To the Editors:

Cataracts, health technology and the spectacle of reversely abled generations

While sitting for the fourth and the last time (2 parents, 2 eyes each!), with my mother in the medical devices company, to purchase the IntraOcular Lens (IOL) to be used in her cataract operation, I pondered on the advances in technology. My 80-year old parents could now read newspapers without spectacles, but their three middle-aged children needed spectacles to read. What next? The Internet mentions replacement hips and spinal discs—who knows, when we are 80 years of age our hips and joints might creak less than our children’s.

But health technology is not without its problems. Very prominently in front of me was an advertisement with detailed charts and diagrams of the eye and the hues of the rainbow advertising the newest model of the IOL that filtered high-energy blue light. However, what caught my eye were the last two sentences in the advertisement.

“Researchers believe that the blue light may cause damage to the retina which could potentially contribute to macular degeneration or loss of vision. The long-term effects of filtering blue light and clinical efficacy of that filtering on the retina have not been conclusively established.”

So, the damage that could occur from blue light is not established and the long term effects of filtering are not known. At least there is no headlong rush based solely on scientific theory without clinical experience. One only needs to be reminded of retrolental fibroplasia leading to blindness after 100% oxygen in neonatal Intensive care units.

Such “advances” pose not only scientific and clinical questions but also economic ones. The IOL that filtered blue light costs more than the ones that do not. Health Insurance companies in the US will not pay for the IOLs that filter, as they do not have proven benefits. They are “nice to have but not necessary”.

When would we know whether or not there was an added advantage? Long term observational studies which will take years would be necessary. Is it reasonable to ask for controlled clinical trials that would take years? Would that inhibit device manufacturers from developing these potentially useful though in the short term unprovable, “advances”? But on the other hand, should the patient pay more for unproven technology?

Perhaps when it is time for my cataract operation they would know; maybe I can ask for the extra cost to be discounted if there was no benefit.

To the Editors:

Should sensitivity testing be suspended in Sri Lanka?

In Sri Lankan hospitals, thousands of sensitivity tests are done every day, mostly for benzathine penicillin, and before the use of certain sera. This is an obsolete procedure in developed countries.

A negative sensitivity test could give a false sense of security. A patient may develop anaphylaxis for the sensitivity test. On the other hand, a patient may develop anaphylaxis even after a sensitivity test, when the drug is administered.

In my opinion, sensitivity testing is a waste of valuable resources such as time of medical personnel, money and material.

Alternatively, patient care could be ensured by following measures:

1. By attempting to predict whether the patient will have an allergic reaction.
   i. A reliable history of a previous adverse response to penicillin, immediate type reactions such as urticaria, angioedema and anaphylactic shock can be taken to indicate allergy.
   ii. Atopic individuals.
   Since alternative drugs such as erythromycin can usually be found, penicillin is best avoided if there is any suspicion of allergy.

2. Medical staff should be ready to treat anaphylaxis at outpatient department or in any other place of the hospital when such injections are given.

I feel this should be seriously considered and a policy decision should be taken on sensitivity testing.

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