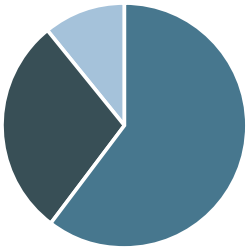
The results of the last survey

When faced with a fundus obscuring vitreous haemorrhage in an under 80-year-old with no risk factors do you:



60.3% Observe closely with regular ultrasound?
29% Refer immediatley?
10.7% Refer routinely?

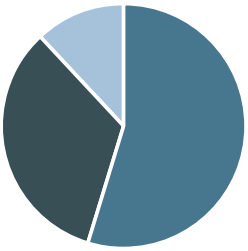
After anterior vitrectomy for posterior capsule rupture do you always close the corneal wound with a suture?

48.4% No
51.6% Yes

Do you routinely use triamcinolone when dealing with vitreous loss during cataract surgery?

33.3% No
66.7% Yes

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:

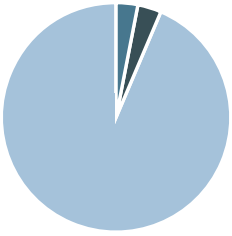


60.3% Cut out IOL and place 3-piece into sulcus?
29% Place IOL into sulcus?
10.7% Other ?

What postoperative drops do you give to your cataract patients?

8.6% Steroid alone
43% Combined steroid and antibiotic
48.4% Separate steroid and antibiotic

How long do you carry on your steroid or non-steroidal anti-inflammatory drop for postoperatively after routine cataract surgery?



3.2% 2 weeks
3.2% 3 weeks
93.6% 4 weeks

Another fascinating response which once more highlights the massive variation in practice. I completely acknowledge that ophthalmology is an art as well as a science and therefore there will be variances in practice and there will not be one 'right' way to do things, but we need to ensure our practice is evidence-based.

The responses to the first question are of great interest. Back in 2014 a *College News Focus* article addressed this very issue [1]. I would encourage you all to access it to refresh your memories. The conclusions were quite clear cut: "Evidence-based approach: High risk patients are therefore adults under 80 with no definite alternative cause of their dense vitreous haemorrhage. Retinal tears are present in 75% or more of such patients. There is an evidence base to justify a default management policy in such patients of early vitrectomy. Visual outcomes are better with this approach because retinal detachments, complicated by proliferative vitreoretinopathy (PVR), are prevented."

Another paragraph is worth quoting verbatim: "Conservative management is not justified by an ultrasound scan which demonstrates an attached retina, no retinal tears and no other causative lesion. The sensitivity of ultrasound in detecting retinal tears is between 44 and 56% [2,3]. This means that half of all retinal tears in eyes with unexplained vitreous haemorrhage will be missed by ultrasound imaging, leaving these patients at ongoing risk of a retinal detachment and long-term visual loss if managed conservatively. Ultrasound is an unreliable tool for this purpose. The role of ultrasound is in detecting retinal detachment at first presentation and identifying alternative causative lesions such as eccentric or sub-macular vitreous haemorrhage."

So, while I entirely appreciate that there is no wrong or right answer, are the 60.3% of us who observe a patient under 80 years of age with an unexplained fundus obscuring vitreous haemorrhage with regular b-scan ultrasound doing the wrong thing? Should such patients be referred immediately to the vitreoretinal service? There are usually local protocols and guidance and it is our duty of care to ensure we are aware of them. If there is no protocol, ask. The British and Eire Society of Vitreoretinal Surgeons (BEAVRS) confirms (personal communication) that urgent referral to the vitroeretinal service is the most appropriate management for such patients.

Again, I see variance with the routine placement of a suture and the use of triamcinolone for anterior vitrectomy. This issue was brought to light by a fellow expert acting for the claimant who asserted that not using a suture after anterior vitrectomy was a breach of duty and I argued the opposite. Was I the only one who did not use a suture routinely? This evidence that it is not a universal practice is welcome but emphasises the problem where one expert gives an expert opinion based on their own practice and the way they were taught.

Regarding triamcinolone, I am embarrassed to say that the only thing that stopped me using it was not really knowing what preparation to use. Does it need diluting? Does it need a filter? Is it the same Kenalog that we use for joints? Rather than not use it, I will endeavour to find the answer to these questions as even though I do not believe it is a breach of duty not to use it, I do believe that it is best.

The other question puts me in the minority of opinion,

which is great as it stimulates practice reflection which is the key to this whole initiative. I believe that we always need to have a plan in our heads for any eventuality. The time to start planning a move is not when the capsule has already ruptured, there is vitreous everywhere and my heart rate increases, but rather in the cold light of day.

