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March 2013

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Optrafair and the Association AGM

This year the ABDO Annual Meeting will be held for the first time at Optrafair, on Sunday 14 April. This will be followed by a special ABDO Presidential Handover Party, which again is a first for the Association. The party is open to all ABDO members but entrance is by ticket only. To obtain a ticket for the party email membership@abdo.org.uk and include your name and ABDO membership number; please note tickets will be allocated on a first come, first served basis.

In addition ABDO will be holding five CET lectures on both Saturday and Sunday, therefore we believe that Optrafair 2013 is a 'must visit' event for all ABDO members.

The CET cycle

The new CET cycle is now under way. In advance of the new system ABDO put in place new arrangements for increasing locally provided CET. Early indications are that these Area events are going to be even more popular than expected. We are of course monitoring the situation and will make the necessary changes to our plans if the need arises. The key thing for members to remember is that like everyone else we are having to get used to the new system and that we will make arrangements for everyone to be covered over the three year period.

Tony Garrett ■

Front cover:
Sari wears Stepper frame style STS 40028

CONTENTS

March 2013

Refractive surgery options part one

by Louise Stainer BSc(Hons)

Competencies covered:

Dispensing opticians: Refractive management
Optometrists: Assessment of visual function

Our patients are no longer restricted to using spectacles or contact lenses as forms of refractive correction. A number of procedures are available and may provide an alternative option. Many individuals are keen on the idea of getting rid of, or at least greatly reducing their dependency on spectacles or contact lenses. Dispensing opticians and optometrists may be approached in practice by patients wanting to know more and are perfectly placed as a reliable source of information. What type of surgery is likely to be most suitable for this person? What does it involve? This article is the first of two that will discuss several different options of corrective surgery in more detail.

LASIK

LASIK (laser-assisted in-situ keratomileusis) can be used to treat myopia, hyperopia and astigmatism and treatment options are also available for presbyopia. The procedure involves creating a hinged flap composed of epithelium, Bowman's layer and anterior stromal tissue either with a blade called a microkeratome or femtosecond laser. The latter technique, creates bubbles within the stroma via photodisruption of the tissue at a calculated depth. These bubbles collectively form an interface that can be utilised for flap formation, This is achieved by using a blunt dissection instrument[1]. Opinions differ as to whether the femtosecond laser is a preferable method of flap creation compared to the microkeratome. Advantages include a more predictable flap thickness and smoother and more stable stromal bed following flap creation[2]. There is also more flexibility for the surgeon as the position of the flap hinge and the shape of the flap can be varied[2].

The ablation of the central cornea is deeper than the periphery for treatment of myopia resulting in a flatter cornea. Conversely treatment of hyperopia involves deeper ablation of the outer optic zone than the central resulting in a more conical shaped corneal profile. In addition, various multifocal ablation profiles have been highlighted for presbyLASIK (in which excimer laser is used for the correction of presbyopia)[5]. These include the central near vision profile comprised of a hyper-positive central corneal near vision zone and a peripheral distance vision zone. The opposite results with the central distance vision profile in that a central zone is created to produce clear vision in the distance[5]. Negative asphericity is created in the peripheral zone enabling an increased depth of field and correction of near vision[6].

Following the ablation the surgeon carefully replaces the flap confirming that no debris or air bubbles are present. The flap should remain in position without any further intervention.

The range of prescriptions treated varies between different centres with some sites treating up to 10D of myopia and 5D of astigmatism[7]. Treatment of high myopia with LASIK alone is not advised. There is a need to preserve a certain amount of corneal stroma, otherwise the risk of subsequent corneal ectasia and an unstable refractive outcome are increased[7]. Post-LASIK ectasia is characterised by thinning and steepening of the central or inferior cornea that is progressive in nature[8]. It is due to destabilisation of the corneal structure and can occur months or

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This article has been approved for **1 CET point** by the **GOC**. It is open to all FBDO members, including associate member optometrists. Insert your answers to the six multiple choice questions (MCQs) online at www.abdo.org.uk, or on the answer sheet inserted in this issue and return by **11 April 2013** to **ABDO CET, 5 Kingsford Business Centre, Layer Road, Kingsford, Colchester CO2 0HT** OR fax to **01206 734156**. If you complete online, please ensure that your email address and GOC number are up-to-date. The pass mark is 60 per cent. The answers will appear in the May issue of *Dispensing Optics*

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even years after the initial surgery[8]. Residual stromal tissue of at least 250µm is recommended to reduce the risk of such complications[7]. It is important to measure corneal thickness pre-operatively using pachymetry and to take a thorough patient history, ideally involving recording previous spectacle prescriptions to confirm stability of the patient's prescription prior to treatment. Anterior segment tomography (scans producing information regarding the elevation of the anterior and posterior corneal surfaces and corneal thickness) should also be performed preoperatively. These help to rule of the presence of any conditions such as keratoconus including forme fruste keratoconus (FFKC) and pellucid marginal degeneration that would predispose the individual to ectasia post-operatively. FFKC describes a very early stage of keratoconus where the only clinical sign is subtle changes in the corneal tomography including islands of steepening situated in the inferior cornea, steep keratometry readings (between 47 and 49 dioptres) and irregular astigmatism. These individuals may also have a family history of keratoconus[9].

Although LASIK is a successful procedure in correcting refractive errors it can sometimes cause increased higher order aberrations that may be debilitating for the patient despite excellent visual acuity. These include spherical aberrations[10]. Laser performed to treat myopia has been shown to increase positive spherical aberration while hyperopic treatments increase negative spherical aberration[11,12]. Such effects increase in severity with the amount of prescription. These aberrations may be perceived by the patient as starbursts and halos and be more obvious at night as the pupil is bigger[12]. Wavefront LASIK is tailored specifically to the eye being treated. It aims to alleviate all optical aberrations that degrade visual quality and reduce their unwanted visual side-effects. However, if an individual's corneal aberrometry scans indicate low amounts of optical aberrations pre-operatively these may increase even following wavefront LASIK treatment[10].

Following LASIK, patients are usually prescribed topical antibiotics and steroids during the post-operative period. Artificial tears may also promote healing of the ocular surface. After the surgical procedure various stages of healing occur[12]. Epithelial cells injured by flap formation release chemicals called cytokines and growth factors[13]. The former trigger the chemical cascade that results in cell death (apoptosis) of keratocytes situated in the adjacent stromal vicinity. The epithelial growth factors stimulate the proliferation and differentiation of remaining keratocytes in the area into specialised cells called myofibroblasts that have a role in the healing response[13]. This transformation is a key factor in the corneal haze that may be observed by the clinician following LASIK as the light scatter caused by myofibroblasts is significantly greater than that caused by inactive keratocytes[14]. Occasionally this may result in symptoms such as glare and a reduction in vision (reduced contrast sensitivity and best corrected visual acuity (BCVA))[14]. Fortunately, this is often only an issue at the flap edges and away from the visual axis so goes unnoticed by the patient[14]. Myofibroblasts migrate throughout the disrupted part of the stroma secreting various tissue building blocks such as collagen. They also produce growth factors that promote stromal and epithelial healing[13]. Myofibroblasts are generally not evident in the cornea either weeks or months following treatment[13]. In general the process of fibrous metaplasia is complete at six months after the LASIK is performed[15].

Epithelial thickening (hyperplasia) and stromal changes resulting from the healing response following LASIK are the likely explanation for the occurrence of subsequent regression that occurs in some individuals[16]. A study found this to be -0.16D a year for myopic eyes of up to -10 dioptres that underwent LASIK[17]. LASIK enhancement may be performed if necessary and if the patient is deemed suitable. This involves lifting the flap and remodeling the underlying stromal tissue with further laser treatment.

Certain complications are associated with the microkeratome and femtosecond laser respectively. Epithelial defects are the most frequent complication associated with microkeratome created flaps and a phenomenon known as transient light sensitivity may result from femtosecond laser usage[2]. Fortunately both of these complications are rare. Transient Light Sensitivity Syndrome (TLSS) has been recorded in only 1 to 2% of Intralase cases and reducing the laser energy settings has been found to further reduce the likelihood of occurrence[3]. The sensitivity to light experienced can vary between individuals, ranging from mild to extreme in severity. The onset of photophobia tends to occur between two and six weeks after uncomplicated LASIK surgery[2]. The symptoms are similar to iritis but slit lamp examination reveals no evidence of anterior chamber activity (the presence of cells or flare) or circumlimbal injection[4]. The individual's visual acuity is generally unaffected. TLSS is normally resolved by a course of topical steroid eye drops.

LASEK (laser epithelial keratomileusis)

The LASEK procedure is characterised by the initial removal of a section of corneal epithelium (flap). This may be achieved by a number of different methods. One approach involves a brief application of a dilute alcohol solution onto the central corneal surface that loosens the epithelial layer. An epithelial flap is then created, the underlying stroma subsequently ablated with an excimer laser and the epithelial flap usually repositioned following irrigation[18]. A bandage contact lens is then usually inserted to keep the flap in position. This also aids initial corneal healing by preventing disruption of epithelial cell migration, proliferation and adhesion during basement membrane repair[19]. Bandage contact lenses help improve patient comfort by preventing contact between exposed corneal nerves and the eyelids especially during blinking[19]. Post operatively the patient is prescribed various eye drops including corticosteroids, antibiotics and lubricants. Oral analgesics may also be given if necessary during the initial few days following the procedure. It is common for patients to experience pain during this period

Continued overleaf

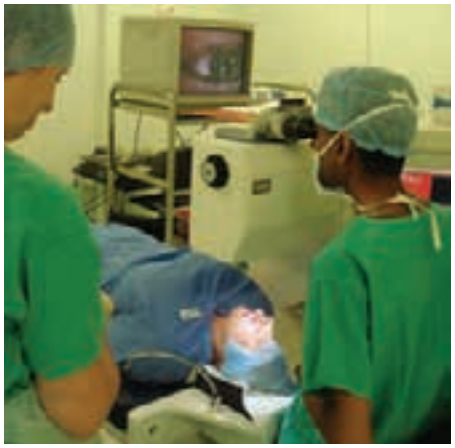

Figure 1: LASEK surgery at Optegra Birmingham

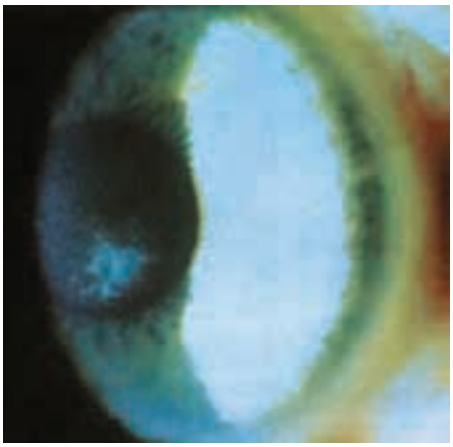

Figure 2: Corneal haze post LASIK[25]

as corneal healing progresses and re-epithelisation occurs.

It is thought that the presence of the epithelial flap may provide protection by providing a protective barrier regardless of cell viability and improve clinical outcome though the underlying mechanisms are not fully understood[20]. The presence of the epithelial flap may prevent contact between the stroma and various protein cell mediators called cytokines that are present in the tears following their release by the injured epithelial cells. Cellular response to cytokines would otherwise result in epithelial regrowth that may be too aggressive possibly resulting in post-operative haze. The preservation of epithelial cell viability within the flap is dependent on the exposure time to the alcohol solution used during treatment. As the alcohol solution is toxic to these cells, cell death can result from prolonged contact. Re-epithelisation is usually complete after four days and an appointment is then arranged for the patient to have the contact lenses removed **(Figure 1)**.

The benefits of LASEK over LASIK include the lack of intraoperative and post-operative flap complications associated with the flap used in LASIK. These include button hole, partial or lost flaps[21]. Other complications associated with LASIK such as epithelial ingrowth, interface debris and diffuse lamellar keratitis (DLK) are also not seen after LASEK[21]. LASEK may also be a viable alternative to LASIK for individuals with an occupation or lifestyle (such as military personnel or athletes) that carries an increased potential risk of flap trauma. The preservation of the posterior stroma following LASEK also reduces the risk of post-operative corneal ectasia as the residual corneal bed thickness is greater. The reduced tissue requirement also means that LASEK is the better treatment option for people with thinner corneas, although obviously there still has to be enough residual tissue for corneal stability post-operatively. The sensory (afferent) nerves of the cornea form a connection with the efferent autonomic nerves of the brainstem that stimulate the lacrimal glands to produce tears. Many of these afferent nerves are severed during the flap creation stage of LASIK treatment. This results in decreased tear production despite the conjunctival and peripheral corneal innervation remaining intact[22]. In addition the creation of the LASIK flap also affects the function of sub-Bowman's nerve plexus resulting in reduced corneal sensation within the parameters of the flap (anaesthetic cornea) that eventually recovers but at a slower rate than in LASEK patients[22, 23].

However LASEK patients have been found to experience increased pain post-operatively compared to those who have undergone LASIK. Complete recovery of vision is also much slower. Individuals may actually notice a decrease in their vision during the first twenty-four hours following the procedure. This is due to swelling and death of epithelial cells damaged by the alcohol solution used during treatment. The risk of long-term corneal haze has also been found to be greater following LASEK than LASIK especially with higher pre-operative prescriptions[24] **(Figure 2)**.

Corneal inlays

The utilisation of corneal inlays for the correction of presbyopia in the UK is currently being considered by the National Institute for Health and Clinical Excellence (NICE) (The Interventional Procedures Advisory Committee)[26]. The inlay is implanted in the central stroma over the pupil centre of the non-dominant eye. It is inserted under a formed corneal flap or in a corneal pocket that can be created by a femtolaser. The latter can help prevent movement and subsequent decentration of the implant. The various principles behind different types of inlays in development include either altering the refractive index of the cornea (by introducing an implant with a higher refractive index), changing the power of the corneal surface or creating of a pinhole effect depending on the product **(Figure 3)**.

The InVue corneal inlay (Acufocus) is a small hydrophilic acrylic lens with optical properties similar to a multifocal contact lens or intraocular lens. It has a central zone that leaves the dioptric power of the cornea unaltered, a mid-peripheral zone for near vision (available in varying add powers) and a peripheral zone for distance vision. When the patient focuses on a distant object the pupil dilates resulting in a greater amount of light passing through the distant component of the altered corneal surface. Pupillary constriction during observation of a close target leads to the majority of light passing through the near component[28].

Another implant in development is the PresbyLens (Revision Optics). The overall result achieved is similar to the InVue inlay but the refractive index of the material is the same as that of the cornea. Instead this optical device is placed with a corneal flap and causes corneal steepening (of the central 2 to 3mm) creating a multifocal surface. The peripheral cornea is used for distance vision tasks. The disadvantage of this type of approach is that a secondary image is produced causing a reduction in contrast sensitivity[28]. The success of this implant is also reliant on pupil size. Patients with large pupils may find near vision problematic if the area

corresponding to the inlay add is small and vice-versa

The ACI 7000 or KAMRA corneal inlay improves near vision by using a pinhole style design (a central aperture surrounded by a virtually opaque material) rather than altering the optics of the cornea. It blocks the transmission of peripheral light rays, leading to an increased depth of focus. There are also small perforations of varying sizes in the surround to allow the passage of nutrients and metabolites through the cornea which was previously problematic with this type of implant[28].

