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Original Article

Impact of cataract surgery on visual acuity and quality of life in diabetic patients: a cross-sectional study.

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Abstract

Background

Diabetes increases the risk of cataracts and complicates postoperative recovery, potentially affecting visual outcomes and quality of life. This study evaluates the impact of cataract surgery on visual acuity and quality of life in diabetic patients.

Objective

To assess changes in visual acuity and quality of life following cataract surgery in diabetic patients and analyze the influence of diabetic retinopathy

Methods

This hospital-based cross-sectional study included 100 diabetic patients aged 45-75 years who underwent phacoemulsification cataract surgery. Best-corrected visual acuity (BCVA) was measured in logMAR units, and quality of life was assessed using the National Eye Institute Visual Function Questionnaire-25 (NEI VFQ-25) before surgery and at 3 months after surgery. Outcomes were compared between patients with and without diabetic retinopathy. Statistical significance was determined using paired t-tests.

Results

The mean age of participants was 59.8 $\pm$ 8.4 years; 52% were males and 48% were females. Type 2 diabetes was present in 62% of patients, and the mean duration of diabetes was 8.2 $\pm$ 3.6 years. The mean preoperative BCVA was 0.8 $\pm$ 0.1 logMAR, improving significantly to 0.2 $\pm$ 0.1 logMAR postoperatively ($p < 0.001$). Postoperative BCVA < 0.3 logMAR was achieved in 87% of patients. Overall NEI VFQ-25 scores increased from 54.6 $\pm$ 8.3 to 85.2 $\pm$ 7.4 ($p < 0.001$). Patients without diabetic retinopathy demonstrated better outcomes than those with mild-to-moderate diabetic retinopathy. Minor complications were observed in 8% of cases.

Conclusion

Cataract surgery significantly improves visual acuity and vision-related quality of life in diabetic patients, with better outcomes in those without diabetic retinopathy. Early intervention and comprehensive diabetes management can enhance surgical benefits.

Recommendations

Routine early cataract surgery, strict glycemic control, preoperative retinal evaluation, and postoperative diabetic retinopathy monitoring are recommended to maximize recovery, improve quality of life, and minimize complications.

Keywords: Diabetes, Cataract Surgery, Visual Acuity, Quality of Life, Diabetic Retinopathy, National Eye Institute Visual Function Questionnaire-25, Phacoemulsification.

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Introduction

Cataract is one of the leading causes of reversible blindness worldwide, disproportionately affecting individuals with diabetes due to accelerated lens opacification¹. Diabetic patients are at a higher risk of developing cataracts at an earlier age and often face more complex postoperative outcomes². The dual burden of diabetes and cataracts significantly impacts visual acuity and overall quality of life, limiting daily activities and independence³.

Cataract surgery, primarily performed using phacoemulsification, is the standard treatment to restore vision. However, the presence of systemic complications such as diabetic retinopathy (DR) can influence the surgical outcomes^{4,5}. Diabetic patients with retinopathy may experience reduced improvements in visual acuity and quality of life compared to those without retinal complications. Additionally, diabetes poses unique challenges during the postoperative period, such as delayed wound healing, increased inflammation, and heightened risks of complications, making it essential to evaluate surgical outcomes specifically in this population^{6,7}.

While previous studies have examined the outcomes of cataract surgery in diabetic populations, there is limited comprehensive data addressing both visual acuity improvement and quality of life changes using validated metrics such as the National Eye Institute Visual Function Questionnaire (NEI VFQ-25). Furthermore, the influence of diabetic retinopathy on these outcomes warrants detailed exploration.

This study aims to assess the impact of cataract surgery on visual acuity and quality of life in diabetic patients, comparing outcomes between those with and without diabetic retinopathy.

Methodology

Study Design and Setting

This hospital-based cross-sectional analytical study with paired preoperative and 3-month postoperative assessment was conducted at Sarojini Devi Eye Hospital, Osmania Medical College, Hyderabad, Telangana, India, from October 2025 to March 2026. The study was carried out in the cataract outpatient

and surgical units of a tertiary care government teaching ophthalmology hospital. The hospital functions as a high-volume referral centre for Hyderabad and adjoining districts and routinely manages cataract, diabetic eye disease, retina, glaucoma, cornea, emergency, and subspecialty ophthalmic services. Eligible patients were identified from the regular diabetic cataract surgical schedule.