So, the scenario I face is that the intraocular lens (IOL) is not sitting correctly and I find a capsule rent, the capsule tear occurs while dialling the IOL or the IOL itself causes the posterior capsule tear as I introduce it.

One-piece IOLs are not designed for the sulcus and, indeed, on the product information it often states clearly and without a doubt that these lenses should not be electively put into the sulcus, however, this is not an elective situation.

I face the choices which I presented to the readership: to chop the IOL out and put a new three-piece IOL in (remembering to reduce the IOL power by 0.5D) or to dial the IOL into the sulcus. Undertaking an anterior vitrectomy in an eye with an IOL in is inevitably harder but I balance that up against the trauma of cutting the IOL out and the risk of the IOL falling to the posterior segment and the risk of corneal decompensation. The eye has already been insulted and I wish to minimise the potential iatrogenic harm. I think that it is much less traumatic to simply utilise the IOL already in the eye and dial it into the sulcus. As long as I can be confident that I will clear all the vitreous (I will be using triamcinolone from now on) and the IOL is secure, then I am happy. I often try and capture the optic in the capsular bag to assist stability and prevent further vitreous prolapse. The only proviso would be in a large eye, as I do not think the centration would be adequate. So far I have had no decentred IOLs in reasonably sized eyes.

The variance in the drops was what I was expecting. I like two separate drops and I use an antibiotic and steroid drop. I know I've been told in the past that the antibiotic is pointless, but I have never had a post-op infective endophthalmitis yet (famous last words) and I am paranoid about changing my regimen. In the day and age of evidence-based practice I see how this last statement is ridiculous but I am human, as we all are.

References

1. RCOphth Focus Winter 2014 Management of unexplained vitreous haemorrhage. Timothy Cochrane, Alistair Laidlaw, St Thomas' Hospital, London.
2. Tan HS, Mura M, Bijl HM. Early vitrectomy for vitreous hemorrhage associated with retinal tears. *Am J Ophthalmol* 2010;**150**:529-33.
3. Dhingra N, Pearce I, Wong D. Early vitrectomy for fundus-obscuring dense vitreous haemorrhage from presumptive retinal tears. *Graefes Arch Clin Exp Ophthalmol* 2007;**24**:301-4.

SECTION EDITOR

Amar Alwitry FRCOphth MMedLaw,

Consultant Ophthalmologist, Leicestershire and Nottingham, UK.

E: amar.alwitry@nhs.net

Our next survey

1. In a moderate glaucoma case where progression has been detected at a pressure in the low 20s and you change / add drops, how soon would you follow the patient up?
   - ❑ 2 weeks
   - ❑ 4 weeks
   - ❑ 6 weeks
   - ❑ 2 months
   - ❑ 3 months
   - ❑ 4 months
   - ❑ Other .....

2. Faced with reviewing another surgeons post-op cataract patient in a case of a shallow anterior chamber and intraoperative floppy iris syndrome (IFIS) leading to iris damage, corectopia and cystoid macular oedema, would you consider the surgical management of the patient to have been negligent?
   - ❑ Yes, definitely, this breaches the duty of care
   - ❑ Yes, maybe there was a breach
   - ❑ Not sure
   - ❑ No, this is an acceptable but not desirable outcome

3. When undertaking intravitreal injections, do you routinely warn about lens touch and cataract?
   - ❑ Yes
   - ❑ No

4. Assuming a pooled operating list and you are the operating surgeon who has not seen or clinically examined the patient before, do you re-examine them preoperatively at the slit-lamp?
   - ❑ Yes
   - ❑ No

5. Assuming you are the operating surgeon and the patient was seen by someone else in clinic but no consent form was signed, do you think it is acceptable to get the patient to sign the consent form on the day immediately prior to their surgery?
   - ❑ Yes, I have no concerns
   - ❑ Not ideal, but I would still proceed
   - ❑ No, I would cancel the patient

6. Assuming routine cataract surgery, how long should the patient refrain from swimming with goggles?
   - ❑ No restriction
   - ❑ 1 week
   - ❑ 2 weeks
   - ❑ 3 weeks
   - ❑ 4 weeks

7. Assuming routine cataract surgery, how long should the patient refrain from flying?
   - ❑ No restriction
   - ❑ 1 week
   - ❑ 2 weeks
   - ❑ 3 weeks
   - ❑ 4 weeks

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