

## Relevance of manual small-incision surgery in today's private practice setting

Manual small-incision cataract surgery (MSICS) has been around for more than two decades and forms the bulwark of cataract surgery training in Indian ophthalmology residency programs at present.<sup>[1]</sup> Its equivalence with phacoemulsification has been proven by numerous randomized control trials and meta-analyses.<sup>[2,3]</sup> It is the most common type of cataract surgery performed under the National Programme for the Control of Blindness and Visual Impairment and by community eye centers, charitable hospitals, and non-governmental organizations where high-volume and high-quality surgery is needed. MSICS, with its frugal need of equipment, relatively lesser time (suturing would consume half the surgery time in conventional extracapsular cataract extraction), and the lesser cost in terms of consumables, equipment, and manpower, has a distinct advantage.<sup>[4,5]</sup>

However, in a private practice setting where the patient-consumer is the king, phacoemulsification and newer femtosecond laser-assisted cataract surgery (FLACS) are supposed to rule the roost. Their smaller incision, predictability of astigmatism, faster rehabilitation, and the use of topical anesthesia all add to their attraction, especially in settings where cost is not the chief concern. The better unaided distance (6/6 or 6/9) vision, coupled with good unaided near vision (N6 or N8) with multi-focal intraocular lens implants, is a unique selling point.<sup>[3]</sup>

In market-driven health care, patient comfort sometimes overrides surgeon comfort, and it is easier to do phacoemulsification rather than SICS under topical or sub-Tenon anesthesia.<sup>[6]</sup> Cataract surgery is marketed as a no-injection, no-stitch, and no-pad technique. The last two are dubious, but “no injection” certainly has a reassuring ring as fear of being poked in the eyes is one of the barriers to cataract surgery.<sup>[7]</sup>

But there are types of cataracts which are difficult to do by phacoemulsification and impossible to do by FLACS. Very hard brunescient or black cataracts, hypermature and intumescent cataracts, cataracts with compromised cornea that make visualization difficult, and even some types of subluxated cataracts can all be done more safely with MSICS, as the nucleus does not have to be fragmented inside the eye, and is removed in totality in one go.<sup>[2,8]</sup> A larger wound may need a suture, but a clear cornea allows earlier rehabilitation without a significant increase in astigmatism. And such cataracts form a significant proportion of even private paying patients in the Indian sub-continent. They are common in very old patients and those whose cataract surgery has been delayed for medical

or social reasons. MSICS thus has a role for managing such cataracts even in developed countries.<sup>[9]</sup> Recent studies have shown that the needle-prick-free cataract surgery can also be done by SICS using the lying down looking down test.<sup>[10]</sup> Newer techniques of MSICS—as elucidated in this issue of the *Indian Journal of Ophthalmology*—promise better unaided distance and near vision. MSICS is a necessary skill in the armament of every cataract surgeon. In spite of all the advancements in equipment and instrumentation, the cataract surgeon is still the most important component in a successful cataract surgery.

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