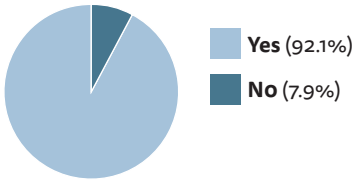
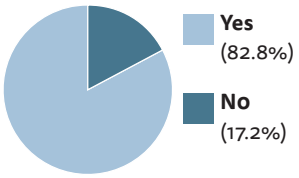
Ophthalmology survey results

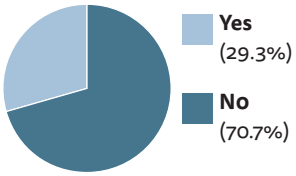
Do you routinely use intracameral cefuroxime at the end of your cataract surgery?



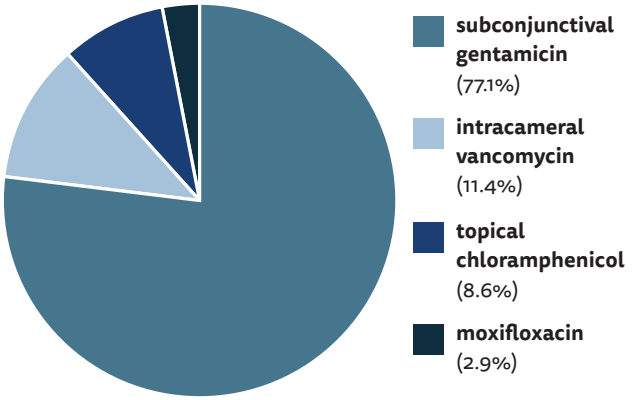
In penicillin allergic patients WITHOUT anaphylaxis do you still give intracameral cefuroxime?



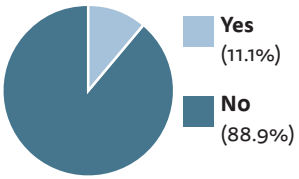
In penicillin allergic patients WITH anaphylaxis do you still give intracameral cefuroxime?



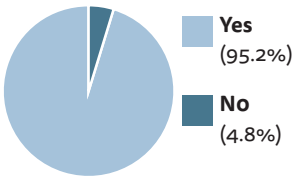
In cases where intracameral cefuroxime is not used then which alternative do you use?



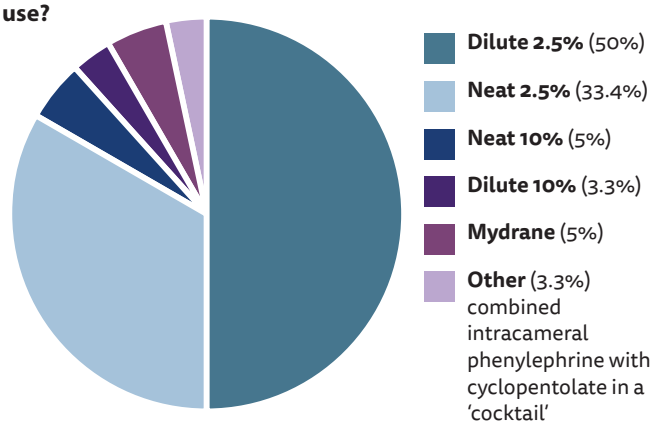
Do you stop tamsulosin prior to cataract surgery?



Do you utilise intracameral phenylephrine in patients with IFIS risk?



What concentration of intracameral phenylephrine do you use?



Firstly may I thank all of you who took the time to answer the survey. I hope you will agree that the findings are very interesting.

From a medicolegal perspective we always consider the Bolam test which can be summarised as "If a doctor reaches the standard of a responsible body of medical opinion, he / she is not negligent."

It does call into question what we define as a responsible body of medical opinion. In our survey we found that only 17.2% of surgeons do not use intracameral cefuroxime in patients who are allergic to penicillin. Is this enough to be deemed to be a body of medical opinion. My personal view is that it is, but where is the cut-off point? If practice is supported by 5% of the profession, is that a responsible body? What if my practice lies within the 5% and I run into problems and my case is assessed by an "expert" whose own practice lies within the 95%?