The implantation of corneal inlays can be performed in conjunction with other procedures such as LASIK or previous monofocal or phakic IOL surgery so that distance correction is addressed as well as presbyopia[28]. However as the individual's accommodative ability becomes negligible (at approximately 60 years of age) the benefits of this type of procedure diminish[28]. Intraocular lens surgery may be suggested at this stage instead.

Conductive Keratoplasty (CK)

Conductive Keratoplasty is a potential treatment solution for individuals with either low to moderate hyperopia or those with a combination of either emmetropia or hyperopia and presbyopia. The procedure involves the delivery of electromagnetic energy into the stroma via a fine tipped contact probe in a ring or series of concentric rings of application spots around the mid-peripheral cornea. The pattern and number of spots are based on current nomograms and tend to be increased in number to correct higher degrees of hyperopia. CK can also be performed on the non-dominant eye to treat presbyopia[29]. Current resistance within the cornea causes a localised increase in temperature that shrinks the individual collagen fibres[29]. The overall tissue contraction causes flattening of the peripheral and steepening of the central cornea, increasing the refractive power of the latter and inducing a myopic shift[30, 31].

Induced astigmatism is one potential post-operative complication of this type of treatment. However the incidence has fallen following the introduction of a CK technique called light touch. In contrast to previous CK techniques pressure does not need to be maintained following tip insertion and during treatment. Previously discrepancies in the pressure applied at different spots resulted in induced astigmatism following the procedure[31] CK may also provide a treatment option for the development of presbyopia in post-LASIK patients. However there is a risk that regression may occur following CK through corneal re-steepening.

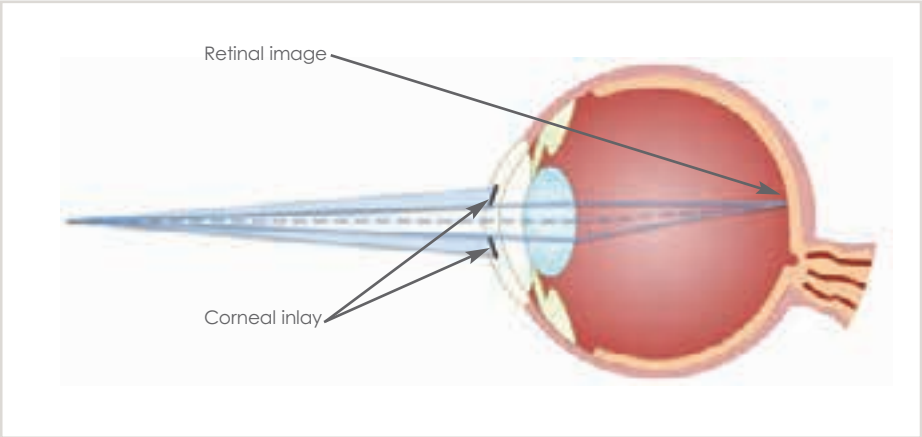

Figure 3: Corneal Inlay (adapted from[27])

Astigmatic Keratotomy (AK)

Astigmatic Keratotomy involves creating arcuate incisions centred at the steepest corneal meridian. These have the effect of reducing the corneal curvature along this axis but steepening the perpendicular axis[32]. This effect is known as the coupling ratio. The coupling ratio varies with the type of incision used.

Limbal relaxing incisions are a form of astigmatic keratotomy and can be performed during cataract surgery or refractive procedures such as phakic IOL or refractive lens exchange[32]. The limbal incision required to perform these types of surgery can be positioned along the required meridian and then extended in length to also correct astigmatism present. The length required can be determined using nomograms. This type of incision tends to produce a coupling ratio of 1:1 meaning that there is no change in the spherical equivalent and the power of the IOL does not need to be adjusted[33]. Alternatively AK can be used as the initial step for reducing higher amounts of astigmatism to residual levels that can then be treated with LASIK[34].

This article has concentrated solely on corneal-based refractive surgery treatments. Surgeries of this type may provide the ideal surgical solution if the patient is happy to proceed after discussion regarding the potential risks and limitations (for example the temporary nature of CK). However some people may not be suitable for certain types of corneal treatment for various reasons. These include corneal pathology, cornea thinness or a prescription that is out of the recommended treatment range. Also, for older patients the likelihood of cataract development increases. As lens changes develop they are likely to have a negative impact on the results of previous refractive procedures performed on the cornea. This may need to be addressed. Calculation of the intraocular lens required may be more complex if the individual has had previous corneal surgery. The next article will explore lens-based refractive surgeries available for individuals with or without cataract.

Louise Stainer is a hospital optometrist at Optegra Eye Hospital, Birmingham. She is involved in the pre and post-operative care of cataract and refractive surgery patients and drug research. She has previously lectured on the ocular component of the Guide dogs for the Blind guide dog mobility instructors (GDMI) Bachelors and Masters degree courses. Louise has also worked in the Paediatrics department at Kidderminister Hospital, in private practice and has written numerous articles for various optometric and dispensing optician journals. ■

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The multiple choice questions for *Refractive surgery options part two* are on page 38 of this issue

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Refractive surgery options part two

by Louise Stainer BSc(Hons)

Competencies covered:

Dispensing opticians: Refractive management
Optometrists: Assessment of visual function

This is the second of two articles looking at a number of refractive surgery options currently available. The last article concentrated on corneal surgery but this may not be suitable for all individuals and is unlikely to be recommended in isolation for those with early lens changes. However, sometimes corneal and lens based approaches may be used in combination to produce an optimal refractive result. This article will discuss the different types of intraocular lens surgery options in more detail.

Intraocular lenses (IOLs)

There are currently a variety of intraocular lenses available. These may be inserted in addition to the natural lens (phakic IOLs) or as a replacement.

Phakic IOLs

Phakic IOLs may provide a surgical solution for patients with high myopia or hyperopia that is outside the range that can be treated with laser surgery. Toric phakic IOLs are also available to correct astigmatism. A major advantage of this type of IOL for younger patients is the preservation of accommodation.

Phakic IOLs are either anterior or posterior chamber IOLs. Anterior chamber IOLs may be angle supported or iris-supported **(Figure 1)**.

Complications associated with angle supported anterior chamber IOLs include potential damage to the corneal endothelium, the angle or the iris. Endothelial cell loss has been found to occur following anterior phakic IOL insertion and the risk increases as the distance between the phakic IOL and endothelium decreases[2]. Therefore this type of refractive solution is not recommended for patients with a low endothelial cell count or shallow anterior chambers[2]. The iris may be affected if the position of the lens haptics distorts the surrounding tissue resulting in iris traction and pupil ovalisation or distortion. The size selection of this type of lens for the patient is extremely important. If the lens selected is too small it is more likely to rotate and decentre. This, in turn increases the likelihood of endothelial contact and subsequent damage. This would also have an extreme impact on the visual quality with toric lenses. Alternatively a lens that is too large may contribute to pupil ovalisation and symptoms such as glare and halos[3].

Commonly used iris-supported anterior chamber phakic IOLs are the Artisan lenses (Ophtec) and the foldable Artiflex IOL which have one universal size. The Verisyse phakic IOL(Abbot Medical Optics) is stabilised in position by hooks either side of the lens which attach to the iris tissue (enclavation)[4]. These lenses are a greater distance from the endothelium than the angle supported type[3], but obviously they are closer to the iris. A complication associated with this type of phakic IOL is pigment dispersion. A large surgical incision is also needed which may result in induced astigmatism and the surgery itself is more complex than for other phakic IOLs[3].

Posterior chamber IOLs are either fixed to the sulcus or zonular fibres or are unattached and rest in a position that is adjacent to the patient's own lens[5]. An example of the former is the

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injectable foldable Visian ICL that can be positioned by placing each of the four corners underneath the iris and into the sulcus to hold it into place[4].

The incidence of traumatic cataract following lens insertion is greatest with the posterior chamber type of phakic IOL[6]. Other complications include an increased risk of retinal detachment in high myopes following posterior chamber phakic IOL surgery (this has been found to occur in 1.3% of cases)[6].

Refractive Lens Exchange (RLE)

Toric IOLs

Toric IOLs are available to correct astigmatism up to -4.00D at the corneal plane[7]. As with other types of refractive surgery, patients have to be carefully assessed to confirm that they are suitable prior to surgery and potential risks clarified. Certain individuals are at an increased risk of unsuccessful outcome with toric IOLs. These include those with weak zonules, pseudoexfoliation (a condition in which abnormal material is produced throughout the body and may be seen on the anterior lens capsule or pupillary margin), an unstable capsular bag or a combination of these[8]. In such cases the risk of the intraocular lens rotating following implantation is increased. This is significant because toric intraocular lenses correct 3.3% less of the intended astigmatic correction per degree of rotation from the correct orientation[9]. In fact rotational instability proved problematic with the older generation toric IOLs in general. However development of newer designs such as those with haptics with improved stability that can withstand greater deformation (seen in the AcrySof IQ Toric IOL from Alcon Surgical) have helped to reduce this problem[9].

Monofocal IOLs.

Monofocal IOLs are designed with a fixed optic power that is usually selected to correct distance vision. Therefore presbyopic patients will usually require reading glasses for close tasks following cataract surgery or refractive lens exchange surgery where a monofocal lens is selected. To reduce the need for correction monovision may be a surgical option. This is based on the surgeon aiming for emmetropia in the dominant eye and slight myopia in the non-dominant eye. The extent of myopia aimed for is decided by taking into account the individual patient's needs. For example the degree of myopia selected for the patient who primarily uses the computer will be different from that which is ideal for the person who spends most of their time reading. However there is a limitation on the difference between the two eyes that can be tolerated. If the patient is keen on the idea of monovision but has not experienced it (either with contact lenses or glasses) they will be demonstrated the prescription in the trial frame and a contact lens trial arranged so that they can experience it for a longer period of time. The dominant eye can be determined using a variety of methods. One of these involves asking the patient to look at a letter on the chart though a hole at the centre of a card that they hold at arm's length. One eye at a time is then covered. The eye that is uncovered when the letter can be seen is the individual's dominant eye.

Successful monovision is dependent on the individual's ability to suppress blur from the eye not being used at a given time. This blur may make binocular fusion difficult or even impossible for some patients such as those whose visual system is already under additional stress. This may include patients who are compensating for a heterophoria or those who have low fusion reserves[10]. Weak ocular dominance is also a requirement for monovision. Patients with strong sensory ocular dominance are more likely to suffer from insufficient blur suppression.

Monovision has been shown to impair the ability to perceive depth (stereopsis). Therefore it is not recommended to individuals whose occupations are reliant on this such as heavy goods vehicle drivers, surgeons and pilots.

Multifocal IOLs

Multifocal IOLs aim to address the issue of presbyopia and provide a

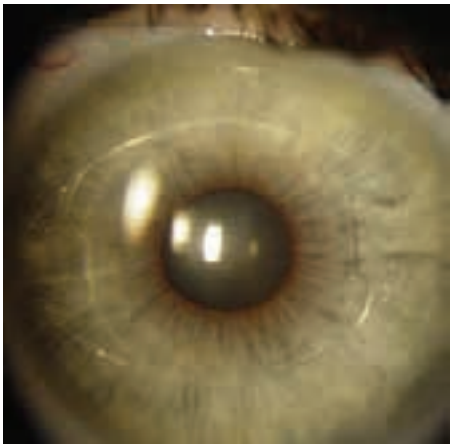

Figure 1: Phakic IOL[1]

correction for distance and reading prescriptions. Designs are based on variation in refractive power across the lens (refractive IOLs), diffractive properties of the material (diffractive IOLs) or a combination of the two. Multifocal IOLs may also be described as pupil dependent or independent. They are based on the principle of simultaneous vision in that multiple images are formed on the retina at the same time for near and far objects with the brain selecting the appropriate one.

Refractive IOLS

Refractive IOLs designs are based on a variation in refractive power in different zones of the lens. An example is the ReZOOM (Abbott Medical Optics) lens that is composed of five concentric refractive zones, three of which are for distance vision and two for near. It is a pupil dependent lens and the central zone is designed to produce optimal distance vision when the pupil is constricted in bright light (photopic) conditions. Studies have found that distance and intermediate vision produced excellent results with this lens but that some patients may feel that their near vision could be improved and need a reading correction[11, 12].

Diffractive IOLs

Diffractive IOLs utilises constructive interference of light directing rays to specific foci (usually two), one for near and the other for distance[13]. Therefore intermediate vision may be adversely affected. However, improvements are being found with newer generation lenses. Alcon Acrysof ReSTOR +3.0 is an aspheric multifocal IOL that utilises

Continued overleaf

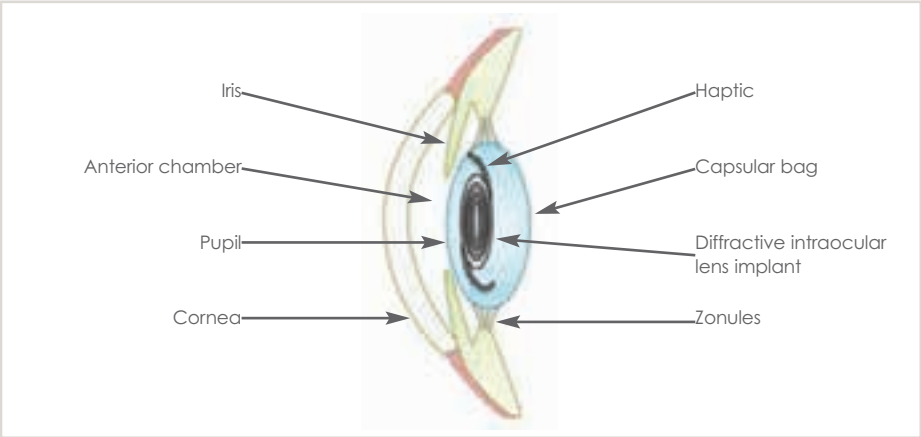

Figure 2: Diagram of diffractive multifocal IOL

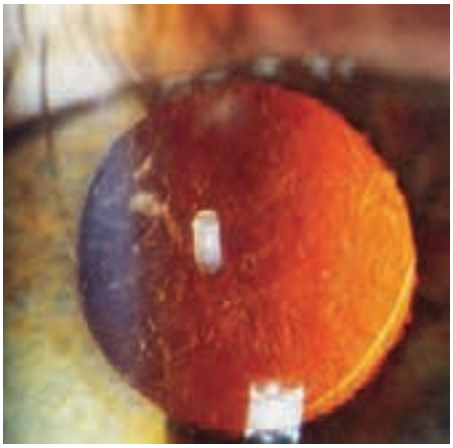

Figure 3: Posterior Capsular Opacification (PCO) viewed with retroillumination[20]

both diffractive and refractive properties. It has diffractive rings on its anterior surface comprising of gradually decreasing step heights creating a smooth transition from the centre of the diffractive zone to the periphery (apodization)[14]. This lens is pupil size dependent. When the pupil is large more of the peripheral diffractive zones are utilised and the amount of light distributed to the distance focal point is greater and when the pupil is constricted the majority of light is directed to the near focal point. There is also a refractive zone surrounding the central diffractive apodized region. This area corresponds to a distance focal point and aims to optimise vision for activities performed under scotopic conditions (when the pupil is dilated) such a night-time driving[14]. The Alcon Acrysof ReSTOR +3.0 has a lower reading add than its predecessor and various studies have shown that it produces better intermediate vision and overall range in comparison[15].

