DISCUSSION
Cataract is the main problem of old age and surgical intervention is the only remedy of cataract. The quality of vision is more or less resemble with that of phakic eye after the cataract extraction with IOL implantation.

The number of complication is much higher in IOL implantation in comparison to simple cataract extraction.

Since 1949, after Ridley's first IOL implant in posterior chamber of eye there have been number of changes from time to time in the field of intracocular lens implantation. Ridley reported higher incidences of complication with IOL implantation during his early series of operation, in which there were very high post operative myopia (-13D to -20D), severe post operative iritis, occlusion of the pupil due to dense inflammatory membrane, opacification of posterior lens capsule, loss of anterior chamber, hyphaema, secondary glaucoma, iris atrophy due to pressure of IOL (PMMA), decentring and dislocation of intracocular lens. The complications of Ridley's IOL implantation led to inception of anterior chamber IOL implantation, first by Baron 1952. Anterior
chamber intraocular lens implantation of that time also resulted into high rate of complications mainly corneal decompensation. Further discovery took place with high incidences of complications, mainly iritis, iris atrophy, dislocation of lens, pigment dispersion and poor pupillary play. Hence the use of iris supported iris clip lenses declined abruptly thereafter. Since 1980 anterior chamber lenses and posterior chamber lenses have been widely used. The advantages of anterior chamber lenses are many, as they can be used in cases of intracapsular or extracapsular cataract extraction, can be implanted primarily or secondarily and easy to place without sophisticated equipments. In trained hands the anterior chamber lens implantation give excellent results. In present study the complication is seen in 26 eyes of 25 patient of IOL implantation in anterior chamber.

**OPERATIVE COMPLICATION**

The operative complications were observed in IOL implantation in anterior chamber of eye. Hyphaema was encountered in (7.7%) ICCE with IOL implantation in anterior chamber. The incidence of hyphaema in ICCE with IOL implantation in anterior chamber of eye have
been reported 12.3% (Subhash P. Kadam 1987) and 8% (AJC 1989). Cases associated with retrobulbar haemorrhage are ideally postponed (Gholam A. Peyman, Edward Duke Elder, Nikhil C. Kaushik 1983, Subhash P. Kadam 1987). Vitreous loss or vitreous in anterior chamber during operation may lead high incidence of post operative complication in cataract extraction with IOL implantation in anterior chamber. The incidence of complications are cystoid macular oedema, peaked or updrawn pupil, endothelial corneal dystrophy and retinal detachment (Alpar, Fechner 1986). When vitreous pressure is high or there is positive iris vitreous pressure into the AC it is difficult to implant an IOL into the anterior chamber although with visilens such problem is minimized (S. Tony Fernandez, 1986) unplanned ECCE or accidental rupture of capsule results in post operativespecification of capsule. Therefore above mentioned cases were excluded from the present study.

**POST OPERATIVE COMPLICATIONS**

Corneal complications mainly striate keratitis were in anterior chamber intra ocular lens implantation (19.23%). In accordance with Daljit Singh et al (1984) - 16.1% (with IOL), C.P. Billon et al (1986) - 19.8% and
29.5% and S. Tony Fernandez 20.1%. However R.K. Mishra et al (1985) reported 70% (mild to moderate) in IOL implantation, which is quite higher. Higher incidences are also reported by M.C. Nahta (1983) - 75% in IOL implantation. This could be with no use of visiolon, more manipulation during surgery or improper formation of anterior chamber during surgery. Lower incidence have been reported by Vilas Bidaye (1985) 2% and Subhash P. Kadam (1987) 4.4% which are too low and need no explanation.

The incidence of corneal oedema was not seen in any case of IOL implant in anterior chamber. The incidence of corneal oedema in IOL implants have been reported by O.P. Rillore (1986) 7.9% (in rigid IOL) and 16.72% (Flexible IOL), M.C. Nahata (1984) 75% and in surgedev closed loop IOL (Arch opth, 1987) 12%.

The incidence of hyphaema was 11.53%. Subhash P. Kadam (1987), S. Tony Fernandez (1986), Daljit Singh (1983), Arch opth 1987, reported 2.1, 4.5%, 6.1% and 12% respectively. These studies are comparable to our present series of study in IOL implant in anterior chamber. In present study and the review of literature show a definite higher incidence of post operative
hyphaema in IOL implant. This hyphaema resolve in all the cases within one week.

