e-ISSN: 0976-822X, p-ISSN:2961-6042

Available online on http://www.ijcpr.com/

International Journal of Current Pharmaceutical Review and Research 2026; 18(8); 1172-1177

Original Research Article

Quality of Life Before and After Cataract Surgery: A Systematic Review and Meta-Analysis

Anuj Kumar[1], Ratan Singh[2], Abhinav Singh[3]

[1]Assistant Professor, Department of Ophthalmology, MVASMC, Bijnor, Uttar Pradesh, India
[2]Associate Professor, Department of Dermatology, MVASMC, Bijnor, Uttar Pradesh, India
[3]Assistant Professor, Department of Physiology, MVASMC, Bijnor, Uttar Pradesh, India

Received: 01-06-2026 / Revised: 02-07-2026 / Accepted: 01-08-2026
Corresponding Author: Dr. Anuj Kumar
Conflict of interest: Nil

Abstract:

Objectives: Cataracts are symptomatic lens opacities that obstruct the passage of light onto the retina due to loss of transparency and cause a reduction in vision. The present systematic review and meta-analysis study was to evaluate the quality of life before and after cataract surgery.

Methods & Results: A numerous article of national and international repute journals (data base: Pubmed, Scopus, Medline, Embase, etc) were reviewed. Factors Related to the Outcome of Cataract Surgery Monitoring cataract surgical outcomes can be observed in four categories: selection (selection of patients related to poor visual acuity due to preoperative comorbidities such as corneal opacity, glaucoma, and damage to the retina and optic nerve); surgery (surgery-related intraoperative and postoperative complications that affect visual acuity, including lens capsule rupture, iridodialysis, zonular dehiscence, presence of residual material, wound leakage, severe uveitis, and keratopathic striae); spectacles (eyeglass correction); and sequelae (post-operative complications such as posterior capsule opacification, retinal detachment, uveitis, and secondary glaucoma). Evaluation of surgical outcomes in each study was measured, including (1) visual acuity with or without the best correction; (2) measurement of refraction and deviation from the postoperative refractive target; (3) incidence of intraoperative or postoperative complications; and (4) return to the operating room for any secondary surgical intervention.

Conclusions: Cataract surgery significantly improved the quality of life across all studies in developed and developing countries. Cataract surgery, a highly effective procedure for restoring vision, plays a crucial role in enhancing the quality of life for elderly individuals. Beyond the obvious visual benefits, this surgery significantly impacts mental health outcomes, including reductions in depression, anxiety, and cognitive decline. Improved vision leads to greater independence, increased social interaction, and overall enhanced psychological wellbeing. Despite these benefits, various barriers, such as socioeconomic factors and limited access to healthcare services, can hinder the positive outcomes of cataract surgery.

Keywords: Cataract Surgery, Quality of life, Visual Acuity.

DOI: 10.25258/ijcpr.18.8.176

Introduction

A cataract is a clouding of the crystalline lens in the eye. It is a common condition after age of 40 and 4,7 million surgeries per year are performed in Europe [1]. In Latvia, around 10,000 cataract surgeries are performed each year [2]. Cataracts can be classified based on their location within the lens, with the three most common types being nuclear, cortical, and posterior sub capsular (PSC) [1]. These types can occur individually or in combi nation. Cataract progression varies depending on the type of cataract and other factors such as general health and environ mental factors [3,4]. Nuclear cataracts tend to progress more slowly, while PSC cataracts progress more rapidly than cortical and nuclear cataracts [4]. General health conditions such as hypertension and diabetes have also been linked to the development of cataracts. Hypertension can lead to changes in the lens capsule and disruptions in ion transport in lens epithelial cells, as well as an increase in oxidative free radicals [5]. Other studies have shown an association between obesity, hyperlipidaemia, and cataracts, particularly PSC cataracts [6]. Cataracts usually develop slowly and may not cause symptoms at first. Depending on the location of the opacity, cataracts can affect vision differently, causing different symptoms in each type. If the opacity is located in the centre of the lens (nuclear cataract), it may affect visual acuity more at a distance than up close. If the opacity is in the form of spokes (cor tical cataract), patients may complain about glare and monocular diplopia [1,4]. If the opacity is located just inside the posterior lens