Participants

Diabetic patients aged 45-75 years who were diagnosed with cataract and scheduled for phacoemulsification with intraocular lens implantation were considered for enrolment. Participants were recruited consecutively from outpatient and preoperative cataract services until the final sample size was achieved.

Inclusion Criteria

Patients were included if they had a documented diagnosis of diabetes mellitus, clinically significant cataract requiring phacoemulsification, age between 45 and 75 years, ability to complete visual acuity and quality-of-life assessment, and willingness to provide written informed consent.

Exclusion Criteria

Patients with advanced diabetic retinopathy, active ocular infection, significant corneal opacity, glaucoma with advanced optic nerve damage, macular pathology unrelated to diabetes, previous intraocular surgery in the study eye, intraoperative complications requiring protocol deviation, or inability to attend follow-up were excluded.

Study Size and Sampling

A formal statistical sample size calculation was not performed. A convenience sample of 100 consecutive eligible diabetic cataract patients was included based on feasible patient availability, routine surgical throughput, and completion of the 3-month postoperative assessment during the defined study period.

Bias

Possible selection bias was minimized by consecutive recruitment of eligible patients from the routine surgical schedule. Measurement bias was reduced by using standardized logMAR-based BCVA assessment and the validated NEI VFQ-25 questionnaire at predefined time points. Observer variation was minimized by following uniform ophthalmic examination and diabetic retinopathy grading procedures. Surgical performance bias was limited by using a standard phacoemulsification protocol performed by experienced surgeons. Attrition bias was addressed through scheduled postoperative follow-up at 1 week, 1 month, and 3 months, and no participant was lost before final assessment. Confounding due to diabetic retinopathy was explored through subgroup analysis.

Informed Consent and Confidentiality

Written informed consent was obtained from each participant before enrolment after explaining the study purpose, procedures, expected benefits, possible risks, and voluntary nature of participation in a language understood by the patient. Patient identifiers were removed from the analysis dataset, and results were reported only in aggregate form to maintain confidentiality.

Data Collection:

Baseline Assessment:

Demographic details, diabetes history, and ocular examination findings were recorded. Best-corrected visual acuity (BCVA) was measured using the logMAR chart, and quality of life was assessed using the National Eye Institute Visual Function Questionnaire (NEI VFQ-25).

Diabetic Retinopathy Grading:

Fundus examination was performed to classify patients into two groups: those without diabetic retinopathy (No DR) and those with mild-to-moderate diabetic retinopathy (Mild-to-Moderate DR).

Surgical Procedure:

All patients underwent phacoemulsification cataract surgery with intraocular lens implantation, performed by experienced surgeons under standard protocols.

Follow-Up:

Patients were followed up at 1 week, 1 month, and 3 months post-surgery. Postoperative BCVA and NEI VFQ-25 scores were recorded at the 3-month follow-up.

Outcome Measures:

Primary outcomes: Improvement in BCVA and NEI VFQ-25 scores.

Secondary outcomes: Incidence of postoperative complications.

Statistical Analysis:

Data were analyzed using paired t-tests to compare preoperative and postoperative outcomes. Subgroup analysis was performed between No DR and Mild-to-Moderate DR groups. A p-value < 0.05 was considered statistically significant.

Ethical Approval

Approval was obtained from the Institutional Ethics Committee of Osmania Medical College, Hyderabad, before initiation of the study. All participants were informed about the purpose, procedures, potential benefits, and possible risks of the study. Written informed consent was obtained before data collection. Confidentiality and anonymity were maintained by coding patient information and using de-identified data during analysis and reporting.

Results

Participant Flow

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Participants were recruited consecutively from the diabetic cataract outpatient and operative schedule. A total of 100 diabetic cataract patients were assessed

for eligibility; all 100 met the eligibility criteria, provided written informed consent, underwent phacoemulsification surgery, and completed the 3-month postoperative assessment. No participant was excluded after screening and no dropout occurred; therefore, no dropout-related reason was applicable. All 100 participants were included in the final analysis (Figure 1).

