BRITISH MEDICAL JOURNAL

SATURDAY 4 MAY 1985

LEADING ARTICLES

CLINICAL RESEARCH • PAPERS AND SHORT REPORTS • PRACTICE OBSERVED

MEDICAL PRACTICE

NEWS AND NOTES

SUPPLEMENT

NO 6478 BRITISH MEDICAL JOURNAL 1985 VOLUME 290 1297-1368
BRITISH MEDICAL ASSOCIATION TAVISTOCK SQUARE LONDON WC1H 9JR.

WEEKLY. ISSN 0267-0623
ASTM CODEN: BMJOAE 290 (6478) 1297-1368 (1985)

CORRESPONDENCE

Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.

Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.

Screening for diabetic retinopathy

SIR,—Mr Anthony Bron (6 April, p 1025) is right to emphasise the urgent need for effective retinal screening for all diabetics, but do we need the DHSS to set up more programmes to determine the most effective way of doing it? Surely what the department should do is provide more funds so that every district may establish the most effective programme for its own locality. Existing conditions, staff, and facilities vary enormously from district to district and there will probably be no such thing as a best system. It is generally agreed that effective screening is not usually achieved in routine general practice, diabetic clinics, or ophthalmic clinics, the reasons for this failure being various and obvious. To be effective screening has to be organised, and wherever or however it is organised it seems to be effective. Foulds *et al* have described a system based on consultant staff[1]; Hill[2] and Dr C J Burns-Cox and Mr J C Dean Hart (p 1052) have independently found that ophthalmic opticians and ophthalmic medical practitioners provide a satisfactory service. Our own system is based on in house staff and uses the permanent clinical assistant staff of the diabetic unit to carry out both screening and most of the treatment (British Diabetic Association development project 1982-4, in press). The details of the individual programme will vary but the unavoidable facts are that screening must be district based, someone must organise it, someone must pay for it, and, without it, some diabetics will continue to go blind.

We trust therefore that districts which do not yet have a screening programme will develop one as soon as possible and will not delay until the results of further pilot studies proposed by the DHSS are available. Each district programme takes time to develop and has to run for several years before the total diabetic population at risk has been screened even for the first time. The logical person to organise the district screening programme is the physician responsible for diabetic care in the district. U-100 coordinating hospital physicians might well come out of presumed retirement to become retinopathy screening coordinators.

A H KNIGHT
V MAYON-WHITE
L JENKINS

Diabetic Unit,
Stoke Mandeville Hospital,
Aylesbury, Buckinghamshire

1 Foulds WS, McCuish A, Barrie T, *et al.* Diabetic retinopathy in the west of Scotland: its detection and prevelance. *Health Bulletin* 1983;**41**:318-26.
2 Hill RD. Screening for diabetic retinopathy at primary care level. *Diabetologia* 1981;**20**:9.

SIR,—The paper by Dr C J Burns-Cox and Mr J C Dean Hart and the leading article by Mr A J Bron (6 April, pp 1052, 1025) highlight diabetic retinopathy as a major cause of preventable blindness and the inadequacy of our screening services in detecting many patients in time for photocoagulation to be effective. Mr Bron states that there is no simple solution to the problem of screening for serious retinopathy.

In recent months non-mydriatic retinal cameras have become available which produce Polaroid photographs of a 45° field of the retina, taking in the macula and optic disc, without the need to dilate the pupils. Our work with the Canon series of these cameras, presented at the recent meetings of the European Association for the Study of Diabetes[1] and the British Diabetic Association,[2] suggests that they are relatively cheap, easy to use, and much better than ophthalmoscopy at detecting both background retinopathy and serious retinopathy.

Time will tell whether they turn out to be nearer the "simple solution" to the problem than other methods currently being considered. This method of screening certainly needs full evaluation and comparison with ophthalmic opticians and the other methods being proposed. We trust that the DHSS will give due consideration to this method in the screening programmes currently being set up.

R E J RYDER
J VORA
T M HAYES

Diabetic Unit

S YOUNG

School of Medical Photography,
University Hospital of Wales,
Cardiff CF4 4XW

1 Ryder REJ, Young S, Hayes TM, Owens DR. The Canon CR2-45NM retinal camera markedly improves the detection of diabetic retinopathy through undilated pupils. *Diabetalogia* 1984;**27**: 326A.
2 Ryder REJ, Young S, Hayes TM, Vora J, Atiea JA, Owens DR. The Canon CR3-45NM Polaroid, non-mydriatic camera—a further improvement in the screening for diabetic retinopathy. *Diabetic Medicine* (in press).

SIR,—I welcome any attempt to improve screening for diabetic eye diseases, which is inadequate in the UK. However, I have misgivings regarding the suggestion by Dr C J Burns-Cox and Mr J C Dean Hart that