

Conflict-Zone Ophthalmology; A report of two vitreoretinal surgical missions to the Gaza strip between May and August 2025

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Purpose and Setting

To report the experience of 2 UK-based vitreoretinal surgeons (MO and YH) who visited Gaza on two 15-day voluntary visits between May and August 2025; in Nasser and Al-Amal Hospitals (Khan-Younis, South Gaza) and The Gaza Ophthalmic hospital (Gaza city, North Gaza)

Results

357 were patients reviewed in the clinics , 18.8 % (n=67) underwent surgery. Of the 67 patients: Mean age : 37.9 years [1–75, ± 18.1]; 16.4% < 18 , Males: 77.7 % (n=52) Females : 22.3 % (n=15) Trauma accounted for 43.3% of cases (n=29) and non-traumatic indications for 56.7% (n=38).

Traumatic Cases

The most common post-trauma procedure was **Vitrectomy for intra-ocular foreign body (IOFB) removal**, representing 52% of cases (n=15). This was followed by **vitrectomy for traumatic vitreous haemorrhage with or without retinal detachment**, comprising 38% (n=11). (Fig1-6)

Table 1 Summary of Trauma Cases

Intra-ocular FB	15
Traumatic VH	11
Open globe injury	2
Eyelid wound	1

Non-Traumatic Cases

Among non-traumatic indications, **silicone oil removal** (with or without additional vitrectomy) accounted for 34% of cases (n=13), while **vitrectomy for rhegmatogenous retinal detachment** represented 26% (n=10) (Fig 7&8)

Table 2 Summary of Non-Trauma Cases

SOFG	13	VH	4
RRD	10	Dislocated IOL	2
Cataract	3	Endophthalmitis	1
TRD	4	OSSN	1

Poor prognosis was reported in 33% of surgical patients (n=22) , (47% trauma vs 22% non-trauma) including 2 patients where surgery was abandoned due to severe trauma. Silicone oil was the only tamponade available. Re-usable instruments were sterilized in steam autoclave. Single use surgical supplies were re-sterilized using ethylene oxide gas or stored in formaldehyde overnight .All patients were seen at day1-2 postoperative and then within 1-2 weeks after .No cases of postoperative endophthalmitis were reported. Among the 81% where surgery was not performed, a small proportion were placed on a waiting list for subsequent missions. The remainder larger proportion were considered inoperable due to advanced clinical presentation and delay of treatment.

Conclusion

Through close coordination with the local ophthalmic team, patients awaiting review or surgery were identified, contacted, and attended clinic and theatre. Supplies brought in with missions, were re-sterilized and reused carefully according to local protocols, ensuring sustainability. Sight-saving surgery was delivered collaboratively, with postoperative care and ongoing follow-up led by the Palestinian surgeons who continue to operate in between missions and are being supported by previous and subsequent visiting teams.

