The 'StudentHappinessQuestionnaire'
It is common practice to present students with a questionnaire at the end of a part of a curriculum, or at the end of a term. The students are asked what they liked or disliked about the content; the teaching; the assessment; the practical arrangements. This can provide useful information about problems. However, it must be used with caution:

- **Students** may be wrong – for example, since they lack a wider understanding they may believe (wrongly) that some of the course content is unimportant
- **Teachers** may believe that this is all the evaluation you need to do. If it is routinely done, year after year, teachers tend to ignore the findings.

concerned. Then we record exactly what they say (by hand or with a tape recorder) and analyse the information afterwards. What were the main points that the respondents raised?

Who Should Evaluate?

Who is best placed to evaluate teaching practice? Do you do it yourself (an 'insider'), or do you get someone else to do it for you (an 'outsider')? Do you evaluate your own practice, or that of your colleagues? The advantages of doing it yourself, about your own work, is that you understand it thoroughly – the background, the players, the details. The disadvantage is that you

Ready-Made Data Collection Instruments
Other teachers who have gone before us can help us with evaluation. It is often possible to find ready-made data collection instruments, which deal with a variety of common problems in teaching. A good source of these is the booklet, *53 Ways to Evaluate Your Teaching* by Gibbs, Gibbs and Habeshaw (published by Educational Technologies, Bristol, UK). Such instruments have been tested and refined, and should provide us with useful information. Of course we don't use them uncritically - they usually need to be adapted a little to fit our own situation.

are used to looking at your work in a certain way, and it is difficult to see it objectively - so an outsider coming with a fresh viewmaybemoreuseful.Outsidersusually want to be paid though!

Three Points

When someone asks you to do an evaluation you must be *opportunistic*. Of course you are going to collect specific data with instruments you have prepared. However, you should use every opportunity to get additional information. Talk to everyone you meet (and write down what they say); look at notice boards and classroom walls (making notes of relevant information), go into the course filing cabinet and read relevant documents. In this way you gain a deeper understanding, which helps you to make the right judgements.

One of the aims of evaluation is to find and clarify problems. The problem is that many people find it difficult to accept that they have been making mistakes. You, therefore, have to present your judgements - your *feedback* - in a sensitive way. Start by listing all the good things that you found (and you will find them). Then, once you have affirmed the persons you are evaluating, you can mention the deficiencies in a polite and non-judgmental way.

Here are two books on evaluation which I have found very helpful:

- Harris D and Bell C. (1986). *Evaluating and Assessing for Learning.* London: Kogan Page.
- Hopkins D. (1989). *Evaluation for School Development*. Milton Keynes: Open University Press.

And Finally ..

Here is a thought. The great philosopher Socrates said that the best teachers are like stinging flies. They make their students uncomfortable, by asking the really important, really difficult questions – then make the students find the answers to those themselves. What do you think?

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The Clinical Picture of Vernal Kerato-Conjunctivitis in Uganda

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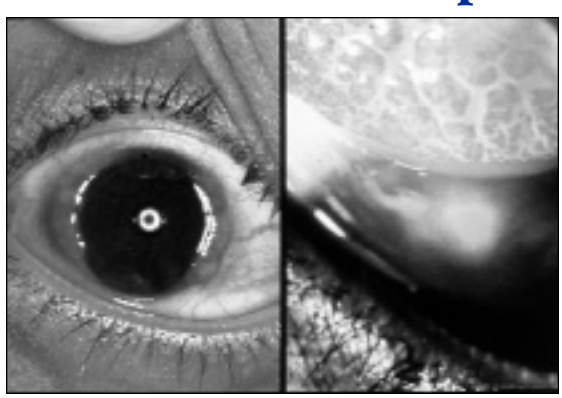
Introduction

Vernal keratoconjunctivitis (VKC) is a recurrent, bilateral, interstitial inflammation of the conjunctiva, resolving spontaneously after a course of several years and characterised by giant papillae (with a cobblestone appearance) on the tarsal conjunctiva, a discrete or confluent gelatinous hypertrophy of the limbal conjunctiva, and a distinct type of keratitis. It is associated with intense itching, redness or brownness, lacrimation, photophobia and a mucinous, ropy discharge containing eosonophils.

