

Table 1: Post-Operative Corrected Visual Acuties in Peripheral Eye Camps and Base Hospital. Aphakic Correction with + 10 D given to 99.1% Patients (1125 out of 1135) and Retinoscopic Refraction given to 63.9% (2000 out of 3130); Six Weeks after Surgery.

Vision	Total	% At Eye Camps	Total	% At Base Hospital
6/6-6/9	58	5.2%	685	34.3%
6/12-6/18	434	38.6%	966	48.3%
6/24-6/36	575	51.1%	227	11.4%
6/60	44	3.9%	92	4.6%
<6/60	14	1.2%	30	1.5%

Table 2: Experience of Surgeon and Post - operative Vision in Base Hospital

Vision	Junior Residents	Senior Residents	Registrar or Medical Officer	Professor
	< 50 ops.	50 – 200 ops.	> 200 ops.	> 4000 ops.
6/6-6/9	33%	30.4%	33.9%	57.1%
6/12-6/18	43.3 %	56.1%	48.7%	38.1%
6/24-6/36	16%	8.5%	10.7%	
6/60	5.6%	3.1%	6.7%	
<6/60	2.6%	1.9%	1.8%	4.8%

Table 3 : Cost of Surgery per Patient (All figures are in rupees)

Expense	Peripheral Eye Camp	Base Hospital
Vehicle	23.0	17.25
Expense	47.0	76.49*
Consumables # for Surgery	75.0	79.91
Medicines for Patients	80.0	78.66
Salary & Wages of Surgical Team	152.5	142.76
Goggles	13.0	13.00
	390.50	408.07
Office Expense		29.91
Hospital		44.10
Maintenance		
Depreciation		15.02
Total	390.50	497.10
IOL Expense		233.66*

* Includes food provided for patient over three days.

Includes suture material, viscoelastic substance, etc.

◆ The cost of IOLs is now almost half the price of 5 years ago.

The surgery in Peripheral Eye Camps was marginally more economical as compared to the Base Hospital (recurring expenses per patient being Rs. 390.5 and Rs. 408.77 respectively). But considering the quality of surgery, early and better

visual rehabilitation, the Base Hospital approach has much to recommend it.

Satellite Centres could be set up to improve follow-up. This shift to Base Hospital and Satellite Centres would ensure quality eye care to all patients, while still keeping community orientation.

There is no significant difference comparing Junior Residents (<50 ops.), Senior Residents (50–200 ops.) and Registrars/ Medical Officers (200–4000 ops.). There is, however, a significant difference between the results of the Professor (> 4000 ops.) and all other categories.

Sources

1. Annual audit report for 1996–97 of Lions NAB Eye Hospital.
2. Personal communication with the District Ophthalmic Surgeon (Class - 1), Sangli District, for Peripheral Eye Camps.

References

- 1 Das T, Venkataswamy G. Surgical results - Comparison of Patients Operated in Eye Camp with Patients Operated in Hospital. *Indian J Ophthalmol* 1983; **31** : 924–927.
- 2 Murthy G V, Sharma P. Cost Analysis of Eye Camps and Camp-based Cataract Surgery. *Medical Journal, India* 1994; **7** : 111–114.
- 3 Nag Subhasish. Comparative Analysis of Camp Surgery at Base Hospital versus Satellite Center versus Rural Eye Set Up. Paper presented at 53rd AIDS Annual Conference, Mumbai, Feb. 1996.
- 4 Natchiar G, Robin A D, Thulasiraj R D, Krishnaswamy S. Attacking the Backlog of India's Curable Blind-The Aravind Eye Hospital Model. *Arch Ophthalmol* 1994; **112** : 987–993.
- 5 Prajna N V, Rahamatullah R. Changing Trends in the IOL Acceptance in Rural Tamilnadu. *Indian J Ophthalmol* 1995; **43** : 177–178.
- 6 Ravindra M S, Rekha Gyanchand. Rural Eyecamps versus Base Hospital Eyecamps. Paper presented at 54th AIDS Annual Conference, Chandigarh, Feb. 1997.

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Letter

Cataract Surgery

Dear Editor

I read J Fumpa's letter in the Journal (*J Comm Eye Health*; 2001; **14**: 15). His concern is fully understood by those who have lived in such circumstances in the past.

Between ICCE and ECCE (phaco is also ECCE), there exists another system which is suitable to any part of the world and any economic situation. I developed the mini-nuc technique. With a very small number

of instruments one can achieve safe and very high standard cataract surgery, with or without an IOL. If a YAG instrument is not available, after implanting the IOL one can perform posterior capsulotomy under the IOL, thus avoiding the necessity of future YAG treatment. As it would be performed under the IOL, the IOL would prevent vitreous prolapse to the anterior chamber.

There are the means to perform perfect cataract surgery around the globe – safely, no viscoelastic material, no sutures, very cost effective. The only thing to be done is to learn how to do it!

References

- 1 Blumenthal M, Assia E, Moisseiev Y. Manual ECCE, the present state of the art. *Asia-Pacific Journal of Ophthalmology* 1995; **4**: 21–24.
- 2 Blumenthal M. "The modern manual small incision extracapsular with mini-nuc technique". Highlights of Ophthalmology. Volume 28, No 1 '2000 series'.

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