Newsmaker Interview

PAACO demonstrates growing global reach of Arab-African ophthalmology

The biannual congress of the Pan-Arab African Council of Ophthalmology (PAACO) continues to go from strength to strength. Originally envisaged as a forum for regional ophthalmologists to share ideas and expertise, this year's VIIIth Congress of PAACO in Dubai, United Arab Emirates, brought together some of the world's most renowned ophthalmologists to share their insights and expertise with colleagues.

In this interview with EuroTimes journalist, Dermot McGrath, Mohamed Alaa El-Danasoury, MD, FRCS, Chairman of the Scientific Program Committee for PAACO 2005, discusses the evolution and future of PAACO and the key issues facing ophthalmologists in the Arab-African region today.

Mohamed Alaa El-Danasoury

ET: *Can you explain a little bit of the historical background and philosophy behind PAACO?*

El-Danasoury: The first big regional meeting took place in Cairo, Egypt in 1991 under the aegis of PACO, the Pan Arab Council of Ophthalmology. The aim of the Council is to promote the science of ophthalmology among all societies and nations in the area, and promote internal cooperation in all matters pertaining to ophthalmology.

The African Ophthalmological Societies were added to PACO at the meeting in Jordan in 1997 and the name was changed to the Pan Arab African Council of Ophthalmology (PAACO) to reflect this shift. And the good news is that the organisation continues to grow. At this PAACO meeting in Dubai, it was confirmed that Iran is joining as a full member for the first time. As a result PAACO will soon be changing its name to the Middle-East African Council of Ophthalmology (MACO) to better reflect the composition and nature of the Council more accurately. We are also hopeful that Turkey will join in the future, making MACO the biggest supranational ophthalmologic organisation.

ET: *How does the Dubai Congress compare to previous PAACO meetings in terms of its size and scope?*

El-Danasoury: I think Dubai marks a special stage in the development of PAACO because it has clearly become not just one of the biggest regional ophthalmic meetings but has also attained global recognition. There is a huge international presence here with delegates attending from Mexico, Argentina, Europe, the Far East and the United States. These are delegates who were not specially invited to attend but registered and came of their own initiative, which gives some indication of the growing stature of the meeting. Indeed, the success of the Dubai congress has led to some speculation that it may become an annual event and that is something that will be considered carefully by the PAACO Board.

ET: *How significant is the fact that Iran has become a member of PAACO?*

El-Danasoury: I think it is a very important development indeed. Iran has over 1,500 ophthalmologists, and it is a big country with very good surgeons and practices. It has a lot to offer both regional and global ophthalmology and we feel that PAACO is the logical organisation for them. So I think it is a very positive development and augurs well for the future development of ophthalmology in the region.

ET: *What do you see as the highlights of this year's scientific programme at PAACO?*

El-Danasoury: From a scientific point of view, we believe that we are giving delegates a first-rate programme covering state-of-the-art developments in all the various ophthalmic specialities. There is a strong international dimension this year, with 43 invited international speakers, as well as another 50 or so well-known speakers from the region who are presenting their work here for the first time.

We also try to innovate as much as possible and keep improving the programme. This year sees live surgery transmission for the first time from a local hospital in Dubai. We have also established an 'expert lunch' where delegates can come and meet the big names in ophthalmology in an informal setting. And we have introduced a new video library this year where delegates can watch any video they want at a time that suits them rather than having to attend a designated session.

So I would say that the scientific programme is keeping up to date with developments in cataract and refractive surgery and compares favourably with other major international meetings. It is a very detailed programme and we want to make sure that we are providing our doctors with the latest and the best techniques and speakers.

ET: *What about the quality of papers submitted for this year's congress?*

El-Danasoury: We had over 800 submissions for presentations, including free papers, posters and videos. The quality was generally of a high standard and some of the papers were excellent. However, I think PAACO differs from other meetings in our approach to those papers that did not make the grade for initial acceptance into the congress. Rather than simply throwing them away, we get in touch with the authors and help them to bring their research methods and their presentation of data up to the required standards. So we teach them how to design a proper clinical trial, how to write a correct abstract and so forth. We believe that this helps to improve standards and encourages greater participation from ophthalmologists who might otherwise be left on the margins.

ET: *What are the major ophthalmic issues facing doctors in the region?*

El-Danasoury: A few years ago trachoma was the big issue in this region, but now I think keratoconus is the major concern facing us. We are seeing a very high percentage of keratoconus cases compared to other regions. The reasons for this are related to factors such as consanguinity, the environment, climate and allergies. So we are really faced with a relatively high incidence of keratoconus compared to Europe and the United States.

ET: *What treatment options are being offered to such patients?*

El-Danasoury: One of the consequences of the increase in refractive surgery is that we are now able to detect these patients much earlier than was possible previously.

Treatment for keratoconus used to mean offering either rigid contact lenses or penetrating keratoplasty to the patient. In our region, rigid contact lenses were not an attractive option because of the climate and associated allergies. And with penetrating keratoplasty, we were giving the patient very good vision but with a risk for corneal rejection for the rest of his life.

At our hospital we favour deep lamellar keratoplasty. This gives great results without the risk of corneal rejection, since we do not transplant the endothelium, which is the main cause of most tissue rejections. We can also offer other techniques such as intracorneal rings - INTACS and Ferrara rings – and we are also implanting phakic IOLs for stable cases of keratoconus. So while there is a clear problem of keratoconus in the region, we can at least offer viable treatment strategies to our patients to deal with the problem.

ET: *What about advances in refractive surgery in the region?*

El-Danasoury: The most significant advance is the treatment with the femtosecond laser technology. We installed the first IntraLase machine in the Middle East at Magrabi Eye Hospital in Jeddah last year. We are using it now for routine LASIK cases, and also for intracorneal rings and some selected cases of lamellar grafts.

We have been using microkeratomes for more than 18 years with very good results. However, the IntraLase gave some added value in terms of a safer cut, which definitely attracted many "blade cautious" patients. Also the quality of the flap and the edge is superior as the angle of the cut with IntraLase can be adjusted as required.