

INTRAOCULAR LENS IMPLANTATION FOR CATARACT FOLLOWING LEPROSY

Editor,

Cataract is the commonest cause of visual loss following leprosy,¹ which is fortunate as it is reversible by surgery. The recent congress in Beijing gave a chance for ophthalmologists to interact, and the following proposals are directed at this group and at programme managers. But first it should be stressed that eye doctors are not themselves the main actors in preventing visual loss, though their support is vital. The pillars of prevention are firstly prompt starting of MDT, and secondly training of front-line workers to detect, treat and refer complications before they become blinding.

However, even with good prevention, many people who have had leprosy will develop cataracts,

mostly just age-related cataracts like the general population, but some complicating uveitis. Nowadays, the standard of care for cataract has become intraocular lens (IOL) implantation even in resource-poor countries.² To date in leprosy patients, simple extraction and spectacle correction has been the norm.³ It is time that they too routinely benefited from IOLs. A few doctors have been doing this for some years, but surprisingly it is only this year that the first reports have appeared.^{4,5} These initial results are very encouraging even in high risk cases,⁶ but even so caution is sensible. It seems that introduction of IOLs in tropical countries has often not been smooth, with far too many bad outcomes. This is partly because of lack of expertise and difficulty of follow-up, but there may also be racial differences (for example, the African eye appears to react more vigorously). To this now is added the leprosy factor, with many MB cases (and some PB) having had uveitis. Probably all MB cases have mycobacteria in the anterior uvea, often in large numbers and for long periods.⁷ The use of IOLs following other forms of uveitis is now becoming widely accepted, but even so caution is needed despite the good initial results reported after leprosy.

In the coming decades, many of the millions now released from treatment will need the operation, so I think it is important that a careful audit/study should be done now to examine the outcome, and to be forewarned of any complications. I suggest that this should be done in different countries using the same protocol so that experience can be shared. The study should be done under the following conditions (which will involve substantial extra work):

1. Surgeons should have completed their learning curves and be getting consistent good results under field conditions.
2. Outcomes should be compared with a control group from the general population.
3. The database should be detailed, with pre- and postoperative features, and also details of the type, duration and treatment of the leprosy; this will enable the contribution of leprosy factors to be evaluated if complications occur.
4. There must be adequate follow-up of at least 1 year, which will necessitate home visits.

What do other ophthalmologists feel about this?

The other blinding complication which involves eye doctors is permanent lagophthalmos. Which operation should be done and when, is, however, quite unclear.⁸ Some series with good results were presented in Beijing but the underlying uncertainty was not addressed. It is surely time that doctors who frequently operate for this got together and brought it also into the era of evidence-based care, though this is going to be more difficult than for cataract.

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