Dear Editor

I read J Fumpa’s letter in the Journal (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!

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
2. Personal communication with the District Orthopaedic 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.