A new aspheric trifocal IOL design called Fine Vision Micro F (PhysIOL, Leige, Belgium) is also available. This multifocal has a purely diffractive design but splits light into three foci for distance, intermediate and near rather than two. This lens is based on the combination of two diffractive profiles for distance and intermediate and for distance and near respectively. These diffractive steps are apodized to the periphery, which reduces the amount of light lost by light scatter before reaching the retina [16].

First generation multifocal IOLs were also associated with problems such as halos, glare that is more noticeable in the dark (dysphotopsia) or a combination of these occurring together. This may be especially obvious when driving at night. Design modifications including the use of aspheric surfaces have helped to address these issues to some extent. Neuro-adaptation also naturally occurs over time and glare and halos become less noticeable. Night vision issues can be exacerbated by a residual prescription following treatment as well as the presence of dry eye disease. Laser surgery may be an option to alleviate the former and the latter may be addressed with lubricants pre and post-operatively. However patients should be warned of the risk of these symptoms occurring following surgery at their pre-operative consultation.

Multifocal IOLs have also been shown to result in a reduction in contrast sensitivity. Therefore they are not recommended for patients with impaired macular function such as macular degeneration or an epiretinal membrane as these conditions also have a negative impact on contrast sensitivity[17] **(Figure 2)**.

Accommodating IOLs

The advantage of accommodating IOLs over monovision and multifocal IOLs is that they do not force the brain to select one retinal image in favour of another. Also they do not pose the risk of glare and halos seen in conjunction with this scenario. They aim to mimic the natural mechanism of accommodation. The accommodating IOL works by the optic either changing with regards to its refractive index, power or axial position (this is achieved with either single or dual optics working in conjunction). Alternatively the function may be based on change in lens shape or a combination of these mechanisms may occur together during accommodation[18]. This means that the patient needs to have some degree of accommodation and that the overall accommodative effect achieved is limited. Consequently although this type of lens often produces good distance and intermediate vision, reading vision may not be as good as that achieved with multifocal IOLs. Reading glasses may still be required especially in poor lighting conditions or for small print.

Complications following RLE

As with any type of surgery there are risks associated with intraocular lens surgery and the individual must be made fully aware of these together with the potential benefits. They are then able to make an informed decision when deciding whether to proceed with surgery. Fortunately serious complications are generally rare. Complications that may develop following RLE include posterior capsular opacification (PCO) which is the most common[19]. The posterior lens capsule can become cloudy months or even years after the initial intraocular lens surgery and the patients vision impacted if the visual axis is affected **(Figure 3)**. PCO can usually be treated with Nd:YAG laser if necessary which creates a central clear gap through the capsular haze.

Continued overleaf

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Cystoid macular oedema (CMO) describes the development of fluid filled cysts and possible swelling at the macula due to capillary leakage within this region. It is another potential complication following RLE. The patient may experience blurring and visual distortion (metamorphopsia). Fortunately CMO can often resolve without the need for treatment. Alternatively a tapering course of non-steroidal anti-inflammatories (NSAID) either alone or together with steroidal eyedrops may be required. Occasionally an intra-vitreal steroidal injection may be necessary. When a patient is deciding whether to proceed with refractive surgery, those who are highly myopic, under fifty years of age and/or with a long axial length (> 28mm) should consider it carefully. Indeed the surgeon may advise against such surgery in some of these cases as there is an increased risk of retinal detachment occurring in these individuals following RLE[19,21]. However for many people considering refractive surgery the overall benefit of such treatment will outweigh the potential complications.

Conclusion

Refractive surgery is a field of ophthalmology that has been, is presently and continues to evolve rapidly. Surgical options for the individual wanting reduced dependency on spectacles or contact lenses are improving all the time. This article attempted to highlight many of those currently available and in development.

Louise Stainer is a hospital optometrist at Optegra Eye Hospital, Birmingham. She is involved in the pre and post-operative care of cataract and refractive surgery patients and drug research. She has previously lectured on the ocular component of the Guide dogs for the Blind guide dog mobility instructors (GDMI) Bachelors and Masters degree courses. Louise has also worked in the Paediatrics department at Kidderminister Hospital, in private practice and has written numerous articles for various optometric and dispensing optician journals. ■

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The multiple choice questions for *Refractive surgery options part two* are on page 38 of this issue


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This month Antonia Chitty explores the ins and outs of selling your practice

Effective exit strategies

Whether you are thinking about starting your own business, own your own business and have yet to consider your exit strategy, or know that your practice is going to be your retirement fund, this article is for you. The sooner you start thinking about your exit strategy, the more likely you are to achieve the value that you need and want when the time comes to sell.

The first step is to make the decision to sell, and the sooner you do this the better. Dominic Watson is a director at Myers La Roche and head of the practice sales division. He says: "When it comes to practice sales, it is never too early to start thinking about it and be in a position of readiness. I've been in this field for over a decade. Sometimes we have a dialogue with practice owners over a number of years."

Timing is critical – you are unlikely to sell up simply because someone walks in and makes you an offer. Instead pick the time that you want to sell and when the market is right. Watson says: "Right now it is a mixed market – some practices are very saleable and some aren't. The ideal scenario is to have a business that is growing and improving when you come to sell. Some people we speak to have waited a few years too long; you are selling from a position of weakness if your business is deteriorating".

There is likely to be a relatively small pool of people looking for a practice at the time you want to sell, which adds to the reasons to consider the sale well in advance. With time to spare, you may find a larger company looking for independents or small groups to buy as a way to fuel business growth; this can have advantages as big businesses are likely to have the finances set in place to make the purchase. What is more, if you start thinking about your exit strategy five or 10 years prior to selling, you may be able to recruit potential successors to your team.

Consider what might motivate you to sell. Watson comments: "We're seeing more people emigrating. You may think you want to exit in three, five or 10 years, but things can change. It is always good to be prepared for catalysts like ill health, divorce or other personal influencers such as seeing friends retiring early. You should always have your business in readiness. One of the questions I would always ask is what your plans are for the future. We may have clients who are 40 and emigrating as well as those in their 80s. We talk about the value, what their plans and needs are. One client wants to raise money to pay off their holiday home. Others think that they may sell their business and then locum but discover that there is an exclusion and they can't work in a certain radius.

"We ask personal questions too which can help find what you need to do," Watson continues. "Would you get the right yield on your money from the practice sale for a pension or in the stock market, for example." You might decide to sell a less profitable branch so you can focus on the rest of the group. Watson adds: "We're also seeing more amalgamations. Sometimes people will pay more for a practice amalgamation. If someone with a good premises and position wants to retire, a neighbour may take that on. People may pay slightly more because of this sort of strategic reason."

You need to consider that it can take time to sell your business – often more time than you might imagine. Watson explains: "The time taken to sell is dictated by supply and demand – the density of optometrists is not even across the UK. There are some areas where the marketing would take longer than others. The areas with higher demand should take less time. We are finding transactions take longer now than in the past due to financing reasons. Banking sector changes mean getting agreement for funding is taking longer. Specialist funders have been decimated. The quickest we've ever done is four weeks, which is exceptional. Looking at averages it can take six months, but in other places it can take a year or two."

Doing the groundwork

With all this information to take on board you may be feeling a little overwhelmed. Whether you think you should have started to consider selling some time ago, or you feel uninformed right now, there are some straightforward actions to take. Start by talking to the handful of firms involved in the sale of UK optical businesses (see February's article). Watson suggests: "Get the right advice. We get evaluations from different parties that can be miles out. If you get someone who doesn't understand the sector you can end up with your business being over or undervalued."

You will want to get a number of estimates of the value of your business, and also think what you can do to maximise the value. Watson explains: "Having a plan is a starting point. Talk to an accountant from a tax perspective. If you are a sole trader or partnership, investigate incorporating before starting the sales process. Get a valuation done so you understand what a business is likely to be worth; your accountant needs this to see what the best advice is. In my mind, the technical valuation and the open market valuation can be different. A business may achieve more than the norm, if it has a prime location. The same business 15 miles away with same yield could be worth half as much."

You may be considering improving your practice prior to selling it: should you invest in your practice appearance perhaps? Watson says that there are downsides to this approach, and sometimes a practice in need of investment can sell well: "If you want to sell your practice soon, banks and buyers want to see tangible evidence of what they are buying. We can critique a business and market it on the basis of unrealised potential. You could go and look at a practice tomorrow and see it needs a shop fit – the return on that will take time. If it costs £50,000 it won't add on extra to the value of the business. It is better for the purchaser to see how the practice is generating business right now. This is the yield; this is the state the business is in. On the other hand, if you have three to five years before you want to sell, it might be worth doing."

It is also worth considering what you will actually sell. Watson explains: "Sometimes if you have more than one branch, an exit strategy may be to sell off on a branch by branch basis. This can lead to a law of diminishing returns, but equally if you sell off your satellite practice and focus on the main one, then sell the other business a year or two later, you'll probably get an uplift on the main business as you focus on it which will lead to a better price."

Spreading the word

Once you have your sales plans in place, have made improvements to the business and are ready to go to market, you need to set up non-disclosure agreements so you can share more business information with potential buyers without fear that they will gossip. Now is time to promote your business for sale. Make sure that you explore every promotional outlet to get the best price. Look at online and print methods of making people aware that your practice is for sale, and remember the value of word of mouth. One of your colleagues at the Local Optical Committee may have been quietly coveting your practice for many years and leap at the chance of buying it to add to his group.

Once you are about to go public about the fact that you are putting your business on the market, you need to consider stakeholder communication. For most practices the key stakeholders are staff and patients. Let staff know what you are doing as soon as you can. They are likely to be concerned about their jobs, and keeping them well informed can help to reassure them. At the same time, remember that you cannot promise everyone will keep their job unless you put this into the agreement with the new purchaser.

Once your marketing begins to have an effect you will get enquirers. Potential buyers will make their own assessment of the value of the practice by assessing its size, profit margin, rate of growth, and the scope for improvements. Hopefully the buyer will then make an offer: now is the time to start detailed negotiations. There are plenty of factors to consider at this stage (see February article for some more ideas).

Dominic Watson says: "We also have lots of buyers who are happy to retain the owner for a period of time. If you need an income stream you get some guaranteed consultancy – plus the benefit of the cash lump sum. A phased exit can be better for your health than a sudden exit. Cut down to a couple of days and it can be a happier outcome." Consider what other factors might contribute to your ideal outcome, and which ones can be negotiated on. The more flexible you are, the more likely you are to come to an agreement.

As well as agreeing what you are selling, you also need to establish how the purchaser will pay. Watson says: "Be aware that the funding situation has changed. It is harder to get funding these days. Five years ago, deals would be cash on completion, but now we do more stretched deals. It is often difficult to fund the business and the freehold at the same time. Now you, the seller, might retain the freehold and sell the business, so you become a landlord on a commercial basis. Or, you might get 75 per cent of the sale value up front and 25 per cent over the next year."

The buyer will have an exclusivity period where you will agree not to look at other offers while due diligence is completed, their accountant checks the figures, and lawyers set up the contracts required. Remember all the way through to consider what you need to do to communicate what's happening to staff and customers, and suppliers of course.

Selling your practice can be stressful, but with sufficient preparation it can give you a strong foundation for the next phase of your life, whatever it might be.

Former optometrist Antonia Chitty now writes on business topics. Her latest book is *Making Money Online*. She has written other books including *Blogging: The Essential Guide* and *Marketing: The Essential Guide* which will help you if you need effective ways to promote your practice. ■

Regular team meetings are a must for new practice managers, writes Rebecca Thompson

Plan well to succeed

In my previous article I discussed some of the behaviours that it is essential to adopt when making the transition from dispensing optician to practice manager. I would like to expand on this by giving some advice for use during the first months of your new management role.

Whether newly promoted within your practice, or making the transition to an entirely new business, the measure of success is value. In a new role it is all too easy to become immersed in the day-to-day trivialities of the job as you get to know your surroundings. The challenge here is that the longer you spend getting to know the business, the less time you have to make an impact and start adding value.

First things first

When you understand your situation, you can focus your energy quite quickly in your new role. It is all about learning versus doing. How will you prioritise which comes first when planning your time? Read on to find out how.

1. Diagnose the business

Your first step should be to clarify your role and what is expected of you in the coming months. In conversation with your manager try to understand which of the following categories apply:

New beginnings: The business is entirely new, and you have been recruited to help build the framework from scratch. More doing is required in this role; swift action is needed to ensure that the business begins to make profit at the earliest opportunity.

Rescue: The business is established, but is in trouble. Here you have been recruited to help get it back on track. More doing is essential here; quick decisions will need to be made without always having the full information.

Back on the path: The business has a plan; here you are needed to prevent the business needing rescuing. The business requires an injection of enthusiasm, direction and good morale. To do this you will need to focus slightly more on learning by getting to know the product, your customers and your team.

Good to great: The business is already successful. You are responsible for building on that success. Slightly more emphasis on learning is needed initially. There is no need for very swift action; you will need to get to know the culture of the business so that any action taken only adds to its success.

Once you have established which bracket the business fits into, create a table that identifies the strengths and weaknesses of this diagnosis. The strengths will show you where the opportunities and resources lie for success in your role.

2. Do a SWOT chart

A SWOT chart consists of four boxes with the headings: Strengths, Weaknesses, Opportunities and Threats. It can be used to help the direction of the business as a whole, or can be used to analyse particular parts of the business, for example team or product.

- Strengths: Characteristics that give it an advantage over others
- Weaknesses: (limitations) Characteristics that place it at a disadvantage compared to others
- Opportunities: Ways performance could be improved (internal or external)
- Threats: Elements that could potentially cause trouble for the business (internal or external)

The most important thing about a SWOT chart is not that you have completed one, or that it looks tidy and pretty; it is how you use it to build on the success of the business and negate its weaknesses. Think about how you can turn your weaknesses into strengths and your threats into opportunities.

3. Know your manager

It is essential that you get to know your manager quickly. They need to outline what is expected of you, a time frame for delivery and you need to have regular conversations to discuss whether these objectives are possible (given your resources) and achievable in the time frame set. It is worth finding out whether there are areas of the business that are non-negotiable.

In the first few months of management you don't want to tread on your manager's toes by trying to scrap something that they have implemented. Ask where the limits of your role will be. It is worth repeating that communication with your boss should be in the style that they prefer. For example, would they like you to communicate in person, on the phone or via email? How often will they need you to contact them? Do they like to know the detail of your actions, or do they just need a broad overview with occasional updates?

4. Profile your team

By understanding the personality profiles of your team early on, it is possible to harness talent and progress quickly. You can pay for personality profiles which can help you understand how each person in your team can be motivated, their learning style, how best for you (and others in the team) to communicate with them, how they may react in certain situations and the strengths of their personal characteristics.

Profiling your team adds real, lasting value to the business when the information it provides is used appropriately. It can also be used as a fun, interactive tool for team building. The team will appreciate that you are making the effort to get to know them, and after all, we like to talk about ourselves.

