EDITORIAL

This issue of 'Eye' is devoted largely to selected papers given at the Oxford Ophthalmological Congress held in July 1989. For various reasons, not all the papers given at the Oxford meeting are to be found here and indeed other papers have been interspersed to give better continuity.

One important subject which was aired at the Congress and which perhaps is not so well represented in these pages, is corneal grafting. The corneal graft is one of the most common transplant operations and is an important sight saving procedure. The success rate is now recognised as being between 80% and 90%. The number of graft operations has been steadily rising both here and in the United States. Across the Atlantic, the number of corneal transplants far exceeds that of all other organ transplants and tissues combined. This would not appear to be the case in this country. In 1988, 1270 corneal graft operations were notified to the United Kingdom Transplant Society (UKTS) whereas in 1987 the total reported figure was 961. It is interesting to note that the total number of corneal transplants done in the United States in 1987 has been put at 35,930, and yet the population of the United States is only about five times that of the United Kingdom. The increase in the number of grafts performed in recent years no doubt reflects to some extent the wave of bullous keratopathy cases which have followed the use of some earlier types of intraocular implant.

This wave of cases must surely now be passing and yet the number of grafts is still increasing and so is the waiting list for graft operations.

The traditional method of short term eye bank storage allows donor material to be used within two to three days of collection. This time limit gives rise to considerable difficulties in regions where donors are less plentiful. Patients may have to wait for an undue length of time and then have to be telephoned for immediate admission. This can often prove inconvenient for the patient as well as the operating theatre team. The use of organ culture was introduced in Bristol in 1986 and subsequently in Manchester. It allows storage for periods of up to 30 days by organ culture at 34°C. This has allowed provision of a service whereby the donor cornea can be ordered for a named patient at a prearranged time. Material is also always available for emergency grafts anywhere in the United Kingdom. The question of the relative success of graft operations following this method of storage has yet to be fully answered but there is no doubt about the increasing popularity of the method. In 1986, 59 out of 770 reported grafts used cultured material whereas in 1988, 979 out of 1270 reported grafts used cultured donor material. To date there does not appear to be any significant difference in the results obtained using either cultured corneae or those stored at 4°C for four days.

But if we now have more efficient donor services using whatever storage method, is the supply of donor material going to be adequate in the future? The waiting list for UKTS material has increased threefold between 1985 and 1988 but the number of grafts done has only doubled.

Improvements have occurred in the method of obtaining material such, for example, as the use of trained technicians in addition to medical staff to perform enucleations. In spite of this more potential donors are needed. The use of the driving licence as a donor card might be extended. The better availability of tissue typed material might be achieved by closer liaison with our colleagues in other specialities concerned with tissue transplants. Finally public awareness and understanding of this type of graft needs to be improved.

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