Authors' reply

Dear Editor,

I am thankful to Kothari *et al*,[1] for taking a keen interest in our article.[2]

We would like to clarify some of the issues raised in the rejoinder to the article.

1. We screened all hospitals and opined that only hospitals which provided inpatient services would be included for the simple reason that such institutions would have the infrastructure to tackle any complications that may arise during surgery. The inpatient facilities do not pertain to specific beds for children but the availability of beds in general. This categorization does not exclude institutions providing ambulatory services and does not in any way mean that all children should be admitted for surgery. Such a categorisation helped us in excluding clinics where the infrastructure would be inadequate for surgery. When outreach camps have been stopped for cataract surgery, it would be important that more care is taken for pediatric surgery. The article clearly mentions that private eye care facilities were also accessed 'quite often' and not 'more often' which has an entirely different meaning. As is evident from the results presented, more pediatric surgery was done at NGO and government institutions than at private institutions. This is evident from Table 4 of the article[2] in addition to what has been mentioned in the text.
2. The WHO endorsement of the team approach cannot be refuted for its conception. What we have mentioned is the

need of a 'team approach' which includes not only the optometrists but also others like counsellors. We agree that a skilled pediatric ophthalmologist can manage in the absence of a trained optometrist. However this comes at a cost as the surgeon is then undertaking tasks which can be handled effectively by another member of the team. It is only if the pediatric ophthalmologist does not have much work to do that such an approach would be feasible. However setting up a pediatric ophthalmology unit in a hospital where the pediatric ophthalmologist does not have adequate work load is not tenable.

3. In the centuries old history of ophthalmic practice, 1990 is recent and not ancient. Recent does not connote a one year or six month period.
4. The point is well taken that at 'mature' pediatric ophthalmology units there would be a substantial amount of squint surgery compared to pediatric cataract surgery. This could also be due to the fact that most anterior segment surgeons are comfortable with cataract surgery but less confident of doing a squint surgery and therefore there would be more squint surgery at 'mature' centers. It should also be remembered that a proportion of squint surgery is done at older ages (more so for cosmetic reasons) and so would not be captured among children. Though the prevalence of all squints would be higher than pediatric cataract for the reasons mentioned above and the community perception where an obvious opacity in a child's eye (which may make parents seek attention) compared to squints where parents perceptions may be different could contribute to the difference. Also the number of 'mature' pediatric ophthalmology units would be limited in comparison to the size of the population in India. Because of the above, as mentioned by the authors, the proportion availing squint surgery may be low due to reasons best known to the parents. We have only presented the situation as it is and cannot sit in judgement on this issue as we do not have any supporting evidence regarding surgical preferences.

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