vertical pleating of retina at the macular hole's nasal rim in our patient. It is possible that a full-thickness foveal cyst, formed by coalescence of multilayered microcysts, was de-roofed by a strong nasal vitreous traction. A macular hole is, however, extremely rare in XLR. Vitreomacular traction is not very strong in most cases; and splitting of the inner retinal layers might slacken the vertical vector of vitreous traction.[7] We could find only one additional report of a macular hole in XLR. Unlike our case, the previous report demonstrated definite anteroposterior vitreomacular traction causing the hole, with localized retinal detachment.[7] Probably due to pre-existing degenerative changes, our patient experienced no further visual deterioration attributable to macular hole, and was conservatively managed.

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Sir,

Retinal diseases in Ibadan

Retinal disease was thought to be uncommon in the developing countries, hence was not given enough attention by the blindness prevention programmes.[1] Secondly, the equipments needed for treatment were expensive and difficult to maintain, hence the high cost of treatment where the equipment are available. These explained the paucity of trained personnel sub-specializing in vitreoretinal surgery in the developing countries such as Nigeria. Retinal disease was found to be a significant cause of blindness and visual impairment in Nigeria.[2,3]

A review of cases seen in the eye clinic of the University College Hospital, Ibadan during a 5-year period (November 1998–October 2003) was carried out. Case files of 395 patients with vitreoretinal diagnoses were enrolled into the study. Male : female ratio was 1.3 : 1. Peak age of presentation was 60 years and above. The common diseases noted were macular diseases 141 (35.6%), comprising age-related macular degeneration (AMD), macular scar, and holes. The elderly, aged 60 years and above carried the burden of retinal disease. This is explained by the presence of macular diseases especially AMD. It is an important cause of blindness and low vision, in Nigeria.[2–4] Other workers found the disease to be uncommon in people of African descent.[5–7] All the patients seen were Nigerians. The early type of AMD with drusens and pigmentary changes predominates. Because of the difficulties in making diagnosis of occult subretinal neovascularization, the prevalence is likely to be higher. Futhermore, the problems of making accurate retinal diagnoses owing to lack of trained retinal surgeons coupled with inadequate facilities made management of AMD and other retinal diseases an uphill task. Retino-choroiditis occurred especially in young adults. More than half of the patients with this condition were below 40 years. Complications noted were vitreoretinal fibrosis and cataract. Diabetic retinopathy is a significant cause of posterior segment disease in this study. As the society urbanizes, the prevalence of diabetes increases. In a developing country such as India, diabetes mellitus is a significant cause of blindness.[8] Laser treatment combined with tight control

Table 1 Retinal diseases in Ibadan, Nigeria

Diseases/age	*0–9 years*	*10–19 years*	*20–29 years*	*30–39 years*	*40–49 years*	*50–59 years*	*60 + years*	*Total (%)*
Age-related maculopathy	—	—	—	—	—	9	59	68 (17.2)
Other maculopathies	1	5	15	8	12	13	19	73 (18.4)
Retinochoroiditis	1	6	18	17	7	4	4	57 (14.4)
Retinitis pigmentosa	4	4	11	6	8	6	5	44 (11.1)
Diabetic retinopathy	—	—	—	1	7	11	11	30 (7.6)
Retina detachment	—	2	4	6	7	4	8	31 (7.8)
Couching + vitreoretinal complications	—	—	—	1	4	6	13	24 (6.1)
Vascular occlussion	—	—	1	1	5	2	11	20 (3.1)
Hypertensive retinopathy	—	—	—	2	2	2	12	18 (4.6)
Vitreous haemmorrhage	—	—	2	3	—	1	6	12 (3.1)
Sickle retinopathy	—	—	5	2	1	—	—	8 (2.1)
Others	4		2	1	—	2	1	10 (2.5)
Total	10	17	58	49	53	59	149	395 (100.00)

of diabetes will prevent retinal detachment, which will need a more invasive treatment. Early detection and detailed examination by a trained vitreoretinal surgeon will improve visual prognosis after retinal detachment surgery. Surgery for retinal detachment is very effective in developing countries such as India and East Africa.[9] A significant number of patients also presented with retintis pigmentosa, retinal vascular occlusions, sickle cell retinopathy, couching, intraocular foreign body, and pseudophakos dislocated into the vitreous (see Table 1). It is likely that the incidence of vitreoretinal disease will increase, with the increasing number of cataract surgery causing more posterior segment complications.

