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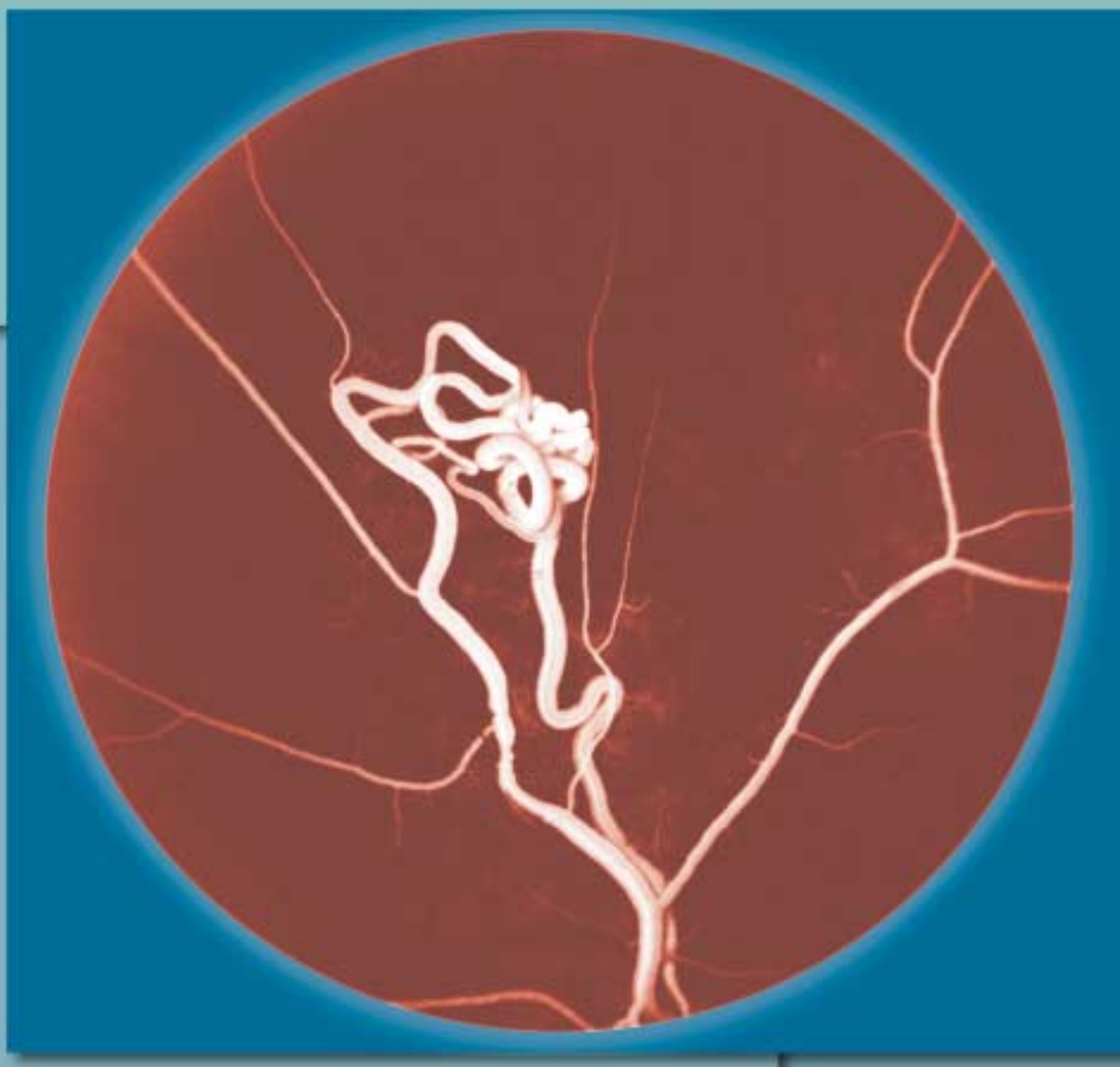
THE Retina TIMES

"ALL THE RETINAS THAT'S FIT TO TREAT"

