

## Guidelines for Re-Sterilising Sutures

In some countries the idea of re-sterilising sutures is not acceptable; however, in other situations people re-sterilise sutures routinely. If you do sterilise sutures, the following should be considered.

### 1. How to sterilise sutures

The two recommended methods are:

- Soak for a full 10 minutes completely immersed in povidone iodine 10% solution, then rinse in sterile saline/water.
- Ethylene Oxide - gas sterilisation.

Sterilising/disinfecting by other methods (autoclaving, boiling, alcohol-soaking) are **not** recommended. Glutaraldehyde has been taken off the market since May 2002. It was never intended to be a suture soaking solution due to its high toxicity and the inability to ensure that all the solution is rinsed off before use.

### 2. Sutures which can be re-sterilised

- Any monofilament (Prolene or Nylon/Ethilon) suture can be soaked in povidone iodine 10% solution with no risk of HIV, or hepatitis B transmission.
- This also applies to 'coated' sutures, e.g. some Vicryl or Ethibond. On the outside of the packets it states whether the suture is coated or not. If coated,

there should be no problem with soaking the suture material.

- Multi-filament or twisted fibres, such as Chromic, Silk, Mersilene and non-coated Ethibond should be discarded after use.

### 3. Tensile strength

There are no reports of wound breakdowns due to loss of tensile strength in sutures following soaking (Nylon, Prolene, coated Vicryl or Ethibond sutures).

### 4. Needle sharpness

Povidone iodine does not affect needle sharpness.

### Key Points

- Monofilament and coated sutures are the only sutures suitable for re-sterilising.
- The recommended technique is 10 minutes fully immersed in povidone iodine 10% solution followed by rinsing in sterile saline/water.

**Ingrid Cox**

*Eye Care Advisor, CBM International, Kenya*

## Providing appropriate medical treatment for childhood cataract in remote tribal regions of India

During a free cataract eye screening camp organised by the Alakh Nayan Mandir Eye Institute in the remote rural village of Kardha, Barwada in Udaipur, Rajasthan, India, we detected a case of a girl aged 3 years with congenital cataract in both eyes. This orphan girl from a tribal area was unable to get proper medical treatment for her blindness. Her carers resorted to using the services of the local 'quacks', who subjected her lower chest and abdomen to red hot iron bars in the belief that this would cure her blindness.

She was escorted to our base hospital for bilateral cataract extraction by phacoemulsification and IOL implantation under general anaesthesia. Post-operatively she had good vision. She was kept under observation for two weeks in the base hospital, to avoid post-operative infection.

The outcome of this surgery was that, in this particular region, the community became aware that 'quacks' should not treat cataract. This has motivated older cataract patients to come for eye surgery despite their earlier reluctance, thinking previously that it is a curse of old age.



Photo: L S Jhala

Timely and successful intervention with regard to childhood blindness, especially in rural and tribal regions, is the need of the hour. Furthermore, we need to find ways to bridge the gap between the 'quacks' response to childhood eye problems, and the urgent medical attention children need.

**L S Jhala**

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## Episcleral nodules and hygiene

Over the past 4-5 years, I have noticed children coming to the hospital with inflamed episcleral nodules, which did not respond to topical antibiotics or steroids and anti helminthics. Blood reports were insignificant and stool examination done for three cases were inconclusive. Once regularity was noted, exised lesions were sent to Christian Medical College (CMC) Vellore. Biopsy was done on 12 cases. Of these, 8 reported that the lesions were probably of parasitic origin.

The interesting part of the exercise was that, of the 8 reports of lesions of parasitic origin, 7 were of Sri Lankan refugees, from a Sri Lankan refugee colony situated on the banks of the Bhavani river, in Mettupalayam. The river is the main source of drinking water for the people of the colony. After repeated visits to the colony to study the problem, health education talks were given on the use of boiled water for consumption, spread of diseases through impure water, and the importance of personal hygiene.

Oral helminthic, Albendazole, was given to every child, with another dose after a gap of 2 weeks.

In our follow-up visits, we have not seen any case of episcleral nodules from this village for the past four years.

This was part of a large programme called 'Operation Community Care'.

**Samuel P John**

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## Exchange

*Community Eye Health* has recently introduced this forum for exchange of inspiring experiences and insights in community eye care. If you have achieved something exemplary, or learnt something interesting in your work, please send us a short description in no more than 200 words.

Please send your contributions to:

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