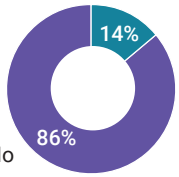
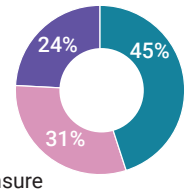
The results* of the last survey

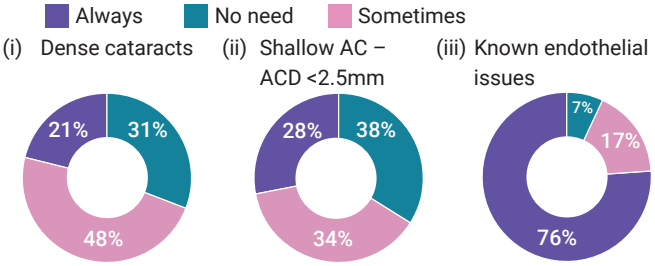
1. Do you believe the use of the "soft shell" technique (the use of both dispersive and cohesive viscoelastics) confers some extra protection to the corneal endothelium during cataract surgery?



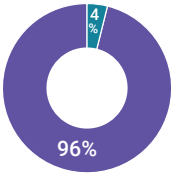
2. A patient is known to have Fuchs endothelial dystrophy. They are operated upon, but the "soft shell" technique is not used i.e., only a cohesive viscoelastic is used. The cornea subsequently decompensates. Is this a breach of duty?



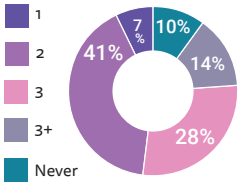
3. When would you consider you should electively use the "soft-shell" technique? (Assume that these issues are documented in the clinical record without further quantification of severity).



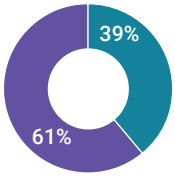
4. A patient with "stable" mild glaucoma controlled on one eye drop did not arrive (DNA's) their outpatient appointment once. Do you:



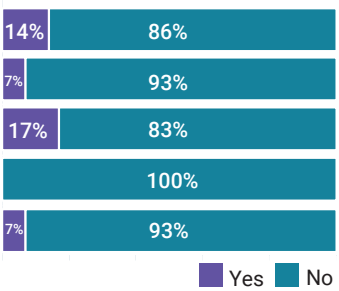
5. Assuming a patient with moderate glaucoma on two drops with a cup to disc ratio of 0.8 and IOP above the target pressure how many appointments would the DNA before you discharge them? (You send a letter to the GP informing them in any case)



6. If a patient cancels their appointment are their clinical records reviewed to triage their next appointment interval?



7. Do you obtain written informed consent for minor clinic procedures such as:



(i) Sac washout
(ii) Removal of corneal foreign body
(iii) Insertion of punctal plugs
(iv) Epilation of lashes
(v) Slit-lamp debridement of corneal epithelium for recurrent erosion

*Please be aware that this data does not form part of a peer reviewed research study. The information therein should not be relied upon for clinical purposes but instead used as a guide for clinical practice and reflection.

I am regularly faced with litigation whereby the claimant's cornea has decompensated after cataract surgery. The procedure may have been complicated but sometimes it is not. The eye may have been high risk, for example, a shallow anterior chamber with a dense cataract, or sometimes the eye is "routine". The cornea may have been felt to be at risk anyway but often no abnormality is detected or documented.

The typical scenarios I see are:

1. Apparently routine case and the cornea decompensates. The patient is sent to a specialist cornea clinic. The other eye is examined and a diagnosis of Fuchs' endothelial dystrophy (FED) is made. An allegation is then made against the clinician who reviewed the patient at their initial clinic attendance that they failed to detect the corneal abnormality and if they had then the operating surgeon (who usually has not examined the patient themselves preoperatively) would have used appropriate techniques to protect the cornea, and it would not have decompensated.
2. Routine case and then the cornea decompensates. An allegation is then made against the operating surgeon that they used excessive ultrasound power or damaged the endothelial cell layer with their intraocular instruments.
3. Normal or higher risk case and the cornea decompensates. An allegation is then made that the patient was not informed of the risk of corneal decompensation and would not have proceeded if they had been appropriately warned.
4. The patient is having intraocular lens exchange and the cornea decompensates. An allegation is made asserting that a reasonably competent surgeon should be able to exchange an intraocular lens without damaging the cornea.

A common theme amongst these cases is the failure to protect the cornea appropriately and often the focus is on the use of, or failure to use, the "soft-shell" technique. The soft-shell technique for viscoelastic use in cataract surgery was developed by Steve Arshinoff as a method of utilising the properties of different ophthalmic viscoelastic devices (OVDs) to confer extra protection to the corneal endothelium during intraocular surgery. Dispersive OVDs stay around in the eye as they are not immediately aspirated away by our phacoemulsification probes. They therefore can form a durable layer of protection that lasts for the whole procedure. Cohesive OVDs provide optimal working space, pressurisation / stabilisation of the anterior chamber and the best flattening of the anterior lens capsule for capsulorhexis creation.