capsule (PSC), it can cause significant visual impairment if it affects the axial region of the lens. The sever ity of symptoms such as reduced visual acuity, reduced contrast vision, glare, and impaired color vision may vary at different stages of cataract development [7]. The treatment outcomes are important and relevant to each patient, and the criteria for a successful outcome can vary depending on patient needs, lifestyle, and medical condition. The outcomes may include reduced visual symptoms, improved visual function, achievement of the desired refractive condition, and improved mental health [8,9]. After cataract removal, people may be able to perform everyday tasks more easily and with greater independence, including activities such as driving, reading, and watching TV. Studies have shown that mental health, physical function, and quality of life can be enhanced when visual function is restored through cataract surgery [10,11]. However, there is a lack of information in the literature about outcome satisfaction for different types of cataracts. Objective of the present systematic review and meta-analysis study was to evaluate the quality of life before and after cataract surgery.

Methods & Results

The present study was conducted in the Department of Ophthalmology with the collaboration of the Department of Dermatology and the Department of Physiology of MVASMC, Bijnor, Uttar Pradesh, India during a period from February 2025 to December 2025. A numerous article of national and international repute journals (data base: Pubmed, Scopus, Medline, Embase, etc) were reviewed during study period.

Factors Related to the Outcome of Cataract Surgery Monitoring cataract surgical outcomes was observed in four categories: selection (selection of patients related to poor visual acuity due to preoperative comorbidities such as corneal opacity, glaucoma, and damage to the retina and optic nerve); surgery (surgery-related intraoperative and postoperative complications that affect visual acuity, including lens capsule rupture, iridodialysis, zonular dehiscence, presence of residual material, wound leakage, severe uveitis, and keratopathic striae); spectacles (eyeglass correction); and sequelae (post-operative complications such as posterior capsule opacification, retinal detachment, uveitis, and secondary glaucoma) [12,13]. Recommendations for evaluation of surgical outcomes in each patient was measured, including (1) visual acuity with or without the best correction; (2) measurement of refraction and deviation from the postoperative refractive target; (3) incidence of intraoperative or postoperative complications; and (4) return to the operating room for any secondary surgical intervention [14,15].

Visual Acuity: Visual acuity before the surgery was a poor predictor of postoperative visual function, even though it was often used as a primary indication when to do cataract surgery. It was assumed that postoperative visual function depends on retinal and optic nerve conditions instead of the severity of the cataract itself. In addition, preoperative visual acuity was measured monocularly, while the function was measured binocularly. Thus, the difference in visual function across the eyes rather than the visual function of each eye being evaluated separately may be more closely related to the patient's perceived visual difficulties. When examining binocular function and subjective visual function, patients with bilateral cataracts have better outcomes following bilateral cataract surgery than unilateral cataract surgery. The advantages of cataract surgery increase after the second cataract surgery. A study by Kessel et al. found that 98.1% of patients with fair preoperative visual acuity (≥40 ETDRS) and 98.8% of patients with poor preoperative visual acuity ≤39 ETDRS) experienced an improvement in visual acuity following cataract surgery and there was no statistically significant difference [16–17].

Co-existing Ocular Comorbidities: Preoperative comorbidities were also risk factors for poor outcomes. Ocular comorbidities include corneal scars, old iritis, retinal disease, glaucoma, and others. For example, as retinopathy grading became more severe, visual acuity and visual function improvements became less significant [18,19].

Surgeon: Surgical Technique The transition of surgical techniques from intracapsular cataract extraction (ICCE) to extracapsular cataract extraction (ECCE) and Small Incision Cataract Surgery (SICS) has occurred in the last decade. Poor outcomes were a risk factor for those who underwent the ECCE technique. Even SICS or phacoemulsification was probably the preferred treatment, ECCE being used as a conversion technique when the surgeon found difficulties such as small pupil, pseudo-exfoliation, corneal haze, etc. In addition, Gogate et al. found improved outcomes as they changed technique from ECCE to SICS over time [18,19]. In developed countries, manual ECCE has been replaced by phacoemulsification techniques, demonstrating their superiority. The superiority of rapid visual improvement, or at least astigmatic induced by cataract surgery, is also considered in developing countries. However, the high price of phacoemulsification equipment is not comparable to the ability of poor or developing countries to eradicate cataract blindness [18,19]. Between the two cataract extraction procedures, such as SICS and phacoemulsification, it is questionable which procedure is safer and provides good visual acuity for patients. The nucleus is extracted with SICS, and the polymethyl methacrylate (PMMA) intraocular lens is implanted

through a self-sealing scleral incision. This technique is cheaper regarding capital equipment, equipment maintenance, and disposable costs per case. SICS is a good alternative for countries requiring very high-volume operations with inexpensive instruments. It is the best method of community-based surgery and has cost-effectiveness and early rehabilitation of patients. Although phacoemulsification is the preferred cataract surgery technique worldwide, cheaper methods are gaining popularity in developing countries where a growing backlog of cataract blindness has resulted from insufficient eye health resources [19,20].

