

Yet, as Ibbotson describes and as I experienced during my recent trip home, such affordable care is possible.

While in Nepal, I had the opportunity to visit some of the medical facilities in Kathmandu, and I was surprised at the speed and efficiency with which an elderly woman with congestive heart failure was managed at a government-run cardiac care hospital in Kathmandu. She had initially been treated for myocardial infarction at a regional hospital a few weeks before. On arrival at the cardiac hospital, the necessary investigations, including electrolyte measurement, radiography and echocardiography, were done and the patient was transferred to the intensive care unit. She was evaluated by a cardiologist and started on angiotensin-converting enzyme inhibitors, spironolactone and cardioselective β -blockers. She made an uneventful recovery the following week and was discharged to follow-up. The cost of her entire hospital stay? Less than US\$200!

Although my experience was limited to the city of Kathmandu, I am sure that the picture at many locations in the remote hills is not much different from what Ibbotson¹ portrays.

Now, as I sit back in the comfort of my living room in the United States, I try to convince myself that the sun has not entirely set on “the roof of the world.” A little help from the more fortunate ones and some reprieve from the cycle of fear and violence could go a long way toward improving the health care situation in Nepal.

Sonal Singh

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Reference

1. Ibbotson G. Nepal: a lesson from chaos. *CMAJ* 2003;169(12):1301-4.

DOI:10.1503/cmaj.1040496

[The author responds:]

Sonal Singh's description of an elderly woman receiving excellent care at so little expense illustrates one of the wonderful things about living in

Kathmandu. The city is truly a different world from the remote valleys on the other side of the mountain ridge that surrounds the Kathmandu Valley. Yet while care is available at low cost in the city, there are many people outside Kathmandu who do not have the resources to cover even such relatively minor expenses: the average annual income is only US\$235.¹ As the Maoist insurgency worsens and the economy crumbles, there is an ever-increasing need for charity health care to help the extremely poor. It is my hope that Nepali physicians, like Singh, will be enthusiastic about returning to their homeland to help build a better health care system, where even the poorest can find assistance. Such individuals represent the hope for the future of Nepal in this time of turmoil.

Geoffrey C. Ibbotson

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Reference

1. Ibbotson G. Nepal: a lesson from chaos. *CMAJ* 2003;169(12):1301-4.

DOI:10.1503/cmaj.1041012

Test for defective afferent pupillary response

As an ophthalmologist, I have a question regarding the clinical history for the 16-year-old boy with progressive vision loss described by Shaun Morris and associates:¹ Was the patient tested for a defective afferent pupillary response in the left eye? This is an important clinical sign of optic nerve function and in general is much more clinically significant than a colour vision test.

For patients presenting with unilateral loss of vision, the possible cause, be it retinal or related to the optic nerve, can be pinpointed by the results of the swinging flashlight test, also known as the Marcus-Gunn pupil test, which tests for defective afferent pupillary reflex.

The test consists of alternately illuminating the pupils with a penlight (or even the white light of an ophthalmoscope) in a dimly lit room, swinging the

light from one eye to the other every 2 seconds or so. The observer checks for visible dilatation of the pupil in the eye with visual loss.

A positive result, in which the pupil exhibits visible dilatation, indicates optic nerve dysfunction or retinal “disconnection” (as in retinal detachment). A negative result, characterized by the maintenance of the initial pupillary constriction in both eyes equally, tends to indicate that the problem lies elsewhere, such as loss of vision associated with macular lesions, retinal vascular disease or cataracts.

Alex Porzecanski

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Reference

1. Morris S, Hiraki L, Muise A. A 16-year-old boy with progressive central vision loss in his left eye. *CMAJ* 2004;170(8):1228.

DOI:10.1503/cmaj.1040692

[The authors respond:]

To respond to Alex Porzecanski's specific question, the patient that we described¹ did indeed have a defective afferent pupillary response in the left eye, as would be expected with optic neuritis.

We can now provide an update on the patient's situation. He returned to the Hospital for Sick Children 4 months later with complete blindness in the left eye (the one with the defective afferent pupillary response). Repeat MRI showed multiple new lesions of the periventricular white matter. This MRI evidence of dissemination in time and space confirmed the diagnosis of multiple sclerosis.

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Reference

1. Morris S, Hiraki L, Muise A. A 16-year-old boy with progressive central vision loss in his left eye. *CMAJ* 2004;170(8):1228.

DOI:10.1503/cmaj.1040849