Eye (2004) 18, 559–560

www.nature.com/eye

EDITORIAL

Phacoemulsification cataract extraction in diabetics from ethnic minorities

CS Brand

Eye (2004) **18,** 559–560. doi:10.1038/sj.eye.6700748

Cataract surgery has dominated conversation amongst ophthalmologists for many a year. Surgical training in ophthalmology has shifted so much that procedures that were once commonplace such as the trabeculectomy are not so any more, to everyday procedures such as the 'simple squint' or even the straightforward ectropion/entropion becoming the responsibility of the Fellow or Consultant subspecialist. Small incision phacoemulsification cataract extraction is different; we hear such things as there is no difficult cataract extraction and extracapsular cataract extraction is no longer mentioned. The experts pronounce poor mydriasis is only a problem if the pupil is less than 4 mm diameter, along with live surgery at meetings. The prevailing concept is that all cataract surgery is easy and anyone can do it. And since it is very cost-effective, this has not escaped the politicians. The National Health Service (NHS) being a major political issue, has meant dramatic changes within ophthalmology, Strategic Health Authorities, and Primary Care Trusts given the task of delivering the government's 10-year plan. The ambitious 3-month wait for a cataract extraction has meant increasing pressure to modernise and deliver more for less. Increase in patient numbers, pooled waiting lists, out-of-hours operating, and referrals to the private sector all contribute to achieve targets. As we look into the cataract crystal ball, we see optometrists scoring and assessing patients. Patients added directly to theatre lists, in NHS hospitals, diagnostic and treatment centres, or the private sector, patient's choice and efficiency being the objectives. Where are we heading? Will we have cataract specialists who will do nothing other than cataract extractions, with no pre- or postoperative patient contact. With increasing competition, inevitable reducing costs, quality will possibly become less of a priority. Costs driven down, will the humble cataract extraction become so affordable that it will be available only as a private procedure? A multifocal, intraocular lens free of contrast sensitivity problems will cure presbyopia along with clear lens extraction for high myopia and hyperopia, the savings on spectacles may make cataract extraction a sound financial decision for the general public as opposed to years of changing one's glasses. The demand would be huge. What if anything will be left on the NHS cataract list? Where will our future ophthalmic trainees learn phacoemulsification.

Whatever changes the government propose, I believe we need to hold firm to the Royal College of Ophthalmology Charter, advancing the science and practice of ophthalmology, maintaining proper standards for the benefit of the public as well as promoting professional education and training.

In this new era, will ophthalmologists adopt the idea that all cataracts are easy and phacoemulsification rules, or will there be 'cherry-picking'! On pooled NHS waiting lists, there is a concentration of one's mind when the list highlights a diabetic patient. Out-of-hour lists have specially selected cases for high volume surgery. Most amusing, if it were not true, is Primary Care Trusts that have sent patients to the private Sector and then asked for the notes to be vetted to decide if the cases are appropriate.

Not all cataracts are technically easy, and one of the most difficult cataract extractions is in ethnic minority diabetics. Postoperative complication rates in diabetics are higher following extracapsular cataract extraction[1,2]. Some studies have shown increased progression of diabetic retinopathy and maculopathy following extracapsular cataract extraction,[3] whereas following uncomplicated phacoemulsification cataract extraction there is no associated progression of diabetic

Correspondence: CS Brand
Ophthalmology Royal Hallamshire Hospital
Glossop Road
Sheffield S10 2JF, UK
Tel: +44 0114 226 1469
Fax: +44 0114 271 3682
E-mail: chrisbrand@tesco.net

retinopathy and maculopathy postoperatively.[4] Studies have also suggested differences in the prevalence of complications secondary to diabetes including retinopathy between various races.[5,6] The UK Prospective Diabetes Study[7] found the prevalence of retinopathy at diagnosis of type II diabetes to be similar between white Caucasian, Asian, and Afro-Caribbean patients. Chatterjee *et al*[8] present an original piece of work assessing diabetic retinopathy and maculopathy progression along with visual outcome following phacoemulsification cataract extraction in South-Asian and Afro-Caribbean patients who are type II diabetics.[8] There results show that 86.7% achieved a final postoperative visual acuity of 6/12 or better. More importantly, there was no statistical difference in the number of operated and fellow eyes that developed progression of retinopathy or maculopathy. The reported rate of progression of diabetic retinopathy following phacoemulsification in the general diabetic population ranges between 20 and 34%.[4,9–11] In Chaterjee's study,[8] 23.4% of patients showed either symmetric or asymmetric progression at a mean follow-up of 12.4 months. The results of this study suggest that uncomplicated phacoemulsification in South-Asian and Afro-Carribean patients with diabetes is associated with a favourable postoperative visual outcome that is comparable with the results of phacoemulsification in the general diabetic population.

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