Surgeon's Skill: Increased surgical experiences from the cataract surgeon are associated with a lower risk of intraoperative and postoperative complications, as well as the need for re-surgery. Gupta et al. reported that odds decreased by 17% (intraoperative complications), 12% (postoperative complications measured 1 day after surgery), and 7% (re-surgery) per 100 additional surgical experiences performed. This study recommends ophthalmology residency programs in developing countries that teach SICS provide the opportunity to perform 300 or more surgeries on residents to achieve intraoperative and postoperative complication rates of less than 2% [21]. In addition, Haripiya et al. reported SICS is a safer initial procedure to learn for unexperienced cataract surgeons in developing countries [22].

Complications of the Surgery: Numerous efforts are made to minimize the occurrence of intraoperative and postoperative complications. Patients were prepared carefully since initial screening as the feasibility of surgery. Patients who have systemic diseases such as diabetes mellitus and hypertension should be regulated first. Complicating factors such as shallow anterior chamber depth (ACD), small pupils, and the presence of synechiae require special preparation and the selection of appropriate surgical techniques. Surgery time is also significantly influenced by the type of anesthesia, the level of case complexity, the size of the pupil and the pupil expander devices used, and intraoperative complications 23,24]. Intraoperative complications such as iris prolapse, posterior capsule rupture, zonular dialysis with or without vitreous loss, etc. Postoperative complications include hyphema, retained lens material, choroidal effusion, endophthalmitis, etc. A study by Winarti et al. found a significant difference between the number of complications of the posterior lens capsule tearing and aphakia with different operator skill levels [25].

Post Operative Follow Up Care: Visual acuity was evaluated at follow-up for all patients undergoing cataract surgery up to the twelfth week. The recommended postoperative visual acuity is divided into three categories uncorrected visual acuity (UCVA) and the best uncorrected visual acuity (BCVA): good (20/20-20/60) 80% and 90%, borderline (<20/60-20/200) 15% and 5%, and poor (<20/200) 5% and 5% [26-28]. Postoperative follow-up is very important to find out the results of surgery, therapy, and plan and to provide valid feedback on the quality of surgical results for cataract surgery for future improvement [23,24,29].

Some strategies to improve the follow up rate after surgery should be considered, such as transportation reimbursement, free spectacles, reminders, and proper counselling needed [18].

Based on some studies, another risk factor for poor cataract outcomes is increasing age and gender. Increasing age could come along with ocular co-morbidities, which could be underdiagnosed before surgery because the cataracts in older patients were more likely to be denser. Even after controlling or managing those ocular comorbidities, it was discovered that increasing age predicted poor outcomes [18,19,21]. On the other hand, cataract patients in younger age groups have more active and important social and family roles than those in older age groups. This can lead to higher expectations of visual ability and may encourage cataract sufferers in younger age groups to seek treatment sooner.

This results in their visual impairment becoming milder in the early stages [30]. Poor outcomes of cataract surgery were also associated with the female gender, as mentioned in several research. The pre-existing ocular comorbidity or condition may have been obscured because females were probably examined for cataracts later than males and had worse cataracts, likely impacting outcomes [18,21]. But in contrast with the study by Matta et al., good outcomes after cataract surgery are most likely in female patients [19,30].

Psychosocial Blindness leads to disability, leading to social exclusion and stigmatization that interfere with access to social networks, formal services, or social institutions. To assess the social status of patients who had undergone cataract surgery, Finger et al. assessed whether patients who were widowed before and after cataract surgery were married as a result of reduced stigma and increased community skills. There is an increase in remarriage among widows or widowers with cataracts who have been operated on. Conversely, the failure of cataract surgery results in continued poverty and decreases the chance of remarriage for widows. This assessment was conducted because social status and stigmatization are difficult to measure [31,32].

