Gilbert, C; Awan, H (2003) Blindness in children - half of it is avoidable, and suitable cost effective interventions are available. BMJ, 327 (7418). pp. 760-761. ISSN 1468-5833 DOI: 10.1136/bmj.327.7418.760

Downloaded from: http://researchonline.lshtm.ac.uk/16009/

DOI: 10.1136/bmj.327.7418.760
Council, despite evidence that patients thought the Nuffield recommendations were appropriate. The Department of Health for England has so far taken a similar line to the MRC. Implied consent is accepted by the Department of Health for using “surplus” tissues in quality control, but explicit consent is now the norm for research. The latest proposals now demand explicit consent for teaching, which will pose problems—especially in histopathology. Using tissue without consent will be a criminal offence.

Acting on individual patients’ wishes has implications for resources. An efficient system to record and retrieve those wishes is required, whether explicit or implied consent is used. This is already needed even to check for objectives to use of human tissue samples in teaching and quality control. Yet at a recent meeting of academic pathologists in Bristol, not one participant could claim that his or her local hospital had implemented such a system. So research is being inhibited; but for teaching, quality control, and audit, consent issues are still being ignored.

If we are serious about empowering patients to control the use of their tissue samples, resources must be allocated irrespective of whether implied or explicit consent is regarded as appropriate. Without such resources our laboratories are forced into paralysis or continuing paternalism. At present we have both.

Peter Furness professor of renal pathology
Department of Pathology, Leicester General Hospital, Leicester LE5 4PW (pff1@le.ac.uk)

Competing interests: PF is involved in non-commercial research using human tissue.

8 van Diest PJ, Savulescu J. No consent should be needed for using leftover body material for scientific purposes. BMJ 2002;325:648-51.

Blindness in children

Half of it is avoidable, and suitable cost effective interventions are available

Childhood blindness is a priority of “Vision 2020—the Right to Sight,” a global initiative for the elimination of avoidable blindness (www.v2020.org), although only 1.4m blind children are included in the worldwide total of 45m blind people. There are several reasons for this. Blind children have a lifetime of blindness ahead, which affects their opportunities for education, employment, and earning potential. Early onset blindness adversely affects psychomotor, social, and emotional development. Blind children have a higher death rate than their sighted counterparts. An estimated 500 000 children become blind each year, but in developing countries up to 60% are thought to die within a year of becoming blind. Almost half of all blindness in children—particularly those in the poorest communities—is due to avoidable causes that are amenable to cost effective interventions.

The prevalence of blindness is higher in developing countries because, firstly, potentially blinding conditions such as vitamin A deficiency, harmful traditional eye remedies, or cerebral malaria, which do not occur in affluent societies, are prevalent there. Secondly, preventive measures for conditions that have been controlled elsewhere such as measles, congenital rubella, or ophthalmia neonatorum are inadequate. Thirdly, facilities and skilled personnel for managing conditions needing surgery are lacking (box).

In middle income countries the pattern of causes is mixed, with retinopathy of prematurity emerging as an important cause in Latin America and some eastern European countries. Currently unavoidable causes (the biggest group in affluent countries) include hereditary retinal dystrophies, disorders of the central nervous system, and congenital anomalies. Uncorrected refractive errors cause visual impairment and
Editorials

are becoming established, particularly in India, to meet targets set by Vision 2020 of at least one trained paediatric ophthalmologist for every 50m population by 2010. Vision 2020 aims to reduce the global prevalence of blindness in children from the current level of 7/10 000 children to 4/10 000 by 2020. If achieved, the number of blind children would be almost halved, as the child population is projected to stabilise at 2bn over the next few years.

Excellent neonatal care can prevent retinopathy of prematurity to a large extent, but babies developing threshold disease need to be identified as treatment of this stage is highly effective at preventing visual loss. Screening programmes are in place in industrialised countries and are being developed in Latin America and large Asian cities.

Many children with incurable visual loss benefit from low vision services, which facilitate near vision and inclusive education. Often these services are lacking where they are most needed. Refractive errors, particularly myopia, often go undetected, and vision screening in schools with provision of affordable spectacles is another component of Vision 2020.

The control of blindness in children is complex, requiring community activities through to sophisticated tertiary eye care services (figure). Multidisciplinary collaboration will be required with comprehensive service delivery encompassing health promotion, specific preventive measures, optical, medical, and surgical services as well as low vision care, special education, and rehabilitation. The challenges are to ensure political commitment towards the alleviation of poverty and the development of models that are effective, replicable, sustainable, and equitable and to mobilise the additional resources required.

Clare Gilbert senior lecturer
International Centre for Eye Health, Clinical Research Unit, London School of Hygiene and Tropical Medicine, London WC1E 7HT (clare.gilbert@iclhstm.ac.uk)

Haroon Awan country representative
Sight Savers International, House No 2, Street 10, F-7/3, Islamabad, Pakistan (siscopak@comsats.net.pk)

Competing interests: None declared.


