INTRODUCTION

Cataract is one of the most important cause of visual disability in our ageing population. The surgical technique of cataract surgery and visual rehabilitation of the surgery has come long way since ancient times of Indians & Egyptians in form of rectification, depression or couching (Stallard) or since the 1st recorded intra-capsular cataract extraction by Charles Saint Yves in 1772.

A successfully performed cataract extraction is only the first step in visual rehabilitation of the patient. The traditional method of correcting aphakia by using spectacles has many difficulties i.e. magnification by 30%, reduced peripheral field of vision and severe state of spatial disorientation of the patient.

The most exciting development in the field of cataract surgery in recent past has been the use of intra-ocular lens implant (IOL), which is free from all the optical problems of the spectacles and physical problems of contact lens.

Harold Ridley was the first to conceive the idea of IOL implant and used it for the first time in 1949. Ridley (1951) correctly postulated that the cataractous human lens would be best replaced by an immobilised artificial one at or near the location of human lens. IOL
implantation initially done along with an extra-capsular cartaract extraction. This further steered the evolutionary surgical procedures & methods to extracapsular methods encouraged by teaching and examples of Kelman (1967), Pearce (1975), Shearing (1977) and Rosen (1990).

It was not until 1977 when Shearing introduced his J loop posterior chambers lens which was essentially a modification of original Barraquer anterior chambers lens, the PCL started to enjoy their present day popularity. Various other types and modifications of posterior chambers lenses i.e. C loop modified J loop etc. have been developed. Other types of lens are the anterior chamber, angle fixated, iris supported & iridocapsular implants, of all these posterior chambers lens have been most promising. In the past few years there have been several modifications.

Ions in design & techniques of implantation of posterior chambers lens & in the search for a perfect procedure with long term stability. Interpreting consideration have assumed a special importance. There has been considerable debate over whether the loops of posterior chambers lens should be replaced in the cleft formed between the posterior capsule and anterior capsule remnant (In the bag) or slide it between the anterior
capsule remnant and the iris to rest in ciliary sulcus. Argument in favour of "in the bag" placement are related to a concern that the contact with soft ciliary tissue might lead to various complications whereas the capsular bag being a non-viable vascular tissue would minimize these complication. In favour of ciliary sulcus placement is surgical simplicity of placement , whereas "in the bag" the surgeon is not salvaging the capsular flaps that may interfere with cortical clean-up.

Taking into account all the studies done in the above regard the evidence is in favour of "in the bag" placement as a surgery of choice as regarding less complications in short term and long term post-operative period. Different methods have been described for anterior capsule surgery which is the first step in a a successful extra -capsular cataract extraction namely capsulopuncture technique, envelope technique and recently described continuous curvilinear capsulorhexis. Till recently envelop technique was probably the choicest of all for ensuring an "in the bag" placement. Till Gimble in 1984 & Neuhan in 1985 described a method of capsulotomy i.e. the capsulorhexis, this is a greek word where hexis means to tear.

Capsulorhexis through difficult to perform initially, seems to be an ideal way to secure long term capsular fixation & centration of a PC IOL. Assia et al (1991). An unwelcome consequence of cataract surgery is an alteration in corneal curvature resulting in an astigmatic