

Editorial: Aphakic detachment: a thing of the past?

Ophthalmologists trained in the late 1960s and thereafter can have no idea how pessimistic we who were trained earlier felt about aphakic detachment. So far as cataract surgery was concerned it was the flaw in the jewel, the great let-down. One was aware that it was unlikely to happen after an undisturbed extracapsular extraction, but with the perfunctory methods of capsulectomy and rudimentary attempts at anterior chamber 'washout' of those days not many extracapsular extractions escaped later capsulotomy, with its well known risk of precipitating retinal detachment; and the perfect intracapsular operation, with its beautiful black pupil and visual acuity correcting to 6/5 within a few days, was even more likely to precipitate detachment.

To make matters worse, although surgery for detachment was beginning to make great strides with the advent of scleral indentation procedures and the use of intraocular air (although vitrectomy was yet to come) one almost insuperable difficulty remained. The ophthalmologist could not see properly into the eye. Anyone who has tried to localise a hole with a direct ophthalmoscope after the removal of sub-retinal fluid (or even before it for that matter) will know what I mean. In contrast to the well illuminated hills and valleys and rivers and streams, albeit sometimes wreathed in mist, that one sees through an indirect ophthalmoscope, the direct ophthalmoscope will reveal a gloomy cavern with slate-grey walls looming over all and blackness in the depths. A good view of the hole or holes and of their relation to any diathermy, cryo or scleral indentation is almost impossible, and, as for air, that blacks out everything. If the situation was as bad as that with ordinary detachments it was ten times worse with aphakia, especially where there was much residual capsule.

Things are much better now. With all the present-

day techniques at his disposal the detachment expert expects to replace the vast majority of retinæ, albeit not always at the first attempt or with perfect visual results. But an eye with even poorish vision and a flat retina is infinitely to be preferred to one with detachment. Better still if the detachment does not occur in the first place, and this is where the article by Gray and his colleagues in this issue comes in. They have shown beyond reasonable doubt that a substantial reduction in aphakic detachment has occurred on the switch from intracapsular to modern extracapsular extraction. It would thus seem that a bonus has been added to the already high dividends resulting from the intraocular lens (IOL).

Before the advent of the YAG laser capsulotomy it was somewhat unusual for capsulotomy to be performed in eyes with an IOL. It could be done but was distinctly awkward, as a choice had to be made between an entry via the pars plana or a rather difficult approach through a peripheral iridectomy, if there was one, or even by pushing the edge of the dilated pupil aside and slipping the Ziegler's needle past the edge of the IOL.

Most surgeons would perform capsulotomy only if a really serious visual deterioration developed due to colonisation of the posterior capsule with metaplastic lens cells, so-called capsular thickening. However, with the advent of the YAG laser capsulotomy is now easier in IOL cases than in simple extracapsular cases, since the IOL helps to focus the laser beam. But a price apparently has to be paid. Gray and his colleagues have found that in the post-YAG years the incidence of detachment in such eyes rose slightly. However, it seems that even with a capsulotomy an eye with an IOL is safer from detachment than an intracapsular eye.

REDMOND SMITH