



Cost effectiveness of cataract surgery

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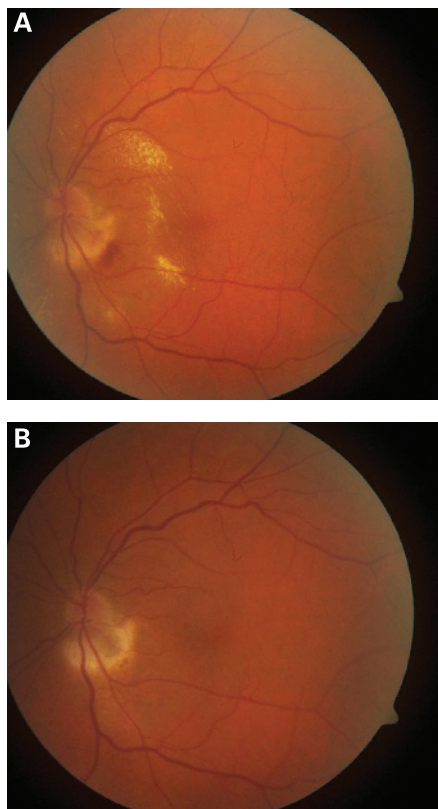


Figure 1 Left eye of a male patient in his early 70s with very exudative peripapillary choroidal neovascularisation before (A) and 1 year after one treatment/session of photodynamic therapy with Verteporfin (B).

Regarding the potential major risks of the surgical approach of peripapillary choroidal neovascularisation, we suggest that PDT could be the first therapeutic choice in these cases.

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According to the Canadian Community Health Survey, approximately 82% of the population of seniors aged 65–80+ (3 000 000 seniors) reported having vision problems in Canada.¹ Cataracts are the leading cause of vision impairment among seniors. During the period of 1994–2003, proportions of seniors with cataracts rose from 14 to 20% with populations aged 75 and over accounting for higher percentages.¹

Cataract surgery is among non-emergency surgical procedures with highest wait times in Canada. There was a 32% increase in cataract surgeries over 5 years between 1997/1998 and 2002/2003. In British Columbia, there were 11 816 patients waiting for surgery and 7897 patients completed in the 3 months from 31 August 2006 to 31 October 2006.² In addition to being a barometer of accessibility to healthcare services, cataract wait times are also a determinant of patient satisfaction, which in turn is correlated with increased health-related quality of life³ and possibly decreased injury risk.⁴

Delay of care is a persistent and undesirable feature of current healthcare systems.⁵ Waits and delays plague healthcare systems worldwide, and wait times for most specialists exceed those for primary care practices.⁶ From a clinical perspective, delay in necessary treatment due to surgical wait lists is a major concern.⁷ Establishing a clinically appropriate time that patients can safely wait for the operation is generally perceived as a method to prevent adverse outcomes of delay.⁸

The cost effectiveness of cataract surgery has been well established.^{9–10} In fact, modern techniques used for cataract surgery today result in rapid visual improvement with 50% of patients experiencing good vision by 24 h and 96–99% experiencing good vision by 4 weeks.¹¹ Evidence supports cataract surgery among older drivers in producing significant improvements in driving performance (best predicted by the concomitant improvement in contrast sensitivity), subsequent crash rates half that of older drivers with cataracts who opted not to have surgery, and self-reported improved visual function and distance estimation.⁴

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Cataract surgery in England

We read with interest the paper by Keenan and colleagues.¹

We recently studied the 2005/2006 Hospital Episode Statistics (HES) data for cataract and have reached similar conclusions. We agree with the authors' observations that as NHS cataract surgery rates (CSRs) in England have increased significantly in recent years, several questions are now raised. What is the appropriate CSR in a developed market economy? Is the observed geographical variation in CSR in England a marker of increased incidence and requirement for surgery in some "high activity" regions or a marker for overprovision? Conversely, in relation to lower activity regions, are there data set issues from the use of an administrative database such as the HES, or are there genuine clinical differences or variations in the organisational provision of cataract care? Private CSR rates are not considered as HES returns are restricted to NHS care. In our consideration of the most up-to-date HES returns, there are some data problems—due to coding issues—at some hospital Trusts (details on request). Observational studies of cataract surgical practice and population studies of regional prevalence of cataract are now needed. An electronic clinical database—a cataract national dataset—is the most pragmatic method of capturing such data in a timely fashion. Such an e-tool