Panel Discussion on Cataract Extraction

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Members of the panel: Prof. J. Francois, Dr. A. Th. M. Van Balen,

Dr. J. Worst and R. J. W. N. Hoppenbrouwers Introduction: Film by Dr. C. D. Binkhorst on an extracapsular cataract extraction with lens implantation

Iridectomy, before or after cataract extraction: The first would cause less suction-cup activity of the iris on the lens and of the lens on the vitreous body. Iridectomy after extraction has the advantage that, due to the narrower pupil, the iris is more stretched and localization and size of the iridectomy is easier. Everybody is convinced that an iridectomy should always be done to prevent pupillary block. Iridectomy should also be carried out in congenital and juvenile cataract.

Source, cause and prevention of intraocular infections after cataract extraction: The incidence of infection is low, less than 2%. 50% are mycotic, and this can even be airborne. Allan [Arch.OphthaL] mentions for 1950 a rate of 11.6% and after 1950 a rate of 2.1%. Of those, 50% are Pseudomonas, 25% Staphylococcus aureus. Most operators do not give an antibiotic subconjunctivally; only in cases with much manipulation, or in cases of intraocular lens implantation would the use of a prophylactic antibiotic appear to be indicated.

Causes of the pupil not being round after cataract extraction: Most speakers see this more frequently after cryoextractions. Causes are: iridectomy, prolapse of the vitreous, and particularly also as a result of catching of the iris retractor in the pupil. Of course, this phenomenon is also observed after accidental freezing fast on the pupillary border.

After cryoextraction, hernia of the vitreous body (mushrooming) in the anterior eye chamber is more frequently observed.

Corneoscleral sutures: These are tied end-to-end by most speakers; if perlon is used, the knots are twisted into the sclera. If a continuous suture is used, at least three supportive sutures should be applied. Virgin-silk sutures cause undoubtedly more reactions than perlon or vanadium sutures.

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(6) Preoperative hypotension: A number of speakers prefer 250 or 500 mg Diamox 1 h before the operation (duration of action: 10-190 min). Objections against this are sometimes raised by the internist or anesthetist. In addition to this, a number of speakers prefer digital massage for 1 or 2 min. Adrenaline is sometimes also injected retrobulbarly, but only in adapted general anesthesia. A disadvantage of this is the risk of a possible retrobulbar bleeding.