5. Have a 'quick win'

Using the results from point 1 and 2 you can identify where your 'quick wins' are. These are actions that add immediate and lasting value to the business, build trust with your manager and ultimately give you the time and space you need to focus on more difficult areas of growth. A quick win might be to develop a patient recall system that means over 70 per cent of patients return every time. It may be implementing a bonus structure that only pays out when the business is in profit or doing a full stock evaluation that streamlines purchasing, reduces cost and increases profit. Remember to select the quick win that matters to your manager first.

6. Communicate

Implementing regular team meetings is a must. At a minimum you and your team need to set time aside once per week to discuss changes, updates and potential issues. At the end of the meeting the team should be aware of who is responsible for delivery, when this will take place and who will be consulted or informed. It is important to set standards straight away in your new role, your team need to know what you expect of them and what will happen in the case of non-delivery. Personal responsibility is key; making clear the fact that they are in control of their own destiny will not only instil a clear framework, it will also embed a sense of ownership. Define particular attitude expectations, rather than skills. The ability to do a task can be taught, but good attitude is essential. Always hold people accountable when they do not deliver, this is especially important in the first few months as a manager as your actions now set a precedent for the future.

7. It's a matter of time

Planning your time effectively is crucial to your success in a new role. Now you know what is expected of you and what resources you have, it's time to write your current project list. There should be a maximum of 10 things on here, and each should be SMART (Specific, Measurable, Attainable, Relevant, Time-bound). Concentrate only on the top three. You will find this easier if you break down each project into parts by identifying specific actions you need to take on the road to completion.

Initially you may find that you need to have a weekly diary that breaks your time into 15 or 30 minute chunks, you can then assign specific times to work on each of your current projects. Around them you can schedule time to answer emails, have staff meetings and deal with queries. By doing this you can ensure that you are working on adding value to the business, rather than spending most of your time dealing with trivia.

The advice given in this article is not only useful for dispensing opticians new to a management role; an established manager may also use these tools to boost the value that they add to a business. In the current working climate, the margin for error is small, so plan well to succeed.

Rebecca Thompson FBDO provides business coaching, training and development for optical entrepreneurs at Practice Building (www.practicebuilding.co.uk). She has worked in both independent and multiple practice ■

As the countdown to Optrafair begins, we preview just some of the great many products and services that will be available to view

Much to see at the NEC

Eyewear eye-openers

"Surely the main attraction of any exhibition is new products and, perhaps, free gifts," said Continental Eyewear's Neal Grimason, who promises to have plenty of both on offer at the show. The company will be displaying new releases from across its portfolio, with the Jaeger range taking centre stage alongside the latest fashions in Jaeger's ladies and gents clothing. X-eyes will also feature with several new acetate and titanium designs, plus the Lazer range. Visitors to the stand will have the chance to win £500 in a free competition.

Mondottica will showcase all of its brands including Hackett, Ted Baker, Lulu Guinness, Anna Sui, Christian Lacroix and Converse. Designer ranges from Dunelm will be displayed including Paul Costelloe, Janet Reger and Celine Dion, as well as Dunelm's own Julian Beaumont, Retro and Whiz Kids ranges. Dunelm will also highlight new sunglass ranges alongside its cases and accessory options. Peter Beaumont, director at Dunelm Optical, commented: "We are delighted to be exhibiting at Optrafair; it is a fantastic barometer of market trends for the year ahead."

International Eyewear, which celebrates its 25th anniversary this year, will be showing its largest ever collection including Hero, Zoffani, Puccini and Episode, sun collections Ocean Blue and Dakota, and children's ranges Star Wars and Eyestuff. There will also be a new collection from British brand, Storm. Rodenstock will debut its own new frames and its luxury eyewear brands, Porsche Design and Dunhill. Meanwhile, Goodlookers Eyewear will be launching a new collection of acetate frames. Also exhibiting are Emporium Eyewear, Face à Face,

Special Optrafair events for ABDO members

ABDO is inviting all of its members to attend Optrafair 2013; to join in a weekend of thought provoking CET, attend the Association's AGM and get together at a special presidential handover party.

To complement Optrafair 2013, and maximise opportunities for members who are planning to attend, ABDO is running a number of special events.

On Saturday 13 and Sunday 14 April there will be the chance to obtain up to five CET points by attending the ABDO lectures, to be held in Concourse Suites 32-33. They will be presented by an international cast of well-respected speakers on topics such as spectacle lenses, frame design and contact lens materials.

"This is a unique opportunity to meet key personnel from some of the world's leading ophthalmic R+D departments and to find out what really goes on behind the scenes before new products are launched," said Elaine Grisdale, ABDO head of professional services. "Importantly, they will outline how you and your patients can benefit from the new innovations they will discuss."

The five lectures will be conducted on both days but in a different sequence, so those who don't get a chance to attend a presentation on day one, there's a second chance on day two. The CET is free of charge to ABDO members, with just a nominal charge for optical assistants and optometrists also wishing to participate. As space is limited, advance booking will be essential.

On Sunday 14 April, the Association's 2013 AGM will be held at 5pm in Concourse Suites 32-33 and all members are invited to attend. The ABDO Benevolent Fund AGM will follow immediately after.

The evening of Sunday 14 April also heralds a milestone for ABDO, with the introduction of a special party to be held in The Gallery at the NEC. During the 'Presidential Handover Party', which is supported by Optrafair organiser the FMO, ABDO President, Jennifer Brower, will step down after two and a half successful years to handover to Peter Black. Peter will be supported by the new incoming Vice President, Kevin Gutsell.

"This informal event will be a great chance to network and to discuss topical issues with fellow members and other colleagues from the optical industry – and to have some fun," said Elaine. The party, from 6-8pm, will include canapés and music; there's no formal dress code so 'traditional Optrafair attire' is appropriate.

"Please come along to support ABDO's incoming President and enjoy all Optrafair 2013 has to offer. We look forward to seeing you there," added Elaine. ■

Flair, Henry Beaumont, Modern Eyewear, Spectacles Direct and the Eyewear Company, plus more.

Followers of fashion

The Optrafair Fashion Quarter (FQ) with its boutique look and adjoining catwalk will be even bigger this time, with enhanced lighting, a catwalk and champagne bar. William Morris Eyewear will be taking three times the space it had in 2011. MD Robert Morris explained: "We are taking five stands this time. We need to be there as we are really passionate about the UK market. Besides OWP, Mexx and William Morris we are set to launch Charles Stone NY, our new recession brand."

Menrad Optics will be in the FQ with its latest collections including the new luxury women's fashion collection from designer, L'Wren Scott. MD Chris Beal commented: "The FQ is akin to where we are with frames and sunglasses. Our brands – Jaguar, Morgan, Joop, Davidoff and Menrad – are associated with fashion and we have deliberately selected stands which are close to the catwalk and have a larger presence in recognition of the importance of the fair." Visitors to Menrad will also see a new Performance Collection in the Jaguar range with unique details and features adapted from the new Jaguar F-Type sports car.

New to the FQ this year will be Wolf Eyewear, which has a large collection to launch. As a first time exhibitor to the FQ, Norville will be honing in on its fashion offering, particularly Duck and Cover, Barbour with both sun and ophthalmic collections, Vera Wang, Jeff Banks and his diffusion Studio label. An enlarged space is the plan for FEI Eyewear, with its three brands Zuma, Dilem and Lightec.

FQ regular Orange Eyewear will unveil new on-trend models from its own Orange label plus a number of designs on show from its designer collection, CC – fronted by actress Jane Seymour – as well as the colourful German designer range Vulkan and the Été collection. Other ranges offering new styles include: iconic French fashion brand, Guy Laroche, Nici, Baby and Vulkani for kids. Also in the FQ will be OKO Eyewear and others.

Lens innovations

Visit the Shamir stand to find out about Shamir Autograph III – its new progressive lens "holistically adapted to the prescription that ensures a clear and comfortable visual experience for all". Also view Shamir Spark, a 3D optical measuring solution that enables opticians to quickly and precisely obtain the necessary ophthalmic measurements. Shamir Online ordering, which offers a Web Thickness Calculator and Shape Manager, will also be showcased. There will be prizes up for grabs, demonstrations and fun activities, promises Shamir.

In addition to showcasing its latest range of retail, testing and workshop equipment, Essilor will present its recently launched Varilux S series lenses, which it says overcomes the varifocal lens compromise between fields of vision and swim effect using exclusive technologies. Staff will demonstrate the Visioffice measuring system and explain the benefits of dispensing personalised lenses. Find out more about M'eye Fit Touch, Essilor's latest hand-held measuring device, or simply attend the stand for a drink and chat.

Rodenstock will be presenting two new generations of lens products with

Continued overleaf

View new X-eyes models from Continental Eyewear

Menrad will launch a new Jaguar Performance Collection

Colourful ready readers from Goodlookers Eyewear

Impression 2 and Multigressive 2. "Impression lenses have been improved again in the Rodenstock Perfection category," said the company. From April, Impression lenses will be available with 'pupil-optimised correction'.
From this spring, Rodenstock will be offering the EyeModel module of the Eye Lens Technology for all Multigressive lenses in the Rodenstock Excellence category. There will be the chance to learn more about Rodenstock's progressive Eye Lens Technology, the practical ordering software WinFit Reference, plus Rodenstock's FogFree anti-fogging cloth.

Tools and equipment

Topcon will show its latest OCT tools, with key features such as pinpoint registration, and combined true colour fundus imaging. Heidelberg Engineering will be exhibiting for the first time as a direct supplier to the market. "OCT is one of the key ways a practice can differentiate itself from competitors, as well as giving patients the best possible care," said Ian Berry, Heidelberg practice programme manager. "Choosing a future-proof, upgradeable instrument is really the smart choice." In addition to the Spectralis OCT, Heidelberg will show the Heidelberg Retina Tomograph, the Heidelberg Edge Perimeter and Heyex image management software.

Grafton believes visitors to the show should have "the exciting and affordable fundus camera, the iCam on their must-have list, which when teamed up with the iVue OCT will bring clinical technology within reach of all practitioners," said Grafton MD Brian Bowles. Birmingham Optical Group will be promoting the Nidek RS3000 OCT Advanced, with improved capturing and analysis performance, auto shot capturing, ultrafine mode, and a new Choroidal mode. The Nidek AFC330 non-mydriatic auto fundus camera is the company's most automated model and replaces the older versions with external camera and removes the need for a PC interface.

Carl Zeiss will be focusing on both the diagnostic and lens part of its business. Rob Lyon, Carl Zeiss Ophthalmic Systems business manager, said: "The Cirrus OCT has continually demonstrated how it is one of the leading OCTs in the business, and this year should prove to be no different with new additions and features. Since the last Optrafair the Visucam 200 with MPD has continued to be an exciting product offering those that invest in the technology a clear advantage over that of their competitors," added Rob.

At the Carlton Optical stand, visitors will be able to get hands-on with the Canon OCT-HS100, which features automatic eye alignment, automatic eye tracking and auto focusing combined with 3µm axial resolution and up to 70,000 A-scans/second. Rodenstock will demonstrate the multimedia Rodenstock Consulting Platform, apps for the iPad, and the ImpressionIST3 service terminal. Also on show will be a selection of Rodenstock's refraction equipment, now being distributed by BiB, also exhibiting.

Essilor Instruments will be showing visitors its award winning edging systems, such as Mr Blue, Mr Orange and the Ultimate Edition range. Some of the systems will feature special offers, which will be exclusively available on orders placed during the show. Essilor's range of Optometry Equipment, used by optometrists and opticians for vision correction, screening and diagnosis of eye diseases, allows the company to partner with opticians and provide equipment for each of their practice areas: refraction room, front office and workshop.

Practice solutions

Cutting the cost of patient reminders by using email, text and out-sourced mailings from the practice management system are just one aspect that the major IT companies of optics will be promoting. "Optrafair 2013 is the opportunity to see state-of-the-art optics, with all aspects represented under once roof, not only IT," according to Optix MD Trevor Rowley. "If practices do not attend the show they could miss out on something that is fundamental and that their competitor down the road is looking to use."

Optisoft will be promoting its comprehensive modular system, which it claims provides independent practitioners with everything from a simple patient recall system to a completely paperless practice. Optinet, the IT division of the National Eyecare Group (NEG), will be there to give demonstrations of its practice management solutions. Phil Mullins, NEG director of business development, said: "Optrafair is one of the most important events for us as a group; it gives us a great opportunity to meet with professionals from across the UK and spend time discussing how we can support their business". Also due to exhibit are Ocuco, Optimed, Ipro, See 20/20 and Thomson Software Solutions.

New prospects

The chances to discuss new job opportunities will be available with a host of companies, including Boots Opticians. Daniel Grinsted, Boots' franchise business development director, says the event is the time to explore "the next step" in careers. "We will be recruiting at Optrafair and as a Top Ten Company to Work for in the *Sunday Times* employee survey for the past three years. We are looking for leaders who share our values of partnership, care, trust and entrepreneurship and the skills to deliver the best possible customer services."

Specsavers will offer visitors the chance to explore business ownership opportunities, or joint ventures, in Australia, New Zealand, Spain and the UK. "Optrafair is a fantastic chance for optical professionals looking to run their own business to speak to the UK's market leader," said Chris Howarth, Specsavers' director of professional recruitment. "We

welcome you to join our recruitment teams to discuss business-ownership opportunities and employed roles here in the UK and in our international territories."

Flame Health is looking forward to meeting existing and new clients. "It is extremely beneficial to sit down face to face and discuss how we can assist moving their career or business forward," said Matthew Spicer, Flame Health divisional partner. "The atmosphere at Optrafair is extremely positive." Prospect Health will be exhibiting for the first time, offering advice on how to have top-performing members of staff in the business in order to maximise profitability and growth.

The Outside Clinic will have both new and long serving optometrists and dispensing opticians on hand to discuss their own experiences and reasons for working for the company. Lynda Oliver, head of HR, said: "Whilst advertising, websites, job boards and recruitment agencies all have their place and in their own way are very good at pointing potential candidates in our direction, often the best way to judge whether an organisation aligns with your own set of values and professionalism is face-to-face."

Financial matters

Practice owners who want to discuss finance issues will have several options when seeking informed advice. Stuart Burn, MD of Performance Finance, said: "Those with a positive mindset can see where change and innovation can help drive practice success. New technologies are giving optometrists a far greater ability to check the health of the eye. Not only is this technology fantastic for early diagnosis of some serious eye related problems, it also provides a superb profit opportunity," he said.

A direct funder to the optical profession for 20 years, Braemar Finance has helped businesses grow by offering finance solutions that are tax efficient, according to MD David Foster: "We have a nationwide team of experienced experts who are available to discuss finance requirements taking personal tax and VAT Deminimis status into consideration. Our range of leasing, hire purchase and loan products can be used for a variety of purposes. We specialise in finance solutions for equipment, shopfitting, vehicles, IT, commercial mortgages and tax loans." Also exhibiting will be Lloyds TSB and LDF with tax, VAT and funding advice.

Find out about Essilor's new S series of Varilux lenses

Getting the look

Optrafair 2013 is the place to see what a 21st century practice can offer and how a modest investment in shop fitting can bring a new lease of life to the practice. "Be bullish about the future and invest during the downturn," said Optrafair exhibitor, Lynx IDG MD Mark Fantom. "The most pro-active optical practitioners in the country share a passion to push on through and keep on striving. Every one of our customers who have invested in practice re-fits and retail development are succeeding – they cannot all be wrong." Lynx IDG will be promoting new developments and looking for customer feedback.