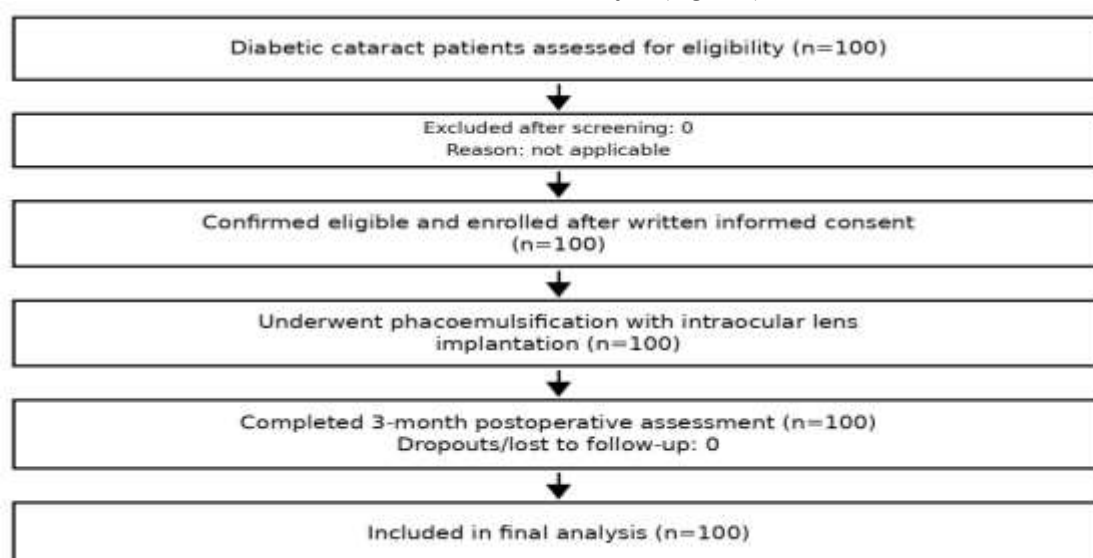


Figure 1: Participant Flow Diagram

Demographic Characteristics

The study enrolled 100 diabetic patients, with a male-to-female ratio of 52:48. The mean age of the

participants was 59.8 ± 8.4 years. Among the patients, 38% had Type 1 diabetes, and 62% had Type 2 diabetes, with a mean diabetes duration of 8.2 ± 3.6 years (Table 1).

Table 1: Demographic Characteristics

Characteristic	Value
Total Patients	100
Males	52
Females	48
Mean Age (years)	59.8 ± 8.4
Type 1 Diabetes (%)	38
Type 2 Diabetes (%)	62
Mean Duration of Diabetes (years)	8.2 ± 3.6

Visual Acuity Outcomes

The mean preoperative best-corrected visual acuity (BCVA) was 0.8 ± 0.1 logMAR, with only 5% of

patients having a BCVA < 0.3 logMAR. Postoperatively, at 3 months, the mean BCVA improved significantly to 0.2 ± 0.1 logMAR, with 87% of patients achieving a BCVA < 0.3 logMAR (Table 2, Figure No:2).

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Table 2: Visual Acuity Outcomes

Timepoint	Mean BCVA (logMAR)	Patients with BCVA < 0.3 logMAR (%)
Preoperative	0.8 ± 0.1	5
Postoperative (3 months)	0.2 ± 0.1	87

