

can be used. After placement of an 18 gauge intravenous cannula, anesthesia is induced; The conduct of the anaesthetic is aimed at obtaining good operating conditions for the surgeon; to this end a little "head up" position for the operating table and the maintenance of a hypotensive technique is employed.

POSTOPERATIVE CARE

After Stage I, a conformer is often in place over the buccal mucous membrane and daily glass rodding is carried out to the fornices to keep them open. The patient uses chlorhexidine and nystatin mouth washes.

Post Stage II, Diamox, steroids and antibiotics are continued. The optic is cleaned and the health of the buccal mucous membrane monitored. The skin sutures are removed after 5 days and the patient is admitted for 1 week for each stage.

FOLLOW UP VISITS

The follow up is life long and at weekly intervals for one month, then monthly for three months then every two months for six months, then every four months.

If stable then follow up can be at longer intervals possibly shared with the referring ophthalmologist.

At the follow up visits the vision is checked, unaided and with correction and pinhole, and a refraction performed. The intraocular pressure is checked digitally, the lids examined, the buccal mucous membrane assessed, including colour, dryness and presence of any areas of thinning or laceration. The optical cylinder is examined specifically looking at the cement, seeing if there is tilting or lengthening and the presence of a retroprosthetic membrane.

The stability of the optical cylinder is also tested by prodding with a cotton tipped stick. Fundoscopy is carried out to check the optic disc and macula, B-Scan to detect early peripheral detachments and visual field assessments are made 6 monthly for diagnosis and monitoring glaucoma. Resorption of the bone may be assessed clinically by palpating the mass and dimensions of the lamina, and radiologically using spiral CT, MRI or electron beam tomography, degeneration can affect statistical results for visual improvement.

CONCLUSION

OOKP surgery is complex and requires meticulous care at each step to ensure the overall success rate. Therefore, surgeons must not attempt to provide a service without first having undergone adequate training. Oral structures have to be sacrificed. All patients experience glare and a restricted visual field. The cost of OOKP surgery is high and formal cost benefit analysis has confirmed its cost effectiveness (un published data) Although it is far from perfect, modern OOKP surgery is the only hope for restoring sight in the long term for desperate cases of corneal blindness not amenable to conventional corneal surgery.

RECOMMENDED READING

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15. *Osteo-odonto-keratoprosthesis: Present experience and future prospects*. *Refract Corneal Surg* 1993; 193-4.
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LITERATURE REVIEW

Renal outcome in patients with congenital anomalies of the kidney and urinary tract

Sanna-Cherchi et al Kidney International 2009,76,528-533

Congenital Anomalies of the Kidney and Urinary Tract (CAKUT) are a major cause of morbidity in children. We measured the risk of progression to end-stage renal disease in 312 patients with CAKUT preselected for the presence of anomalies in kidney number or size. A model of dialysis-free survival from birth was established as a function of the renal CAKUT categories of solitary kidney; unilateral and bilateral hypodysplasia; renal hypodysplasia associated with posterior urethral valves; and multicystic and horseshoe kidney. Cox regression analysis took into account the concomitant presence of vesicoureteral reflux, year of diagnosis, and time-varying values of serum creatinine, proteinuria, and hypertension. By 30 years of age, 58 patients had started dialysis, giving a yearly incidence of 0.023 over a combined 2474 patient risk years. The risk for dialysis was significantly higher for patients with a solitary kidney or with renal hypodysplasia associated with posterior urethral valves (hazard ratios of 2.43 and 5.1, respectively) compared to patients with unilateral or bilateral renal hypodysplasia, or multicystic or horseshoe kidney, and was independent of other prognostic factors. Our study shows that sub-clinical defects of the solitary kidney may be responsible for a poorer prognosis compared to more benign forms of CAKUT. Prospective studies are needed to validate these results.

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