The need for vitreoretinal intervention was assessed. One hundred and forty-two (35.9%) cases needed laser therapy, 82 (20.8%) cases needed vitreoretinal surgery such as scleral buckling and vitrectomy whereas 158 (40%) needed further vitreoretinal investigations like flourescein angiography and fundus photography that were not readily available. The need for laser treatment was assessed. About one-third of the patients require laser treatment, especially in patients with diabetic retinopathy, vascular occlusions, and sickle cell retinopathy. The facility is not available in the hospital, hence referral to hospitals where the facilities are available. It is likely that most of these patients would find the cost of treatment in the private hospitals unaffordable. In Nigeria, cost is a barrier to hospital presentation.[10]

A vitreoretinal centre manned by a trained vitreoretinal surgeon is desirable in the University College Hospital, Ibadan, a tertiary centre involved in training. The general ophthalmologist will benefit from a sponsored training in vitreoretinal surgery. He will in turn train residents and other general ophthalmologists. Vitreoretinal equipments though expensive can be made to be cost effective when high volume treatments are carried out.

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Sir,

Bilateral big-bag intraocular lens implant for highly myopic eyes

Cataract surgery in highly myopic eyes presents several challenges to the surgeon, ranging from choosing an appropriate intraocular lens, potentially complicated surgery, to possible postoperative complications. We here report the results of phacoemulsification with implantation of a negative power Big Bag™ posterior chamber intraocular lens (IOL) implant in both eyes of a patient.

Case report

A 65-year-old Asian lady with high myopia and best-corrected visual acuities of OD 1/60 (−18.0 DSph) and OS 6/60 (−19.0 DSph) was seen in our clinic. She was noted to have bilateral posterior subcapsular cataracts and fundii showed posterior staphyloma, which was confirmed by ultrasound examination. Biometry revealed an axial length of 31.50 and 31.72 mm in right and left eyes, respectively, and predicted IOL power (SRK/T formula) −12 D to achieve postoperative emmetropia. The unusual IOL power prompted us to use the Big Bag™ IOL (SD Ophthalmics), a single-piece foldable acrylic lens (overall diameter 10.35 mm) with a meniscus optic of 6.5 mm diameter and three windowed flat haptics available in 0.5 D steps from −10 to +13 D (Figure 1). The extended Tri-Haptic configuration offers 240° contact arc supporting the zonules (Figure 1).

Phacoemulsification was performed (right eye followed by the left eye) through a 2.8 mm clear corneal incision. IOL (−10 D) was implanted in the capsular bag after enlarging the incision to 3.2 mm. The capsulorrhexis was 5 mm in diameter and viscoelastic was aspirated with simcoe cannula through the sideport. Lens folding and implantation were difficult owing to the thick edge, and forceps was used instead of the injector. The surgery and the postoperative course remained uneventful. The patient was followed for a year and the IOL maintained excellent centration with good coverage of the pupillary area (Figure 2). The best-corrected postoperative visual acuities were OD 6/12 and OS 6/18. The final refractive error was within 1 D of the predicted refractive error.

Figure 1 Single-piece foldable acrylic lens with three windowed flat haptics.

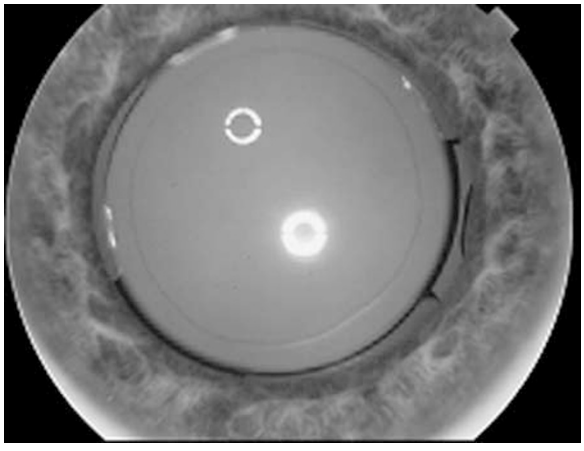

Figure 2 Well-centred IOL with excellent coverage of the pupillary area.

Comment

Negative power IOL implants following cataract surgery have been reported using the conventional two-haptic IOL design.[1–4] The larger diameter of the capsular bag seen in highly myopic eyes[5] led us to believe that the three-haptic design would prevent lateral displacement of the IOL and a larger optic diameter would minimise