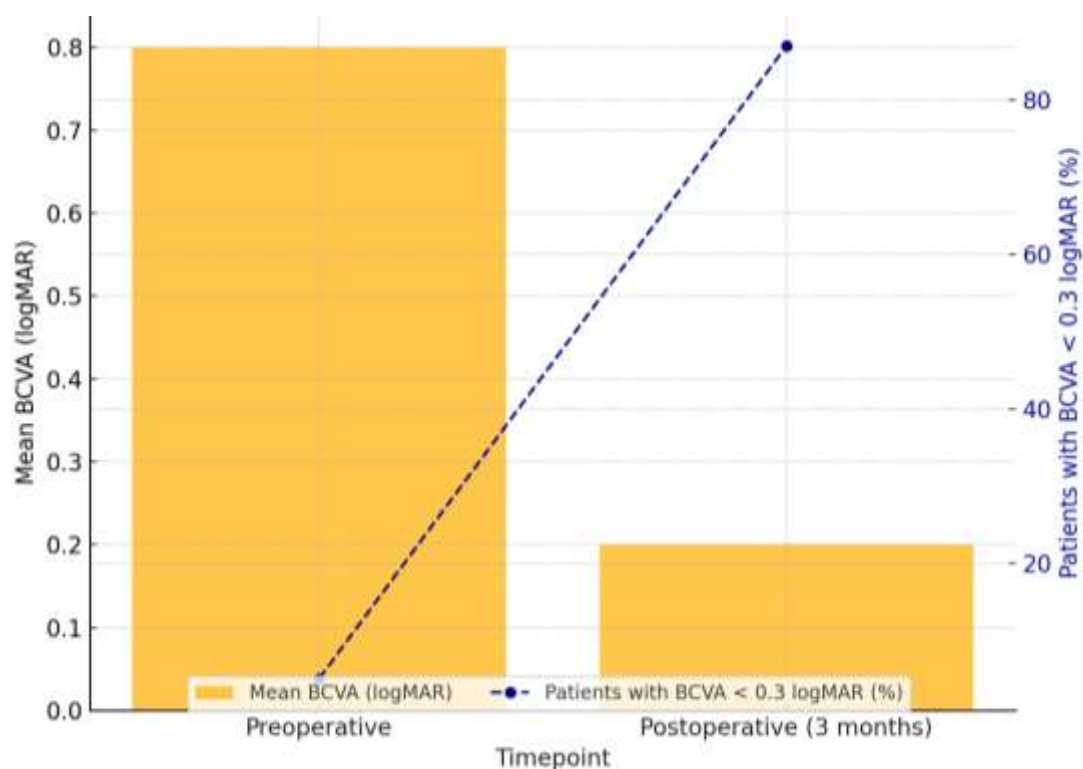


Figure No:2 Visual Acuity Outcomes
Quality of Life Outcomes

The mean NEI VFQ-25 scores improved significantly across all subscales. The overall score increased from 54.6 ± 8.3 preoperatively to 85.2 ± 7.4

postoperatively. Subscale improvements were noted for general vision (from 45.2 ± 9.8 to 83.1 ± 8.2), near vision (from 47.8 ± 11.2 to 81.5 ± 9.5), and distance vision (from 50.5 ± 10.7 to 87.3 ± 7.9) (Table 3, Figure No:3).

Table 3: Quality of Life Outcomes (NEI VFQ-25 Scores)

Subscale	Preoperative Score (Mean $\pm$ SD)	Postoperative Score (Mean $\pm$ SD)
Overall	54.6 $\pm$ 8.3	85.2 $\pm$ 7.4
General Vision	45.2 $\pm$ 9.8	83.1 $\pm$ 8.2
Near Vision	47.8 $\pm$ 11.2	81.5 $\pm$ 9.5
Distance Vision	50.5 $\pm$ 10.7	87.3 $\pm$ 7.9

