

# Unsung Heroes

**T**his past April, I had the unique opportunity to perform high-volume phacoemulsification in a Nepalese cataract camp through an invitation from American ophthalmologist, Geoffrey Tabin. Geoff founded the Himalayan Cataract Project in 1994 with the legendary Sanduk Ruit, MD, of Nepal. Their worthy mission is to eradicate cataract blindness in the Himalayan region. Dr. Ruit and his staff from the Tilganga Eye Center conduct regular charitable cataract camps throughout mountainous Asia, and I joined one near Kathmandu.

As I discuss elsewhere in this issue, manual, sutureless, small-incision cataract surgery (SICS) is the most cost-effective and appropriate technique for addressing the backlog of advanced mature cataracts in the developing world. Manual SICS is fast, inexpensive, and completed through a sutureless, temporal incision that minimizes surgically induced astigmatism. Although centers such as Tilganga had previously published their outcomes with this technique, no one had conducted a study directly comparing manual SICS with phacoemulsification. The question was, how different would the outcomes be in a cataract camp population?

I was recruited to be the phaco surgeon for this prospective study, and Advanced Medical Optics, Inc., generously supplied the phaco machine, viscoelastics, and foldable IOLs. More than 100 patients in the cataract camp were randomized to receive either phacoemulsification with a foldable IOL implanted by me, or manual SICS with a PMMA IOL implanted by the acknowledged Himalayan master of the technique, Dr. Ruit. Although it may have resembled the TV cooking competition, Iron Chef, it was a rare opportunity for a Western surgeon to perform high-volume phacoemulsification in a cataract camp. Because patient turnover occurred in the time that it took to rinse our gloves with antiseptic and prep the next eye, we completed the study in 1.5 days. While the final results have not yet been tabulated for publication, I can attest to the difficulty of performing phacoemulsification in a camp setting with a very high prevalence of mature white and brown cataracts. An unexpected difficulty for me was the poor corneal visibility in this population where trachoma is quite common. Overall, manual SICS was significantly faster, and I could appreciate first-hand what a clever solution this technique represents for the developing world.

When you read his autobiography, *Blind Corners*, you quickly realize that Geoff is not one to back off from a challenge. Aside from his ophthalmic accomplishments, Geoff is a real-life adventure hero who was formerly among the



Geoff Tabin, MD, and the author, Nepal, April 2005.

world's elite mountain climbers and the fourth person to climb the Seven Summits. He twice dropped out of Harvard Medical School to take part in the only two attempts ever made to scale the unclimbed East face of Mount Everest.

While in Nepal, I convinced Geoff to be the section editor for a new regular column in *Cataract & Refractive Surgery Today* on international humanitarian ophthalmology. Many dedicated American ophthalmologists annually travel abroad on volunteer missions to assist, mentor, and teach ophthalmologists in developing countries—efforts that are for the most part unseen and unsung here in the US. Because the greatest challenge for our field is the huge backlog of cataract blindness in developing countries, I think it is important that a publication for cataract surgeons highlight and update these noble humanitarian efforts. To initiate this effort, we have devoted the minifocus of this issue to an overview of world blindness, for which Geoff enlisted a blue-ribbon panel of international experts. In this issue and in the months ahead, let's momentarily forget about declining reimbursement and administrative burdens and celebrate these unsung efforts about which our profession should be most proud. ■

*David F. Chang*

David F. Chang, MD, Chief Medical Editor