VKC is a type 1 hypersensitivity reaction but with additional immune mechanisms involved in its pathogenesis.

VKC has a global distribution with a widely varying incidence. It is less common in northern Europe and North America, and more common in the Africancontinent,the Mediterraneancountries, in Central and South America, and the Indian subcontinent. [1,2]

All patients in this study were indigenous Africans, and all had been exposed to similar environmental conditions.



Vernal keratoconjunctivitis affecting the limbus (left), the conjunctiva and cornea (right). The conjunctiva has pronounced papillae ('cobblestones') and fluorescein dye shows a corneal ulcer

Photos: John Sandford-Smith

The high prevalence of VKC in Uganda, and the lack of data on the pattern and typical clinical picture of this medical condition provided the impetus for this study.

Subjects and Methods

This study was carried out in two places, at the eye clinic, Department of Ophthal-

mology, Mulago National Hospital, and at the Medicare Clinic, a private eye consulting clinic in the capital city, Kampala, over a period of seven years, 1989 to 1996. A total of 420 patients with VKC were diagnosed on the grounds of their history, the presence of characteristic symptoms and on the basis of their clinical features. Clinical signs varied from mild to severe.

The history of each patient was taken including a record of age, sex, place of residence, change of place of residence, age at onset of the disease, seasonal variations, associated allergic or 'atopic' illnesses, family history of VKC or associated allergic or atopic conditions.

Each patient was thoroughly examined with a slit-lamp or a binocular 3x loupe. Refraction with determination of visual acuity, retinoscopy, and assessment of the cornea with the placido disk to determine the presence of keratoconus were carried out. Patients who had any other keratoconjunctival disease were excluded from the study. All male patients underwent a full systematic examination.

Patients were reviewed once a month, and the period of follow-up ranged from a minimum of three months to a maximum of six years.

Each patient received treatment to relieve symptoms, hydrocortisone eye drops or prednisone eye drops, whichever was available at the time. If both were available, one or the other was given, picked at random by the clinic dispensing nurse.

Results

Of the 420 patients, 231 (55%) were males and 189 (54%) were female.

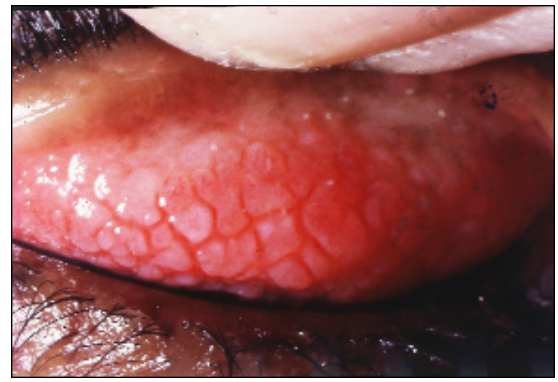
Table 1 displays the age and sex distribution at the onset of VKC; the highest incidence of VKC occurred in the age group 5–9 years, and the lowest 20 years and above.

Corneal complications occurred in 231 (55%) patients; 196 had minor complications and 35 major complications or associations. The minor complications usually consisted of superficial punctate keratopathy,orotherepithelialdisturbance.Major complications or associations consisted of superior pannus and 15 with huge plaque formation which had already compromised patients' visual acuity.

Patients with VKC often give a history of allergy or of atopic diseases such as allergic rhinitis, asthma, or hay fever [3] but in my study, co-existing allergic conditions could be detected in only 47 (11%) patients. Of the 47 patients, 37 gave a history of asthma, rhinitis or both. The remaining 10 had atopic dermatitis.

All the three sub-types of VKC, namely limbal, mixed, and palpebral were seen. The most dominant sub-type is limbal, which constituted 75% of all patients. This was followed by the mixed type which was 18% of the total. Palpebral sub-type VKC was diagnosed in only 7% of the patients.

