Table 2
Vision on presentation and after treatment.

	Measurements
Median (range) vision at presentation (Snellen)	6/60 (6/12-NPL)
Median (range) final vision (Snellen)(n = 13)	6/9 (6/5-NPL)
Median(IQR) time from injury to canthotomy and cantholysis (hours)	4 (2.5–8.75)
Median (IQR) time from presentation to canthotomy and cantholysis (hours)	2.23 (1.55–4.58)

NPL = no perception of light.

the four hours for permanent complete optic nerve damage seen in rhesus monkeys.[3]

Two patients had poor visual outcomes. Case 4, who had a retrobulbar haemorrhage during cataract surgery under sub-Tenon's anaesthesia, was 6/36 five years later. Case 7 had 6/9 vision before injury, and canthotomy and cantholysis after 4.5 hours. Repeat cantholysis with drainage was delayed by 13 hours (while fast atrial fibrillation was brought under control and prothrombin complex concentrate given). She continued to be unable to perceive light and being already only counting fingers in the other eye was subsequently registered severely sight-impaired. Possible predictors of poor visual outcome include no perception of light, vision at presentation, anticoagulants, delay in presentation, and delay in further acute procedures if orbital pressure is not lowered adequately.

The most useful diagnostic sign in all five unconscious patients was a tense orbit.

Unusually, this is the second report of orbital compartment syndrome from causes such as: hair braiding,[4] rupturing subgaleal veins with haematomas tracking into the orbit,[4] and contrast extravasion during cerebral angiography.[5]

Canthotomy and cantholysis should be based on clinical findings. Most patients had computed tomography before their operations, which delayed treatment that could have saved their sight. Addressing this issue could improve outcomes.

In summary, our results show good documented Snellen visual acuity outcomes after treatment of orbital compartment syndrome in 11 of 13 patients. Treatment after the traditional two-hour window is beneficial, and close monitoring after canthotomy and cantholysis is essential, because a third of patients will require further acute intervention to lower orbital pressure and prevent permanent blindness.

Conflict of interest

We have no conflicts of interest.

Ethics statement/confirmation of patients' permission

Ethics approval not required. Patients' permission was obtained.

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Importance of activity and recreation for the quality of life of patients treated for cancer of the head and neck

Sir,

We read with great interest and thoroughly enjoyed the recent paper by Rogers et al that drew much deserved attention to the importance of activity and recreation in patients who have been treated for cancer of head and neck.[1] Our experience in dealing with these patients has made it evident that the burden of such a disease does not end with its diagnosis and treatment. It extends to self-esteem, confidence, physical outlook, social circle, family inter-relationships and their dynamics, professional work graph, and economic status, among many other aspects of life.

Resuming physical activity and recreation not only has physical benefits, but also affects mental and social health. We have treated many patients who avoided outdoor activities

and social gatherings for reasons such as: social embarrassment; the darkening of their skin after radiation; unwanted public attention; the feeling of a morbid physical appearance after resections or flap reconstructions; feeling low in the family hierarchy; the inability to chew food properly; drooling saliva; lack of a proper smile; and various others. A substantial number of patients were also depressed,[2] the identification of which is extremely important, because it has been found to affect survival outcomes.[3] In our experience, the reluctance to socialise and resume physical activity can also be signs of depression.

Physically the long-term effects of stress and lack of activity include the loss of muscle mass and strength, stress-induced anovulation, and a reduction in libido. Exercise and activity not only help to reduce these,[4] but also help many patients who struggle with addictions to tobacco (smoking and smokeless) and alcohol. These patients might benefit from the behavioural and neurobiological effects of exercise as a coping mechanism.[5]

Recreation and physical activity, in our opinion, not only improves the quality of life for the patients, but also help to reduce many challenges for the immediate social and family circle.

Conflict of interest

We have no conflicts of interest.

Ethics statement/Confirmation of patients' permission

Neither were required.

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