Dear Sir

I have read with interest your excellent Journal devoted to blind children and their care and rehabilitation (J Comm Eye Health 1998; 11: 33–48). May I make some comments to emphasise some of the points in the article by Dr P Vijayalakshmi about the possibility of treatment for some of these blind children. It is interesting to note that there were significant numbers of children in blind schools in south India for whom some treatment was possible. Sadly, this is even more true in Africa where quite frequently children with treatable conditions are placed in blind schools. The possible treatment is nearly always surgical treatment, either for congenital or early onset cataracts or surgical treatment for corneal scarring and its complications.

I would like to make the following points:

1. The treatment for congenital cataract is evolving quite rapidly at present and there is considerable uncertainty as to which is the preferred method of treatment and at what age intraocular lenses should be recommended. However, all these children have many years of potential vision ahead of them. It is well worthwhile taking the time, trouble and expense of referring such children to a unit with good microsurgical facilities and someone experienced in treating congenital cataracts, because the results of such treatment are often significantly better in specialised units.

2. Nystagmus is a very useful clinical sign. Severely nystagmus points to a congenital cataract and a prognosis for vision which cannot be very good. The absence of nystagmus and good fixation, however, would indicate a post-natal cataract and potentially good vision.

3. Children who have been blind for many years, but did have vision in early life, often take a long time to ‘learn to see’ again. This is sometimes a psychological stress for the children and difficult for those around them to accept.

4. Children with corneal scars may receive real benefit from an optical iridectomy. In very severe cases of corneal scarring, the iris may be bound down to the lens. There may also be secondary lens opacification, and these children may have severe degrees of astigmatism. A very careful refraction may produce a dramatic improvement in their visual acuity.

5. Any patient with a corneal scar or who has had an optical iridectomy will be looking eccentrically through the cornea. These children may have very severe degrees of astigmatism. A very careful refraction may produce a dramatic improvement in their visual acuity.

6. Finally, there are some children who have blind eyes with staphylomas or buphthalmos where the eye is both painful and unsightly. These children may receive some symptomatic benefit from an evisceration or an enucleation.

I hope all these remarks are helpful.

Children in blind schools, particularly in developing countries, present a very special challenge to the ophthalmologist, as well as to other carers who are involved in rehabilitation and support.

John Sandford-Smith
FRCS FRCOphth
Consultant Ophthalmologist
Leicester Royal Infirmary
UK

---

**Blindness Provoked by Locally-Produced Antibiotic Eyewash**

Dear Sir

In order to alert other eye departments, we present the case of a man aged 46 who was blinded by locally-produced antibiotic eyewash.

The patient was living in Gabon, and in May 1997 he suffered from irritation of his eyes. He attended a general hospital in Gabon, where he was provided with penicillin and tetracycline in powder form, to mix in boiled water and to use as an eyewash. It was very painful and he lost his vision.

He came to the eye clinic at Enongal, Cameroon (the closest eye department, despite being in another country) on 10 November 1997. We found:

- **Visual acuities:**
  - Right: no perception of light
  - Left: hand movements

- **Right eye:**
  - Cornea completely scarred

- **Left eye:**
  - Thick scar upper cornea; lower cornea clear, but endothelium easily seen at x10 magnification: many posterior synechiae; dense cataract: IOP 21 mm Hg (applanation tonometry)

We imagine that the eyewash was very hypertonic and alkaline. This misfortune emphasises the need for care and precision in the local production of topical eye medicines.

Dr Martin Stagles, Mr Jean-Jacques Ekotto, Mrs Sarah Nkoum
Hospital Central d’Enongal
BP 91, Ebolowa
Cameroon