

Letters

Latanoprost for Pediatric Use

Our compliments on “Glaucoma Drops: Rx for Success, or Trouble?” (Feature, March). We have additional information to share on the section regarding the treatment of children.

In particular, we would like to address Dr. K. David Epley’s comments that 1) latanoprost has not been well studied in children and 2) prevailing thinking is that most drops are not effective in infantile glaucoma.

He is correct that until now there have not been any long-term studies of latanoprost relative to a comparator. Currently, however, there are two studies in pediatrics: a pharmacokinetic study and a phase 3 clinical trial examining the safety and efficacy of latanoprost compared to timolol in children with elevated IOP. (Details on the study designs can be found by visiting www.clinicaltrials.gov and searching for NCT 00638742 and NCT 00716859.)

The phase 3 study includes 120 children up to 18 years of age with primary congenital, secondary and juvenile open-angle glaucoma and will follow them through 12 weeks of treatment. The facts that infants are included and that surgery is allowed with stipulations built into the

inclusion/exclusion criteria suggest that the data may provide insight into the role and timing of hypotensive therapy in infantile and pediatric glaucoma.

The phase 3 study is scheduled to be completed this year.

*Tomoko Maeda-Chubachi, MD
Susan Raber, PharmD
Charles S. Tressler, MD
Barbara Wirostko, MD
Pfizer, Inc.
San Diego and New York*

Loaner Eyeglasses and Contact Lens Complications

In “Recession in Your Practice: How Will You Respond?” (Opinion, January), Dr. Richard Mills asks what we can do to help our patients during this economic downturn. After reading “Keeping Contact Lens Patients Problem Free” (Clinical Update, January), I’m reminded of one solution readily at hand, especially for patients with corneal infections.

When patients present with contact lens complications, they are frequently noncompliant with instructions to discontinue contact lens wear, responding that they cannot afford to buy glasses at the moment.

A comprehensive Eye M.D. can easily maintain a small set of eyeglasses in appropriate powers to loan to a patient until the cornea

heals and the proper spectacle prescription is filled. Such myopic loaner specs can be obtained for a small amount of money.

An ensemble of these loaner eyeglasses provides inexpensive but invaluable assistance to patients.

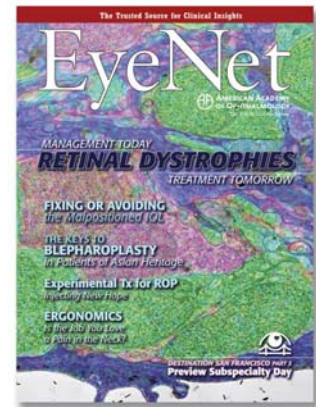
*Robert G. Smith MD
Lancaster, Wis.*

Phaco, ECCE and the World’s Bottom Billion

Your timely article “Phaco and ECCE” (Feature, April) astutely recognizes the efficacy and need for ECCE/IOL implantation as a cost-effective procedure appropriate for surgical venues in the world’s poorest countries.

Rehabilitation time for patients who have undergone manual small-incision ECCE/IOL surgery is only slightly longer than that of phaco, but long-term ECCE/IOL outcomes are virtually identical with those performed using phaco. The advantages of ECCE/IOL—including lower cost and basic-but-reliable technology—extend meager resources in countries where health care budgets are severely limited.

In many of even the poorest nations, phaco is available privately for those patients able to pay. However, the percentage of people who have sustained vision loss from cataract and who



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are able to access phaco is quite small compared with the overwhelming need of both the cataract-disabled and blind.

In sub-Saharan Africa, approximately 80 percent of the population lives in rural communities, often at insurmountable distances from eye surgery centers. Compounding the problem is that only one in 10 Africans blind from cataract ever receives sight-restoring surgery of any type.

For the world’s “bottom billion” and for cataract surgeons operating in rural venues throughout the developing world, ECCE/IOL is safe, practical and cost-effective. It should and will be the surgical choice to restore sight when phaco is unavailable, too costly or impractical.

*Larry Schwab, MD
Morgantown, W. Va.*