

History of Cataract Surgery and Practical Choice in Black Africa

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Although we do not have written document such publications, it is accepted that the art of healing cataract dates back to ancient Egypt. Physicians of the time practicing couching that allowed patients to recover vision, certainly not perfect due to non-correction of hyperopia, but it allowed them to remain socially active [1].

Between 1900 and 1970 intra capsular surgery is the gold standard in cataract surgery. Compared with the couching, inflammation related to lens masses had regressed considerably. The contribution of glasses significantly improved patient vision [1,2]. 1948 had marked the history of cataract surgery with the laying of the first intraocular lens (seen the 25/05/2018: <http://www.aaofoundation.org/what/heritage/exhibits/online/cataract/antiquity.cfm>).

From 1980 to 1990 the manual extra capsular surgery had supplanted intra capsular. The frequency of the post-surgical retinal damage, such as Yrvin Gass' syndrome, was reduced as well as the optical aberrations due to the aphakia glasses [2,3].

In the early 80s phacoemulsification had completely supplant the extra capsular. It has become the gold standard in rich countries [2-4]. But this technique requires costly and sophisticated equipment. It's not accessible to the vast majority of Africa patients who live under the poverty line, without social security and health insurance. In some African families children and parents must sometimes alternate meals (children eat on Monday, parents waits Tuesday). It's true that black Africa should not margins of technology. But Africa must also be aware of its weaknesses. Want to impose phacoemulsification such African gold standard in cataract surgery is in our humble opinion a mistake. For some African countries this is currently possible, but for the vast majority of African countries between the tropics of Cancer and Capricorn the situation is difficult.

The objectives of the WHO initiative "Vision 2020" can only be achieved if a simple, cheaper than and as effective as phacoemulsification is not adopted. We believe that the Small Incision Cataract Surgery (SICS) may be an alternative. It does not require suturing, therefore less astigmatism and infection risk. SICS is fully manual, does not require sophisticated equipment, and therefore suitable for large cataract surgery campaigns in rural areas where the majority of Africans live. About 15 minutes are enough to make the SICS. Finally, the difference in visual acuity figures is not statistically significant compared to phacoemulsification [4-6].

Some countries cannot even give drinking water to their entire population. To think of phacoemulsification today to treat the cataract of these same populations seems incongruous.

Conflicts of Interest

None.

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