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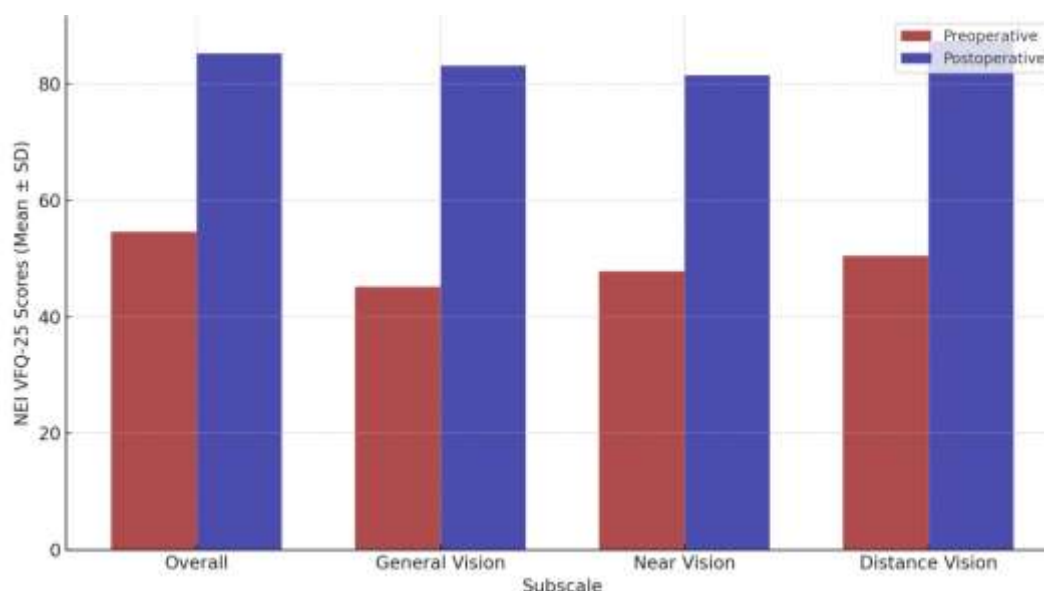


Figure No:3 Quality of Life Outcomes(NEIVFQ-25 S)

Influence of Diabetic Retinopathy

Patients without diabetic retinopathy showed superior outcomes compared to those with mild-to-moderate diabetic retinopathy. The postoperative

BCVA for patients without retinopathy was 0.2 ± 0.1 logMAR, while it was 0.3 ± 0.1 logMAR for those with retinopathy. Similarly, NEI VFQ-25 scores were higher in patients without retinopathy (85.2 ± 7.4) compared to those with mild-to-moderate retinopathy (77.4 ± 8.5) (Table 4, Figure No:4).

Table 4: Influence of Diabetic Retinopathy

Group	Postoperative logMAR	BCVA (Mean $\pm$ SD)	NEI VFQ-25 Score (Mean $\pm$ SD)
No Diabetic Retinopathy	0.2 ± 0.1		85.2 ± 7.4
Mild-to-Moderate Diabetic Retinopathy	0.3 ± 0.1		77.4 ± 8.5

