Update on Ocular Leprosy

Dear Editor

The report by Professor Gordon Johnson and the recommendations by Dr Paul Courtright summarise beautifully the Workshop on Practical Eye Care GuidelinesforLeprosyPatients. (*J Comm Eye Health* 2001; **14**: 25–26).

In addition, I would like to clarify one point on treatment of lagophthalmos:

Recent lagophthalmos, independent of size of lid gap, should be treated first with a course of systemic steroids as per general guidelines for type 1 reaction and recent nerve damage in leprosy. Usually a durationofnervedamageof≤6 months, is taken as indication for steroid treatment in leprosy.

Even recent lagophthalmos with a lid gap of 8–10 mm in mild closure may recover, provided steroid treatment is given in time. Meanwhile the cornea should be protected by conservative means in combination with blinking exercises.[1]

Reference

1 Treatment of recent facial nerve damage with lagophthalmos, using a semi-standardized steroid regimen. Kiran KU, Hogeweg M, SuneethaS. *LeprosyReview* 1991; **62:** 150–154.

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Cataract Surgery

Dear Editor

Cataract Surgery in Developing Countries

I wish to write in response to the expressions of various ophthalmologists published in the last issue of the *Journal of Community Eye Health* 2001; **14:** 30–31, on the method of cataract surgery in developing countries.

It seems that couching is still practised in some parts of the world with better results than ICCE. Because the advantages of ECCE + PCIOL can hardly be exaggerated,themajorityofnewlytrained eye surgeons perform ECCE more confidently than ICCE even in developing countries.Sofarastheissueofavailability of YAG laser is concerned, the use of primary posterior capsulotomy can be advocated to avoid its need.

In Nepal, for example, you can hardly find anybody who would be doing ICCE either in outreach camps or in the hospitals. It would be incredible to think of this 10 years ago! I do not believe that ICCE can be done faster than ECCE + PCIOL once one starts doing it.

Nepal's experience in developing eye care infrastructure for cataract surgery through coordination with the NGOs and INGOs can be an example for many developing countries with huge cataract backlogs.

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Dear Editor

I agree with John Standford-Smith (*J Comm Eye Health* 2000; **13**: 62) that intracapsular cataract extraction (ICCE) has been relegated to the history books without necessary discussion taking all the facts into account.

Like others in the 80s, I trained to do ICCE using a loop. We face the choice of having to retrain to carry out ECCE + PCIOL, or continue to practice what is increasingly regarded as a substandard technique.

While ICCE has its complications (vitreouslos s, macularoedema,retinaldetachment, etc.), so does ECCE even when performed in good conditions (posterior capsule opacification, etc.). Perhaps the truth is that all methods can give suboptimal results despite the best of intentions.

At the Bamako, Mali, launch of Vision 2020, Dr Daniel Ety'aale of the WHO, reminded delegates that the majority of ophthalmologists in Francophone West Africa had only been trained in ICCE.

As John Standford-Smith suggests, anterior chamber IOLs are a useful way forward, enabling surgeons doing ICCE to offer their patients the benefits of pseudoaphakia.

Another factor in the ICCE/ECCE debate is cost. To set up for ECCE + PCIOL requires more expensive equipment than for ICCE+ACIOL (microscope, YAG laser, etc.) The extra consumables for ECCE+PCIOL are more expensiveandlesseasilyproducedlocally (Ringer's lactate solution, methyl cellulose, nylon sutures, maintenance of expensive equipment, etc.). The main consumables for ICCE + ACIOL are the cryo refrigerant and the sutures. Now that ozone friendly refrigerants are available in many African cities, this is less of a problem.

Also, certain types of cataract such as intumescent with a tough capsule, hypermature with a shrivelled cortex are better dealt with by ICCE. In this part of Africa, these types of cataract are still very common.

Perhaps we need a certain amount of humility in realising that a mixture of methods is needed to deal with the many varied types of cataract that we meet. We also need to take into account what our patients can realistically afford.

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