ELECTIVE (SSC5c) REPORT (1200 words)

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

My time at Tilgange Eye Hospital was eye-opening in many ways. I was pleasantly surprised at how different OPD clinics and theatre sessions oprated and were managed. However, at the same time, the days felt familiar in that the methods and eye conditions were somewhat similar. Firstly, what caught my attention was the speed at which procedures were performed and patients were seen in the OPD - like a conveyor belt! A swift yet extremely efficient process.

Cataract was the most common eye condition I saw, as expected. I was lucky enough to see cortical catracts (with the classical spokes), very advacned brown cataracts, and posterior capsule cataracts (which have a more severe affect on vision). Cataract is by far the most common cause of blindness in Nepal. Although treatable, many patients arrive with advance cataract, which dramatically affects their vision. Tilganga Eye Hospital undertake screening and surgical camps for cataracts, within the surrounding Kathmandu Valley. It is programmes like this which have pioneered the advancement of management of cataract in Nepal.

What I found interesting was that the method of cataract surgery is identical to the UK - phaecoemulsification. Small incicison cataract surgery (SICS) is still performed (and I was lucky enough to observe it on my first day), however phaecoemulsification is preferred and more commonly undertaken at Tilganga Eye Hospital. The most common reason for SICS is patient choice due to cost. The phaecoemulsification method costs $140. Again, the logistics of the cataract surgical list was amazing. Procedures and movement of patients was swift and efficient. Faster than the UK!

I examined a patient who experienced total iridectomy as a result of a cataract surgical blunder. NOTE: it was not performed at Tilganga, however I learned that this a common blunder and occurs 'once' during training.

In the UK, cataracts, are discovered much sooner and surgery is performed usually before vision is affected to 6/9. Therefore, although incidence is high, cataract is no longer a 'common' cause of blindness in the UK.

Diabetic retinopathy and macular degerneration would qualify as the leading causes of blindness in the UK. What I found interesting was that I saw many cases of moderate to severe diabetic/hypertensive retinopathy during OPD clinics. It seems that these conditions may be more common than we understand in Nepal, and in the future may become leading causes of blindness here. In the UK, patients with diabetes mellitus are screened annually for diabetic eye disease (and other complications of diabetes e.g. peripheral neuropathy).

I learned that eye related health is not part of the 'general health work up' in Nepal. It runs parallel and independent to 'general health' in Nepal. Therefore, currently diabetic eye diease is not screened for. Upon discussion I learned that retinopathies are common and frequently present when disease has progressed as a result of late referral due to asymptomatic affect on vision. However, diabetic/hypertensive eye disease can be quiet in early stages. It is important to monitor and control the underlying process to slow progress of retinopathy. Today, there has been a push for physicians to quickly refer patients with underlying diabetes mellitus and/or hypertension for monitoring via an ophthalmologist. This will require a lot of patient education because they are more likely to attend if

they understand the complcations of diabetes and risk of blindness. Furthermore, this highlights the importance of national health promotion/education.

In conclusion, my time at Tilganga Eye Hospital was fascinating. I saw a variety of conditions from cataract, glaucoma and diabetic retinopathy, to more unique cases of cranial nerve palsies, herpes zoster infection and toxoplasmosis.