Mr B J Moriarty (Cheshire) discussed the clinical features and management of sickle cell retinopathy. The stimulus for blood-vessel proliferation is retinal ischaemia due to occlusion of the retinal capillaries by deformed red blood cells. Since this process starts in the periphery of the retina, it is mandatory to use a slit-lamp and indirect ophthalmoscopy to examine the retina. Blindness can be prevented if the junction of the perfused and non-perfused retina is treated by laser photocoagulation before proliferative retinopathy and its sequelae, vitreous haemorrhage and retinal fibrosis, develop. The incidence of visual loss in patients with sickle cell disease in Jamaica is 32.4/1,000 eyes per year. A screening programme for sickle cell patients is imperative to allow early treatment of retinopathy.

The skin and the eye

Mr Peter Wright (President of the College of Ophthalmologists) gave a well-illustrated lecture on skin conditions which can affect the eye.

Training in medical ophthalmology

Dr Elizabeth Graham (London) gave an historical account of the long-established connection between ophthalmology and general medicine, ranging from the time of the Egyptian pharaohs, through Helmholtz’s introduction of the ophthalmoscope into clinical practice, to the present interest in the molecular biology of eye disease. She then outlined her personal view of the training required for medical ophthalmology. Two types of doctors were suggested: 1. ophthalmologists, as now with the usual normal training in ophthalmology but who retain a greater interest in its medical aspects and perhaps acquire the MRCP; 2. medical ophthalmologists who will have a physician’s training including experience in rheumatology and neurology, with two years’ research in an appropriate topic. To give them a background in ophthalmology, they should have two years of surgical ophthalmology and possibly qualify for membership of the College of Ophthalmologists.

A joint colleges working party is now considering details of a training programme for such individuals, and the colleges have made proposals for training in medical ophthalmology.

Conclusions

The wide areas of common interest between ophthalmologists and physicians were demonstrated in this conference. The benefits of combined clinics for conditions such as diabetic retinopathy, retinal vein occlusion, uveitis, thyroid eye disease, and sickle cell disease were amply demonstrated. More combined clinics need to be established in other localities.

The enthusiasm displayed by the delegates and speakers is a sign that medical ophthalmology will continue to be advocated as a specialty in its own right.