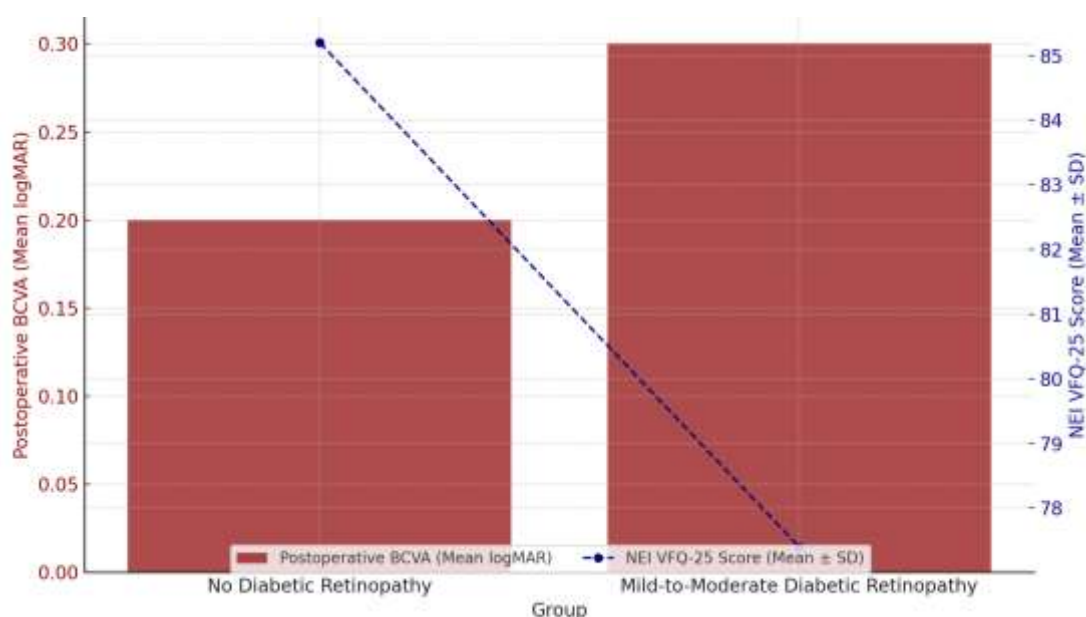


Figure No:4 Influence of Diabetic Retinopathy

Complications

Postoperative complications were minimal and included mild corneal edema in 5% of patients and transient intraocular pressure elevation in 3% of patients. No cases of endophthalmitis or significant vision loss were reported (Table 5, Figure No:5).

Table 5: Complications

Complication	Patients (%)
Mild Corneal Edema	5
Transient Intraocular Pressure Elevation	3
Endophthalmitis	0
Significant Vision Loss	0

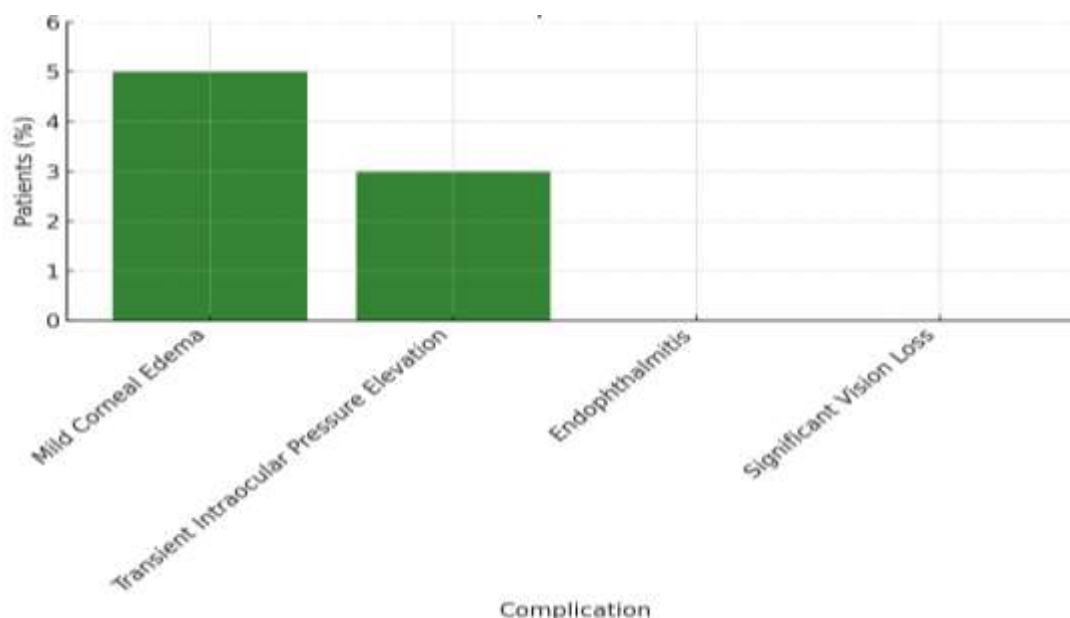


Figure No:5 Complications
Discussion

This study demonstrated that cataract surgery significantly improves visual acuity and quality of life in diabetic patients. The mean best-corrected visual acuity (BCVA) improved from 0.8 ± 0.1 logMAR preoperatively to 0.2 ± 0.1 logMAR postoperatively, with 87% of patients achieving $BCVA < 0.3$ logMAR after surgery. These findings are consistent with prior studies, such as those by Lamoureux et al. and Zhu et al., which highlight the efficacy of cataract surgery in restoring vision and enhancing quality of life in patients with diabetes^{8,11}.

The quality of life, as assessed by the NEI VFQ-25 questionnaire, showed marked improvements across all subscales, particularly in general vision, near vision, and distance vision. This is consistent with previous reports by Lamoureux et al. and Chia et al., who demonstrated that better postoperative vision contributes to improved daily functioning and psychological well-being^{8,14}.

