The results of the last survey

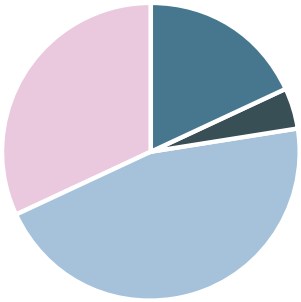
Do you cancel cataract surgery on the day if the blood pressure is high?

81.4% Yes
18.6% No

Which BP reading concerns you more?

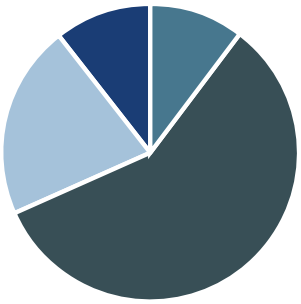
29.2% Diastolic
35.4% Systolic
35.4% Both

If you do cancel, at what level of systolic blood pressure would you cancel the procedure?
(Range 180 to 220mmHg)



18.1% 180mmHg
4.5% 190mmHg
45.6% 200mmHg
0% 210mmHg
31.8% 220mmHg

If you do cancel, at what level of diastolic blood pressure would you cancel the procedure?
(Range 95 to 120mmHg)



10.5% 95mmHg
58.0% 100mmHg
21% 110mmHg
10.5% 120mmHg

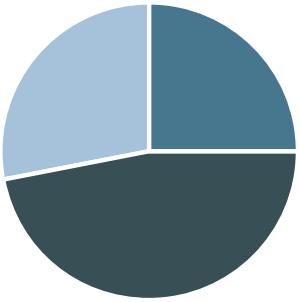
Does this figure vary with whether they are on antihypertensive treatment?

18.2% Yes
81.8% No

Do you cancel diabetic patients on the day of surgery due to a high blood glucose level?

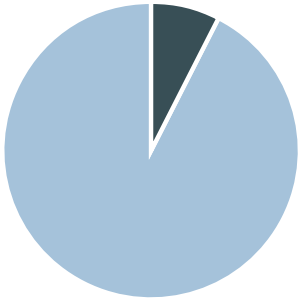
59.3% Yes
40.7% No

Of those who do cancel, above what blood glucose level would you cancel?
(Range 10 to 25mmol/L)



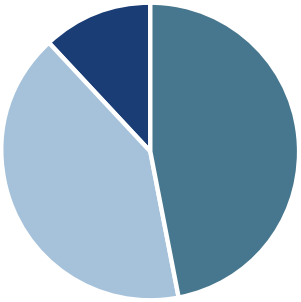
25% Figure above 10 to 15mmol/L
47% Figure above 15 to 20mmol/L
28% Figure more than 20mmol/L

Assuming a block anaesthetic for cataract surgery, do you place a pad, pad and shield or nothing on postoperatively?



0% Pad only
7.6% Shield only
92.4% Pad and shield
0% Neither pad nor shield

Assuming a topical anaesthetic cataract procedure, do you place a pad, pad and shield or nothing on postoperatively?



47% Pad only
0% Shield only
41.2% Pad and shield
11.8% Neither pad nor shield

Thank you once again for participating in the survey. Some fascinating results once again.

Almost one in five of us do not cancel cataract surgery on the day if the blood pressure (BP) is high, which I am surprised about.

My worry is the stroke risk. I do not know the figures or the risk profile of this but if the blood pressure is high, is there not a risk of haemorrhagic stroke on the operating table? Cataract surgery is stressful for patients and I worry their blood pressure would go too high during the procedure. Thankfully we are past the days of expulsive haemorrhages but I believe that high episcleral and venous pressures are not ideal.

The concern about the blood pressure figures is evenly spread between diastolic, systolic and both being the main concern. A cardiologist's opinion would be handy but I seem to remember that it is the high diastolic which is the concern as the cerebral vasculature has no time to decompress.

The threshold whereby we do cancel the surgery is spread widely. A range of 180mmHg to 220mmHg for systolic pressures and 95mmHg to 120mmHg. I think that these figures are reasonable but considering the hardship to the patient of cancelling on the day, should we not have some consistency amongst us? Why does one patient on one operating list get cancelled if their diastolic is above 100mmHg whereas another one down the

road does not get cancelled whatever their blood pressure readings? Is this fair to the patient or is there a postcode lottery?

My threshold is based on the diastolic and I pick 120mmHg as my cut off point. I have no evidence to support this, but I have not had an incident thankfully (so far). So who is correct? Should we as an ophthalmology profession be seeking some guidance on this issue?