Mid West Displays, a new exhibitor to Optrafair, has been supplying displays to opticians for some time. MD Mark Newman said: "We have a range of ultra modern looking designs that light up with low energy LEDs for a bright yet cost effective display. Choose your display 'off the shelf', or have one tailor made to the specification you require. Both of these options can be personalised with branding engraved into the acrylic, which once the lights are switched on glows with a stunning effect. As we manufacture in the UK we have complete control from the initial site visit through to design, manufacture and fitting."

For those looking for a more modestly priced practice boost, Mid West will

Continued overleaf

Practice technology will be to the fore

Discuss your shopfitting requirements with Lynx and others

Guide Dogs will be in the charity sector

be promoting window poster displays for offers and promotions, dispensing desk screens, bespoke shelving, leaflet dispensers, and rotating displays. Also exhibiting their fresh ideas on shopfitting will be Mewscraft and Store Graphics.

Professional issues

Visit all of the optical bodies under one roof to find out how the profession is moving forward, from the Association of Optometrists to the General Optical Council. The AIO – Association of Independent Optometrists and Dispensing Opticians – is keen to show that "optics cannot advance without an active independent faction" according to Pat Cameron Davies, honorary secretary.

Pat said: "AIO is non-profit making and run by independent practitioners, with an online group, conferences, newsletters and, most importantly, the companionship of other practitioners who have exactly the same problems and dilemmas as all other independents. Discussion with your fellow colleagues can often direct you to the solutions," she added.

The British Contact Lens Association (BCLA) will be giving details of how to book for its conference and exhibition, to be held from 6-9 June at Manchester Central. A special offer will be available for visitors who sign up for 18 months of membership: 18 months for the price of 12. A fantastic prize will be up for grabs in the BCLA stand prize draw competition, with information available about membership benefits and resources.

The Local Optical Committee Support Unit will have guidance to help to develop, negotiate and implement local primary ophthalmic services. The Federation of Ophthalmic and Dispensing Opticians (FODO) will also be there, and holding its Annual Board Strategy Day during the show. The Worshipful Company of Spectacle Makers (WCSM) will be explaining its various opportunities for optical training. Visitors can find out about the WCSM's educational programme, which now attracts government funding.

Charitable concerns

Guide Dogs will lead the charity sector at Optrafair with a new sensory tunnel. The semi-circular chasm creates a realistic feeling of disorientation with traffic and countryside noises simulating the experiences of blind people. Making its first appearance at an optical show, the sensory tunnel is expected to create much interest.

Optometry Giving Sight will also be there to raise the profile of its work at home and abroad. Donna Power, OGS regional manager, said: "Last year saw the first locally trained eyecare professionals graduate from OGS funded schools of optometry in Malawi, Mozambique and Mali. We are excited to be able to report on the impact these pioneers of optometry are having in their home countries."

Also addressing the visual needs of the disadvantaged will be UK charity Vision Care for Homeless People. Elaine Styles, chair of the charity, explained: "It will be fantastic to be at Optrafair again. Our first attendance at the show achieved a broad range of objectives particularly raising the awareness with optometrists and dispensing opticians who may be potential volunteers. Knowledge about the service that we provide amongst the general optical industry including labs and equipment manufacturers is also very important," Elaine added.

Vision Aid Overseas (VAO) will highlight the volunteering opportunities available. Jeremy Jalie, VAO development director, commented: "It is extremely kind of the FMO to give us a free stand as it is an important event for us to engage with optical professionals who support our development work so we are very excited to have the chance again. Optrafair 2011 was a great success and it is fantastic that so many people are interested in volunteering overseas and working to transform access to eyecare in developing countries."

Fight for Sight is gearing up to highlight the importance of research into sight loss under the banner, 'A future everyone can see'. Director of development, Julian Jackson, said: "Our vision is to fund pioneering research to prevent sight loss – and to treat eye disease – in adults and children. The aim is for earlier diagnosis of eye diseases, increased understanding of how the diseases develop, improved treatments and awareness of reducing the risk factors." Also sponsored by the FMO to attend are the International Glaucoma Association, and the RNIB promoting the UK Vision Strategy.

Optrafair 2013 takes place at the NEC Birmingham from 13-15 April. For all the latest information about Optrafair 2013, including the latest exhibitor list, visit www.optrafair.co.uk ■

We'll see you there!

Optrafair - 13th - 15th April 2013

SIX REASONS TO ATTEND

- **ABDO stand S60** in the main exhibition hall, Saturday 13th to Monday 15th April
- **ABDO CET event** featuring five international speakers. Saturday 13th and Sunday 14th April
- **ABDO Annual General Meeting** Sunday 14th April: 5.00pm
- **ABDO Presidential handover party** Sunday 14th April: 6.00 - 8.00pm
- **ABDO College** will also be exhibiting (stand P14) and conducting special activities in conjunction with **Canterbury Christ Church University**
- **The UK's biggest and best optical trade fair**

OPTRAFAIR

Optrafair 2013

THE MUST-ATTEND EVENT FOR **EVERY** ABDO MEMBER

Optrafair 2013 will take place 13-15 April at the National Exhibition Centre in Birmingham, ABDO is using the show to host a CET event, its AGM and a special party that will feature the presidential handover. All these events are free for ABDO members to attend so we look forward to seeing you there!

CET LECTURES • AGM • PRESIDENTIAL HANDOVER PARTY • THE UK's LARGEST OPTICAL EXHIBITION

Association of British Dispensing Opticians

What must seem to many the most daunting requirement for contact lens opticians and optometrists is the introduction by the GOC of mandatory peer review or peer discussion. It is NOT a statutory requirement for dispensing opticians, but it is a very enjoyable way to gain points, learn what others do - and keep awake! - writes Paula Stevens

Setting up a peer review/discussion group in your practice

Peer review and peer discussion differ slightly, but both are accepted for the CLO/optometrist requirement. In peer review, participants bring along cases they have been involved with in practice, whereas for peer discussion, the group discusses pre-prepared (hypothetical/edited) case records. Apart from that, the specification for the two modalities is the same (Fig 1), and both are interactive forms of CET. Interactive CET is classified as any CET which brings the optician into contact with other optical professionals, for example, other delegates at a CET event, or individual interaction with a tutor, or personalised feedback and discussion.

Figure 1 is an extract from the GOC Enhanced CET scheme Principles and Requirements v2.1.

The GOC have made it fairly easy to set up a peer review session, which means that you can register as a peer review group leader/facilitator, set up

Continued overleaf

Figure 1: Peer review and peer discussion specifications

Enhanced CET Scheme Principles and Requirements - final version 2.1, December 2012

1.27.1 Interactive CET - use of this form of CET is not limited

Type of Enhanced CET	Requirement	Good Practice Guidance – not mandatory, alternatives supported by clear rationale will be considered	Points
Peer Review Group I am interacting with my peers to discuss and understand clinical decision making, diagnosis, management and record keeping processes and practices	- Minimum number is 4, including the leader - A leader - Real cases brought by the members of the group - An appropriate venue - Registrant is required to record a reflection statement on the Enhanced CET Platform after the event	- Maximum number is 10 - Recommended group size 6-8 - Minimum time 2 hours - A minimum of 2 cases to be discussed but aim to cover 4-8 - Lasts 2 hours	3
Peer Discussion Group I am interacting with my peers to discuss and understand clinical decision making, diagnosis, management and record keeping processes and practices	- Minimum number is 4 - A facilitator - Prepared and approved case based patient scenarios - Example cases can be used - An appropriate venue - Registrant is required to record a reflection statement on the Enhanced CET System after the event	- Maximum number is 10 - Recommended group size 6-8 - A minimum of 2 scenarios to be discussed but aim to cover 4-8 - Lasts 2 hours - Cases and scenarios can be presented from the front by a presenter with a facilitator on each table	3

DON'T MISS YOUR OPPORTUNITY...

SPECSAVERS ARE COMING TO A TOWN NEAR YOU...

- **Manchester: Saturday 6th April**
- **Nottingham: Sunday 7th April**
- **London: Monday 8th April**
- **Birmingham NEC for Optrafair: (Sat 12th to Mon 14th April 2013)**

Are you a top class Manager of a busy optical store, managing a team of 6 or more and at least 8-10 years' experience?

Are you looking for the next step in your career or hungry for your chance to be a business owner in Australia/New Zealand?

This is exactly where many stop, often because they think it is difficult or impossible....Specsavers Australia/New Zealand works hard at the possible!

Come and find out how we have become a market leader and a massive success story in only 5 years at one of our above roadshows. Fantastic employment and business ownership opportunities for great people and a lifestyle that people can only dream about!

To register your interest in booking a place for your meeting simply email anz.opportunities@specsavers.com or call Jerry Dunn on 07799 581 281 quoting DO-March.

We welcome enquiries from everyone and value diversity in our workforce.

Specsavers

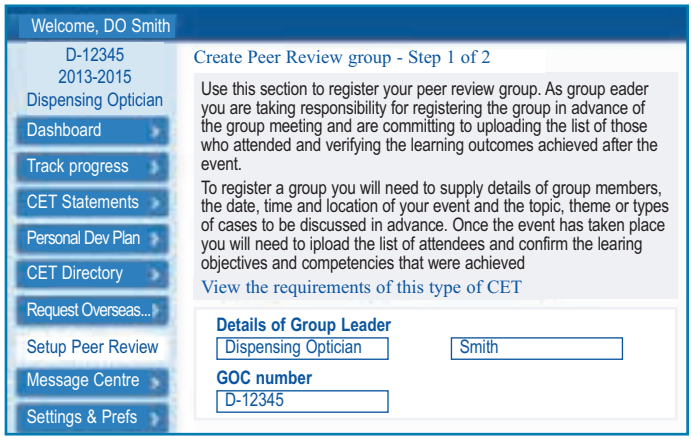


Figure 2

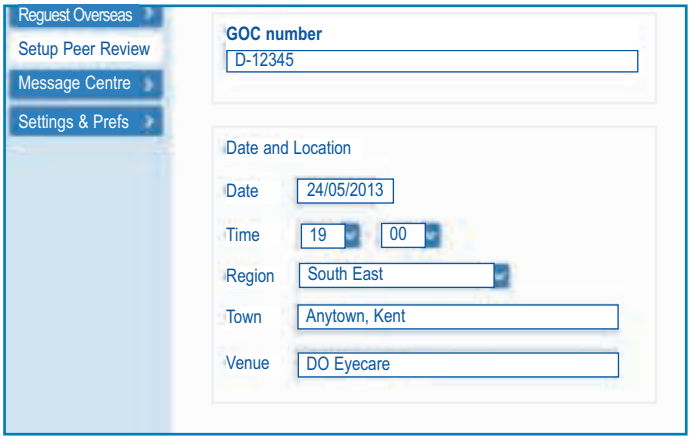


Figure 3

These screenshots have been retyped to enable them to be read. Please refer to the GOC website for the actual screenshot

a discussion about case records in your practice with your colleagues in the practice and/or invited local practitioners, and gain 3 CET points for a two hour session. Although it is desirable to have completed some training as a leader/facilitator, peer review can be led by any registrant. Having some training gives an insight into what to expect, how to handle difficult situations and how to cope with unexpected incidents. Also it can sometimes be difficult to remain impartial and keep on track with the direction of the discussion. When the members confirm their points, they will be asked for feedback on how successful the session was, and a poor facilitator can damage the value of the whole experience.

On the MyCET website

Figure 2 shows the first screen after clicking 'Setup Peer Review Group'. You can click 'View the requirements of this type of CET', but it's a link to an old version. Hopefully the latest version will be available when you make your application.

The next part of the screen is shown in **Figure 3**, where you can enter the venue, date and time of your planned event.

Continuing down the screen **(Figure 4)**, you will be asked to complete some more details about the group, and the broad topics of discussion.

Then you finish the section by agreeing to the requirements. The hyperlink here links to the same info as the 'View the requirements' link.

Learning objectives

You must consult the GOC Core Competencies to complete this section **(Figure 5)** properly, which means that you must download/view the competency documents which are available on the GOC website. These can be hard to find, so here is the web address for the competency documents page: http://www.optical.org/en/Education/core-competencies--core-curriculums/index.cfm

The ones you are most likely to need are the:

- 2011 contact lens speciality competencies
- 2011 dispensing optics core competencies
- 2011 optometry stage 2 core competencies

You can usually enter the learning objectives in exactly the same way as they are laid out in the documents, with the 'indicators' as the proposed learning objective(s) in Step 5 **(Figure 6)**.

It's a bit fiddly, but just a case of finding which indicator best describes what you hope the members of the group will have learned from the discussion. You may find it easier to decide on the indicator first, and then work backwards up the steps. Remember to 'Save' after you have finished each learning objective, or you will lose your work. When all the learning objectives have been completed, click 'Save' again, and

Figure 4

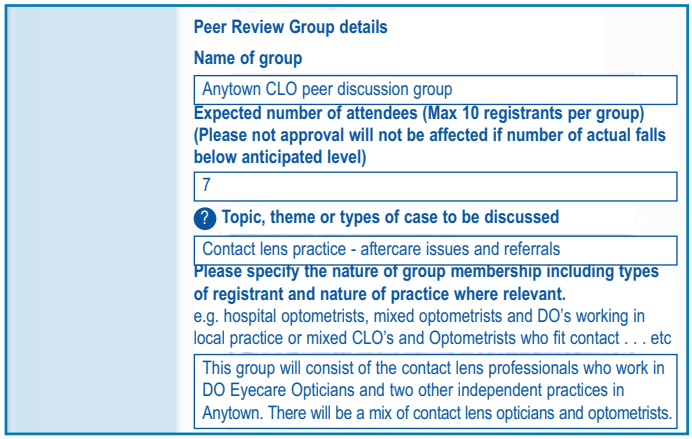
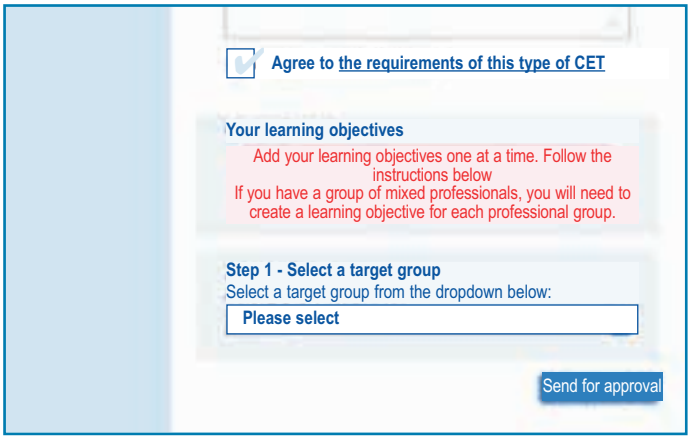


Figure 5



These screenshots have been retyped to enable them to be read. Please refer to the GOC website for the actual screenshot

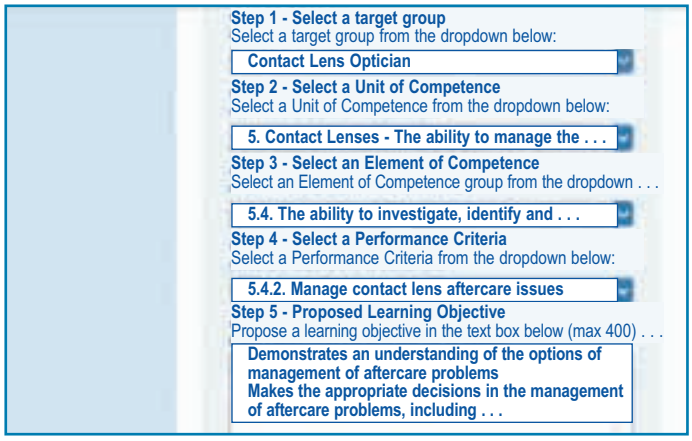


Figure 6

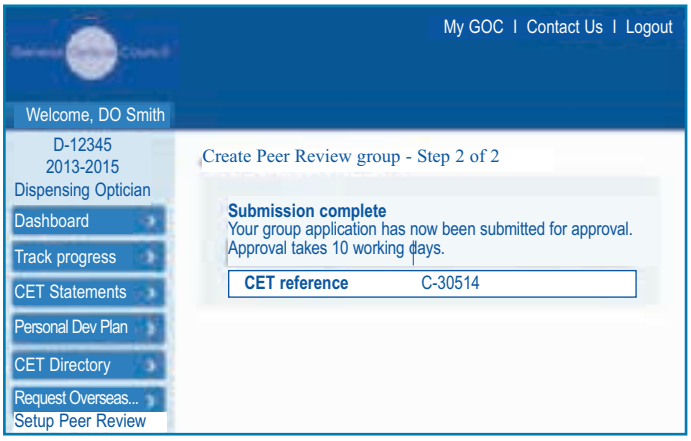


Figure 7

These screenshots have been retyped to enable them to be read. Please refer to the GOC website for the actual screenshot

check the displayed summary, and then 'Send for approval'. The screen in **Figure 7** will be displayed.

