Exchange

Gender and use of cataract surgical services: experiences from Munawwar Memorial Hospital in District Chakwal, Pakistan

Problem identified

In 2000 a survey of cataract blindness in our district showed that an estimated 3,095 people were bilaterally blind due to cataract, 647 males and 2,448 females (79%). The cataract surgical coverage for persons at VA<3/60 was 93% for males and 74% for females, a significant difference. At the <6/60 and the <6/18 level the differences were not significant (Haider S, Hussain A, Limburg H. *Ophthalmic Epidemiology* 2003, Vol.10, No.4, pp. 249-258. (http://www.szp.swets.nl/szp/journals/op104249.htm)

Action taken

It was not possible to provide an exclusive service to females, but we examined barriers specific to women and took a series of measures to raise awareness, improve detection, streamline referrals, improve access, reduce costs, and to make the programme more friendly to the patients' family members.

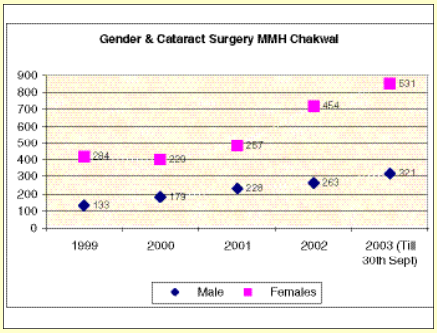
Photo: Sajjad Haider

The following were put in place:

- A resident facility so the family can reach home for the evening
- Day case surgery to reduce effort and indirect costs
- Service over the weekends, when a younger family member may more easily accompany the elderly female patients
- Cost reduction through subsidy
- Transport to reduce indirect costs and improve access
- 1,650 Primary Health Care workers within this district were trained in Primary Eye Care, including detection and referral of the female blind.

Outcome

Community detection of cataract improved from 160 cataract patients identified at community level in 2001, to 463 identified in 2003. We were also able to increase the acceptance of surgery considerably in the four years. The rate of cataract surgery in females has remained consistently higher than males. The volume of cataract surgery has doubled but the male/female distribution remains roughly the same. Increasing the coverage in females with bilateral cataract may require more focused interventions.



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Hans Limburg ***Consultant, International Centre for Eye Health, London, UK***

Letters to the Editor

Astigmatism after Sutureless Cataract Surgery

Dear Editor,

I read the current *Community Eye Health* (Issue 48) with a lot of interest as these are the issues we deal with daily. An aspect which I feel needs further discussion is astigmatism after the sutureless surgery. Some claim that this gives more against-the-rule astigmatism and hence recommend that at least one suture will give more of a with-the-rule astigmatism. Question: is this true and is this of any consequence to the quality of life for the patient?

Dr. Kibata Githeko
Lighthouse For Christ Eye Centre, Mombasa, Kenya

Editor's note

A member of our editorial committee, Dr David Yorston, has kindly agreed to respond to this question.

Dr Githeko raises an interesting point. The sutureless wound leads to a flattening of the cornea in the direction of the wound. If it is placed superiorly, the cornea will be flatter along the vertical axis than along the horizontal. This causes "against the rule" astigmatism. Placing a suture might reduce this flattening effect. There is some evidence for this. A 1995 paper from Berlin showed that a single suture reduced the astigmatism by 0.5D (Haberle H, Anders N, Drosch S, Pham DT, Wollensak J. See abstract on page 11 of this issue.)

However, the paper does not say if this increased the number of people with good unaided acuity. Dr Githeko asks the very pertinent question "is this of any consequence to the quality of life for the patient?" Using a stitch may reduce astigmatism, but, unless it reduces it enough to improve patients' unaided vision, I don't think it will improve their quality of life. On the other hand, using a stitch increases the risk of suture-related complications, such as erosion and irritation. Albrecht Hennig has pointed out that it also significantly increases the time taken to carry out the surgery, and adds to the cost.

The only way to be sure if the benefits of placing a suture outweigh the possible risks would be to perform a randomised trial.

David Yorston
Specialist Registrar
Moorfields Eye Hospital, UK

Sterilising Instruments

Dear Editor,

With reference to John Sandford Smith's article: Sutureless Cataract Surgery in Issue 48 of *Community Eye Health*, I would like to make the following recommendation.

If surgical knives are soaked in povidone iodine or autoclaved, a 'protector' needs to be placed on the tip of the knife before soaking/sterilistion takes place. 'Protectors' can be made out of old intravenous infusion tubing or silicone pieces. If the knives are placed directly into a metal kidney dish without a protective rubber mat or gauze on the bottom of the dish and without the tip protected, they will soon become blunt.

Ingrid Cox
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