Dear colleagues, dear friends,

First of all I would like to thank my friend Zoran Tomić and my colleague Ulrich Spandau – editors of this book – for giving me a chance to write the first chapter of this book, the chapter on history of vitreoretinal surgery. With the contributions of numerous authors, besides pathogenesis and clinical picture, it provides an elaborate description of operative treatment of all forms of detachment with proliferative retinopathy. Particular interest of the readers will be aroused by the unusual chapter on individual approach and technique of the proliferative retinopathy treatment.

I am sure that this book even in this era of digital technology and gaining information from the Internet will arouse great interest with all those who pursue this difficult job.

Congratulations to all who contributed to writing and publishing of this book.

Ladies and gentlemen, I would like to use this occasion today to say a few words from this place about the problem concerning all those who are engaged in this surgery, and which has been pre-occupying me for years and of which I have written and spoken on several occasions. It is the problem of the so called complex cases whose treatment is beyond the limits of everyday surgery. During my last years of work in v.r. surgery there was a more and more obvious tendency of decreased interest for the treatment of complex cases as well as for proclaiming such cases inoperable. Without denying the existing number of young surgeons who are interested and willing to face this difficult pathology, I find that the number of difficult cases that are proclaimed inoperable is still large. They are mostly cases after serious trauma as well as after failed operations of retinal detachments etc. Most frequently it is a case of patients whose other eye is healthy (who, surprisingly, comparatively easily accept such a decision). In such cases the decision to give up the operation is very questionable and finally also wrong. On the contrary – the decision to perform the operation should be brought after a discussion and detailed informing of the patient about the course of the operation and possible results of the operation. The patient should hear that the desired and mostly possible success is impossible to be predicted, that the success even might not be permanent, and that the possibility that another operation might be necessary, in order to secure permanent result, often occurs. The treatment of that kind of case demands from both sides – the patient and the surgeon – a lot of patience, persistence and belief in the final positive result.

The difficulty, length of treatment and comparatively modest final result of the whole treatment, may seem unattractive to many surgeons and to some extent be an excuse for giving up the operation. However, at present time with the existing concept and technique of successful treating complex cases that promise comparatively good prospects for regaining at least minimal functions and decreasing of a patient’s invalidity, not to offer help such patients is a serious ethical offence.

The development of society in recent decades and within it the development of health care influenced in many ways, frequently negative, the work of physicians. Such changes certainly cannot be an excuse for the negative attitude towards the difficult and unprofitable work, yet they certainly are in part the explanation of their existence. For a long time the social health care system in which the patient had a central place and the patient's interest dictated all events in hospitals, has been turning into saving and rationalization by the introduction of a new system of management. That new system, in many ways good and rational, is gradually changed into a system where the priority target is profit and earning money. Such system whose aim is making profit by treating the ill, is naturally to the utmost interested in routine surgery with operations as short as possible, maximum result and as short as possible stay of the patients at hospital. In such institutions an operation is called a product while a patient is a client. Ophthalmology as a surgical branch with brilliant results (operations of cataract, refractive surgery) is practically without complications with a minimal stay at hospital. As such it is the favourite discipline in private hospitals. Therefore it is certainly clear
that vitreoretinal surgery complex cases, with long operations of undefined duration and uncertain outcome, is not suitable for such institutions. An easier vitreoretinal operation now and then may be welcome in order to complete the positive image of the institution. The number of those private clinics and medical companies is growing, so that in some countries which used to have or have well organized health system, they overtake public hospitals becoming an important factor in health care of the respective state. An additional pressure on v.r. surgeons, who are ready to take operations of complicated cases, is the practice of complaints and law proceedings filed by the patients unsatisfied with the result of the operation. That habit, very frequent in America, appears ever more frequently in Europe.

The described situation of pressure and confusion of different systems, the possibility of better earning by easier work and everything that emerges, does not stimulate a young surgeon to be dedicated to that difficult and complex surgery with uncertain result. Therefore it is to some extent understandable – not justified – that in such a situation they avoid the difficult and often unrewarding task. Consequences of such decisions are catastrophic for the patient. Patients lacking persistence return home believing that there is no hope for them, while those more persistent start seeking a surgeon that could help them, losing precious time and making the already serious situation even worse.

The next aspect of the problem concerns education of young surgeons. It is clear that this surgery cannot be learnt by practising on animals, neither with computer simulation, but only on patients with that kind of pathology. Therefore the number of patients with that kind of pathology that a young physician can see or treat during his education is essential for acquiring experience. A relatively small number of patients with serious conditions – complex cases – distributed at present time in relatively large number of centres, is, in particular cases, even smaller, so it is hard to suppose it would be sufficient for gaining experience in the said treatment. Exposed in practice to all afore numbered pressures at the workplace, with insufficient experience in treatment of such cases, the surgeon is liable to giving up, which slowly becomes permanent practice. Such an ending, besides presenting to the patient a tragic outcome of illness, presents the loss in the education of the particular surgeon.

Being a person who in this field spent a long period of time treating such patients, I guess you can imagine that this development makes me sad and I keep considering what could be done in order to resist this phenomenon. An ideal solution of this problem would be the selection and concentration of such cases and their treatment in special institutions where the question of their treatment by competent surgeons and the education of young surgeons would be solved in the best possible way. However, I think that this solution, though it seems attractive and logical, for different reasons is not feasible in wider application.