The incidence of iridocyclitis was 19.3%. This may be due to excessive manipulation, surgical trauma to the iris or mechanical foreign body irritation by the implant itself. R.K. Mishra et al (1985) reported 22% mild and 63% moderate in IOL implant cases. C. Billebe (1986), Vilas Bidya (1988), Subhash P. Kadam (1987), N.C. N heute (1983), Daljit Singh et al (1983), S. Tony Fernández (1986) and N.B.D. Raju (1983) reported 9.8%, 2%, 11.6%, 20%, 11.5%, 6.6% and 8% respectively. The higher incidence of iridocyclitis in IOL implants is comparable to most of the authors report and resolved with medical treatment in our series leaving no adverse effect.

Shallow anterior chamber is not encountered if proper corneoscleral sutures are applied to prevent wound leakage during early post-operative period. Shallow anterior chamber have been reported by few authors like Daljit Singh et al (1983) who reported 1.6% and S. Bharti et al reported 1.6%. We did not come across such incidence in our study. Collapse of anterior chamber in IOL implant
may lead to serious complication due to damage of corneal endothelium. This can be avoided by proper suturing during surgery and proper protection of eye in post operative period.

Tucking of iris is a common finding in anterior chamber intraocular lens implantation. The incidence have been reported more in rigid anterior chamber IOL's as compared to flexible loop anterior chamber IOL. R.K. Mishra (1985) reported 15%, O.P. Billore found 22.02% (Rigide IOL) and 3.19% (Flexible loop) Subhash P. Kadam (1987) reported 4.1%. Our figure of 3.84% is in accordance with the above figures. No adverse effect occur in post operative follow up.

The incidence of riding of pupillary margin on IOL was found to be 7.69%. This figure is slightly higher than the figure reported by R.K. Mishra et al (1985) 2%. The riding of pupillary margin on IOL lead to slight tilting of lens and high degree of astigmatism correction was needed in these patient. As the visual acuity was good after correction with astigmatic glasses, no surgical manipulation was attempted. The riding of pupillary margin disappear after 8 weeks of follow up.
The riding of pupillary margin is not a serious complication and may disappear after some time as seen in our case. It can be avoided by using strong miotics after lens extraction and before IOL implant in anterior chamber.

The pigment deposit was seen only in IOL implant cases. In present study the no incidence was found. It is reported by O.P. Billore 13.11%, R.K. Mishra et al (1985) reported quite high incidence (30%). These pigments deposit disappeared with in one month. No effect in vision occur but may be attributed to iridocyclitis in these cases.

Deposition of precipitates were found in 3.84% cases in our study. This figure is less than 7% reported by R.K. Mishra et al (1985). These deposits were seen on examination by binocular loupe.

The incidence of cystoid macular oedema was not seen in our present study of IOL implants in anterior chamber. In IOL implant J. Watt (1984) reported 2.2%, R.K. Mishra reported 15.8%, Daljit Singh (1982) 2-3%, R.C. Nanata (1983) reported 5% and Surgedev closed loop IOL's (Arch opth 1987) was reported 13%. 
Symptoms like disturbances in looking at light and shiny objects were seen in IOL implant in anterior chamber in (7.69%) cases. These symptoms appear due to optical characteristics of intraocular lens, which causes internal refraction of light. S. Tony Fernandez reported such incidences in 33% and having shiny objects in 5% cases. Jonathan H. Frantz also reported in 3% cases. These symptoms also disappear in our present cases of IOL with in 2 months with the adoption of patients to these problems.

**VISUAL ACUITY**

Visual acuity in IOL implant 77% cases achieved 6/12 or better vision. Rest of the cases of IOL implant achieve 6/24 or better vision.

In present study of IOL implant cases the percentage of cases who achieved 6/12 or better vision were better than S. Tony Fernandez who reported 70%, Vilas Bidaya reported 64% and M.C. Mahata (1983) who found 60%. Our figure coincide with R.K. Mishra et al 81% and C.R. Billore 79% achieves J. Watts reported 92%, Y.K. Paranjpe reported 84% and S. Bharti et al 90% are better than our results.
Binocular vision was obtained by almost all cases of IOL implant in anterior chamber. The patient were well satisfied as far as there binocularity and visual acuity was concerned. These patients did not face any problem after 6 weeks.