

Editorial: Temporary balloon buckle

In this issue of the *BJO* H Lincoff and colleagues report their experience with a temporary balloon buckle in the treatment of 100 cases of aphakic retinal detachment, mainly following intracapsular cataract extraction. Relatively simple cases were selected, and those with extensive periretinal membranes or large breaks were excluded.

The authors of this paper have once again championed the cause of performing as conservative an operation as is consistent with success by favouring the use of a local buckle in this relatively simple type of aphakic retinal detachment. This is particularly useful comment to make, because many surgeons tend to favour the use of the encirclement procedure routinely in the management of aphakic retinal detachment, even in the simple type of cases where retinal holes can be found and the retina is free of periretinal fibrous tissue. This tendency has arisen because of the erroneous concept that aphakic retinal detachments are usually associated with multiple small holes widely scattered throughout the post-oral region of the eye and that these holes may be missed if local procedures are used. Most of the more serious complications of encirclement, such as the various anterior segment ischaemic syndromes and a poor cosmetic appearance, due to ptosis and enophthalmos, are caused by high encircling buckles and excessive constriction of the globe. Appreciation of these complications has led the retinal surgeon over the

years to take care not to produce an excessively high buckle. In spite of these precautions, however, the height of the eventual buckle is not always easy to control accurately, and even if the buckle height is not excessive some postoperative complications may still be encountered, such as lasting postoperative pain. The encirclement procedure has also been advocated in the belief that it may contribute to the prevention of redetachment at a later date, but there is very little evidence to substantiate this view.

In this series, although permanent reattachment was achieved in only 70 patients following the initial procedure, the authors point out that operative failure often helps to define the true position of the retinal holes. The balloon procedure could then be followed by conventional buckling operation. The procedure itself leaves a quiet eye, inflicting minimum trauma and very little disturbance, particularly in the form of interference with muscle balance. The relatively high incidence of failure with the local buckle balloon procedures has dissuaded most retinal surgeons from adopting this type of procedure routinely, but, whether or not the surgeon prefers to use the balloon or conventional full-thickness scleral buckling, the authors have made a powerful case against routinely encircling the aphakic eye, particularly when the more simple types of aphakic retinal detachment are encountered.

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