Following the afore idea about supplementary education and treatment of complex cases in institutions appropriate for such work, my friend and successor Dr. S. Natarajan, pioneer of this surgery in India and owner of a hospital in Mumbai, India, as the founder of Dr. Živojnović Foundation, initiated, in cooperation with me, that kind of education. Young surgeons after having completed a two year fellowship in vitreoretinal surgery are given an opportunity to dedicate six additional months to the theory, analysis and processing of such cases. The emphasis in additional education is not primarily on practical work, because they already possess basic operating experience from the previous education, but the point is much more the analysis of the etiology and treatment of particular cases of the kind, as well as the final result. With such additional education we hope to encourage stronger interest in treatment of such cases and convince young surgeons that even the minimal return of function of the operated eye after the treatment is of immeasurable use for the patient.

Aiming to realize this intention we have founded, in agreement with several colleagues and clinics that are able to offer that kind of education, a fellowship in duration of six months. After the selection of candidates
the stay of the chosen candidates will be sponsored during the fellowship. Details can be found on the website The Zivojnovic Fellowship.

Ladies and gentlemen,

My today’s appearance is probably my last one at a scientific meeting, therefore I would like to say a few words about my career and mention some names which left a deep trace in my memory.

After spending three years at general surgery in Yugoslavia and Germany, in 1963 I started specializing ophthalmology in the Eye Hospital in Rotterdam. The Eye Hospital was then with its 150 beds and 5 to 6 thousand operations a year among the largest eye hospitals in Europe. Regarding its structure it was a private non-profit foundation and regarding its function it was a teaching hospital connected to the University in Utrecht. The large-scale task was mastered by the senior staff of five and additional eight residents. Ten private physicians from the town treated and operated their patients at the Hospital on their own. At the time the Hospital was considered a referall place for serious cases in Holland. Although not numerous, the staff physicians were always ready to help the younger ones who were soon introduced into independent practical and operative work with patients. The lack of an academic run for publication, promotions and titles, allowed full dedication to work with patients. In that pleasant, fruitful and stimulating atmosphere I was able to stay for two years and a half after completing my specialization as a junior member of the staff at the Hospital. Practicing entire ophthalmic surgery I show ever more interest in the surgery of the retina. After six years and a half spent in Rotterdam I returned to Yugoslavia, which I left dissatisfied with professional opportunities, returning to Holland after three years. Upon returning I dedicate myself utterly to retinal surgery. Using the opportunities provided by work and my position in the Eye Hospital, I travel around Europe, in particular England, visiting local centres and colleagues, compare my work with theirs, and learn from them. Unsatisfied both with the results of the others and mine, I venture into unknown in extremely serious cases and introduce the retina into the surgical process. Towards the end of 70’s the period of searching comes to an end by my concept of surgical treatment of complex cases that was immediately accepted. It is a period of my visits to many countries where surgeons show interest in the new way of treating serious cases. Since those days, at home, at the Eye Hospital, I have daily operated complex cases, referred to me from the whole world.

On this long journey of over 20 years of intensive and successful work in the Eye Hospital in Rotterdam I would like to mention several names that are inextricably linked to that period. Professor Harold Henkes and my good friend director Jan Renardel de Lavalette – both no longer alive – who with their committed work made the Eye Hospital a unique place in the world; Diana Mertens, colleague with whom in 20 years I passed through all difficulties and obstacles in the struggle against PVR, Ger Vijfvingel, creator and constructor of the majority of instruments without which the progress in surgery could not be imagined; Bert Smit, the photographer who for hours with incredible patience with his 16 mm camera through microscope tube took the course of operations before the time of television and later directed all our video presentations.

Of my international contacts John Scott, Klaus Heimann and Robert Machemer – are not alive any longer – were not only colleagues, but also good friends.

In 1989 to my deep regret I left Rotterdam and the Eye Hospital due to the changes in the Hospital that I have described before, and moved to Antwerp, where working in Middelheim Hospital under much more convenient conditions I completed my working life.
My working life and the result of my work were conditioned and enabled by the time and place where they took place. The time when I moved to Europe was the time of economic boom, construction, optimism and trust in the future. Holland, as a country of order, wealth and tolerance, was an ideal place to work for somebody arriving from the neglected Balkans. My first contact with ophthalmology was at the time when ophthalmologic surgery, after decades of stagnation, started to develop fast. The surgery of the anterior and posterior segment of the eye developed in its own way. Microsurgery of cataract, glaucoma, implantology and phacoemulsification became attractive both for young surgeons and patients who till then had to lie for days in bed with closed eyes after the operation. The surgery of the posterior segment does not stay behind the anterior. By appearance of modern microscope, surgical procedure on the posterior segment becomes possible. Xenon and laser coagulation enable the treatment of diabetic retinopathy and other illnesses, while new materials improve results in surgery of the detachment of the retina. This new development produces an atmosphere of curiosity and creativity and also opens challenge to new inventions. While still a young physician I took part in full measure in the departure of the old and arrival of a new era in the development of surgery. The work at the Hospital was getting on in a collegial atmosphere with great care for the patients. In addition, openness in contact with other clinics in the country and abroad influenced the quality of work and results at the Hospital. Care for patients was high on the scale of priority in work, and material interest definitely did not dictate work results. In such an atmosphere I was given the possibility to dedicate myself to vitreoretinal surgery. Nobody tried to shorten, count or rationalize the long hour operations. Numerous travels abroad were never objected to. Results of work could not fail in that environment. Often and with pleasure I remember the years spent in Rotterdam.

Without diminishing my personal contribution I want to say once more that I am convinced that the time, place and conditions of work significantly contributed to the success in my career.

At the end of this long story, ladies and gentlemen, I thank you for your attention.