Discussions

Visual Outcome in Different Studies: A study done by Harpreet Kapoor et al. in 1999 and 6383 eyes operated in camp. At discharge with standard aphakic spectacles, poor visual outcome (less than

6/60) was seen in 11.2% of eyes after ICCE, 11.8% of eyes after ECCE without IOL, and 5.7% of eyes after ECCE with IOL, while good vision (6/18 or better) was found in 44.5% of the eyes which underwent ECCE with IOL, 29.4% having ECCE without IOL and 21.6% having ICCE with aphakic spherical glasses [33]. One more study done by R Anand et al. in 2000 in rural Punjab. Of the 428 operated eyes 45.3% gained good vision, 37.85% had low vision and 16.82% were blind. Without sufficient refractive correction only 32.7% of the operated eyes had visual acuity of 6/18 or better. Refractive correction with aphakic glasses and pinhole enabled 45.3% of the operated eyes to see 6/18 or better [34]. Similar study done in Pakistan by A R Malik in 2003, 181 patients. The type of cataract operations they had had were ECCE in 50%, phacoemulsification in 11%, ECCE with intraocular lens (IOL) in 17% and phacoimulsification with IOL in 22%. At presentation, 49.7% had poor functional vision; after refraction 68% had a good visual outcome [35]. In 2011, study done in Ibadan by O.O. Olawoye at. el , A total of 184 patients were enrolled for the study. 17.4% had severe visual impairment (VA<6/60-3/60) while 7.1% had borderline vision (VA< 6/18 – 6/60). 1.1% presented with VA 6/18 [36].

In 2016, study done in LVPEI, Hyderabad, and 2049 were randomly selected using. The most common procedure was SICS with PCIOL (Posterior Chamber Intra Ocular Lens) 91.8%. 61.8% had good outcome and based on Based Corrected Visual Acuity (BCVA), 91.7% had good outcome. Based on Presenting Visual Acuity (PVA) and BCVA, those with less than 6/60 were only 2.9% and 1.6% respectively [18].

As per Mohammed Seid Hussen et al. (2017), 223 cases were evaluated. Nearly, 99% of cataract-operated eyes had poor vision preoperatively (6/60). 26.6% achieved good visual acuity (≥6/18), 28.9% of them had borderline acuity (<6/60).

A study done in Ghana in 2018 by E Kobia-Acquah et al. and total 100 patients were operated. After 1 month, 21.69% had visual acuity of 6/18 or better, 48.19% had a visual acuity of 6/60 - 6/24 and 30.12% had a visual acuity worse than 6/60. Further, 22.89% had visual acuity of 6/18 or better, 48.19% had a visual acuity of 6/60 - 6/24 and 28.92% had a visual acuity worse than 6/60 after three months [37].

Visual Acuity Related to the Quality of Life After Cataract Surgery: Zhu et al. showed that visual acuity is the most important factor associated with decreased vision and quality of life, and a study conducted by Chan et al. reported that visual acuity has a high correlation with quality of life [38,39]. Polack et al. sought to explore factors related to changes in preoperative and postoperative quality of life scores. The influence of overall vision and general and psychosocial functioning consistently had a major impact on each level of visual acuity, indicating that surgery at the visual level of <6/24 is beneficial to the quality of life associated with visual acuity. Improvements in quality of life also consistently improved in people who had bilateral cataract surgery compared to unilateral surgery alone, so it was concluded that surgery in both eyes provided more benefits, so efforts were made to support surgery until the second eye. Poor postoperative visual acuity is associated with minimal improvement in quality of life. Visual acuity results that unmet the World Health Organization (WHO) target criteria indicate the need for improved surgical outcomes to optimize quality of life. Monitoring visual acuity is a priority in postoperative cataract services to assess the cause and determine the appropriate intervention [40,32].

Conclusions

Cataract surgery significantly improved the quality of life across all studies in developed and developing countries. Cataract surgery, a highly effective procedure for restoring vision, plays a crucial role in enhancing the quality of life for elderly individuals. Beyond the obvious visual benefits, this surgery significantly impacts mental health outcomes, including reductions in depression, anxiety, and cognitive decline. Improved vision leads to greater independence, increased social interaction, and overall enhanced psychological wellbeing. Despite these benefits, various barriers, such as socioeconomic factors and limited access to healthcare services, can hinder the positive outcomes of cataract surgery.

