BRITISH JOURNAL OF OPHTHALMOLOGY

Editorial

Cataract management

The changes which have taken place in cataract management over the past 20 years are profound but are by no means complete. This issue sees the publication of a survey of current practice in cataract management, for both surgery and anaesthesia, by Hodgkins *et al* using data obtained from consultants in England and Wales during the first half of 1991.

Such a survey provides a useful source of information about what is going on across the country so far as this ophthalmic 'bread and butter' activity is concerned. In addition, it allows each of us a glimpse of how our own clinical values and actions match with those of our colleagues. No laurels are awarded but there is hopefully some spur to those of us who might be thought to be lagging behind and so depriving themselves and their patients of widely agreed advantages.

There are, necessarily, many questions left unanswered. The design of surveys of this kind is a balancing act between the amount of information obtainable and the rate of effective cooperation by the contributors. A return rate on this occasion of 86% must be considered creditable, but at the expense of all sorts of other things it may have been useful to know. Nevertheless, interesting matters are brought to light and bear further discussion.

Extracapsular surgery is now the norm. Any lingering idea that such techniques could be mastered only after a thorough grounding in intracapsular surgery has clearly been abandoned. That even a small number of surgeons continue positively to favour intracapsular surgery and do not consider intraocular lens implantation as routine is a surprise. One wonders how they are able to resist the pressure of patient demands quite apart from being able to reject (assuming they have considered) the copious evidence in favour of alternatives.

A similar small number of contributors are found on 'the frontier' with only 2% practising phacoemulsification despite, as the authors point out, the availability of the techniques for many years. Judging by the popularity of the well filled courses on this subject over the last 18 months I predict the emergence of a different picture at the next survey. This is not the place to consider the merits of small incision techniques, but I suspect they will prove irresistible.

The authors of this survey report have concentrated particularly on the role of anaesthesia in cataract management. Despite the fact that local anaesthesia was used frequently by only one fifth of their respondents, the burden of discussion has fallen so heavily on this subject one cannot escape the conclusion that the authors are using their findings willy nilly to grind an axe of their own devising. Wong and Steele, with their survey in 1985,¹ did much the same with

regard to extracapsular surgery and it will be interesting to see whether time will reward these authors in a similar manner. The issues, however, are not so straight forward.

General anaesthesia continues to enjoy some inherent advantages for the cataract surgeon – guaranteed akinesia and peroperative control of ocular physiology for instance. Besides, general anaesthesia is making advances of its own with the introduction, for example, of laryngeal masks and relaxing agents from which patients can enjoy an almost instantaneous recovery. In our own hospital both local and general anaesthesia are deemed suitable for the management of day cases. These two issues must now be separated for consideration of their advantages in patient management. Local anaesthesia must stand or fall on its own value in assisting the surgeon to achieve the desired clinical outcome.

There are yet more complicating factors which have to be considered. Patients can succumb to the exigencies of local anaesthesia, particularly if it is a technique reserved for the least fit, or accompanied by the administration of intravenous sedation. Regulations now advocated by the Association of Anaesthetists involve the introduction of a measure of supervision and monitoring, not only during the surgery but from the start of the administration of the anaesthetic, be it local or general. Such arrangements will have, as yet, uncalculated cost implications. Surgeons will not be in a position to resist these developments, designed as they are for the greater safeguard of the patient, without exposing themselves to the risk of accusations of impropriety, or even professional negligence. The days when ocular local anaesthesia can remain the exclusive province of the ophthalmologists are numbered. The interest of our anaesthetic colleagues in this field really needs to be welcomed rather than resisted.

Speed and costs were considered relatively unimportant by the respondents to this questionnaire. They are, however, very important having a direct bearing on the efficient use of resources. Reorganisation of the National Health Service with its emphasis on fiscal matters, together with the introduction of regular audit, will combine to lift the profile of these factors and their influence on our activities. Failure to appreciate this may carry heavy penalties.

These surveys reveal a fascinating spectrum of clinical behaviour and attitudes with aggressive pioneering at one end and seemingly willful intransigence at the other. I look forward to the next analysis of this subject with great interest, but not, please, for several more years.

ARTHUR D Mc G STEELE

1 Wong D, Steele AD. A survey of intraocular lens implantation in the UK. *Trans Ophthalmol Soc UK* 1985; 104: 760–5.