Dear Editor

Which form of cataract surgery in developing countries?

This letter is in response to the letter by John Sandford-Smith on the desirability or otherwise of intracapsular cataract extraction (ICCE) surgery in many developing countries (*J Comm Eye Health* 2000; **13**: 62). It is indeed true that in some developing countries (like northern Nigeria) the practice of couching has increased in relation to cataract surgery, especially in rural areas. This is of course a cause for concern for eye care personnel in this part of the world. A recent study in a rural community of northern Nigeria revealed that couching of the eye is being practised 5 times more than cataract surgery. What are the factors that tend to make people have couching rather than cataract surgery? There are 3 main reasons for this attitude in most parts of northern Nigeria.

1. Couching is more readily available to the people than cataract surgery. Many couching practitioners now move from village to village to solicit clients (people with cataract or at times any eye problem) on whom they will practise their trade. They conduct their services often within the premises of their patients/clients without any delay. Thus, couching is mostly done on the first visit. Cataract surgery often requires the poor villager to travel long distances several times before having the surgery. In some instances the service (i.e., cataract surgery) is just not available.
2. Couching is often more affordable to these poor people. Some couching practitioners are paid in kind (e.g., by receiving agricultural products), instead of money. Sometimes services are paid only after the patient is satisfied with the outcome of the couching. This is in contrast to surgery where the patient is required not only to pay in money, but to pay before surgery. Even if the surgery is free the indirect cost involved (travel cost, lost wages, etc.) in accessing the surgery is an enough hindrance to the surgery.
3. The visual outcome of couched eyes may be better than some cataract surgery eyes, especially eyes after intracapsular surgery (ICCE) which is basically the form of operation done in outreach activities and many peripheral hospitals in Nigeria. Indeed we have encountered several couched eyes with much better vision than ICCE post-operative eyes. Even ICCE eyes with good visual outcome may not be better than a well performed couched eye, as the couching practitioners have learnt to issue +10 aphakic spectacles to their clients.

So the poor villager with cataract can have his eyesight restored instantly by a few minutes couching procedure in his own house without having to travel, without leaving his family, without leaving his village, without several visits and at an affordable rate or agreeable terms. More importantly, the sight of the couched eye is restored with the same aphakic spectacles which the ICCE eyes will require post-operatively.

The point here is that a well performed couched eye may be equal in visual outcome to well performed cataract surgery (ICCE) in our environments. As such, my opinion is that apart from attempts at overcoming barriers relating to unaffordability and inaccessibility of cataract surgery in our part of the world , we necessarily have to provide a cataract service that is competitively better in outcome than the best couched eye – a cataract service that will inspire confidence in the people. This requires that the visual outcome of the post-operative surgical eye will be obviously better than the best couched eye with aphakic spectacles. That procedure, I believe, is extracapsular cataract extraction with posterior chamber IOL (ECCE+PCIOL) or possibly ICCE with anterior chamber IOL (if its safety is assured).

With low-cost IOLs, portable low price operating microscopes, I believe cost may not be a problem. Furthermore, more ophthalmologists in developing countries are abandoning ICCE and getting well acquainted with the IOL surgery. Governments, eye care personnel and NGOs in developing countries should face this challenge. Cataract outreach programmes, as well as the routine form of cataract surgery in hospitals should be ECCE+PCIOL as much as possible, rather than the lower quality ICCE.

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Dear Editor

I write in response to Dr John Sandford-Smith's letter on intra capsular cataract extraction (*J Comm Eye Health* 2000; **13**: 62). In my experience, most ophthalmologists prefer ECCE with PC IOL to ICCE, because ICCE, the traditional method, has the potential complication of cystoid macular oedema. This is much less common in ECCE. However, there are a number of problems associated with ECCE plus IOLs.

1. IOLs remain expensive for most of the population of poor countries, especially when we consider that food is the first priority, even for the blind.
2. There is limited access to operating microscopes and laser equipment in many developing countries. When available, they are based in urban centres where most ophthalmologists also live. The bus fares necessary to reach the service are a big burden for the poor.
3. Difficult access to YAG lasers is the biggest problem. People may have to be referred to other countries to get this service.
4. As many people are aware, in developing countries patients do not follow the service, but services should follow them. This means giving priority to social and economic factors, local beliefs, religious taboos or fear of witchcraft, and making every effort to provide health education. Charging for IOLs in this kind of society will be a further barrier to stop people seeking surgery.
5. I have to say that it is not true that in a developing country an aphakic patient without an aphakic correction is good for nothing. He or she can improve from light perception to counting fingers, which enables the patient to walk around, and this is a significant gain amongst poor blind people in developing countries.

Therefore, if we are to abolish ICCE in developing countries, various facilities need to be provided and maintained, remembering that electricity and reliable water supplies are still the exception rather than the norm in many countries.

It is necessary to have:

- Cheap portable microscopes with good co-axial illumination
- Very cheap IOLs, viscous fluid and BSS solutions
- YAG lasers which can be afforded and operated in third world countries.

More consideration needs to be given to ICCE with A/C IOL which does not need access to microscopes and YAG laser facilities. I think this may be preferable in many developing countries. However, I remain in a dilemma because most ophthalmologists give much less priority to this method.

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