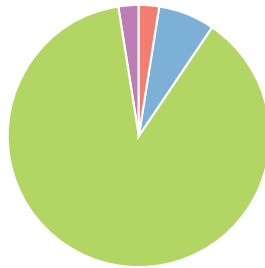


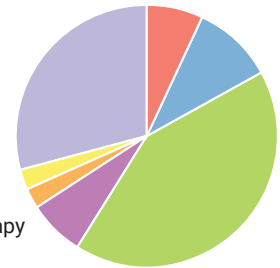
**The results\* of the last survey**

1. When considering a patient presenting four weeks after routine cataract surgery off their postoperative eye drops, with reduced vision due to OCT-proven cystoid macular oedema, what is your management?



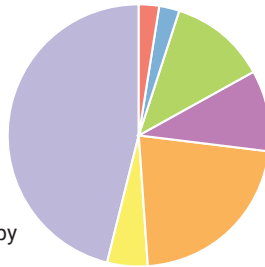
- 2.5% ■ Steroid eye drops alone
- 7% ■ NSAID drops alone
- 88% ■ Combination of topical steroids and topical NSAIDs
- 2.5% ■ Topical steroids, topical NSAIDs and oral Acetazolamide
- 0% ■ Sub-Tenons triamcinolone injection
- 0% ■ Intravitreal triamcinolone injection
- 0% ■ Intravitreal steroid implant
- 0% ■ Intravitreal anti-VEGF injection
- 0% ■ Referral to medical retina / vitreoretinal service

2. When considering a patient with persistent cystoid macular oedema three months after routine cataract surgery, despite topical steroids and NSAIDs, what is your management?



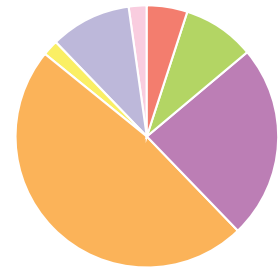
- 7% ■ Continue current topical therapy
- 10% ■ Add oral Acetazolamide
- 42% ■ Sub-Tenons triamcinolone injection
- 7% ■ Intravitreal triamcinolone injection
- 2.5% ■ Intravitreal steroid implant
- 2.5% ■ Intravitreal anti-VEGF injection
- 29% ■ Referral to medical retina / vitreoretinal service

3. When considering a patient with persistent cystoid macular oedema six months after routine cataract surgery, despite topical steroids and NSAIDs, what is your management?



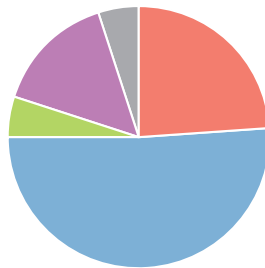
- 2.5% ■ Continue current topical therapy
- 2.5% ■ Add oral Acetazolamide
- 12% ■ Sub-Tenons triamcinolone injection
- 10% ■ Intravitreal triamcinolone injection
- 22% ■ Intravitreal steroid implant
- 5% ■ Intravitreal anti-VEGF injection
- 46% ■ Referral to medical retina / vitreoretinal service

4. When undertaking cataract surgery on the second eye of a patient who had postoperative cystoid macular oedema in the other eye, which lasted six weeks but resolved with topical steroids and NSAIDs, how do you manage the patient (multiple responses allowed)?



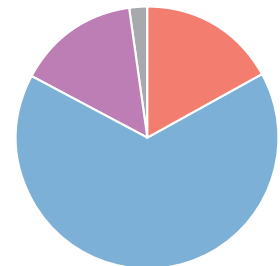
- 5% ■ No change in management
- 0% ■ Preoperative steroid drops alone
- 9% ■ Preoperative NSAID drops alone
- 24% ■ Preoperative steroid and NSAID drops
- 48% ■ Postoperative NSAID drops
- 2% ■ Postoperative oral acetazolamide
- 10% ■ Per-operative steroid injection
- 2% ■ Per-operative anti-VEGF injection

5. Assuming no other co-morbidities, when undertaking cataract surgery on a patient who has had a recent myocardial infarction (MI), when is it safe to undertake the surgery under topical anaesthetic?