THE OFFICIAL PUBLICATION OF THE AMERICAN SOCIETY OF RETINA SPECIALISTS



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August 16–20, 2003
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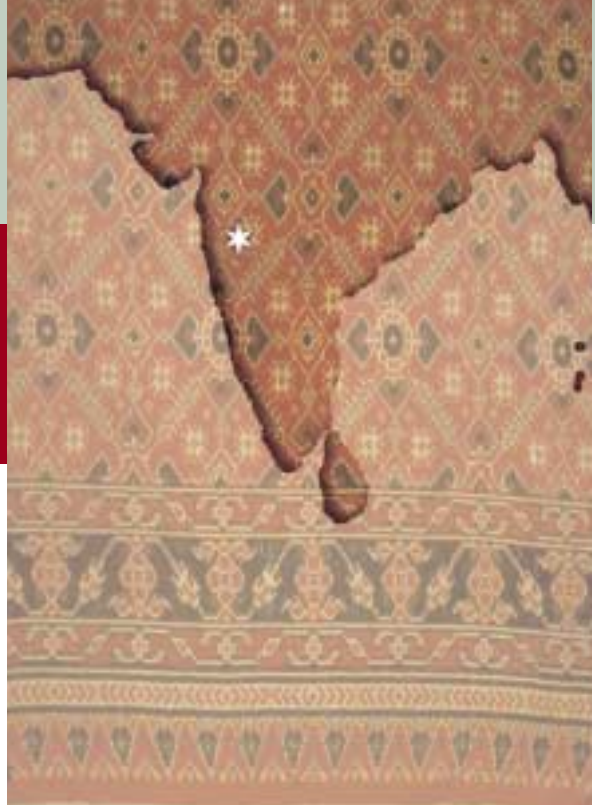
International*news*

RETINA CARE AROUND THE WORLD

Spotlight on India



Hugo Quiroz-Mercado, MD
Section Editor

Our International News section is intended to keep all of us abreast of issues and subjects of interest from around the world. If you would like to contribute to this section or have ideas for this section, please contact Dr. Hugo Quiroz-Mercado at hugoquiroz@yahoo.com.

EDITOR'S NOTE: In this issue, Dr. Quiroz-Mercado interviewed Dr. Salil Gadkari. Dr. Gadkari is engaged in full-time retina practice in Pune, India which is located in the hills, 120 miles from Bombay. Dr. Gadkari said that, as a university town for over a century, it has been called the "Oxford of the East." It has also been called the "Detroit of India" due to its large automobile industry including Mercedes Benz. He said that, "It drains a large rural hinterland with a predominantly agricultural economy." –BF

How do most retina specialists recruit patients?

The practice is a tertiary referral practice from anterior segment colleagues very much the same as elsewhere. I also receive patients from NGOs [non-governmental organizations, mostly charities] who mainly help the cataract blind but do diagnose patients with retinal problems as well. These patients mainly from a poor socioeconomic class are treated with grants from philanthropic organizations, at a concession at our centre.

Do patients with retina pathology arrive on time for treatment?

This is a very important issue especially in my kind of a practice, which has a large rural referral. Patients tend to go to the primary ophthalmologist late, therefore reach us later than we would like. Sometimes patients ignore the problem with the first eye and start running around when the second eye becomes symptomatic. I see more retinal detachments with changes of PVR rather than fresh cases.

What I feel very strongly about is that a lot of patients, even diabetics get their eye examination at optician outlets, which merely address the refractive error, so the patient presents to us only when they have bled or developed a bad macular edema.

How patients pay the doctor: insurance, private, government?

There is a substantial difference in trends between urban and rural areas. Rural patients have still to catch up with insurance. Poverty is a major issue. The health ministry by itself, as well as by coordinating with NGOs is doing a great job in taking care of cataract blindness. 2.3 million cataracts (source: NPCB newsletter July 2002) were operated in the year 2000-2001 by them. Retinal problems by virtue of their complicated pathology, the need for advanced instrumentation and frequent follow up have not been addressed in a substantial way. Even government hospitals in cities barring a few, do not have a fully equipped vitreoretinal unit. Between private payment and insurance in urban centres, the ratio is 50–50. Health insurance is a high growth area now, especially with the entry of international players.

