



INTRODUCTION

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The relationship between the glaucoma and cataract is very close. The combination of glaucoma and cataract in the same patient in ophthalmic practice is not infrequent. Management of co-existing glaucoma and cataract is difficult and controversial (Sugar H.S. Amer, J. Ophthalmol., 69 : 740, 1970). Simultaneously glaucoma and cataract in a patient poses the problems, whether to perform the glaucoma and cataract surgeries at the same time or to do one operation first followed by the second at a later date.

Some clinicians would surgically attack glaucoma first reasoning that the damage from glaucoma is irreversable, where as the visual deficits from cataract can be managed later. Others remove cataract first in the hope that intra-ocular pressure control will be easier later. One answer to dilemma in these cases is combined glaucoma and cataract operation. It has been attempted with varying degrees of success, encouraged by the good results and low rate of complications of single stage surgery. This has been favoured by many surgeons because of various advantages (Sorsby, 1967) such as -

One surgical & psychological trauma to the patient, short stay at hospital so reduction of cost, avoidance of malignant glaucoma, avoidance of second stage operation in high risk patients, avoidance of prolonged medications and early restoration of vision. Eye is only once exposed to the hazards of surgery, such as iritis, corneal diseases, infection, hyphaema and others.

The disadvantage is that it carries the higher risk of complications. However, the chances of complications depend upon the preoperative preparation and the surgical technique. The operative procedure become easy with judicious use of the hypotensive drugs, such as - carbonic anhydrase inhibitors, glycerol, hypertonic solution as Mannital, retrobulbar anaesthesia with pressure and it is further easier by cryoextraction. The combined procedures with various types of filtering operation have been attempted for many years with varying degree of success.

Most glaucoma procedures have been combined with cataract extraction including trephening, iridencleisis, sclerotomy, combined sclerotomy and iris inclusion and scleral cauterization. Each of these is a filtering

procedure and has the problem of attempting to produce a tight cataract wound and a filtering wound. In 1963 Cairns introduced the trabeculectomy, which has the advantage of a guarded filtering wound. This possibly avoided shallow or flat anterior chamber, post-operatively. Several authors in recent past have tried trabeculectomy in combination with cataract extraction. The results were encouraging, so this procedure of cataract operation extraction with trabeculectomy was performed in the present study for its further evaluation.