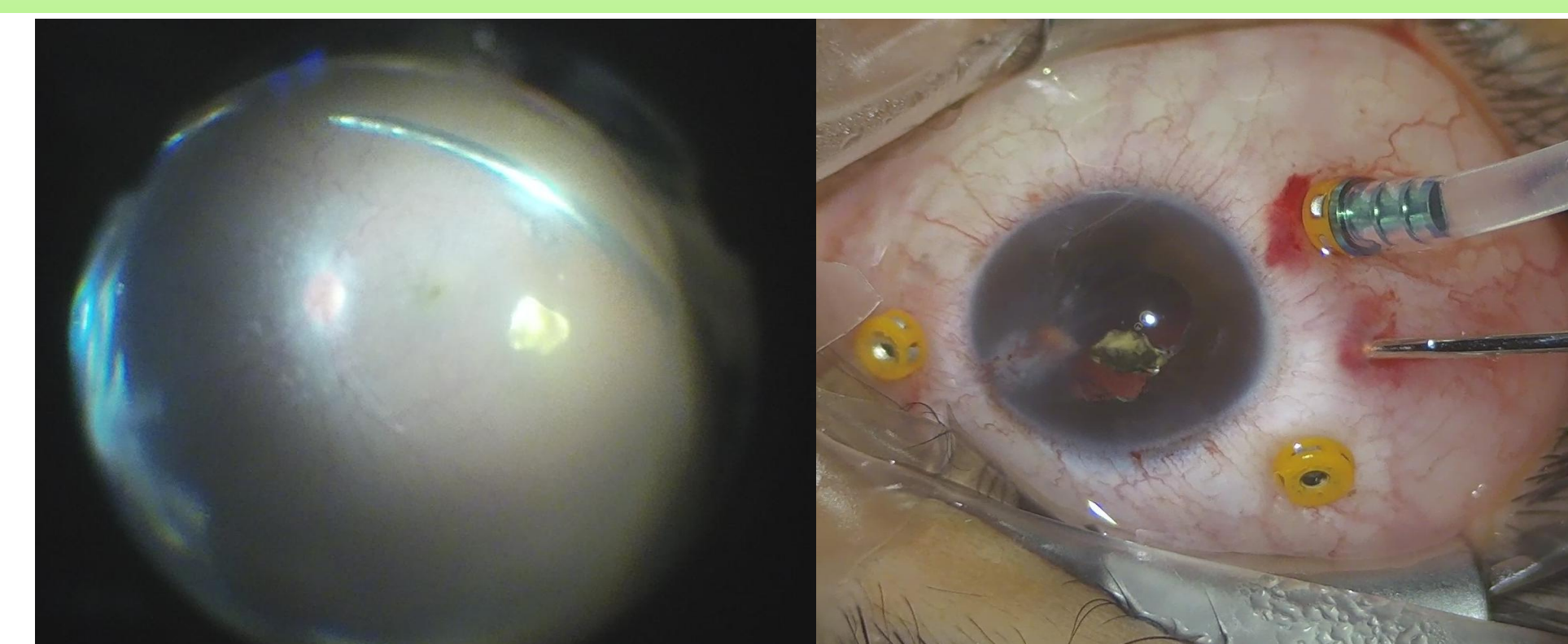


Fig 1 & 2 : Large non-metallic IOFB removed using a basket forceps through a sclerotomy