Which are the most frequent retinal diseases in your country and what differences of diagnosis and management do you see compared to other countries?

Retinal diseases account for 4.75% of causes of legal blindness (Source: National Program for Control of Blindness newsletter July 2002). Diabetic retinopathy is a major problem at hand due to longer lifespan of diabetic patients, thanks to medication. Florid retinopathy in young adults is the focus of attention in Asian countries. Our large geriatric population thanks to increased longevity is now presenting with

ARMD. Eales' disease is an entity not uncommon to our region and accounts for one in 150 general ophthalmic outpatients. Posterior segment trauma and retinal detachment is also seen in significant amounts. A disturbing fact is the increase in the number of patients of CMV retinitis due to HIV, which have steadily grown during the last few years.

Patients are very result-oriented and are seldom interested in what you do as long as they regain some sight. Illiteracy can make it difficult to explain things to certain patients. However we usually empower the patient to make the final choice. Patients in our country are very averse to a second surgery. If you do not get it right the first time you don't have the luxury of a second surgery. Hence if you are in doubt whether to do a pneumoretinopexy or a buckle, buckle or vitrectomy, gas or oil, err in favour of the surer fix. Though doctors now come under the purview of the consumer protection act, our patients seldom go in for litigation.

Is photodynamic therapy (PDT) available for most of patients with AMD? Which therapeutic options are available besides PDT in India?

PDT is available to a privileged few who can afford the extremely expensive Visudyne. A vial of Visudyne costs about five times the monthly salary of a university head of faculty. To add insult to the injury, a customs duty, as of going to the press is levied on the same. There is no clear understanding from insurance about coverage. Hence, even well to do patients shy away from the treatment. The number of patients who require this treatment in India is very large. I suppose that pharmaceutical companies have to have a pragmatic approach to pricing these drugs cheaper and recover their investment in R and D through a larger volume of sales.

There is more interest here in TTT and feeder vessel treatment. Macular translocation also appears to be a more viable alternative. In our scenario, surgery would be more economical than PDT.

Where are most retina specialists trained?

Fortunately a good number of vitreoretinal training programmes are run in our country. Sankara Netralaya, Chennai; Aravind Eye Hospital, Madurai; Retina Foundation Ahmedabad and L V Prasad Eye Institute, Hyderabad have trained a large number of retina surgeons. More programs with international centres would be a great help to retina surgeons in various stages of evolution. Given the large explosion of diabetics expected over the next few decades it would make sense to upgrade the skills of a significant number of comprehensive ophthalmologists to assess and deliver retinal laser treatment.

Which lasers are most frequently used for retinal diseases?

We use both red and green as per the preference of the surgeon and condition. The red laser works well due to the pigmented fundi in our country. Its wider spectrum of application makes it more cost-effective as well. Unfortunately, in the field of retinal laser we do not have a local manufacturer. We use all the same international brands like Iris, Zeiss, Coherent, Alcon, etc. A few years ago the government had completely waived the customs duty on sight saving equipment, making it possible to import the best machines at no extra cost.

One extra question which I thought I should ask. Is there anyway that the international retina community can contribute to improving retina facilities in India?

Vitreoretinal surgery is a process of evolution for the surgeon. There is always something further to be learned. Training programs with advanced centres can help the surgeon to go back with newer skills. For example, limited macular translocation could be a very useful tool in our scenario. In rich economies we see machines being decommissioned merely because a newer variant has arrived. While the newer variant has certain advantages the older machine in working condition could still be useful to a centre in a developing country. A classic example is of the Fundus camera. Lot of centres got rid of perfectly good fundus cameras with a 35mm format to acquire a digital imaging system. I am happy to note that the American Society of Retina Specialists and *The Retina Times* give us a chance to deliberate on such matters related to our practice and contemplate on methods to improve our patient care wherever we may be located in the global community.

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