I am not at all surprised that they found a lack of enthusiasm among surgeons.

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Charles Wright and colleagues[1] reported highlights of the RESIO study, including information about patients undergoing cataract surgery. The comprehensive report of that study[2] states that 10% of the patients had preoperative vision better than 20/50 and therefore might not have met the cataract surgical guidelines. Wright and colleagues have suggested that these patients might have undergone unnecessary surgery.[1] In fact, the policy manual of the College of Physicians and Surgeons of British Columbia states that patients with vision better than 20/50 but significant functional visual impairment are suitable candidates for cataract surgery.[3] For example, bus drivers, police officers and airline pilots need vision that is considerably better than the 20/50 level to function in their jobs.

Wright and colleagues claimed that the outcome of cataract surgery was poor.[1] In the RESIO study, the average visual function score before cataract surgery was 79 out of 100, and this score rose to 88 after the surgery.[2] I suspect that the 9-point improvement in patient-reported visual function was interpreted as a very small improvement and therefore a poor outcome. However, given that 100 represents absolutely no visual disability, a score of 88 is in fact an excellent outcome, and this score was higher than the postoperative scores for any of the other surgical procedures in the study.

In the routine cataract assessment program at the University of British Columbia, 94% of the patients have better visual acuity, 3% have the same visual acuity, and 3% have worse visual acuity after cataract surgery.[4] The RESIO study measured objective visual acuity before but not after surgery. It would have been helpful to have objective postoperative data to determine why, if only 3% had worse vision, 26% scored worse on their visual function form. We are currently re-examining the RESIO data to try to answer some of these questions.

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[One of the authors responds:]

LeBlanc and Bellan both take issue with our conclusion,[1] based on VF-14 questionnaire results, that cataract surgery is currently being performed for doubtful indications in a substantial proportion of patients. There is no perfect instrument to measure visual function, but the VF-14 was developed by ophthalmologists for their use in assessing cataract patients and is apparently acknowledged as the best tool there is. Anderson also acknowledges that on the VF-14 "a score of 88 is in fact an excellent outcome" and that "100 represents absolutely no visual disability." It is therefore difficult to understand the decision to operate in the 15% of patients who scored above 95, and especially in the 4% of patients with the astonishing score of 100, at the time of preoperative assessment in our study. In choosing the VF-14 for our study we relied on the ophthalmology literature, the epidemiologists working in the University of British Columbia Department of Ophthalmology and the advice of the ophthalmologists associated with the project. The consensus remains (as quoted by Bellan himself) that the subjective VF-14 score correlates more strongly with visual function than any objective measurement of visual acuity made by the surgeon. Anderson's last paragraph seems to deny this accepted conclusion from cataract outcomes research, and he returns to suggesting that measured visual acuity, rather than the VF-14, is the most appropriate measure of outcome.

In claiming that the ophthalmologists involved in the project have reported "visual improvement" in 92.4% of patients, LeBlanc perpetuates the misapprehension that visual acuity as reported by the surgeon is a better measure of visual function than the VF-14 as reported by the patient and as used in our study. We agree that the question he suggests for determining patient satisfaction would be a good one in any evaluation of elective surgical outcomes. For example, it could be added as a final question in the postoperative application of the VF-14 questionnaire.

The reported results were restricted to patients undergoing first-eye surgery because the steering committee was uncertain how to deal with the 1-eye or 2-eye issue raised by Bellan, and current practice varies widely in relation to indications for and timing of surgery on the second eye. Bellan seems to be arguing for routinely operating on both eyes, but we must leave this question (for patients with or without mild cataract in the second eye or postoperative anisometropia) to be answered by ophthalmologists on the basis of research evidence.

Finally, we did not suggest that the VF-14 should be used with some kind of absolute threshold as the sole criterion of the need for surgery. As with any operation, the recommendation to proceed