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CORRESPONDENCE

We may return unduly long letters to the author for shortening so that we can offer readers as wide a selection as possible. We receive so many letters each week that we have to omit some of them. Letters must be signed personally by all their authors. We cannot acknowledge their receipt unless a stamped addressed envelope or an international reply coupon is enclosed.

Photocoagulation and diabetic retinopathy

SIR,—Dr G P Walsh's letter (7 July, p 48) calls attention to the problem of a patient with early proliferative diabetic retinopathy and the long wait for an ophthalmic department appointment in his area. A long wait for an outpatient appointment in an eye clinic is fairly widespread in this country at present. The development of treatment for diabetic retinopathy has led to a big increase in work, which was already more than the departments could bear.

Ophthalmologists have been aware of this problem. It has been estimated that between 50 and 1000 extra ophthalmic consultants would be needed to deal with diabetic retinopathy. There are approximately 400 consultant ophthalmologists in the United Kingdom hospitals at present.

In the short term, physicians need to carry out regular fundoscopy and to refer those patients who show early and treatable retinopathy to an ophthalmologist who is carrying out photocoagulation or laser treatment. There is a risk that the system will be further swamped and patients will, I fear, have to be rigorously screened to select only those likely to benefit. In the long term we would hope for a breakthrough in the medical management of diabetes which will prevent diabetic retinopathy and other complications such as nephropathy.

In the meantime, photocoagulation can help at least a proportion of patients and health authorities might look to the creation of further consultant posts in ophthalmology.

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SIR,—I was rather expecting a reply such as that of Drs Eva M Kohner and P Leaver (28 July, p 273) to my letter on diabetic retinopathy photocoagulation (7 July, p 48). Certainly the diabetic clinic is the main gathering ground, yet the Moorfields specialist claimed most came through eye clinics. He also claimed that with homatropine instilled the diagnosis was not difficult.

There is, however, a litigation side in that glaucoma may be induced—so the diabetic clinic would have to see each of its patients twice and be acquainted with the risks. Provided, then, that sufficient lasers were available for the increased flow, 60% of perhaps 3000 patients annually would have their sight saved or acuity extended. This would throw an increased burden on eye clinics with the continued checking.

Professor H Keen was demonstrating a new test, the "flush test" (rather like antabuse in the alcoholic), which would more or less eliminate 30% of diabetics from the likelihood of retinopathy.

I am afraid that the days are now numbered, seeing that a remedy is available, before failure to recognise retinopathy in time leads to litigation—in other words, we are dealing with a calculated risk.

G P WALSH

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Extradural haematoma: effect of delayed treatment

SIR,—The article "Extradural haematoma: effect of delayed treatment" by Mr A D Mendelow and others (12 May, p 1240) and the subsequent correspondence (30 June, p 1793; 14 July, p 134) have highlighted some of the problems concerning successful treatment of extradural haemorrhage. Unfortunately, the issue concerning modern technology remains clouded. The clinical facts are well known: delayed treatment of extradural haemorrhage for whatever reason increases mortality and morbidity and the signs which develop during the inevitable delay in instituting treatment often make computerised axial tomography (CAT) scanning a redundant and unnecessary diagnostic procedure.

Unfortunately, the time available from the first clinical evidence that there is something seriously wrong to the moment when the haematoma must be evacuated to ensure a favourable outcome is very short. This point is made with abundant clarity in the article. For this reason Mr Mandelow and his colleagues recommend that all patients with head injuries be admitted to a neurosurgical unit. However, Mr G M Teasdale and Mr S Galbraith (30 June, p 1793), point out that while this may be possible in a city like Edinburgh it is certainly not feasible as a general policy throughout the United Kingdom. They propose that selected cases should be transferred for CAT scanning, but this assumes that there are valid criteria for the selection of cases particularly at risk.

In a study of 175 cases of supratentorial extradural haemorrhage admitted to the Brook Hospital, we found that over half the patients when first seen at hospital had no alteration of consciousness or focal sign, and many had no easily demonstrable fracture. The mortality in this group was 25%. We were forced to the conclusion that the mortality could be reduced only if the diagnosis were made earlier, before deterioration occurs, at a time when the haematoma is present with no clinical sign. The CAT scanner makes this feasible. Whether saving the lives of these people is worth the price is a political question. However, it should