There is no correct answer and just because there is practice variance does not indicate substandard practice. I do think, however, that it does stimulate practice reflection, which is the whole point of this new *Eye News* initiative.

As part of that practice reflection we will be publishing articles on these two issues and discuss the evidence base behind these practice variances.

Personal perspective / practice reflection

I was happy to see that my practice fitted in with others.

I undertake approximately 1600 cataract procedures a year and have always used intracameral cefuroxime (ICC) at the end of my cataract procedures as a matter of routine, even in patients with a penicillin anaphylaxis. I have never had an issue to date but I do ask the ward staff to monitor the patient for a bit longer than other patients to ensure there are no adverse effects. I am aware of three cases of anaphylaxis secondary to ICC in the world literature so it can and does occur. I try and balance up the endophthalmitis risk reduction associated with the use of ICC against the apparently extremely rare risk of anaphylaxis.

I do not have access to intracameral vancomycin but I think it is an elegant alternative. If I had access to it I would probably consider its use.

I worry that not giving any prophylaxis or simply subconjunctival gentamicin may be criticised because we know that intracameral therapy is proven to reduce the risk of endophthalmitis. If a patient developed endophthalmitis could we definitely say that the subconjunctival gentamicin was as efficacious as ICC when the evidence for not using ICC in penicillin allergy is lacking? Would a patient reasonably argue that they should have been given the ICC despite their penicillin allergy and that that could have prevented their endophthalmitis?

I do not stop tamsulosin in my patients as I do not believe it makes any difference to the risk of intraoperative floppy iris syndrome (IFIS). I prophylactically use intracameral 2.5% phenylephrine neat to make the iris more rigid and induce a bit more mydriasis. My experience is that if the pupil is mid dilated and the patient is on tamsulosin they are significantly more likely to develop IFIS. I appropriately consent the patient and explain that there are risks that the iris will cause us difficulty at operation but forewarned is forearmed.

I used to dilute my phenylephrine down to 1.25% until I learnt other colleagues were using 10% neat and then I increased up to neat 2.5%. The risk of cardiovascular detriment is extremely low in my opinion. I do not believe that neat 10% is too strong but I find that 2.5% gives me the clinical effect I desire.

I hope that this information is of help and will stimulate practice reflection of your own. The anecdotal comments above are based upon my understanding and my clinical acumen. I am happy to be challenged by the evidence and I look forward to the future editorial in *Eye News* which will explore these issues further.

Our next survey

1. Do you dilute your 10% betadine for preoperative prep?
   - ❑ Yes
   - ❑ No

2. What do you use for pre-op prep if the patient is allergic to iodine?
   - ❑ Chlorhexidine
   - ❑ Other: .....

3. Assuming an office job, how long do you sign people off work for after cataract surgery?
   - ❑ I do not
   - ❑ 1 week
   - ❑ 2 weeks
   - ❑ 4 weeks
   - ❑ Other: .....

4. Assuming the other eye reaches the driving visual threshold, how long do you tell patients not to drive for after cataract surgery?
   - ❑ They can drive immediately
   - ❑ 1 week
   - ❑ 2 weeks
   - ❑ 4 weeks
   - ❑ As soon as they can read the number plate at 20M in their operated eye
   - ❑ Other .....

5. Assuming the other eye does not reach the driving visual threshold, how long do you tell patients not to drive for after cataract surgery?
   - ❑ They can drive immediately
   - ❑ 1 week
   - ❑ 2 weeks
   - ❑ 4 weeks
   - ❑ As soon as they can read the number plate at 20M
   - ❑ Other .....

We would welcome questions from the readership which they would like answered. Please email AmarAlwitry@btinternet.com with your suggestions.

You can complete the survey online here: www.eyenews.uk.com/ophthalmology-survey-june-2019

SECTION EDITOR

Amar Alwitry FRCOphth MMedLaw,

Consultant Ophthalmologist, Leicestershire and Nottingham, UK.