No patient presented with either hypogonadism or hypoadrenalism (see below).



Papillae of vernal conjunctivitis in an 18 year old Afghan male. The patient also had trachoma

Photo: John D C Anderson

Discussion

I found no disproportionate high prevalence of the disease in male patients. Some previous workers have found a high prevalence of the disease in male patients.[1,2,4]

Some experimental work has shown that VKC is associated with hypogonadism and hypoadrenalism in males. Clinical evidence for this is based on findings in a Japanese population.[6] However, my own findings in this study do not support the stated association.

Since 80 of my patients were under 15 years of age, this disease in Uganda is one of young persons, resolution mostly occurring at puberty.

Over 70% of all patients noted significant seasonal variations of their symptoms; more than 85% reported accentuation of symptoms during the hotter, drier months. Seasonal variability was marked in all the three sub-types, but was most marked in the limbal sub-type.

Limbal or mixed VKC had proportionately more corneal complications than the palpebral type. This finding agrees with those of Easty and others working in Europe and the Middle East. [7,8] The high incidence of corneal involvement in limbal VKC is most likely due to poor limbal nutrition, affecting the nutrition of the avascular cornea. Some of my patients had keratoconus; other studies have reported even higher incidences.[9]

The often described typical appearance of changes on the tarsal conjunctiva in tarsal VKC, that of cobblestone formation, was hardly seen. Only one patient out of the 29 with palpebral VKC presented with a mild form of cobblestone formation. Instead, there was a red to pink uniform colour, completely concealing all tarsal conjunctival vessels.

There is a well established association of atopic disease with VKC. Several authors who have investigated the exact nature of this relationship have come to varying conclusions.[3,10] A low incidence of atopic disease in VKC in Uganda has been recorded. Relatively low incidences of atopic diseases in VKC have been recorded in other parts of the world. [5,8] There are no previous studies in either Uganda or other East African countries to make comparisons.

Table 1: Age and Sex Distribution of Patients

Age Group in years	Sex		
	Male (%)	Female (%)	Total (%)
0–4	38 (9)	29 (7)	67 (16)
5-9	88 (21)	64 (15)	152 (36)
10–14	59 (14)	59 (14)	118 (28)
15-19	15 (3)	32 (8)	47 (11)
20 & above	9 (2)	28 (7)	37 (9)

References

1 Khan M D,KundiN,SaedN,GulabA,Nazeer A F. A study of 530 cases of vernal conjunctivitis from the North West Frontier Province of Pakistan. *Pakistan J Ophthalmol* 1986; **2**: 111–114.

2 Dahan E, Appel R. Vernal keratoconjunctivitis in the black child, and its response to therapy. *Br J Ophthalmol* 1983; **67**: 688-692.

3 Tuft S J, Kemeny S M, Dart J K G, Buckley R J. Clinical features of atopic keratoconjunctivitis. *Ophthalmology* 1991; **98**: 150–158.

4 Cameron J A, Al-Rajhi A A, Badr I A. Corneal ectasia in vernal keratoconjunctivitis. *Ophthalmology* 1989; **96**: 1615-1623.

5 Aoki H. Relations of eye disease with thymus and endocrine glands especially with regard to experimental allergic conjunctivitis. *Acta Soc Ophthalmol Jap* 1968; **72**: 1949-1965.

6 Easty D L, Birkinshaw M, Merrett T. Immunological investigations in vernal eye disease. *Trans Ophthalmol Soc UK* 1980; **100**: 76-82.

7 Emarah M H. Vernal keratoconjunctivitis, diagnosis and management. *Bull Ophthalmol Soc Egypt* 1985; **78**: 5-10.

8 Khan M D, Kundi N, Saeed N, Gulab A, Nazaar AF. Incidence of keratoconus in spring catarrh. *Br J Ophthalmol* 1988; **72**: 41–43.

9 Tuft S J, Dart J K G, Kemeny M. Limbal vernal keratoconjunctivitis: clinical characteristics and immunoglobin E expression compared with palpebral vernal conjunctivitis. *Eye* 1989; **3**: 420–427.

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