The GOC will send you an automated email to confirm your application, and an approval notification will (hopefully) follow in about 10 working days. In the meantime, an approver might contact you to ask for clarification or additional information.

Group leader/facilitator responsibilities

As a group leader, it is your job to:

- Gain approval for the session by applying to the GOC
- Pick 3 or 4 records from the practice - perhaps some cases which have been particularly challenging or interesting
- Anonymise the records - particularly important when involving staff from other practices, and provide enough copies for each member of the group to take away and reflect upon
- Make notes about the discussion while it progresses
- Ensure that the discussion lasts a minimum of two hours
- Make the CET Declaration after the event
- Upload the points for the participants to their GOC number and surname

It is not your task to teach or criticise the opinions of any member of the group. You should stimulate discussion by drawing attention to the points on the records which are linked with the learning objectives that were approved, and make sure that each member of the group contributes to the discussion.

The great thing is that, even though DOs do not have to undertake peer review, a DO does not have to rely on Providers to supply interactive CET in a convenient location - you can set up a group when it is convenient for a group to get together, provided that you are in an appropriate setting, like a practice, prepare properly and give enough notice for it to be GOC-approved. All members of the group can gain 3 interactive (non-capped) CET points.

Make sure you allow sufficient time for the GOC to consider your application – impromptu sessions cannot be approved after the event, and it may take 10 days for your application to be approved.

In the next issue the preparation and aftermath of your peer review will be explored. ■

abdo|CET

Most ABDO members now complete the MCQs for *Dispensing Optics* CET online. However, around 10 per cent still submit their answers by fax or post. In response to a request by ABDO, the GOC have agreed to allow a proportion of ABDO's CET articles to have published MCQs, but, to comply with the **Principles and Requirements of the Enhanced CET scheme**, most will have to be presented and completed online in future.

Extended usernames

Under the CEToptics system, those yet to join the register used an extended username, eg, julieculshaw/BCFT to which CET points were uploaded. These usernames are now no longer valid and have been replaced with a U-number, eg, U-1234.

IF you have been using an extended username, please update your ABDO record with your U-number, to ensure we are able to upload your points correctly. You must cease to use the U-number as soon as you have been issued with a full GOC number. ■

Run a BCLA workshop in your area

'BCLA to go' offers workshops UK-wide

The British Contact Lens Association (BCLA) has introduced a new CET workshops concept called 'BCLA to go', allowing members to apply for a workshop to be run in their area.

Members can suggest a workshop topic and location or choose from the following topics: multifocals, RGPs; soft torics; hayfever; keratoconus; contact lens case record peer review discussion. The BCLA will provide the presenter, organise CET and registrations, and provide publicity support.

Susan Bowers, chair of the BCLA Education Committee, said: "Traditionally, our London CET workshops are always oversubscribed but we have struggled to fill our regional workshops. This is all set to change with 'BCLA to go', which will be available all year round, and provide BCLA members with yet further opportunities for continuing education, peer discussion and networking."

Each two-hour workshop (6-8pm) will require a minimum of six confirmed participants, up to a maximum of 12. They are free for members and cost £80 for non-members to attend (refundable if joining the BCLA within four weeks of the workshop taking place). For more details email events@bcla.org.uk ■

Warning over Aspirin link to increased risk of AMD

A leading sight loss charity has warned patients with heart disease not to stop taking prescribed Aspirin even though a new study has linked it with a serious eye condition.

The study suggests that Aspirin may increase the risk of developing wet age-related macular degeneration (wet AMD). However, the Macular Society says that, for patients at risk of heart attacks, the dangers of stopping or not taking aspirin are much higher.

The study of 2,389 participants in Australia was conducted by Dr Gerald Liew and colleagues. They monitored people over a 15-year period, finding a 2.5 fold greater risk of incident of AMD with regular low-dose aspirin use.

Helen Jackman, chief executive of the Macular Society, said: "We understand that patients will be concerned and they should discuss the risks with their doctors. Specialists we've consulted say that the evidence of a link between Aspirin and wet AMD is accumulating but it is not overwhelming.

"For patients with cardio-vascular disease who are taking Aspirin, the risk of heart attack is higher than the risk of developing wet AMD. In addition, there are treatments for wet AMD as long as it is diagnosed in time.

"However, patients with wet AMD in one eye should have their other eye carefully monitored so that any sign of wet AMD can be found quickly. We urge patients not to stop taking prescribed Aspirin without speaking to their doctors," concluded Helen.

For information, advice or support concerning macular disease, patients can contact the Macular Society's Helpline on 0300 3030 111 or email help@maculersociety.org ■

Students win Africa travel bursary

Two university students, one from City and the other from Cardiff, are set to join a Vision Aid Overseas (VAO) project in Africa next year after being awarded a travel bursary each.

"With great difficulty, due to the quantity and quality of the applications this year, the Trustees of the Irvine Aitchison Memorial Fund narrowed down their choice to seven second-year optometry students who were invited to an expenses paid interview in London in December," said trustee, Brain Keefe.

"After even greater difficulty of choice," continued Brian, "the two places available for a Vision Aid Overseas Travel Bursary were offered to, and have been accepted by, Janaka Sasitharan from City University and Ciara Hankins from Cardiff. They will attend an obligatory training day in the spring and then join a VAO project to Africa next summer." ■

Jennifer Brower

Seven Years Rule reminder

ABDO has some important information about the Seven Years Rule for those who have begun, but not completed, their Certificate in Contact Lens Practice Examinations.

Those with partial success in the examinations for the Certificate in Contacts Lens Practice qualification should note that candidates are required to retake any element/s of the Contact Lens Certificate examinations which were passed seven or more years previously.

"A limit on the time for which a successful assessment is valid was introduced in the light of the ever-advancing status of contact lens practice, and relates to theory examinations or sections of the practical examination," said Rosemary Bailey.

The above does not affect those who already hold the CL Certificate or Advanced CL Diploma ■

If you have a job vacancy in your practice, please remember that the **Situations Vacant** section in the Bulletin Board area of the ABDO website provides you with a quick and easy facility to advertise completely free-of-charge. ■

The President's diary

At the ABDO Board meetings we always discuss a wide range of issues and last month's meeting was no exception. I reported on events and meetings I had attended and some topics raised by members, the general secretary gave an update on political matters, and the chief finance officer presented the financial review of 2012 and the budget for 2013. We discussed the new CET rules, which were still awaiting final confirmation by the GOC, and how these rules could affect ABDO members in their choice of CET events and gathering of points.

Following this we discussed and finalised the new ABDO Regulations. These are designed to go hand in hand with the new Articles approved by members at the AGM last September, to provide explanation and the fine detail of the Articles. The Regulations include matters such as clarification on the use of professional suffixes, terms of membership, Area activity, and criteria for election to the Board and Directors' terms of office. This is the first issue of the Regulations, which may be amended if and when necessary in the future in response to members' needs, and are now available to view on the ABDO website.

We talked about the next ABDO conference. It seems no time at all since our last conference but plans are already well in hand for the next one, in the spring of 2014. There are many points to consider so that the conference has maximum appeal, including the date, suitability and accessibility of venue, the CET content, timings of lectures and social events and, not least, the cost to delegates.

Other issues at the meeting included the recommendations of the Awards Committee who handle proposals for Life Membership, Honorary Fellowship, and Medals of Excellence, the appointing of a new ABDO College Trustee, and arrangements for the AGM and CET at Optrafair this April. We also received reports from the Chairmen of the ABDO CET, Contact Lens and Low Vision Committees.

I have been out and about as usual over the past few weeks, including a visit to a packed CET meeting in Area 4, and at the time of writing am due to visit Areas 6, 8, 10 and Northern Ireland, all of which I will report on next month. There are, however, two special events to mention which took place in the last week of January. The first was the graduation of our BSc (Hons) members at Canterbury Cathedral. I felt very proud of our graduands as they stepped up to receive their diplomas, particularly in view of the high number of first class degrees awarded. The ceremony included other degrees and awards from Canterbury Christ Church University, plus the conferring of an Honorary Doctorate on the broadcaster Moira Stuart, and consequently the cathedral was full to capacity with academics, graduands and proud families and friends.

A few days later I was delighted to attend the awards ceremony for the foundation degree at Godmersham and met some very talented and enthusiastic students who I am certain will go on to become excellent dispensing opticians. After obtaining their foundation degree, the students choose whether to study for the BSc (Hons) in Ophthalmic Dispensing and the FBDO in their final year, or opt to take the fellowship diploma only. Whichever route they choose to qualification, I look forward to welcoming them as qualified dispensing opticians later in the year.

Jennifer Brower

Paul with Gill Brabner and Bryony Pawinska

Devon OO leads the way in peer review

Devon-based optometrist Paul Bradford has become the first optometrist to be accredited by the College of Optometrists as a peer review facilitator.

Paul, who is the peer review lead for his LOC in Devon, said: "I have been running peer review sessions in Devon for almost a year. In some sessions I use real case studies or adapt cases to develop specific learning outcomes. Coupled with support materials like the College's Clinical Management Guidelines, I can try to maximise a positive outcome for each participant.

"Peer review and peer discussion are an excellent way to keep up-to-date or even just reflect more informally to get perspective on an unusual case," continued Paul. "A key benefit is that they help to build relationships with colleagues even across different practices." ■

If you know of a dispensing optician, or a dependant of a dispensing optician, who might benefit from the **ABDO Benevolent Fund** please get in touch with Jane Burnand on 020 7298 5102 or write to her at ABDO, 199 Gloucester Terrace, London W2 6LD. ■

Optra Awards 2011 winners

Hunt is on for 'Frames of 2013'

Frame entries for the Optra Awards, Frames of 2013, are now being sought by the FMO by the 18 March deadline.

A panel of optical professionals will be looking for inspired design, good fit and the best use of modern materials, and the winners will be showcased during Optrafair in a special gallery and on Optrafair TV.

Entries are invited for five categories: children's frames; women's ophthalmic; women's sunglasses; men's ophthalmic; and men's sunglasses. There are also two new awards – for the most creative use of a shell scheme stand and the most inspiring non-shell scheme stand.

"These two new awards will highlight the outstanding quality of presentation that our industry provides for the profession. Optrafair is a show which stands out as being very smart," said FMO chairman, John Conway.

Both aspects of the competition are open to all Optrafair 2013 exhibitors, who are allowed to enter frames in any category. For further details visit www.optrafair.co.uk or telephone 020 7298 5123. ■

New tome for optical history buffs

The past century of manufacturing optics, with many of its personalities, challenges and successes, are brought together in a new book published by the Federation of Manufacturing Opticians (FMO).

'The UK Ophthalmic Industry in the 20th Century' highlights the technical developments, political scene and how this influenced the business of optics and drove progress. Written by Shelagh Hardy and Jacques Desallais, retired director of Essilor UK, the book features recollections from many well-known figures.

Shelagh said: "Charting the history from Clerkenwell and Hatton Garden, where the industry really evolved from the jewellery trade, the book seeks to show how the industry developed. Key highlights include the influence of the NHS; the advance from bifocals to progressives and the mid-80s move from a largely glass lens market to predominantly plastic. It has been interesting to note how history so often repeats itself in terms of the adaption of new technology."

Priced £25, the book is available from the FMO on 020 7298 5123 or email onsfisher@fmo.co.uk

Nigel Wilson

Driving VAO's sustainable agenda

Vision Aid Overseas (VAO) has appointed an international programme director to lead its overseas programmes and help drive its sustainable agenda in its seven partner countries in Africa.

Nigel Wilson joins the head office team in Crawley and will be working closely with VAO's professional volunteers. Originally training as a teacher and working in both the UK and Kenya, Nigel then spent 16 years in the British Army in a variety of roles including that of a training advisor and developing the doctrine for United Nations Peace Keeping Operations.

Leaving the Army in 2000, he has worked extensively in the humanitarian and development system, both for the British Government and for various international development charities.

Nigel said: "I am delighted to have the opportunity to bring my experience from across the development sector to join an eyecare organisation that has capacity building and patient care at the centre of its operations. Vision Aid Overseas concept for Vision Centres is really exciting and unique and I am looking forward to being part of a team which has such a long term sustainable approach." ■

Frequently asked questions

Answered by Kim Devlin FBDO (Hons) CL

Glazing someone else's frames

A young lady came in to my practice one day and asked me to put lenses in a 'frame'. What she actually wanted was for me to glaze a frame with her new prescription. Not a problem, all part of a day's work. Except the frame was new, brand new, Prada, display lenses still in place, not a break on it. This was my problem: should I do it? Patients willing to spend money are rare these days; surely it wouldn't do any harm?

But that's the rub. I knew, as sure as eggs is eggs, that the frame had been stolen. Perhaps not by this young lady but by someone, somewhere, and that is receiving stolen goods and is a criminal offence. What to do? I put on my best smile and assured her there was no problem but I needed the receipt. She looked shifty, and told me she'd bought it off ebay. She probably did but, as I explained, there would be no problem getting a receipt from ebay and that would then prove she hadn't stolen it from an optician's practice. As I spoke, she started heading for the door. "I'll think about it," she said, and was off. Never to be seen again.

