The lack of effect modification by linoleic acid found in the BMES data is interesting and possibly not surprising. We found a complex U-shaped interaction between dietary intake and the risk of AMD and the decision as to where cut points are taken will strongly influence the outcome (fig 1). It would be more informative if Mitchell presented his data either with the same cut points we had used, or presented his data in a continuous form.

Nevertheless, these two studies confirm the lack of evidence to support recommendations for a specific increase in dietary intake of lutein and zeaxanthin to protect against macular degeneration. At the same time of course no one would encourage people to deviate from a normal healthy diet including fresh fruit and vegetables.

We were very pleased to see the data from the Blue Mountains Eye Study (BMES) and recognise the advantage of incidence data over cross sectional data. However, both cross sectional and longitudinal studies are susceptible to recall bias in the ascertainment of historical dietary intake. In nutritionally non-deficient populations people do alter their diets in response to the available commercial information. However, the bias caused by public awareness of hypothesised protective associations applies equally to both cross sectional and longitudinal observational studies, as many know about either their disease or family predisposition to AMD before participation. However, our data were collected before the recent upsurge in publicity — the dietary intakes in the two population sections based studies is so much lower than the volunteer case-control studies clearly indicates “healthy volunteer bias” as we point out in our paper.

Mitchell raises several points, the first of which is the way he handles missing data. Age related macular degeneration (AMD) can be assessed either clinically or photographically. Rather than throw away data and run the potential bias of by excluding patients who did not have a retinal photograph, we chose to include in our analysis those people for whom we did not have a retinal photograph for one reason or another but for whom we had clinical macular grading. In separate analyses the data were not materially different if the analysis was confined to only those with photograding. In the data Mitchell et al report they excluded 15% of their sample as they lacked data and there is no evidence of what bias this may have induced.

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Figure 1

**Figure 1** Estimated odds ratios derived from the analyses, including all participants.

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References
1. Mitchell P. Lutein and zeaxanthin dietary intake and age related macular degeneration (letter). http://www.bjophthalmol.co.uk/content/90/3/389/

BOOK REVIEWS

The Video Atlas Of Eye Surgery — Phacoemulsification (Part 1)


Phacoemulsification 1 — Basic Techniques is the first in a series of DVDs forming the complete Video Atlas of Eye Surgery. The atlas will consist of five sections: phacoemulsification, vitrectomy, glaucoma, refractive and orbital, lacrimal and lids. Each section is planned to have three subsections, concentrating on (1) basic techniques, (2) challenging cases, and (3) complications. The authors are a well respected international group of experienced ophthalmologists. They aim to provide a comprehensive and structured surgical training programme based on their experience of the topics presented. Their charity, The Eye Movies Foundation (www.eyemovies.org) works closely with Vision 2020 and contributes profits from this atlas as well as supporting ophthalmology training in the developing world. They collaborate with an audiovisual company (www.eyemovies.co.uk) to produce an interactive video suite that is used throughout the series of DVDs. These are all PC and Mac compatible and will run on most modern systems. They will not, however, run in stand alone DVD players. The movies are accessed through a custom built interactive application and this has been well conceived. Navigation is simple and sections of videos can be digitally spliced and attached to a “Learning Pad” and even exported for inclusion in personal lectures or teaching sessions. This then is the appetiser for the forthcoming series.

Phacoemulsification 1 — Basic Techniques is presented as a single DVD. It has been divided into 10 sections with multiple subsections. All of these can be directly accessed through the menu on the main screen. The sections include: preparation, local anaesthesia, incisions, capsulorhexis, hydrodissection, nucleus disassembly, epineedle removal, irrigation and aspiration, IOL insertion, trimming off. Each section commences with basic principles and common procedures and where appropriate, moves on to more complex techniques. Thus, for example, the “nucleus disassembly” section includes videos on the classic “divide and conquer” technique as well as more advanced techniques such as “stop and chop,” “phaco chop,” and “chip and flip.” It also goes on to mention “bimanual phaco techniques.” There are 35 videos in this DVD, lasting a total of 3 hours and 27 minutes. The videos are clear and concise and as expected are of superb quality, with bold and succinct narration. This theme is evident in all sections of the DVD and attention to detail is apparent throughout. The authors admirably serve up their collective experience in the field of phacoemulsification and must be congratulated for the time and effort put into this project. This DVD will serve as an excellent foundation for all trainee cataract surgeons. It will also provide sufficient tips and tricks for it to be of interest to the experienced surgeon.

As far as I can see, the only prohibitive feature of this DVD is its price tag. At over $400, it is likely only to attract institutional purchasing. That said, it is a must have for any unit with trainee surgeons, and my opinion is that it should be evaluated by the Royal College of Ophthalmologists for inclusion in their training curriculum. I am thoroughly impressed by this product.

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The Video Atlas Of Eye Surgery — Vitreoretinal (Part 1)


Vitreoretinal 1 — Basic Techniques is the second in the series of this video based atlas of Eye Surgery. The presentation is similar to the Phacoemulsification 1 — Basic Techniques. It is supplied on a single DVD, being PC or Mac compatible. The standard Video Atlas interface is used with chapters being presented on the right hand side of the main screen. These are easily collapsible or expanded to reveal the subsections and each video is, therefore,