INTRODUCTION
It is well established fact that the replacement of natural cataractous lens with an artificial one is one of the best ways to rehabilitate the cataract patient. It should be pointed out briefly; why ophthalmologists did not continue to perform the simple cataract operation which in this century became one of the safest procedure in medicine. The answer is self evident – aphakia has many disadvantages.

The aphakic glasses are not ideal optical aids. Although the patient might achieve the normal central vision; his visual field is markedly constricted which is compounded by ring scotoma. Further, difficulties develop through the spherical aberrations of the aphakic lenses. And above all from the prism effect that occurs when one looks through the side of the lens.

Further the cataract glasses magnify the image between 25 to 30%. It is therefore, impossible to correct a patient with monocular aphakia. Even with bilateral aphakia; the magnification effect is a handicap objects appear to be nearer than really they are. This leads to false visual orientation and difficulty with coordination. The patients with aphakic glasses are unable to estimate the distance properly and that even crossing of a road becomes dangerous.
significant improvement for the enucleated patient came with introduction of the contact lens because its magnification effect is considerable smaller only about 8. and problems of spherical aberration, distortion and ring scotoma are eliminated.

The contact lenses can be fitted in monocular aphakia. However, contact lens can lead to corneal vascularisation or endothelial decompensation. If lens hygiene is neglected, it may lead to corneal ulcers even loss of the eye. Contact lens are not useful for patient, who are working in dusty environment. Old patient with diminished lacrimation have trouble in wearing them. Further, many contact lens frequently get lost.

Keratophakia and epikeratophakia is still limited to investigative condition and to a few centres. The usual recovery time is longer and final visual result is same time less satisfactory than that obtained with other modalities of rehabilitation.

All the just mentioned difficulties are minimised if an artificial intraocular lens is implanted. This statement is based on well documented, clinical evidence gathered by many ophthalmologist through out the world.
There are many types of IOL implant lens, anterior chamber IOL, iris supported IOL implants and posterior chamber IOL implants. The best one is as good as naturally occurring lens is post chamber intraocular lens with better centering and fixation.

The other advantages of posterior chamber IOL implants over anterior chamber lens and iris supported lens are reduced incidence of corneal complications, iridocyclitis, cystoid macular oedema, iris atrophy, secondary glaucoma, UGH syndrome, implant dislocation and retinal detachment.

These are very useful for patients whom aphakic spectacles are unpractical or even dangerous to wear (Monocular Aphakic patients, Pilots, Surgeons, Drivers and active outdoor people who require good Peripheral vision such as, sportmen and hunters).

These are also useful in farmers, ranchers, road workers, labour of fumy chemical contaminated environment, whom contact lens are contra-indicated.

With these posterior chamber implants patient can be discharged after few hour to one day and can perform his routine work within a week time, hence early rehabilitatio is great advantage, with good visual acuity and good binocular vision along with better field of vision and no enlargement of image.
There are few disadvantages also like it can be put mostly after extracapsular cataract extraction. Late thickening of posterior lens capsule which need a posterior capsulotomy is a difficult procedure if polishing of post capsule was not done properly during implantation and there are chances of dislocation also.

The various posterior chamber implants are pearce rigid tripod lens, Sinclair 'J' loop lens, Simcoe 'C' loop lens, Sinsky, Kratz, Kelman modified 'J' loop and Mazzocco silicon (elastic) lens. These lenses are made up of rigid or flexible loop, made up of polypropylene or PMMA and are sterilized by ethylene oxide gas.

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