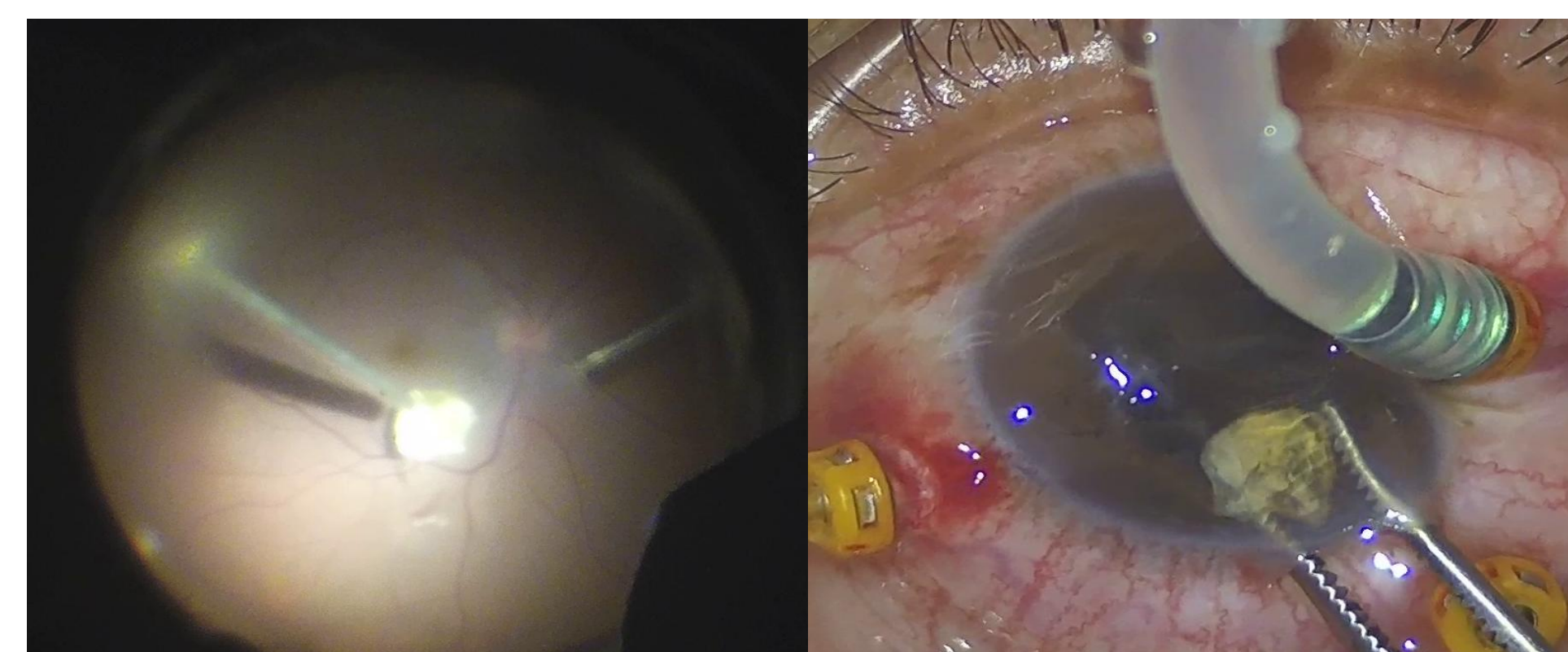


Fig 3&4: Large non-metallic IOFB aspirated into the AC and removed using a non-toothed forceps through a clear incision

