Editorial

Not enough cataract surgeons

Just over a year ago an editorial entitled 'Blindness in two worlds' was published in the *BJO*,¹ and we make no apology for returning to this important subject again, this time in response to articles on blindness and eye disease in Kenya and India. The previous editorial dealt with the contrast between the results of a survey of blindness and low vision in The Gambia² and two surveys of blindness in the United Kingdom – in Bristol and in Leicester.^{3,4} As would be expected, there were considerable differences, the burden of blindness being heavier in the African study and the causes being differently distributed, so that, for example, cataract and corneal disease accounted for the majority of African blindness whereas in the UK macular disease was the chief aetiological factor.

So what is new about the present studies? Sad to say the answer is not very much.

The Kenyan study method, described as random cluster sampling, was similar to that used in The Gambia, though the total number of people examined was greater, at 13 803 compared with 8174 in The Gambia. Fairly substantial differences in prevalence for the principal causes of blindness show up in the figures. For example, cataract accounts for 36% of all blindness in Kenya compared with 55% in The Gambia, and corneal scarring, with or without trachoma, for about 15% compared with 37%. In contrast to The Gambia, where retinal disease made hardly any impact on the figures, Kenya has approximately as many blind from retinal disease as corneal, rather a surprising finding. Both studies report substantial visual impairment due to refractive error, a good proportion of which is probably uncorrected aphakia.

In spite of these differences, which are probably due to a variety of circumstances, the total of blindness comes out at exactly the same figure for each country as a whole, 0.7% of the population. One is getting used to this figure for blindness in Third World countries, but it is terrifyingly high if compared with the 'developed' world at around 0.2%.

The introductory paragraph to the current Kenya paper sets out the problems very well, though one is surprised to read the claim that blindness rates in poor countries are often '10 to 20 times those in industrialised nations'. Even if we reduce this somewhat to an average difference of, say, three to four times the rate, there is clearly a huge task ahead if the difference is to be reduced.

As is confirmed in the Indian study cataract is the main problem. Although there is a possibility that the burden of cataract may be reduced in future as aetiological factors

become gradually better understood, such hopes certainly do not apply to the immediate future and cannot apply to those already suffering from cataract. As noble initiatives to enable the underprivileged and the undernourished to survive in spite of war, drought, and famine are introduced by the numerous relief agencies and energetic individuals devoted to this cause, so does the number of cataracts, present and future, increase as the populations increase. And in spite of the ever swelling chorus of (mostly ill informed) criticism of orthodox medicine there is little dissent from the present view that the only way cataract can be effectively treated in 1990, and probably for at least the rest of the decade, is by surgery. Virtually anyone concerned with world blindness agrees with this opinion; the difficulty is to organise matters so that the surgery can be made available for the huge number of people who need it. The International Eye Foundation and the Royal Commonwealth Society for the Blind are examples of two organisations devoting time and resources to the problem, but there are many others too numerous to name which are also trying in various ways to improve the situation.

When we were young the cataract problem was mostly a matter of 'how to do it' to get the best and most reliable result. The means to these ends consisted of learning the appropriate techniques and acquiring by practice the requisite manual dexterity. We were also, it has to be admitted, usually worried to a greater or less extent whether we would ever arrive at the position of consultant in the UK (or its equivalent rank in other countries), so that there would be an opportunity to perform cataract extractions on our own patients. The thought that there were millions of patients scattered about all over the world worrying about whether there would ever be an ophthalmologist available to remove their cataracts never entered our heads. We may have to rethink our attitude now. As a start it could well be useful, and I am sure this or something like it has been suggested and even practised many times before, for training authorities to consider an overseas elective as, if not compulsory, at least highly desirable.

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- 1 Smith RJH. Blindness in two worlds. *Br J Ophthalmol* 1989; 73: 81.
- 2 Faal H, Minassian D, Sowa S, Foster A. National survey of blindness and low vision in The Gambia: results. *Br J Ophthalmol* 1989; 73: 82–7.
- 3 Grey RHB, Burns-Cox CJ, Hughes A. Blind and partial sight registration in Avon. *Br J Ophthalmol* 1989; 73: 88–94.
- 4 Thompson JR, Du L, Rosenthal R. Recent trends in the registration of blindness and partial sight in Leicestershire. *Br J Ophthalmol* 1989; 73: 95–9.