

over surgical outcome. Improved education and publicity showing cataract patients with restored vision, should hopefully overcome this.

Recommendations

Mobile eye programmes should be integrated into existing primary health care programmes at district hospitals.

Community health workers, traditional healers and schoolteachers should be given basic training in recognising eye conditions.

Community awareness about the prevention of blindness should be raised. For example, it could be included on the teaching syllabus of primary and secondary schools.

References

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VISION 2020 PLANNING COURSE

A one-week course for eye care project managers about the VISION 2020 programme will be held at the London School of Hygiene and Tropical Medicine, **July 15-19, 2002**. Faculty include Allen Foster and Clare Gilbert. Fees are £500, accommodation and travel not included.

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THE GLAUCOMAS

Dear Editor

The several articles on adult glaucoma that appear in the *Journal of Community Eye Health* 2001; **14**:33-52 are especially well done and much appreciated. Recent epidemiological studies combined with advances in instrumentation will undoubtedly combine to make it possible to detect more individuals in developing countries who have glaucoma. Mention is made of referral to tertiary care centres for definitive diagnosis and appropriate treatment. This affords me the opportunity to call attention to a major barrier to appropriate glaucoma care in many developing countries – the relatively low level of glaucoma knowledge in teaching institutions and tertiary care centres.

During the past 8 years I have conducted 2-week glaucoma workshops at 26 training centres in 23 developing countries scattered throughout most areas of the world. Based on this experience I am comfortable in making the generalisation that most ophthalmologists in the so-called tertiary care centres in the majority of developing coun-

tries do not have the clinical skills necessary to accurately differentiate the various causes of glaucoma. The diagnosis of glaucoma continues to be made on the basis of elevated IOP. PACG is diagnosed on the basis of the signs and symptoms of the acute variety. A serious problem is the lack of gonioscopy skills resulting in the rare performance of this most important examination component. The result is frequent misdiagnosis and inappropriate treatment. Visual fields are either not done or are usually unreliable. Secondary glaucoma is not recognised as such and often treated inappropriately.

The ophthalmologists that I have encountered are bright, usually hard working and highly motivated to learn. They suffer from poor basic training even though the duration of the residency training is often longer than in the developed countries. Glaucoma is a very complex and challenging condition. At the beginning of the workshop there is invariably a low level of confidence especially in diagnostic skills. It is satisfying to see what only 2 weeks of concentrated teaching can accomplish. The participants return to their respective teaching institutions with a fresh

outlook and confident enthusiasm in seeing glaucoma patients and an eagerness to teach others.

In summary, it is exciting that new and better screening techniques are becoming available but this begs the question of who will do the final diagnosis and treatment in the tertiary referral centres. A subcommittee of the American Academy of Ophthalmology is compiling a list of training centres in developing countries; the number is now over 200 and still growing. I hope that the preceding comments will stimulate more teaching effort in updating the clinical skills of those who are receiving glaucoma referrals from the primary and secondary allied health personnel in the field. Books, journals and occasional lectures by visiting experts are helpful but not enough. What is especially needed is intensive, basic and practical 'hands-on' clinical training, including gonioscopy, by volunteers from the developed countries or by well-trained ophthalmologists from the developing countries.

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Dear Editor

I have followed with interest the very favourable responses to John Sanford-Smith's earlier appeal for a reappraisal in selected circumstances of ICCE with the newer 'open loop' ACIOL's.

We have used hundreds of ACIOL's in Guatemala over the past ten years - both the classic 4point Kelmann and more recently the 'Omnifit' 12.8mm 3point Kelmann (Aurolab A5528). This is in large part due to the very high incidence of pseudoexfoliation among the Mayan popu-

lation. We have noticed no more post-operative problems than with PCIOL's.

As our patients are poor and often from isolated mountainous areas, I have the feeling we may not be seeing the long range effects of posterior capsule opacification. Our clinic has a YAG laser but few understand its purpose or are able to return to take advantage of it. In the occasional case of operating on one eye with ICCE/ACIOL and the other with ECCE/PCIOL, I have been surprised to see how quickly the patient reports subjectively clearer vision

following the former procedure – even though tested visual acuity may at the time be the same.

We routinely use the above ACIOLS after vitreous loss with often just a scissors vitrectomy. Again, we see few complications. Not to use an intraocular lens in the case of vitreous loss is virtually to ensure a 100% complication rate.

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