References

1. A.A. of Ophthalmology. Cataract in the adult eye preferred practice pattern. Am Acad Ophthalmol. 2021;1:1- 126412.
2. Kataraktas Operacija IK gadu palıdz atgut Redzi vairak neka 10 000 latvijas iedzıvotaju. (n.d.). [cited 2023 Jan 7] https:// www.rsu.lv/aktualitates/kataraktas-operacija-ik-gadu-palidz atgut-redzi-vairakneka-10-000-latvijas.
3. Leske MC. Nine-year incidence of lens opacities in the barbados eye studies. Ophthalmology. 2004;111:483-490.
4. Lewis A, Congdon N, Munoz B, et al. Cataract surgery and sub type in a defined, older population: the SEECAT Project. Br J Ophthalmol. 2004;88:1512-1517.
5. Michael AJ, Afshari NA. Cataract and Systemic Disease: a Review. Clin Experiment Ophthalmol. 2021;49(2):118-127.
6. Park S, Taehun K, Sung-Il C, Eun-Hee L. Association between cataract and the degree of

obesity. Optometry Vision Sci. 2013;90(9):1019-1027.
7. McCarty CA, Mukesh BN, Dimitrov PN, et al. Incidence and pro gression of cataract in the melbourne visual impairment proj ect. Am J Ophthalmol. 2003;136:10 -17.
8. Leinonen J, Laatikainen L. The decrease of visual acuity in cata ract patients waiting for surgery. Acta Ophthalmol Scand. 1999;77:681-684.
9. Zhang JH, Ramke J, Lee CN, et al. A systematic review of clini cal practice guidelines for cataract: evidence to support the development of the WHO package of eye care interventions. Vision. 2022;6:36.
10. Foss JEA, Harwood RH, Osborn F, et al. Falls and health status in elderly women following second eye cataract surgery: a randomised controlled trial. Age Ageing. 2006; 35:66 -71.
11. Finger RP, Kupitz DG, Fenwick E, et al. The impact of successful cataract surgery on quality of life, household income and social status in south india. PLoS ONE. 2012;7:e44268.
12. Gogate P, Optom J, Deshpande S, Naidoo K. Meta-analysis to compare the safety and efficacy of manual small incision cataract surgery and phacoemulsification. Middle East Afr J Ophthalmol. 2015;22(3):362.
13. Cook C. How to improve the outcome of cataract surgery. Community Eye Health. 2000;13(35):37–8.
14. Asia-Pacific Association of Cataract & Refractive Surgeons. Prinsip-prinsip Petunjuk Teknis Operasi Katarak [Internet]. 2020. Available from: www.apacrs.org
15. Gogate PM, Deshpande M, Wormald RP, Deshpande R. Extracapsular cataract surgery compared with manual small incision cataract surgery in community eye care setting in western India: a randomised controlled trial [Internet]. Vol. 87, Br J Ophthalmol. 2003. Available from: http://bjo.bmj.com/
16. Kessel L, Andresen J, Erngaard D, Flesner P, Tendal B, Hjortdal J. Indication for cataract surgery. Do we have evidence of who will benefit from surgery? A systematic review and meta-analysis. Acta Ophthalmol. 2016;94(1): 10–20.
17. Tan ACS, Tay WT, Zheng YF, Tan AG, Wang JJ, Mitchell P, et al. The impact of bilateral or unilateral cataract surgery on visual functioning: When does second eye cataract surgery benefit patients? British Journal of Ophthalmology. 2012;96(6):846–51.
18. Matta S, Park J, Shantha GPS, Khanna RC, Rao GN. Cataract surgery visual outcomes and associated risk factors in secondary level eye care centers of L V Prasad Eye Institute, India. PLoS One. 2016;11(1).
19. Gogate P, Vakil V, Khandekar R, Deshpande M, Limburg H. Monitoring and modernization to improve visual outcomes of cataract surgery in a community eyecare center in western India. J Cataract Refract Surg. 2011;37(2):328–34.
20. Yan X, Guan C, Mueller A, Iezzi B, He M, Liang H, et al. Outcomes and projected impact on vision restoration of the China million cataract surgeries program. Ophthalmic Epidemiol. 2013;20(5):294–300.
21. Hashemi H, Mohammadi SF, Z-Mehrjardi H, Majdi M, Ashrafi E, Mehravaran S, et al. The role of demographic characteristics in the outcomes of cataract surgery and gender roles in the uptake of postoperative eye care: A hospital-based study. Vol. 19, Ophthalmic Epidemiology. 2012:242–8.
22. Haripriya A, Chang DF, Reena M, Shekhar M. Complication rates of phacoemulsification and manual small-incision cataract surgery at Aravind Eye Hospital. J Cataract Refract Surg. 2012;38(8):1360–9.
23. Nderitu P, Ursell P. Factors affecting cataract surgery operating time among trainees and consultants. J Cataract Refract Surg. 2019;45(6):816–22.
24. Gupta S, Haripriya A, Vardhan SA, Ravilla T, Ravindran RD. Residents' Learning Curve for Manual Small-Incision Cataract Surgery at Aravind Eye Hospital, India. Ophthalmology. 2018;125(11):1692–9.
25. Winarti T, Mahayana IT, Setyowati R, Pawiroranu S. Perbandingan komplikasi antara fakoemulsifikasi dan manual Small-Incision Cataract Surgery (mSICS) pada operasi katarak massal: Sebuah penelitian kohort retrospektif. Journal of Community Empowerment for Health. 2019;2(1):97.
26. Meyer JJ, Murray NL. NL Correlation of early and late cataract surgery outcomes. Vol. 12, Nepal J Ophthalmol. 2020.
27. Congdon N, Yan X, Lansingh V, Sisay A, Müller A, Chan V, et al. Assessment of cataract surgical outcomes in settings where follow-up is poor: PRECOG, a multicentre observational study. Lancet Glob Health. 2013;1(1).
28. World Health Organization. Informal Consultation on Analysis of Blindness Prevention Outcomes. Geneva; 1998.
29. Gupta S, Ravindran RD, Subburaman GBB, Vardhan S. A, Ravilla T. Evidence on Importance of Follow-up Visits after Cataract Surgery. Ophthalmology. 2019;126(6):910–2.
30. Venkatesh R, Muralikrishnan R, Balent LC, Prakash SK, Prajna NV. Outcomes of high volume cataract surgeries in a developing country. Vol. 89, British Journal of Ophthalmology. 2005: 1079–83.
31. Polack S. The impact of cataract surgery on health related quality of life in Kenya, the