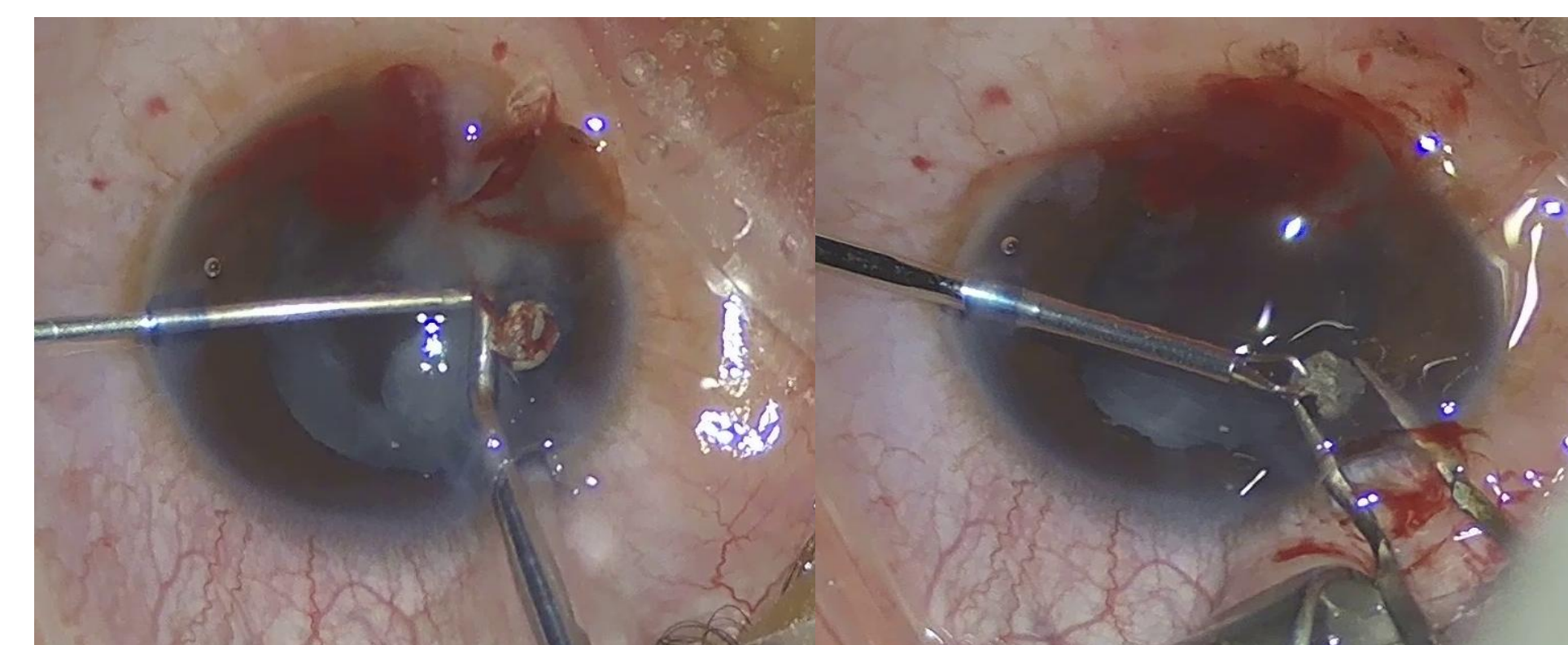


Fig 5&6 Small metallic intra-lenticular FB maintained in the AC with a basket forceps and then removed using a non-toothed forceps via a clear corneal incision .

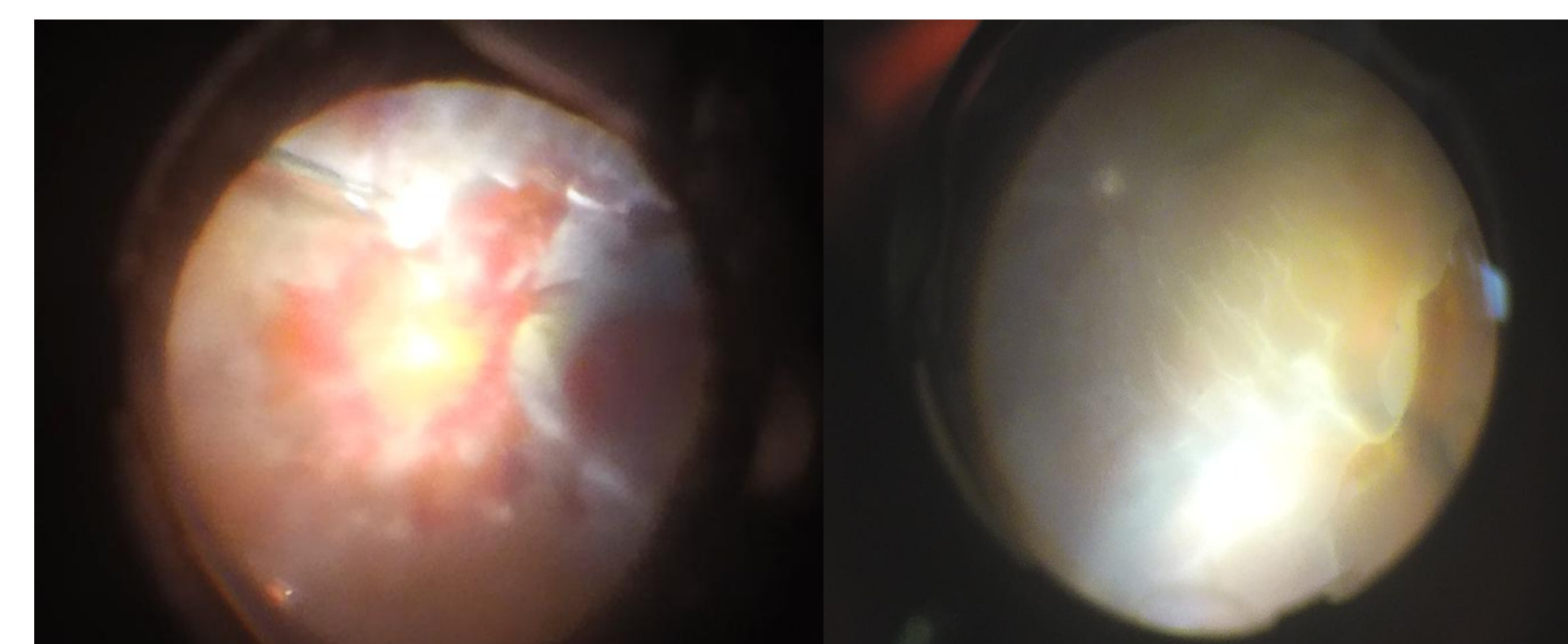


Fig 7 Extensive TRD 2ry to DM

Fig 8 Long-standing GRT RRD