

Cataract Surgery

Dear Editor

There is still a place for intracapsular cataract extraction (ICCE), especially in remote areas of developing countries. The main reasons are known to all who have practised in developing countries or who have experience travelling in remote areas.

John Sandford-Smith (*J Comm Eye Health* 2000; **13**: 62) mentioned that in northern Nigeria they still practise couching rather than ICCE. That is the method they can afford. It is not unusual to find well-trained personnel in those areas but they lack essential instruments. Even those patients who have ICCE surgery lack spectacles which may not be available or be available but expensive.

I agree that IOL implant surgery has excellent results compared to the previous technique. The major problem is the unavailability of the equipment, although it may be easy to train the existing personnel who are readily available.

The DU – AL Corporation* still has much to contribute, as their equipment could be carried to the remotest areas without difficulty. I have used their cryoextractors for ICCE ever since I qualified from ICEH, London, in 1986. Post-operative results are very good.

If we want to promote IOL implant surgery in full capacity let's follow the recommendations of Dr David Yorston in his article in this Journal (*J Comm Eye Health* 2000; **13**: 51–52).

You, as Editor, have the means of evaluating what is written and recommended in most of our Community Eye Health Journals. Please give ICCE time – it will phase out as soon as we reach our goals of supporting the Districts and Regional Eye Workers with essential instruments.

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*Now acquired by

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Dear Editor

I am now retired 11 years after 35 years practice in India, much of it in cataract work among rural communities. The letter by John Sandford-Smith and its subject captured my interest as I had prepared a similar article while I was on a working visit back to my old territory in 1992. My thesis was, and still is, akin to the subject of John Sandford-Smith's letter (*J Comm Eye Health* 2000; **13**: 62).

In some parts of India, the mounting backlog of cataract patients is indeed being brought under control with the use of surgery by ECCE + IOL insertion. Around Delhi is one such area. However, in many rural areas cataract surgery of any sort remains unavailable at the local level. Government eye doctors rarely ever visit such places. All my work was in the State of Bihar, the area now known as Jharkhand. Towards the end of the '80s when ECCE-IOL was becoming available in India, a team capable of this method came our way for a week. The results were indeed good, but each operation had lasted 15–20 minutes, and some of the day's prepared patients had to be put off until the next day. We had been used to ECCE or sometimes ICCE with no implants and no sutures. One extraction was completed in 3–5 minutes. Yet the overall incidence of cataract in the area was not being reduced. If we had all switched to the new team's technique then, numerically, many patients would have been the losers, though some of

those operated on may indeed have benefited in some ways.

My contention is that where a cataract backlog remains, those qualified to carry out cataract surgery should maintain a flexible approach in those rural areas where so many patients with mature and hypermature cataracts still exist. Most of the older, mature cataract patients in those areas are illiterate. They do not particularly want to be able to read. All they require is vision to enable them to get about their own homes again, and their local market, without the need for someone to guide them. A simple, quick operation is enough for them. For the time being, I see a place for any 'quick' operation which, properly applied, will help to reduce cataract waiting lists. Once cataract waiting lists are coming down and show signs of being under control, then yes, by all means, settle on a regime to restore all patients' vision to as near 6/6 as you can get, cost problems being dealt with at the same time.

End piece: after their successes around Delhi I heard that there were so few cataracts left for the doctors to do, that they started on patients with 6/24 vision or better. It kept their hands in! Sadly, they did not consider going to those places where many mature cataracts are found.

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Dear Editor

'Is there still a place for Intracapsular Cataract Extraction...?'

(*J Comm Eye Health* 2000; **13**: 62)

Thank you for bringing this subject up for discussion. During most of my time at Enongal, we were not equipped for extracapsular cataract extraction. A Lions Club team had been past before I arrived, brought a microscope with them, and did extracapsular cataract extractions with posterior chamber lens implants; a few of their patients did very well, but most did badly. The problems we noticed with these patients were mostly 'inflammatory' – pupil membranes and thickly opacified capsules, sometimes with displacement of the lens implant. Our general experience was that intracapsular cataract extraction was more reliable in giving moderately good results for most people.

Our colleagues at Acha Tugi in northwestern Cameroun routinely used extracapsular cataract extraction and reckoned to get good results – but they used huge doses of steroids that were not available at Enongal. They commented too that there seems to be a change as you go westwards across equatorial Africa: east African eyes generally react mildly to being operated on, but in Cameroun at least, eyes react very briskly. David Yorston from Kikuyu in Kenya has commented on a minority of patients there who have an unusually brisk inflammatory reaction after cataract surgery (*Br J Ophthalmol* 2001; **85**: 267–71, and *Br J Ophthalmol* 1999; **83**: 897–901), but patients of this sort seem to be the majority in Cameroun. We also noticed that glaucoma is common and aggressive in Cameroun, and that many patients have a lot of Tenon's capsule stuck down on the sclera. Might there be some local factor (genetic, perhaps?) which links these phenomena?

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