Philippines, and Bangladesh. Ophthalmic Epidemiol. 2010;17(6):387–99.
32. Lindfield R, Kuper H, Polack S, Eusebio C, Mathenge W, Wadud Z, et al. Outcome of cataract surgery at one year in Kenya, the Philippines and Bangladesh. British Journal of Ophthalmology. 2009;93(7):875–80.
33. Harpreet Kapoor. Evaluation of visual outcome of cataract surgery in an Indian eye camp. Br J Ophthalmol. 1999;83:343–346.
34. R Anand. Visual outcome following cataract surgery in rural punjab. Indian Journal of Ophthalmology. 2000,48,153-161
35. A R Malik. Visual outcome after high volume cataract surgery in Pakistan. Br J Ophthalmol. 2003;87:937–940.
36. Gauri Shankar Shrestha, Ramesh Sigdel, Jyoti Baba Shrestha, Ananda Kumar Sharma. Visual outcome after cataract surgery at the university college hospital, Ibadan. J Ophthalmic Vis Res. 2018; 13 (4): 461-469.
37. E Kobia-Acquah, TM Pascal, A Amedo, NY Koomson. "Visual Outcome after Cataract Surgery at the Sunyani Regional Hospital, Ghana". EC Ophthalmology 9.4 .2018; 181-188.
38. Zhu M, Yu J, Zhang J, Yan Q, Liu Y. Evaluating vision-related quality of life in preoperative age-related cataract patients and analyzing its influencing factors in China: A cross-sectional study Cataract and refractive surgery. BMC Ophthalmol. 2015;15(1).
39. Chan CWN, Wong JCC, Chan KSK, Wong WK, Tam KCK, Chau PSY. Evaluation of quality of life in patients with cataract in Hong Kong. J Cataract Refract Surg. 2003; 29(9):1753–60.
40. Polack S. The impact of cataract surgery on health related quality of life in Kenya, the Philippines, and Bangladesh. Ophthalmic Epidemiol. 2010;17(6):387–99.