Unilateral Congenital Cataract

The article by Khokhar et al.1 in the March/April 2018 issue highlights some important facts about congenital unilateral cataracts. Unilateral cataract in children often goes undetected or presents late in a developing country such as India, which may lack early and compulsory screening protocols. These patients present only when leukocoria or strabismus is evident. Moreover, we as clinicians often fail to recognize persistent fetal vasculature (PFV) in the setting of a unilateral cataract in a child.

Although the authors reported a sufficiently large number of unilateral cataracts, the study failed to reveal an important factor that we consider when dealing with such cases. There was a wide range of ages in the study, making the data worthless when we put it to clinical use. We do not know the number of patients who had surgery at younger than 2 years, which is the age group that has the largest bearing on preoperative and postoperative data.2,3 The age distribution of the cataracts and other parameters such as morphology and biometry are missing. It is unfair to compare the axial length and keratometry of the affected eye with the fellow eye of a 4 month old and a 15 year old. It would also be useful to know other ocular associations such as microphthalmia and systemic abnormalities in this cohort of children. The authors should compare their results to the largest trial on unilateral cataract (Infant Aphakia Treatment Study), which also observed PFV to be the most common ocular association4 with similar biometric comparisons.5

Presence of a small globe should lead to early detection in a case of PFV, as pointed out by the authors. But in non-PFV cases, there was a greater “time difference” between detection and presentation that reflects the lack of information given to the parents at the primary health level once the cataract is diagnosed. After detection of a unilateral cataract in a child, there should be no delay and it is the responsibility of the referring physician to alert the parents to the long-term consequences and need for early surgery in these cases. Government policies should include stricter screening protocols for asymptomatic diseases and mandatory education of the physicians and parents.

Belonging to the same geographic region as the authors, our center faces the same hurdles of illiteracy and lack of awareness. We reviewed the data of 93 children with unilateral cataract presenting at our center over a 9-year period (January 2007 to January 2016) and found 37.8% of the children (n = 37) presented within the first 7 months of life. We had 10.8% cases of PFV (n = 10).

We congratulate Khokhar et al. for emphasizing vital details in cases of unilateral cataract and urging caution at the societal level.

REFERENCES


Savleen Kaur, MD
Sonam Yangzes, MD
Jagat Ram, MD
Chandigarh, India

The authors have no financial or proprietary interest in the materials presented herein.

Reply

We thank the authors for their interest in our article “Unilateral Congenital Cataract: Clinical Profile and Presentation.”

We designed this study predominantly to focus on sociodemographic characteristics of unilateral congenital cataract such as age at detection, age at presentation, presenting complaints, and distance from the treatment center. Our results highlighted the lack of awareness among the parents, pediatricians, and ophthalmologists. We also looked at the morphology and biometry of cataract. We agree with the authors that stratification of data based on age can yield more meaningful results.

Kaur et al. mention the failure of clinicians to diagnose persistent fetal vasculature (PFV) as a cause
Correspondence

of unilateral congenital cataract. Once the child has presented to the clinic, meticulous examination for signs of PFV is mandatory. The clinician should actively look for microphthalmia, elongated ciliary processes, posterior capsular plaque, or PFV stalk on ultrasonography. A definitive preoperative diagnosis helps in better prognostication and management of the case.

As pointed out by the authors, we did compare few parameters with baseline characteristics of children enrolled in the Infant Aphakia Treatment Study. Because the upper age limit for enrollment was 210 days in the Infant Aphakia Treatment Study versus 15 years in our study, all biometric parameters could not be compared.

We congratulate Kaur et al. for their interesting collection of cases. The data presented provide an elaborate picture of clinical characteristics of patients with unilateral congenital cataract. We thank the authors for their valuable suggestions and will attempt to inculcate the points raised in our ongoing work.

REFERENCES


Sudarshan Khokhar, MD
Cijin P. Jose, MD
Ramanjit Sihota, MD
Neha Midha, MD
New Delhi, India

The authors have no financial or proprietary interest in the materials presented herein.

doi:10.3928/01913913-20180828-01