

effect of MMC on fibroblast proliferation is stronger on recurrent pterygial cells than on primary ones.⁷

Our small prospective interventional study documented favorable outcomes of the use of topical MMC in the management of acutely recurring pterygium. It effectively halted progression and led to regression of the growth, avoiding the need for repeat surgical excision. However, larger clinical trials are warranted to evaluate the long-term safety and efficacy of this treatment.

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Range of drugs associated with IFIS

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Recently, a variety of medications other than tamsulosin (Flomax) and specific antiprosthetic hypertrophy medications have been noted to have α_1 -antagonism and result in floppy-iris syndrome during cataract surgery.

We had a case involving a woman with a small pupil who was a well-compensated schizophrenic on a psychotropic medication, a dopamine agonist. More recently, we had a patient with a very floppy iris, which we had not anticipated, who was taking ropinirole (Requip) for restless leg syndrome. Ropinirole is also a dopamine agonist.

We are aware of a recent report in the *Irish Medical News* of a similar case of a floppy iris in a ropinirole-medicated patient and think the ophthalmic community should be aware that many drugs are potentially

capable of participating in the etiology of floppy-iris syndromes in cataract patients. It is important to recognize that every small pupil must be viewed as a potential floppy-iris syndrome.

Ophthalmology carbon footprint: Something to be considered?

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Greenhouse gases are changing the global climate, and it is now widely believed that human activity is responsible.¹ It follows that each of us has a role to play by reducing our individual carbon footprint. Indeed, there is little time to waste for such action to avoid dire consequences for human health.² The environmental impact of medical conferences,³ clinical trials,⁴ and hospitals⁵ is now discussed, and nonclinical issues such as the fair trade of surgical instruments have become topical.⁶ Should we as ophthalmologists be thinking about climate change?

Cataract continues to be the leading cause of blindness in the world, and cataract surgery is one of the most commonly performed surgical procedures. Much of the burden of cataract blindness falls on developing countries, and cost-benefit studies suggest that phacoemulsification is not the gold standard for all surgeons operating in all surgical environments. The optimum number of clinical visits (optimum stop strategy) for efficient cataract surgery is unclear. A 5-stop strategy is often used, which includes the following visits to hospital: first referral, preoperative assessment clinic, surgery, first-day postoperative examination, and 1-month postoperative refraction. The requirement for first-day postoperative checks is debated,⁷ and in some places a 1-stop clinic involving a single trip to the hospital has proved successful.⁸ Clinical practice patterns are often driven by cost effectiveness, but should we also begin to weigh the environmental impact of different techniques and follow-up strategies?

At 2 Scottish centers, we looked at the environmental costs of 2 cataract surgery techniques, phacoemulsification and a modified phacoemulsification technique (modified small-incision cataract surgery [MSICS]). The amount of disposable waste used during a single standard uneventful lens extraction was evaluated by separating all the waste into categories of paper or plastic and recording the energy used by the phacoemulsification machine. Lens extraction with phacoemulsification resulted in an excess of 280 g of plastic waste, 8 g of paper waste, and 78.7 g of CO₂ emissions compared with MSICS (Table 1).