Was I right? Legally yes, even morally. But was I just a mug for not taking advantage of a sales opportunity? This was not the first time such a situation has arisen. I've had a Mum bring in a frame for her six-year old daughter she'd 'bought' at a boot fair and another young man, bold as brass, ask me to glaze a brand new designer frame, with the price still stuck on the display lens. It is difficult not to feel slightly priggish about such a refusal; we hear it all the time. "I bought it from a guy down the pub" is the old one, but with the rise of ebay and boot fairs, the chances of buying stolen goods, innocently or not, are many.

There are many strange, but perfectly legal, situations for glazing a frame that doesn't belong to the patient. One such situation comes to mind. I had a patient who was terminally ill; it gave her great pleasure to order new specs. I'd go round to see her and we'd try on half my stock, giggling at the sight of them with her bald head or patterned scarf. I'd glaze them and go back a week later when she'd try them on, argue with her husband over which credit card to use and with me over which case/spec chain she wanted. She had no fewer than four different pairs in the space of the two months she was at home. A few weeks after her funeral, her daughter and two (adult) granddaughters arrived at my practice requesting me to use these frames for their prescriptions; a very good memento mori. There was no question, then, of the legality of the situation.

So are you breaking the law or some professional dictat by accepting these frames? It all comes down to interpretation. You must ask yourself: would an average person reasonably assume that the frame was legally obtained? The request for a receipt is the key. If a person has purchased a frame, without lenses, legitimately from anyone they will have a receipt. On the presentation of a frame with a receipt, you may happily proceed (always provided it is suitable for required lens).

The boot fair scenario makes for serious doubts; why would anyone sell brand new spectacle frames at a boot fair unless they were 'knock-off'? The detective investigating a break-in at my practice (when designer sunspecs were stolen) said to me, in a world-weary voice: "If there was not a ready market for such items there wouldn't be any reason to steal them." Pause for thought.

Kim Devlin is chair of ABDO's Advice and Guidelines Working Group ■

Jessica Chatwin in training

Jessica aims to reach her peak

Anglia Ruskin student Jessica Chatwin is running the Yorkshire Dales infamous '3 Peaks' this month in aid of Optometry Giving Sight (OGS).

Jessica was inspired to raise money for the charity following the AOP Student Eye Opener conference, and has a personal attachment to the Yorkshire hills having spent much of her childhood hiking in the Dales.

Jessica said: "It is important to me that the issue of a simple lack of eyecare services and access to glasses is recognised as the unnecessary cause of blindness and visual impairment in over 600 million people, among not just healthcare professionals but also local people in my community in Yorkshire and East Anglia."

Jessica will run the Yorkshire 3 Peaks – a distance of 25 miles – on 24 March. She has already conquered Pen-y-ghent (694m) and Whernside (736m) individually, with just Ingleborough left to tackle. To sponsor Jessica and see updates on her training progress, visit http://www.justgiving.com/Jessica-Chatwin ■

Signature lens options

In parallel with a new national TV advertising campaign, practices can now ask labs to supply Younger Transitions Signature VII lenses in either grey or brown.

The lenses are available in finished CR39 single vision stock powers (hard coated and multi-coated) and in 1.6 multi-coated and to prescription in single vision CR-39, FT28, CT28 and Image Progressive. Spherical single vision Trilogy (made with Trivex) polycarbonate, 1.6 and 1.67 (including 8 base options) are also available. Trilogy is available in aspheric single vision and form this month, in single vision 1.74.

"Younger Optics is delighted to deliver the most comprehensive range of Transitions Signature VII available as we did with Transitions XTRActive last year," said Julian Wiles of Younger Optics, who can be contacted at julian.wiles@youngereurope.com or on 0790 133 7530. ■

Mini offer on frames

Pennine Optical is offering a free iPad mini to customers who place orders to the value of £2,000 or more of fashion frames from the current Pennine collection. There are 50 of the popular Apple iPad mini products available for practitioners to claim. Telephone Pennine on 0161 477 8964, email pennine@pog.co.uk or visit www.pennine optical.co.uk ■

Fusion of contact lens technologies

Safilens has launched its next generation Fusion 1-Day contact lens in the UK through No 7 Contact Lenses.

Using its proprietary Fusion technology, Safilens has incorporated what it says are the two most successful natural polymers used in relieving dry eye symptoms: hyaluronic Acid (HA) and tamarind-seeds polysaccharide (TSP), creating the potential for "an ultra-comfort lens".

Maxine Green, commercial director for No7, commented: "No7 are delighted to be working with Safilens who bring to contact lenses new, exciting and innovative lens technologies.

"Fusion 1-Day, with its patented material containing the bi-polymer of hyaluronic acid and tamarind seed polysaccharide, has the real potential to be especially helpful for patients with CLIDE, as well as first-time contact lens wearers. It will be a very welcome addition to the contact lens fitters armoury in the ongoing battle to maximise comfortable wearing times and reduce the drop-out of our contact lens patients," Maxine added.

Fusion 1 day is available in a base curve of 8.6mm at parameters of -0.50/-6.00 (0.25) -6.50/-12.00 (0.50); +0.50/+4.00 (0.25) +4.50/+7.00 (0.50).■

abdo COLLEGE

Let us further your career

ABDO College provides comprehensive education for dispensing opticians and is currently accepting applications for a range of different courses. Some of the reasons why you should make ABDO College your first choice to either start or further your career in optics are:

- An extensive range of courses to suit your individual needs
- Dedicated and experienced academic staff
- Friendly and supportive learning environment
- Consistently high theory and practical examination results
- Helpful course tutors
- Vibrant and positive attitude towards students
- Committed to the furtherance of dispensing optics
- Established by the profession for the profession
- A proven track record of success for over a decade

Foundation Degree / BSc (Hons) in Ophthalmic Dispensing (Year 1)

Fellowship Dispensing Diploma (Year 1)

ABDO College offers a choice of two distance learning courses on the route to becoming a qualified dispensing optician:

Option 1

A two year Foundation Degree course followed by a third year BSc Degree course in Ophthalmic Dispensing – leading to BSc (Hons) and the ABDO Level 6 FBDO qualifications.

Option 2

A three year diploma course in Ophthalmic Dispensing – leading to the ABDO Level 6 FBDO qualification.

Course features

- Combines academic and work-based learning
- 32 weekly distance learning units in each academic year
- Four weeks block release at Godmersham in each academic year
- Access to supplementary web-based interactive tutorial presentations
- Block release accommodation can be provided
- Year 1 courses will commence in September 2013

Entry requirements

- Grade C or above GCSE in English, mathematics, science and two other subjects, including evidence of recent learning
- Applicants must be working in practice as a trainee dispensing optician for a minimum of 30 hours per week and have the support of their employer

For further information and application forms for these and other courses, or to request a copy of the ABDO College Prospectus, please contact the ABDO College Courses Team on

01227 733 911

or email **info@abdocollege.org.uk**

ABDO College Operational Services, Godmersham Park, Godmersham, Canterbury, Kent CT4 7DT

www.abdocollege.org.uk

www.twitter.com/abdocollege

KEEPING EXCELLENCE IN YOUR SIGHTS

Registered by the General Optical Council www.optical.org

Brian Bowles and Malcolm Polley

Mark of lens origin

Polley opens new member showroom

FMO chief executive, Malcolm Polley, opened Grafton Optical's new showroom recently and helped the Watford-based company celebrate its 30th anniversary.

"The FMO team is always keen to learn more about our valued members," said Malcolm Polley, pictured with Grafton Optical MD Brian Bowles. "Investing time in visiting this important independent supplier of technology to the UK market was very worthwhile.

"We enjoyed the customer experience and learned more about the new slimline OCT technology from Optovue, and what Reichert, Shin Nippon, Frastema, DGH and CSO are bringing to the world stage for optical professionals," added Malcolm. ■

Lens brand engraving on trial

Rodenstock has developed laser-based brand engraving for its customised lenses featuring its distinctive 'R'.

It is initially being trialled with selected opticians, who Rodenstock says are already reporting positive feedback from patients. Thanks to revolutionary laser technology, the brand mark is invisible to the spectacles wearer but can be seen by anyone standing in front.

Rodenstock lens product manager, Debbie Bathgate, said: "We wanted to create a visible, highly sophisticated proof of origin on our lenses that would clearly differentiate us from our competitors, using state-of-the-art laser technology for visibility without limitations in visual comfort. The branding is a guarantee of Rodenstock quality, and proof to end users that they have chosen the very best and are getting excellent value for money." ■

Educating the educators worldwide

The International Association of Contact Lens Educators (IACLE) has a new website, www.iacle.org, with more educational and information resources for educators worldwide.

Following a major review of its communications and branding, the association also has an improved format for its global member e-newsletter and a new logo.

Fellow of IACLE Dr Christine Purslow was recently appointed Professor of Optometry and Academic Lead in Optometry at the UK's new optometry school at Plymouth University. She said of the website: "The resources are amazing, especially the DVDs and the image library. Whether I am preparing presentations for undergraduates or postgraduates I find something useful to include from IACLE." ■

Ready readers donated

Ready readers from Dibble Optical have provided a boost to Vision Care for Homeless People.

The 2,000-piece donation means that volunteer optometrists and dispensing opticians can provide instant support for the visitors who attend the centres in London, Birmingham and Brighton.

Elaine Styles, chair of the charity, said: "The Dibble Optical donation is wonderfully generous and has filled the store cupboard so that we know this aspect of dispensing is taken care of for at least the next 18 months. About a quarter of the people we see require a simple reading correction and being able to give them this immediately after the test is fantastic. We really needed more male styles as most of our patients are men, and this is what has been donated. It frees up our thoughts for looking to open the next regional centre later this year," added Elaine.

To volunteer contact will.pearce@vchp.org.uk ■

David Foster

Andy and colleagues at Essilor

Digging deep to mark 20th year

To celebrate its success and 20-year history, lender to the professions Braemar gave away £4,000 during 2012.

Throughout the anniversary year, Braemar organised prize draws via its website and at trade exhibitions. Most of the winners received £100 in John Lewis vouchers while veterinary surgeon David Eager, the overall winner, was presented with a cheque for £2,000.

David Foster, Braemar's managing director and a company founder, said: "We have been glad of the opportunity to acknowledge all the support we have had from professionals and advisors over two decades. Thanks to all the professionals who entered the draw and congratulations to all winners, especially David Eager, on his £2,000 win." ■

New AR coating has the E-SPF factor

BBGR has introduced a new flagship anti-reflective coating, Neva Max UV.

In creating Neva Max UV, BBGR's R&D team based their work on the Eye-Sun Protection Factor (www.espf.com) – or E-SPF – international standard for measurement of UV protection for eyes. It offers a minimum E-SPF of 25 on all lens materials except 1.5 clear.

The coating features an additional layer in the rear-surface stack enhancing the original Neva Max anti-reflective coating. It also offers smudge resistance, 99 per cent transmission, dust repellence, hydrophobicity and, according to BBGR, the highest possible level of scratch resistance.

BBGR Independents MD, Nick Browning, commented: "Neva Max UV is a ground-breaking product that signals the next generation of anti-reflective coatings and, more importantly, it enables opticians to offer patients a new level of perceived value, packaged in an attractive consumer message." ■

Staff support sight challenge

Silver National Sponsor Essilor and its staff dug deep and raised more than £1,000 for Optometry Giving Sight (OGS) as part of the 2012 World Sight Day Challenge.

Opportunities to donate money came in several ways just a few days before Christmas with a raffle and simple donations plus selected managers serving Christmas lunch for a small donation. Santa Clause, aka a well-known "Scrooge within the production team", sat for photographs before his identity was revealed.

Donna Power, OGS regional manager, Europe, said: "We're incredibly thankful to the entire Essilor UK workforce who donated funds to help eliminate avoidable blindness."

Essilor professional relations manager, Andy Hepworth, is pictured with members of staff and the giant cheque that was presented to OGS. ■

Polarised lens slims down

NuPolar 1.67 is now available from Younger Optics using its own film technology and manufacturing facility.

NuPolar lenses are available in single vision 1.5, 1.6, polycarbonate and Trilogy materials and some bifocals and progressives designs, and in Grey (17 per cent LTF,) Brown (21 per cent LTF) and Green (15 per cent) and 8 base curves.

"NuPolar 1.67 means that you can offer your clients polarised lenses which are up to 25 to 35 per cent thinner than 1.5," said Younger's Julian Wiles.

"NuPolar 1.67 SV can be also used for production of the most advanced and sophisticated digitally surfaced progressive and single vision lenses.

"The lenses will block glare, offer 100 per cent protection from UVA/UVB and offer your clients improved depth perception, enhanced contrast and they will see what ordinary tinted sunglass lens wearers are missing," added Julian.

Visit www.nupolar.com and download for free from Apple AppStore 'NuPolar iPad'. ■

New Paul Costelloe sun

Latest Elle sunglasses

Designer sun range debuts

Dunelm has launched an inaugural sun range within the Paul Costelloe collection. It includes 12 styles from delicate, minimal frames to bold retro frames with strong shapes, fully glazable and suitable for multifocal lenses.

Peter Beaumont, director at Dunelm Optical, said: "We are so excited about the launch of the new sun range from Paul Costelloe. All the frames reflect his strong design credentials with the clothing collection bringing an important influence to the collection, from the texture to form and colour, reflecting the true Costelloe style which makes him one of the most established names in British fashion." ■

Make an Elle of a display

In support of the 2013 Elle sunglass collection, independent practices are being offered a package of 12 Elle sunglasses and a purpose-built stand with all frames supplied in branded cases.

The new sunglass collection presents a range of styles in a variety of feminine shapes. Many models are formed from translucent acetate adding depth to the frames, whilst metal detailing is largely subtle, and all are glazeable. Point-of-sale material is available to match Elle's High Street clothing and accessories campaign. ■

Giving a Definitive answer

Contamac has expanded its Definitive range of lathable silicone hydrogel materials.

"It would have been naive to imagine that one polymer would be suitable for all applications in such a specialised industry," said Rob McGregor, director of Contamac. "Development of new products is a continuous process, and we are pleased to be the first company to offer a comprehensive range of silicone hydrogel materials suitable for a wide range of lens designs and applications."

The range will comprise of a Definitive 50, Definitive 65 and the established Definitive 74 – all designed to enhance corneal health and satisfy demand for specialty silicone hydrogel lenses. Visit www.contamac.com ■

Hoya offers to be tour guide

Gain an insight into lens manufacture on a guided tour of Hoya's factory in Wrexham.

Customers will find out about creating lenses, from the application of coatings to quality testing as well as the latest technologies and innovations being applied from order to dispatch.

"We were delighted to have had such as great response to the factory tours in 2012," said Dale Hughes, Hoya marketing manager. "We hope that the tours in 2013 will offer more customers an opportunity to see firsthand the technology and stringent quality measures that contribute to every lens manufactured by Hoya."

