Bilamellar Tarsal Rotation

Dear Editor

In 1994 you published a review of this procedure (*J Comm Eye Health* 1994; **7**: 21–26). We are indebted to Mark Reacher and colleagues for the clear description and the good research underlying it. It is easier to do and to teach than the Trabut-type operation. Even so I find it tricky to get consistently good results. With the millions needing surgery around the world (often by paramedicals and with no follow-up) it is clearly important to make it as fail-safe as possible. I have some comments about the points I find difficult and would like to hear other people's experience.

The hardest part (but vital to success) is to make a good incision at the correct level. I find holding the lid margin in two artery forceps whilst cutting is not easy, and I worry about crushing the edge. It would be much easier to be able to stabilise the lid in a clamp and cut down through both lamellae onto a base plate that protects the eye. A Cruickshank forceps with the plate in the conjunctival sac can work, though not in very deformed lids. A large ring clamp is similar. Could a special one be designed? It is much easier to identify, clamp and safely tie the marginal artery when the tissues are stable. Otherwise, the operation is hampered and serious bleeding can recur later (I was once up all night!).

Three double armed sutures are recommended for each lid. As our patients come from afar we have to use absorbable material, and six atraumatic sutures (two lids) are too costly. I find one single armed absorbable suture will do for it all, starting and ending above the lashes (I prefer 5/0 or 6/0). It is also easier to catch the upper tarsal plate fragment on the front near its edge with a part-thickness side-to-side bite. This also avoids the stitch rubbing the cornea. The stitches can be tied one at a time, or left long and tied after all are in place. The correct tension is very difficult to judge and I have often had over-correction. I tried trying the stitches with a bow to allow adjustment next morning without resuturing, but the sutures are then too sticky to loosen (though using a bow during the operation is useful, allowing readjustment at the end). I now realise that it is essential to judge the correct tension with the patient looking directly ahead (at your face), because over-correction can be obscured on downgaze. This means the patient must not be squeezing; if they find relaxing is impossible, a van Lint-type facial block helps.

Finally two questions: is it necessary to suture the skin edges, as they usually lie neatly together? For the grossly thickened and deformed tarsal plate we sometimes see, is this the best operation, or is the Trabut more certain for these?

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Car Seat Belts

Dear Editor

We read the letter by Margreet Hogeweg *(J Comm Eye Health 2000*; **13**: 62) and we agree that one of the main causes of corneal perforation and ruptured globe is road traffic accident. In Yemen, ocular trauma is a significant cause of unilateral blindness.

In a recent retrospective study performed in Al-Thawra Hospital in Sana'a, Yemen we found that road traffic accident accounted for 42% of all eye injuries that required surgical intervention. Perforating injuries (ruptured globe with iris prolapse) were the most common ocular trauma treated and accounted for 67.8%.

Most patients were in the first three decades of life and were male; 82.8% of the patients were under 30 years of age. Young males were found to run a higher risk of ocular accidents, especially from road traffic accidents, gunfire and bomb explosions.

Roads are not safe in Yemen because driving licence regulations are not enforced. We don't have any regulations to wear car seat belts and many people drive without a driving licence. Unfortunately, children under the age of 16 years old can drive cars.

Health education and safety strategies should consider targeting the road traffic accidents in Yemen for the prevention of these serious eye injuries. Wearing seatbelts has to be introduced as a law, similar to our neighbouring countries Saudi Arabia and Egypt.

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Chloroquine

Dear Editor

A Cause for Concern

The recent decision by some African countries to initiate the 'Roll Back Malaria' programme (RBM) is a good one, especially with theincreasingnumberofdeathsfrommalariaanditscomplications.

The idea of allowing presumed malaria sufferers to buy chloroquine across the counter, by making the dosage regimen available to everyone, is however a cause for concern. I foresee chloroquine replacing analgesics for relief of mild aches and pains. This definitely may result in abuse of the drug, resulting in its accumulation in the body, which may cause visual impairment.

The RBM programme should not run as a vertical programme. Instead, it should be incorporated into the already existing primary health care system; thus, chloroquine will only be given in health centres, where staff who are aware of its complications are present.

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