An Embarrassment of Riches

Our primary objective at *Cataract & Refractive Surgery Today* is surgical education, and this issue focuses on novel and innovative approaches to teaching cataract surgery. Last year saw the debut of the AAO's Ophthalmic News & Education Network. During the past month, *CRSToday* launched Eyetube.net, and the ASCRS introduced EyeSpaceMD. I doubt, however, that we fully appreciate how fortunate we are to have such remarkable resources available to us for continuing education.

At the recent ASCRS meeting, attendees donning stereo glasses at *CRSToday*'s SOURCE symposium watched me lose vitreous in stunning high-definition 3D clarity (Figure 1). This was made possible by the amazing TrueVision video technology used to film surgery in my OR. Our SOURCE symposium featured the first ever demonstration of a 3D teaching video, and one could sense the audience members cringe as vitreous practically prolapsed into their laps.

In stark contrast, 1 week earlier, I was in Kathmandu, Nepal, just as a cataract surgical team from the Tilganga Eye Center was departing for a follow-up training mission to North Korea. The section editor of *CRSToday*'s "Tackling World Blindness" column, Geoffrey Tabin, MD, founded the Himalayan Cataract Project with talented Nepalese ophthalmologist Sanduk Ruit, MD, in 1994, with the mission of eradicating blindness from cataract in mountainous Asia. The Tilganga Eye Center has not only evolved into the regional center of surgical excellence, but it has done a remarkable job of organizing mobile cataract surgical camps throughout rural Nepal and neighboring developing countries. Most important has been the center's ability to train surgical teams from other small, developing countries in its cost-effective and well-proven method of high-volume, manual, small-incision cataract surgery.

In terms of healthcare delivery and training, North Korea is at the opposite end of the spectrum from the US. North Korea operates in such isolation that even the World Health Organization has no statistics on its healthcare delivery, which is extremely poor and primitive. When Dr. Ruit and the Himalayan Cataract Project's team from Nepal first visited in 2003, North Korea's per capita rate of cataract surgery was among the lowest in the world. Nearly every patient had bilateral mature cataracts, and most underwent intracapsular cataract surgery without an IOL.

Figure 1. The faculty of *CRSToday*'s recent SOURCE symposium.

Imagine being a North Korean ophthalmologist trying to learn modern surgical techniques but facing severe restrictions on travel, international correspondence and Internet communication, and access to most foreign technology and teaching. In order to introduce manual small-incision cataract surgery to North Korea, the Himalayan Cataract Project's team supplied five operating microscopes, 20 sets of surgical instruments, thousands of IOLs and surgical packs, and, most importantly, the hands-on training of a core group of eye surgeons and assistants in the capital of Pyongyong who could eventually train others. Although this was only the fourth trip by the Himalayan Cataract Project into North Korea, that country's cataract surgical rate has already more than doubled, and the majority of patients now benefit from quality small-incision cataract surgery and an IOL.

The next time we attend a meeting, peruse a journal, or log on to an educational Web site, we should contemplate how fortunate we are to have so many educational resources available to us. ■

David F. Chang, MD, Chief Medical Editor