The factory tour dates are 25 March, 17 June, 23 September and 16 December. Email enquiries@hoya.co.uk ■

Optician Index - December 2012 summary

- **With the exception of new contact lens fits and solutions the Key Performance Indicators fall below those reported in November**
- **Key Performance Indicators are higher than last December, except for single vision lenses**
- **Year on year growth for total turnover is negative by -1.52 per cent at 163 Index points**
- **Total sight tests year on year growth is positive by just under 2 per cent at 100 Index points**
- **Single vision lenses annual growth is positive by just under 3 per cent at 63 Index points**
- **Panel members show slight decrease in optimism for future trading compared to last year**

Opticlar

The full December 2012 *Optician* Index report was published in the 25 January 2013 issue of *Optician*

BUSINESS BENCHMARKS

Ti-Lite from Rodenstock

Police in a pack

Paul Allen

Completing the picture

Rodenstock has announced the release of four new Complete Spectacle Collections including classic version of Ti-Lite, which celebrates its 10th anniversary this year.

Weighing just 2.5 grams, the fourth generation Ti-Lite frames are almost invisible and feature flexible titanium material. Stockists will be offered full marketing support from Rodenstock, including posters, promo display, patient mailers and a rotating counter display.

The other collections are Titanium Essentials, the Wimbledon Sunglasses 2013 collection, and the Globe Hinge package. For details telephone 01474 325555. ■

Q&A to aid with the dispense

Hoya has introduced an online version of its Hoyalux iD LifeStyle V+ patient questionnaire.

The five questions are designed as a prompt and aid in dispensing the correct Hoyalux iD LifeStyle V+ lens for the patient; providing the patient an opportunity to participate and understand the most appropriate lens choice for them.

The company said that the questionnaire had already proven to be "an extremely valuable tool when dispensing Hoyalux iD LifeStyle V+". It can be downloaded from www.hoyanet.co.uk ■

30 year Police package

As part of its 30th anniversary celebrations Police has introduced a range of prescription sunglasses. Working in partnership with Hoya, the Police package, available from De Rigo, is designed to provide a total sunglass solution, encouraging an increase in practice turnover and margin. Police has also created a marketing support package - 01923 249491 or email info.uk@derigo.com ■

North East contact

Paul Allen has joined Seiko Optical as business development manager for the North East.

Paul has worked in the optical industry for more than 30 years, with experience in manufacturing, business development and marketing. He says he is looking forward to continuing existing business relationships and developing new ones. ■

Get dressed up for New York

A trip to New York is the prize for the best dressed optical practice window in the UK to be judged at Optrafair.

Sponsors, Luxottica, Mondottica and Brulimar are looking for the UK practice leading the field in promoting the very best of eyewear. The free competition is open to every practice in the UK.

Images should be emailed to jenny.wright@necgroup.co.uk by Friday 8 March, and from these four finalists will be selected. They will then be invited to dress one of four windows at the entrance to the NEC show in Birmingham.

"Window dressing is the key that opens the door for so much practice success," said FMO chairman, John Conway. "Whether it is promoting designer fashions, contact lenses, sports eyewear, drivers' vision or just good health – the message starts before the patient enters the practice and yet the opportunity is so often overlooked." ■

LOCSU seeks new board directors

Local Optical Committees (LOCs) in London and the Midlands and East areas are invited to nominate two new directors to represent these regions on the LOCSU Board.

Alan Tinger, chairman of LOCSU said: "With the NHS reforms nearly upon us, these are exciting albeit challenging times for the LOCSU Board as it provides the strategic direction for the organisation. We ask LOCs in these regions to consider carefully the best person(s) to support and influence the planning for the future of community eye health services."

All LOC nominations will be considered at the LOCSU Board Meeting in March and the results will be announced shortly afterwards. The full list of LOCSU board directors is available here at www.locsu.co.uk ■

CET is a two-way street, says provider Cliff Williams

Be kind to your CET provider

Cliff Williams

A few years ago I was asked to become a CET provider, which was an honour but a tad daunting at the same time. What would I put in and how would I put it together? Luckily my first presentation had been a little before that when I had been asked to provide some HES (Hospital Eye Service) training. My immediate reply was how many were going to be present and would I freeze on the spot? Would the audience be kind to me – or would I have to duck and cover from a hail of swabs?

Don't be silly you will be fine was the consensus and, no, it was only going to be a select handful of people. So I agreed and got writing with many thoughts running through my head, not least finding the floor plan for the nearest fire exit!

How could I create my unique spin to this first presentation and what would it be? By chance I had stumbled over one of the first weekly ABDO course papers I had written; this not only gave me my crude opening slide, but the theme for the presentation: 'Differential prismatic effects'.

We have all sat through presentations ranging from the absolutely awesome to the 'death by PowerPoint'; the type where the bullet points get so small you cannot really see them despite wearing the most expensive lenses known to DO kind. So I decided that I would keep my presentation image rich with as little on screen text as possible. I also decided not to write any notes but, rather bravely, to use the images as visual reminders of what I wanted to discuss and ad lib my way through it all. Brave indeed.

Arriving early to 'case the joint' for quick getaway fire exits, it dawned on me that it was not going to be a select handful of people at all. Instead there were rather too many rows of seats laid out, which then started to fill up. That really made the old ticker race. I was introduced to the congregation and realised that there was a healthy cross section of more than 40 HES staff right across the grades.

I looked at the clock and began, realising that I had to alter the theme to cater for everyone in the room – not just those with ophthalmic knowledge. The rest was a blur and before I knew it, the bottle of water was empty and the presentation was over. This was swiftly followed by questions for another 20 minutes. Little did I know then that this was a sign of fully engaging with the room; when the audience felt they could ask questions about the presentation.

Rewarding interaction

Now the word was out that I had given a presentation, I was quickly asked to provide a few more for optical companies catering for much smaller groups. These passed smoothly and showed that my image rich presentations with no scripts worked and went down well, keeping the audience awake. Then I was asked if I could write a presentation to be delivered at Optrafair. I agreed with a big gulp.

With the presentation approved for CET, I headed down to the NEC and was shown the stage, closely followed a split second later with me looking up for those nice green signs around the hall. This would indeed be the biggest presentation I had ever delivered and, as I was getting myself settled down to deliver it, I was told off the cuff that morning that, "Oh they also want you to deliver it to camera afterwards." No pressure then.

Thankfully this first Optrafair main hall presentation went without a hitch and in another blur, even with the daunting prospect of the images appearing alongside me on a massive video wall. The delegates were excellent too by not throwing a hail of redundant 1.5s at me. Instead they asked questions afterwards, which is something CET providers really do appreciate as it shows one's work has inspired some thought. I have also noted the phenomenon of people seeking you out on the stand

Disjointed jottings from a DO's desk . . .

afterwards to ask questions privately, and I find this most rewarding.

Some of the recent presentations I have given have been to very large groups in lecture halls where you are timed to six minutes to deliver and two minutes for questions. This stops me waffling, and it is worth the effort to deliver the dispensing optician message further out into the HES, ophthalmology and orthoptist communities. It is always good to watch the pennies drop as you discuss the issues and resolutions in a new way for these groups, with fire exits clearly marked of course.

More recently I have written a presentation on how to dispense and fit plugged rimless, with audience participation encouraged throughout the presentation. So far the audiences have indeed been kind, and hails of rimless pliers have thankfully been avoided. The MD who sponsored my last presentation enjoyed watching the audience come to life when they realised this presentation could directly influence the success of the products.

What will the CET of the future bring? Well, at the time of writing there is the prospect of peer review and I do know my good friend Barry Duncan is working on this for our membership. Do we know fully what will be involved? But more importantly, will you as part of the audience be kind to your CET provider and participate with questions?

CET is about learning for both sides and if you have good input, then I am quite confident when I say that most if not all CET providers would welcome your input. After all, it is how we all learn. Remember though if you see the CET provider casing the joint for fire exits then please be extra kind with your questions. Who knows, it might just be me!

Cliff Williams FBDO owns an independent Practice in Kirkcaldy and supports ABDO, Carl Zeiss and Silhouette with his front-line experience. ■

Multiple choice questions (MCQs)

Refractive surgery options part one

1. Compared to the microkeratome, the femtosecond laser method of flap creation:
a. has a less predictable flap thickness?
b . produces a more stable stromal bed?
c. has a fixed position of the flap hinge?
d. results in photodisruption at a calculated depth of the epithelium?

2. The most frequent complication associated with microkeratome-created flaps is:
a. photophobia occurring between two and six weeks after surgery
b. anterior chamber flare
c. the occurrence of defects within the epithelial layer
d. the presence of circumlimbal injection

3. A significant factor in corneal haze following LASIK is:
a. proliferation of over-active keratocytes
b. light scatter caused by myofibroblasts
c. lack of chemotactic chemicals such as cytokines
d. thinning of the epithelial layer

4. Conductive Keratoplasty involves:
a. treating individuals with low to moderate myopia and/or presbyopia
b. overall tissue contraction causing flattening of the central and steepening of the peripheral cornea
c. a localised increase in temperature that expands the individual collagen fibres
d. the delivery of electromagnetic energy into the stroma

5. In astigmatic keratotomy, the aim is to create arcuate incisions centred along:
a. the shallowest corneal meridian, steepening corneal curvature
b. the steepest corneal meridian, steepening corneal curvature
c. the steepest corneal meridian, reducing corneal curvature
d. the shallowest corneal meridian, reducing corneal curvature

6. Treatment of myopia above 10.00D with LASIK alone is not advised due to:
a. the risk of keratoconus
b. the need to preserve a certain amount of corneal stroma
c. starbursts and halos becoming more noticeable
d. an increased risk of Transient Light Sensitivity Syndrome

Refractive surgery options part two

1. Accommodating IOLs often produce good intermediate vision, but reading vision may not be as good because:
a. they force the brain to select one retinal image in favour of another
b. it is not possible to change the axial position of the optic
c. the overall accommodative effect achieved is limited
d. they are based on the principle of simultaneous vision

2. Where monofocal IOLs are chosen, the surgeon usually aims for:
a . emmetropia in the dominant eye and slight myopia in the non-dominant eye
b. slight myopia in the dominant eye and emmetropia in the non-dominant eye
c. slight myopia in both eyes to suit the patient's occupation
d. bilateral emmetropia

3. Which statement regarding the Artiflex IOL is correct?
a. it is angle-supported close to the endothelium
b. a relatively small surgical incision is needed
c. there is no risk of pigment dispersion with this type of phakic IOL
d. it is iris-supported within the anterior chamber

4. Which of the following would NOT be a contraindication to a monovision correction?
a. uncompensated heterophoria
b. weak ocular dominance
c. low fusional reserves
d. inability to suppress blur

5. Which statements about phakic IOLs is true?
a. angle-supported IOLs should not be used in patients with a low endothelial cell count
b. phakic IOLs cannot be used to correct astigmatism
c. the use of a phakic IOL that is too small can cause pupil ovalisation
d. the risk of traumatic cataract is greatest with an iris-supported IOL.

6. Which statement is correct? Multifocal IOLs:
a. can cause problems with night vision
b. cause a reduction in contrast sensitivity
c. may have aspheric surfaces
d. all of the above

The deadline for posted or faxed response is 11 April 2013 to the address on page 4.
The module code *Refractive surgery options part one* is C-30261 and for *Refractive surgery options part two* it is C-30263

Online completion - www.abdo.org.uk - after member log-in go to 'CET online'

After the closing date, the answers can be viewed on the 'CET Online' page of www.abdo.org.uk. To download, print or save your results letter, go to 'View your CET record'. If you would prefer to receive a posted results letter, contact the CET Office 01206 734155 or email cet@abdo.org.uk

Occasionally, printing errors are spotted after the journal has gone to print. Notifications can be viewed at www.abdo.org.uk on the CET Online page

Diary of events

06 March
Area 11 (London) - Evening meeting now FULLY SUBSCRIBED. Area 11 will endeavour to provide a second training day/event as soon as possible.
March
Area 12 (Scotland) - Evening meeting, 3 CET points anticipated, South Queensferry. For details email Brenda Rennie breandarennie@f2s.com
03 March
Area 6 (West Wales) - Day meeting now FULLY SUBSCRIBED. Area 6 will endeavour to provide a second training day/event as soon as possible.
04 March 2013
Area 5 (Midlands) - CET day,7 CET points, £20 per ABDO member or student, £45 for non-members, bookings will be taken on a first-come first-served basis, The Riveside Centre, Derby. To reserve your place email ian@ihardwick.orange home.co.uk or phone 07814 558343
19 March
Area 9 (South East) - Evening meeting, 3 CET points anticipated, Arundel. For details email Anthony Blackman abdoarea9@gmail.com
20 March
Area 2 (North East) - Evening meeting, 3 CET points anticipated, Wentbridge. For details email Lynda Matthias Lyndamatthias@yahoo.co.uk
20 March
Area 10 (Kent) - Evening meeting, 3 CET points anticipated, Maidstone. For details email Julian Silburn julian@spectrumeyecare.co.uk
26 March
Area 4 (East Anglia) - Evening meeting, 2 CET points anticipated, Cambridge. For details email Joanne Abbott abdoarea4@gmail.com
13-15 April 2013
Optrafair 2013 - NEC Birmingham. For details visit www.optrafair.co.uk.
ABDO stand S60
ABDO College stand P14
13 April 2013
ABDO CET Event - Concourse Suite 32-33, NEC Birmingham, 11.45am-17.45pm
14 April 2013
ABDO CET Event - Concourse Suite 32-33, NEC Birmingham, 10.30am-16.30pm
ABDO AGM - Concourse Suite 32-33, NEC Birmingham, 5pm
ABDO Presidential Handover Party - The Gallery, NEC Birmingham, 6-8pm
15 April 2013
ABDO College - 'Supporting Academic Learning', Concourse Suite 31-33, NEC Birmingham, 9.30am-4pm
17 April 2013
BCLA - Evening CET meeting, London. For details visit www.bcla.org.uk
May
Northern Ireland - Evening meeting, 3 CET points anticipated, Antrim. For details contact Barry Doherty on 07989 896650
May
Identity Optical Training - PQE and FQE Practical Exam and Theory Revision Courses, Birmingham and London, £75 each. For details contact Sally Bates on 020 8504 0967 or email sal_bates@hotmail.com
22 May
President's Consultation Day - All members are invited and welcome to attend at the Macdonald Manchester Hotel, London Road Manchester M1 2PG. To confirm your attendance email Jane Burnand at jburnand@abdolondon.org.uk, or call her on 020 7298 5102.
22 May
Area 3 (North West) - Evening meeting, 3 CET points anticipated, Manchester. For details email Lorraine Wallbank lorrainebleasdale@virgin.net
26/27 May
Area 12 (Scotland) - Day/evening meeting, 6 CET points anticipated, venue TBC. For details email Brenda Rennie breandarennie@f2s.com
June
Identity Optical Training - PQE and FQE Practical Exam Revision Courses, London, £75 each. For details contact Sally Bates on 020 8504 0967 or email sal_bates@hotmail.com
05 June
Area 2 (North East) - Day meeting, 3 CET points, Wrexham. For details email Lynda Matthias Lyndamatthias@yahoo.co.uk
05 June
ABDO Golf Society - ABDO Challenge Cup, open to DOs and guests, Moseley Golf Club, Birmingham. To join the Society email Mike Stokes m.stokes67@ntlworld.com or phone 01204 411722 for further information.
6-9 June 2013
BCLA - 37th BCLA Clinical Conference and Exhibition. Details www.bcla.org.uk
8 July 2013
Independents Day 2013 - 'Close encounters of the patient kind: the sequel'. For details visit www.independentsday.co.uk ■

ABDO members are welcome to attend Area meetings in any area they wish

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