Only 18.2% of respondents said that their BP threshold varied if the patient was on hypertensive treatment. Mine does and I am more likely to cancel if they are not on treatment. My rationale is that there is no pharmacological limit to how high the BP can go on the table if they have no medication at all. In a newly diagnosed hypertensive, albeit probably simple white coat in nature, I think it wiser that they have their blood pressure addressed before I stress them with an operation.

There has been a safety message from the Royal College about blood glucose, but it failed to offer any specific guidance. Forty percent of us do not cancel on the day regardless of the blood glucose. I think we know that poor diabetic control can result in poor wound healing and increased risk of infection but is that general rule applicable to eyes? There was also a wide variance as to what level to cancel at. My feeling is that a high blood glucose per se does not mean that we need to cancel, but we need to try and optimise the patient's medical condition. If the patient is having a blip in their control and we stand a chance of improving the diabetic control significantly then I think it is reasonable to wait. If they are never going to get any better then I think it is unfair to simply cancel based upon a spot blood glucose reading.

Most people place a pad and a shield on in cases of block anaesthetic. This is what I do. I believe it stops them blinking in the very early postoperative period and fish-mouthing of the wound is a worry with the risk of ingress of conjunctival floral organisms. I think it also minimises the irritation from the corneal wound once the anaesthetic has worn off. Overnight I also worry about them lying on their backs and all the secretions / tears bathing the newly operating eye. I like to think the pad would soak up any excess lacrimation.

I was not surprised that surgeons did not put a pad on in topical procedures as they wish to visually rehabilitate immediately. I was surprised that a large proportion do not put a shield on either. I would worry that they will rub their eyes in the early stages, albeit inadvertently, and this may result in harm.

This survey has given us a lot to think about but also highlighted that we are not consistent in our rules regarding cancellations on the day. Different units clearly have different policies and I welcomed the comments of some of the responders as to how unhappy they were with the rules imposed upon them. Hopefully they can use this survey to justify change and maybe the powers at be can address these variances and recommend rules for all of us to stick by, thereby stopping the different treatments in different parts of the NHS.

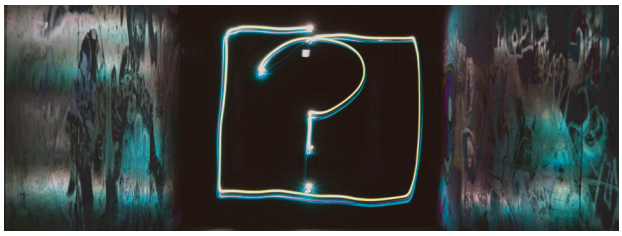
As ever, I look forward to the article in the next *Eye News* which will educate me as to the evidence base behind these practices.

SECTION EDITOR

Amar Alwitry FRCOphth MMedLaw,

Consultant Ophthalmologist, Leicestershire and Nottingham, UK.

E: amar.alwitry@nhs.net



Our next survey

1. When faced with a fundus obscuring vitreous haemorrhage in an under 80-year-old with no risk factors do you:
   - ❑ Refer to VR immediately?
   - ❑ Refer to VR routinely?
   - ❑ B-scan and if no retinal detachment seen observe very closely until haemorrhage has cleared?
   - ❑ Other? .....
2. After anterior vitrectomy for posterior capsule rupture do you routinely close the corneal wound with a suture?
   - ❑ Yes
   - ❑ No
3. Do you routinely use triamcinolone when dealing with vitreous loss during cataract surgery?
   - ❑ Yes
   - ❑ No
4. Assuming a posterior capsule rupture precluding in the bag placement of a one-piece IOL when the IOL is already in the eye do you:
   - ❑ Place the IOL in the ciliary sulcus?
   - ❑ Cut out and replace with a three-piece IOL in the ciliary sulcus?
   - ❑ Other? .....
5. What postoperative drops do you give to your cataract patients?
   - ❑ Steroid and antibiotic combined in one drop
   - ❑ Steroid and antibiotic in two separate drops
   - ❑ Steroid alone
   - ❑ Non-steroidal anti-inflammatory drop and antibiotic
   - ❑ Non-steroidal anti-inflammatory drop alone
6. How long do you carry on your steroid or non-steroidal anti-inflammatory drop for postoperatively after routine cataract surgery?
   - ❑ 2 weeks
   - ❑ 3 weeks
   - ❑ 4 weeks
   - ❑ 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-october-2019/