Phaco nightmares

I am interested in the stressful nature of cataract surgery from the surgeon rather than the patient's perspective. It is an issue that has quite literally kept me awake at night. Part of getting to grips with a problem is understanding its nature and there is no good at all in just lumping all the horror in together as the whole thing becomes utterly indigestible that way and we can make no progress in our crusade against the vitreous. So after a lot of rumination, I will outline common scenarios the cataract surgeon faces so that at least we can categorise our various nightmares and, as with the Standardisation of uveitis nomenclature (SUN) classification in uveitis, start to put order to disorder.

Preoperative nightmares. These can vary widely, from the utterly kyphosed elderly lady that you would need to position upside down so that her face would be flat, to the aggressive lawyer type you find booked on to your list with 6/6 vision and ludicrous expectations. The traditionalists would say that honest conversations with patients about risks would be best here, but in a rushed preoperative situation such niceties can only be dreamed of. No, here we must occasionally reach for crutches such as blood pressure a single mmHg above guidelines, a blood sugar which is a bit borderline, perhaps a hint of a speck of blood seen at the macula which may need further investigation in clinic or the old perennial favourite, a touch of blepharitis. Never has the diagnosis of blepharitis correlated so well with perceived surgical difficulty than at the pre-op cataract ward round. I remember with dismay a patient who was in his late nineties and who potentially weighed more than an ice cream van, struggling to get behind the slit-lamp for the pre-op check of the posterior segment, and the sheer unbridled joy I felt at diagnosing a retinal detachment that must have occurred since the last visit that meant the operation was sadly put off.

Anaesthetic nightmares. By this point the patient is in theatre and you are beyond the help of your old friend blepharitis. But the patient before you has had a subtenon block undertaken that has resulted in the eye rolling almost completely under the upper lid, or alternatively right under the lateral canthus, and perhaps for good measure the conjunctiva has billowed up such that even before starting the patient looks as if they have been a victim of an assault. This is a tricky one, but the key is not to panic. It is better to redo the block than fight the eye with forceps, tearing at the conjunctiva to get the eye in an even partially good position. How to do this without offending your anaesthetist or distressing the patient, I hear you say? We say to the patient loudly and confidently that our colleague has done a sterling job of numbing some muscles and you will now complete the job by numbing the others. Then deflate the conjunctival bullae with a keratome, otherwise you will find yourself operating at the bottom of a swimming pool of doom.

Intraoperative nightmares: unexpected findings. This category really does have the potential to induce a stroke in the surgeon. One of the worst things has to be an unexpected phacodonesis, where you expected a nice straightforward operation but find the anterior chamber deepening much more than it should on initial injection of viscoelastic and the lens obligingly and politely trying to turn with you as you try and perform a rhexis. The true horror is when you only really realise after starting the rhexis, as once the capsule is breached you are committed. Up until then if the lens is ready to sublux and fall but the capsule is intact you can tidy it all up and let your wonderful vitreoretinal colleagues do the work another day, much the same as hurriedly passing by the scene of an accident without looking too closely and pretending to all the world as if you hadn't seen a thing. But once the capsule is breached there is no honourable way out. Try and rescue the situation with capsular tension rings and hooks in your rhexis and when these fail, as they always do, gear up for the phone call of shame. If you succeed it is almost always the case that you would have done so without these trappings of "I know what I'm doing, look at me, I'm asking for extra things". Other unexpected things include patients that suddenly turn into pneumoconiosis sufferers the instant they lie flat, massively talkative patients that insist on moving their head as they recount anecdotes and won't shut up, patients that jerk their head for no good reason at particularly vital points in the procedure and patients that decide to have a suprachoroidal haemorrhage. Once the capsule is breached there is no turning back and you must tighten your sphincter and try as best you can to finish the procedure. A good tip here is not to abandon all hope and lie down on the theatre floor.

Intraoperative nightmares: trainees. Trainees are great for many different reasons and one of them is the interesting ways in which they can test our surgical skills at a moment's notice. A common trainee induced situation is the forming of a bowl of despair that you then have to get out of. Others include ludicrously small rhexes that require the surgical skill of Brian Little to get the lens out without splitting it wide open; tearing the posterior capsule when the lens has not yet fallen (if it does it is then your fault as it was all fine and in the bag when you took over); cheerfully and suddenly phacoing right into the iris in a patient on alpha blockers; and the classic one of making sudden jerky movements that don't actually cause any damage but every time it happens you feel a small part of your own myocardium infarcting. The true solution here is to manfully and confidently take over at an early stage instead of watching from the assistant's microscope with increasing sadness as the situation gracefully slips beyond any hope of salvation. What people actually do of course with such trainees is say: "Ah, yes, this list is a bit difficult for you unfortunately. What about that 70-year-old in perfect health and a widely dilated pupil? Well, she is a little bit deaf and might be a borderline diabetic so not suitable. What other lists are you on? Oh him, he's got good cases, not like my cases which of course you could have done if they weren't so gosh darn difficult." All the time the other trainer may be saying exactly the same thing.

So I have tried to lay bare as much as I can situations that I have seen that exist in reality and perhaps by talking more about these things we can work towards actual solutions rather than hiding it all. Or we can carry on diagnosing blepharitis, using forceps as a tool against bad blocks, abandoning operations for spurious reasons once begun and telling scary trainees all our cases are just so dreadfully complicated that day and what a pity they can't do any, but it's all okay as they can do the theatre note instead.

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