epithelium of lenses in our trial was, however, less than the minimum dose reported to cause cataract (200 cGy). In addition β radiation is often used on bare sclera to treat pterygia. Despite a larger dose of radiation to the lens, cataract is not common. Finally, radiation induced cataract is a characteristic pattern of corrical opacity, starting at the site of application. This pattern was not observed in our patients.

Extremely shallow anterior chambers have been linked with cataract formation. In our study such chambers were rare. It has also been suggested, although reports vary, that eyes with slightly low intraocular pressures may be at higher risk of cataract formation. Lower intraocular pressures in the β radiation arm could explain some of the increase in cataract risk.

We observed a higher incidence of mild uveitis among the radiation group. After controlling for this, evidence of an association between β radiation and risk of cataract remained. Uveitis therefore does not explain all of the increased risk.

The use of steroids during the postoperative period may induce cataract formation but would require differential use between the two groups. Randomisation and a similar pattern of follow-up visits in the two groups make this less likely.

β radiation is carried out at the time of original glaucoma drainage surgery and does not require postoperative compliance or direct costs. It has a major, clinically important benefit on control of intraocular pressure and has appeal in resource poor settings.

Although blindness caused by cataract is reversible, blindness caused by glaucoma is not. Restoration of vision with subsequent cataract surgery must represent a better outcome than permanent blindness from glaucoma.

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Ethical approval: This study was approved by the research ethics committees of all included centres, along with the Institute of Ophthalmology.

References

Corrections and clarifications
August is medical staffing month
Lain Varley, the author of this filler article (BMJ 2006;333:751, 7 Oct), has asked us to point out that the medical staffing department that he criticised was not that of York Hospital, whose address he gave as the place where he was working at the time. The BMJ apologises for a failure of communication that meant we didn’t edit the filler to make this clear.

Watchdog brands two thirds of NHS trusts as “fair” or “weak”
After we went to press, we were alerted to an error in one of the Health Commission’s results given in this news article by Adrian ODowd (BMJ 2006;333:765, 14 Oct). In the fifth paragraph, we said that, of all the NHS trusts in England examined in the commission’s annual “health check,” primary care trusts performed least well, with 78% of them being rated as “fair or weak.” In fact, the percentage should have been 70%.

Anaesethic, Elics, and laumnnners
The Association of Anaesthetists’ Anaesthesia Heritage Centre mentioned by M Dylan Boulid in this filler article (BMJ 2006;333:793, 14 Oct) is at 21 Portland Place (not Portland Road), London W1B 1PY (see www.aagbi.org/ for more details).

Clinical problem solving and diagnostic decision making: selective review of the cognitive literature
A misspelling of an author’s name has rather belatedly been brought to our attention. In this Education and Debate article by Arthur S Elstein and Alan Schwartz, we wrongly omitted the “t” from the second author’s name (BMJ 2002;324:729-32).