Retinal Diseases and VISION 2020

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Historically, retinal disease has had a low priority in prevention of blindness programmes in developing countries. There are several reasons for this. Firstly, it was thought that retinal disease was an uncommon cause of blindness in the developing world; secondly, that the results of treating retinal disease did not justify the effort and expense involved; and, thirdly, that the equipment required was too costly and unreliable for use in a developing country environment. Finally, there is a lack of skilled personnel with sub-speciality training in retinal disease.

Retinal Disease Worldwide

As countries become wealthier, and per capita income increases, the prevalence of blindness decreases, and the causes of blindness change. In a poor African country, the major blinding conditions are likely to be cataract and corneal scar. In a middle income country in Latin America, the leading causes of blindness will be glaucoma and diabetic retinopathy. Because cataract surgery is more readily available, fewer people become blind from cataract. In a wealthy country, glaucoma and cataract will continue to be very common and important conditions, but most of the blindness will be due to retinal disease.

Retinal diseases are already the most common cause of childhood blindness worldwide.1 Some of these children are blinded by inherited retinal conditions, such as retinitis pigmentosa, which can neither be treated nor prevented at present. However, many of them have retinopathy of prematurity, which can be prevented, and is treatable in its early stages. The excellent and very detailed Andhra Pradesh Eve Disease Study (APEDS) found that retinal diseases were a much more common cause of adult blindness in India than had previously been thought.2 The APEDS study dilated the pupils of every subject, and all those with reduced vision had their fundus checked by an ophthalmologist. Blindness surveys in which the fundus is not routinely examined may underestimate the prevalence of blindness caused by retinal disease.

Diabetes is a growing problem in developing countries. In India, it is estimated that 8–10% of the population is diabetic, and the prevalence is increasing.³ Although population-based studies suggest that diabetic retinopathy is not a major cause of blindness in India at present,⁴ this is likely to change in the future.

Our own efforts will increase the incidence of retinal disorders. At present, there are about 10 million cataract operations per year. By 2020, it is intended to increase this to over 30 million. Almost all this growth will take place in poorer, developing countries. More cataract surgery will lead to more posterior segment complications of cataract surgery, such as retinal detachment, and retained lens material. These complications are very treatable, provided

a skilled and well-equipped vitreo-retinal surgeon is available.

In view of these trends, it is likely that retinal diseases are already a significant and increasing problem in every part of the world

Treatment of Retinal Disease

The second reason for the low priority of retinal disease is the belief that little can be done to treat these conditions. It is true that there are many retinal degenerations for which no cure is available. However, patients can benefit greatly from receiving an accurate diagnosis, with a detailed explanation and clear prognosis; provision of low vision aids; and genetic counselling. Even where the disease is untreatable in one eye, prevention may be possible in the other eye. For example, the Age Related Eye Disease Study showed that in patients with age-related macular degeneration in one eye, daily vitamin and zinc supplements reduced the risk of macular degeneration in their other eye.5 Recent studies have shown that surgery for retinal detachment in India and East Africa can be very effective. Retinas were successfully re-attached in 70-80% of patients, and even in 'macula-off' detachments, over 60% of eyes could see 6/60 or better.6 Approximately 25% of retinal detachment operations restored sight to a blind person.

Equipment

The third issue is the availability and reliability of equipment. Newer technology offers significant improvements. For example, conventional fundus cameras rely on film to record the images. This is expensive, and developing the films is also costly. Digital fundus cameras are more expensive to buy, but record the image directly to a computer, and do not need film, which substantially reduces the running costs. The first Argon lasers were bulky, expensive, and fragile. However, newer diode lasers are robust and portable. While they are not cheap, the running costs are very low. Assuming a cost of \$40,000, and a five year life expectancy (which is pessimistic), if 400 treatments are carried out each year, the cost per treatment is \$20. The key to cost effectiveness is volume – if the number of treatments is reduced, the cost per treatment increases. Vitrectomy equipment is also expensive, and can be more difficult to maintain. However, it is useful not only for retinal surgery, but also



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for managing congenital cataract, trauma, and complicated cataract surgery. Because the capital cost of lasers and vitrectomy machines is so high, they should only be used in centres that have sufficient volume of patients to justify the expense.

Training in Retinal Disease

To summarise, retinal disease is likely to become more common in the developing world. Treatment of retinal conditions is improving, and may be cost effective, even in a developing world eye clinic. Owing to advances in technology, equipment to treat retinal disease, although still expensive, is now much more suitable for use in a developing country. However, a significant limitation remains the shortage of skilled personnel. Ophthalmic education should prepare eye workers not only for the challenges they will face today, but also for future developments. This means that we need more developing world ophthalmologists with sub-speciality training in retinal disease who can train future generations of eye workers.

Questions:

1. Is your training programme orientated towards diseases that are becoming less

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- common, or is it aimed at preparing eye workers to manage the conditions that are going to be most important over the next twenty years?
- 2. Is retinal disease an increasing problem in your country and if so, how is your training programme planning to address this challenge?

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