However, the influence of diabetic retinopathy (DR) was notable. Patients without DR experienced better visual and quality of life outcomes compared to those with mild-to-moderate DR. This aligns with findings from Liu et al. and Javadi et al., which suggest that retinal pathology limits the full benefits of cataract

surgery^{12,13}. These findings highlight the importance of early detection and management of DR to optimize surgical outcomes.

Postoperative complications were minimal, with no severe adverse events, reinforcing the safety of phacoemulsification in diabetic patients. Similar results have been reported by Wang et al. and Jemeberie et al., who also found low rates of complications and emphasized the importance of diligent postoperative care^{9,10}. Mild corneal edema and transient intraocular pressure elevation, observed in a small proportion of cases, further highlight the need for careful postoperative monitoring.

Generalizability

The findings are reasonably generalizable to middle-aged and older diabetic patients undergoing uncomplicated phacoemulsification in tertiary care settings, particularly those with controlled systemic disease. Applicability may be lower in patients with advanced diabetic retinopathy, significant ocular comorbidities, poorly controlled diabetes, or those treated in resource-limited settings with postoperative care protocols.

Conclusion

The findings of this study indicate that cataract surgery leads to significant improvements in visual acuity and quality of life among diabetic patients. The mean BCVA improved from 0.8 ± 0.1 logMAR preoperatively to 0.2 ± 0.1 logMAR postoperatively, with 87% of patients achieving $BCVA < 0.3$ logMAR. Quality of life, measured by NEI VFQ-25 scores, showed substantial enhancements across all subscales, particularly in general, near, and distance vision. Patients without diabetic retinopathy demonstrated better postoperative outcomes compared to those with mild-to-moderate diabetic retinopathy, underscoring the impact of retinal health on visual and functional recovery. Although minor complications such as mild corneal edema and transient intraocular pressure elevation were observed in 8% of cases, no severe complications or vision loss were reported, affirming the safety and efficacy of the procedure.

Limitations

This study is limited by its single-center design and relatively short follow-up period. Future studies with larger sample sizes and extended follow-up are warranted to assess long-term outcomes. Despite these limitations, the findings align with the broader literature, including studies by Zhu et al. and Liu et al., which emphasize the benefits of cataract surgery in diabetic patients and the importance of addressing comorbid conditions to maximize surgical outcomes.

Recommendations

Diabetic patients planned for cataract surgery should undergo thorough preoperative assessment including glycemic status, fundus evaluation, and grading of diabetic retinopathy. Surgery should be considered at an appropriate stage before visual disability becomes severe. Good perioperative blood sugar control, meticulous phacoemulsification technique, and careful postoperative follow-up are essential for optimal recovery. Patients with diabetic retinopathy require closer retinal monitoring and timely management to improve final vision. Counseling should address realistic expectations, adherence to medications, and follow-up visits. Integrated care involving ophthalmologists, physicians, and diabetologists can further enhance surgical

outcomes, reduce complications, and improve long-term visual quality of life.

Acknowledgement

The authors sincerely thank all study participants for their cooperation and trust. We also acknowledge the support of the Department of Ophthalmology, operating theatre staff, nursing personnel, and technical team for their assistance in patient evaluation, surgery, follow-up, and data collection throughout the course of this study.

Abbreviations

BCVA – Best-corrected visual acuity
logMAR – Logarithm of the minimum angle of resolution
NEI VFQ-25 – National Eye Institute Visual Function Questionnaire-25
DR – Diabetic retinopathy
No DR – No diabetic retinopathy
Mild-to-Moderate DR – Mild-to-moderate diabetic retinopathy

Source of funding

The study had no funding.

Conflict of interest

The authors declare no conflict of interest.

Author contributions: SA-Concept and design of the study, results interpretation, review of literature and preparing first draft of manuscript. Statistical analysis and interpretation, revision of manuscript

JA-results interpretation, review of literature and preparing first draft of manuscript, revision of manuscript.**MR**-review of literature and preparing first draft of manuscript, revision of manuscript.

Data availability

Data available on request



Author Biography

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