The dispersive OVD is injected first into the eye and then the cohesive viscoelastic introduced underneath that. This creates a shell of dispersive OVD adjacent to the corneal endothelium with a compartment of cohesive viscoelastic beneath where we can work.

It would be very hard to get definitive evidence that this is indeed beneficial, however I believe it is as the theory is sound and at the end of the procedure, where I have utilised the technique, I have to physically go around with my aspiration probe to remove the shell. I therefore know it is still there and theoretically it should have been able to confer a protective effect throughout my case.

When I asked you whether you felt that the use of the soft-shell technique confers some extra protection to the corneal endothelium during cataract surgery, 86% of you agreed with me. Interestingly, 14% of you did not. If those 14% do not use the technique then they need to be able to robustly explain why if the cornea does decompensate. Almost inevitably they could face allegations that they should have used it.

When asked whether it was a breach of duty not to use the soft shell technique in a case of cataract surgery in a FED patient the opinion was split. Forty-five percent of you felt it was not a breach of duty while a third of you were unsure. I find it hard to reconcile

this response, as 86% of you felt that the soft-shell technique offered extra protection to the cornea and yet if you chose not to use it in a case which you knew had higher risk of corneal decompensation it was not a breach of duty. Furthermore, in the next question 76% of you felt that it should be used in cases of FED.

There was an equal spread of opinion about whether there was a need to use soft-shell in cases of shallow-AC and / or dense cataracts.

Corneal decompensation really compromises visual outcome in cataract surgery and if patients need to have a corneal graft to try and restore vision then they often seek to attribute blame, particularly when all of their friends and relatives had straightforward procedures. I would encourage you to consider using the soft-shell technique in cases which are slightly higher risk. Even if you feel the benefits are not great, the downsides are minimal, and you can guard against an allegation of failing to protect the cornea.

The next two questions relate to what to do with patients with glaucoma who do not attend their appointments (DNA). With the pressures we face after the COVID-19 pandemic, each appointment is precious. How many chances do we give our patients? There is strong consensus that we give them at least one chance to attend again. When dealing with a patient with moderate glaucoma who does not attend there is a widespread of opinion as to how many chances they should get to attend, ranging from one to never discharging them. I wonder if this is an example of a postcode lottery of care.

After a DNA the notes are reviewed, and we can decide on whether another appointment should be sent and how soon. Another scenario is when the patient cancels their appointment. In my work, these patients are simply removed from the clinic and rebooked. The notes are not reviewed and there is no clinical input in to when they are rebooked. Approximately 60% of you do get to see the notes of the patients who cancel their appointments so you can make clinical decisions on how soon they should be seen. I think this is best practice.

The last question relates to written consent for minor procedures. Consent is not about signing a piece of paper but instead about giving patients all the salient information about a proposed procedure and allowing them to make an informed choice about their care. Procedures and interventions need to be discussed with the patient, but I am not sure that they need to sign a consent form for the minor procedures I detailed in this question. However, a small minority of you disagree with me and I will reflect on that.

Once again, we have highlighted variance in practice and opinions. There is clearly no "right way" of doing things, but we need to be able to justify our actions and decisions. Potentially, our actions may face the scrutiny of laypersons in the form of judges, who may be assisted by "experts" who have different views to you, and so it makes sense to protect ourselves.

Our next survey

1. Do you routinely use intracameral cefuroxime at the end of your cataract surgery?
   ❑ Yes ❑ No
2. In penicillin allergic patients WITHOUT anaphylaxis do you still give intracameral cefuroxime?
   ❑ Yes ❑ No
3. In penicillin allergic patients WITH anaphylaxis do you still give intracameral cefuroxime?
   ❑ Yes ❑ No
4. In cases where intracameral cefuroxime is not used then which alternative do you use?
   ❑ Subconjunctival gentamicin ❑ Topical chloramphenicol
   ❑ Intracameral vancomycin ❑ Intracameral moxifloxacin
5. After routine cataract surgery do you think that topical antibiotics postoperatively are needed?
   ❑ Yes ❑ No
6. In hypermetropes undergoing cataract surgery what refractive outcome do you aim for in the biometry?
   ❑ Slightly minus
   ❑ Slightly plus
   ❑ As close to emmetropia as possible irrespective of whether it is slightly minus or slightly plus
7. When using a toric IOL you should aim for the smallest residual cylinder irrespective of whether the axis is flipped. Do you agree?
   ❑ Yes ❑ No, you need to avoid flipping the axis

Complete the next survey online here:
www.eyenews.uk.com/survey
Deadline 3 January 2023

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