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UVEITIC CATARACT

Dr Jagat Ram, Chandigarh

- Several factors affect the outcome of uveitic cataract, such as uveitic diagnosis, pre-existing structural damage (cornea, optic nerve and macula), perioperative management of inflammation, surgical technique and management of postoperative complications.
- Preoperative evaluation also involves assessment of visual potential; assess cornea, cataract, optic disc and macula.
- Intraocular lens (IOL) implantation is not contraindicated if there is adequate control of inflammation. Avoid silicon IOLs and anterior chamber intraocular lenses (ACIOLs).
- Juvenile idiopathic arthritis (JIA), pars planitis and chronic diseases (e.g., sarcoidosis) resistant to remission are risk factors for IOL intolerance.
- Factors limiting visual outcomes include glaucoma, hypotony, pupillary membranes and cystoid macular edema.
- Phacoemulsification with in-the-bag implantation of IOL is the procedure of choice for a patient with well-controlled uveitis.
- Preoperative and postoperative control of inflammation is important. Preoperatively, the eye should be quiet for 3 months. Meticulous surgical technique is of utmost importance.

AFTER THE SURGERY – VISUAL REHABILITATION OF PEDIATRIC APHAKIA

Dr Varshini Shanker, New Delhi

- Managing children with congenital cataract is a complex long-term process, which requires considerable input from parents, who are responsible for the occlusion and optical correction and long-term follow-up.
- IOLs are not recommended to be implanted in children <6 months (Infant Aphakia Treatment Study [IATS]).
- Spectacles provide satisfactory correction for bilateral aphakia. But lenses scratch and frames break easily, are difficult to replace due to expense and unavailability and they are not suitable for monocular aphakia.
- Contact lenses are the best optical device in postoperative unilateral and bilateral aphakia. But, there are issues such as noncompliance, difficulty in insertion and removal, expensive, easily lost, poor ocular hygiene, follow-up difficult due to cost and travel distance.
- Foldable IOLs in the sulcus are associated with a high rate of decentration and dislocation.
- About 50% of all children with cataracts develop strabismus. Early onset unilateral cataracts have the highest risk of strabismus.
- Strabismus usually requires surgical management. Children with better vision and binocularity have better stability of ocular alignment.
- Rehabilitation is combined and coordinated use of medical, social, educational and vocational measures for training the individual to the highest level of functional ability.

SUTURELESS SFIOL

Dr Indranil Saha, Sitapur

- Causes of aphakia are trauma (lens absorption, posterior dislocation), surgical aphakia (most common), heritable disorders associated with posterior dislocation of lens such as Marfan's, homocystinuria and congenital absence of lens (rare).
- Complications of aphakia are: High hypermetropia, anisometropia, ring scotoma, loss of protection from UV rays, cystoid macular edema and retinal detachment (RD); risk of amblyopia in pediatric age group.
- Treatment options are refractive correction, in sulcus IOL, ACIOL, iris claw IOL, SFIOL (sutured and sutureless).
- Sutureless: Glued, Yamane's technique, modified Yamane's technique, CMT flex Swiss fold SFIOL.
- Aphakia can be conquered. IOL placement is desirable.
- The best technique is a combined decision between the patient's ocular condition and the surgeon.

RETROPUPILLARY IRIS CLAW IOL: IT'S EASIER THAN IT LOOKS

Dr Karan Bhatia, Sitapur

- Iris claw IOL is a safe and faster backup to manage aphakia.
- Indications include aphakia (surgical, traumatic lens dislocation, congenital disorders like Marfan's), large zonular dialysis.
- Contraindications include acute uveitis, rubeosis iridis, excessive iris chafing posterior segment pathologies like CME, choroidal neovascular membranes (CNVM).
- Iris claw IOL prevents primary aphakia and precludes the need for second or multiple surgeries. It also avoids delayed visual recovery and awkward situation with the patient.
- Advantages of iris claw IOL: It is technically easier, fast, cheaper lens, minimum skill required, easily reproducible, requires minimum instrumentation and no retina backup is required.

THE IMPACT OF THE COVID PANDEMIC ON TRAINING

Prof Bernie Chang; President, RCOphth

- Due to COVID, surgical waiting lists have been adversely affected. In 2021, approximately 3,00,000 patients are 52+ week waiters; around 5 million patients on the waiting list. There are an additional up to 4 million patients who haven't been referred yet.
- In the first wave, the College developed an immediate response to the pandemic. It set up a COVID-19 response team, worked across the NHS organizations and government representatives via the Academy of Royal Colleges, service guidelines with initial focus on urgent care (emergency and sight threatening), recommendations for prioritizing care, guidance on PPE and safe clinical environment and restoration of services, training and research.
- Rethink delivery to reduce need to attend hospitals (use of telephone and virtual technology to conduct appointments), prioritization of ophthalmic procedures, set up alternative care options for patients out of hospital settings, work with local charities to ensure that vulnerable patients are not excluded, communicate effectively with patients, families and carers to avoid DNAs.
- Develop and adopt new safe and efficient ways of working, increased collaboration with optometrists, nurses, health care assistants, orthoptists and Techs (improve training), hope for normality (vaccination programs, continued COVID testing and safety measures – end of overcrowded cities).
- In the RCOphth OTG Survey of trainees in August 2020, 725 felt that they could not complete training objectives; 47% had an exam they planned to sit canceled.
- Less busy clinics: Make every patient count, more time to observe a consultation.
- Trainers and trainees should seize surgery opportunities: Less cases on lists, more time to teach and review surgery/videos, ensure trainees actively watch senior's surgery, discuss surgical techniques, canceled cases use simulation models with supervision.
- Be creative; use all opportunities to train. For this use any appropriate setting (remote/virtual delivery of education and training).

GONIOSCOPY FOR ALL: INCORPORATING GONIOSCOPY IN ROUTINE EXAMINATION

Dr (Col) Madhu Bhadauria, Sitapur

- Gonioscopy is the most neglected test in OPD.
- Glaucoma management is totally dependent on gonioscopy.
- Angle of AC is not visible on slit lamp without aid.
- The mindset that it is time consuming, cumbersome and not essential is a major hurdle in its use.
- Most of the challenges are based due to inability to understand the value of gonioscopy as to how it can help.
- Gonioscopy should be done in all >35 years age, young adults with F/H of glaucoma, H/o trauma, steroids, symptoms suggestive of glaucoma.
- Gonioscopy should be done at first diagnosis in all suspects, pre- and post-PI, every 6 months in stable angle closure, whenever fluctuation/poor control.

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