- 24% ■ Six weeks after MI
- 51% ■ Three months after MI
- 5% ■ Four months after MI
- 15% ■ Six months after MI
- 5% ■ No response

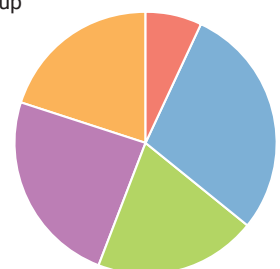
6. Assuming no other co-morbidities, when undertaking cataract surgery on a patient who has had a cerebrovascular accident (CVA), when is it safe to undertake the surgery under topical anaesthetic?



- 17% ■ Six weeks after CVA
- 66% ■ Three months after CVA
- 0% ■ Four months after CVA
- 15% ■ Six months after CVA
- 2% ■ No response

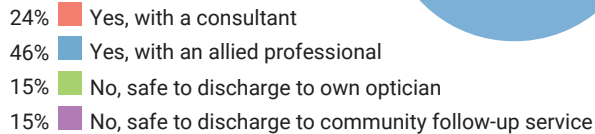
7. When undertaking cataract surgery on a patient with controlled glaucoma on two drops, when and how do you follow the patient up assuming no operative complications?

- 7% ■ No routine hospital follow-up, follow-up at optometry practice or community follow-up in two weeks or less
- 29% ■ No routine hospital follow-up, follow-up at optometry practice or community follow-up in four to six weeks
- 20% ■ Hospital follow-up at one week
- 24% ■ Hospital follow-up at two weeks
- 20% ■ Hospital follow-up at four to six weeks



\*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. The sample size for the Dec-Jan 24 survey was: 41 respondents.

8. Assuming there are appropriate pathways for contact with the provider in case of problems, do you think glaucoma patients undergoing routine uncomplicated cataract surgery require hospital follow-up?



9. Do you feel delays to follow-up appointments for glaucoma patients are:



**T**hank you to all those who participated in this edition's survey and for those of you who attended my recent Medico-legal Seminar at the Royal College of Ophthalmologists. It was a fascinating and educational day, made a success by the enthusiasm and engagement of the delegates. This next survey addresses some common 'bread and butter' issues we face on a daily basis.

Cystoid macular oedema (CMO) is a common complication of apparently routine cataract surgery, with published incidence rates ranging from 1.2–3.4% [1-5]. Known as Irvine-Gass syndrome, patients commonly experience good vision in the immediate postoperative period, followed by a painless central visual deterioration a few weeks later [3]. CMO is believed to result from a postoperative inflammatory response [6]. The incidence of postoperative CMO peaks at 4–6 weeks, but most cases are self-limiting, though visual impairment can persist, with duration of CMO reported to range between 72 and 249 days [7].

Our first question relates to the management of CMO presenting four weeks postoperatively. There appears to be a consensus that treatment should be with a combination of topical steroid and non-steroidal anti-inflammatory drugs (NSAID) with 88% of you agreeing. A small proportion of you use only a steroid or an NSAID, however in my personal opinion both are required ideally. The use of acetazolamide is often not without its risks to elderly patients with co-morbidity. The literature does have some evidence for its use in certain chronic inflammatory diseases, but I think it's probably overkill for 'simple' postoperative CMO.

The next question deals with the patient who has failed to settle. Almost one third would refer onto another colleague for assistance. Almost half would give a depot periocular steroid injection which is also my favoured next step at this stage. Others are giving intravitreal steroid or anti-VEGF agents.

Question 3 takes the clinical scenario a step further with CMO now persisting to six months postoperatively, a

frustrating situation for both surgeon and patient – now almost half of us would seek assistance. There is a spread of other treatments, with a fifth of us electing for an intravitreal steroid implant such as Ozurdex™.

What is clear from the responses is that there is a variance of opinion regarding management, and thus guidance would be welcome. When undertaking second eye surgery on a patient who has had CMO in their first eye, the majority of you do change your practice which I think is sensible. Clinicians are often criticised for not treating each patient as an individual and considering the material risks to them and how to mitigate them. If we have a scenario where the first eye underwent surgery and developed CMO which resolved in three months, and then the other eye was operated upon without any alteration of management, you could be criticised if the second eye subsequently failed to resolve. My question would be: "You knew the first eye developed it and you knew there were simple ways to try and stop the second eye developing it, so why didn't you use them?" I give NSAID drops five days pre-op and carry them on in the postoperative period.

These next two questions highlight a postcode lottery which patients face. In one unit a patient may be allowed to have their cataract surgery six weeks after their myocardial infarction (MI) but the same patient would be refused it in another Trust until they were six months post MI. More than half of you went for three months as the cut-off period after which it is safe to have their cataract procedure. When looking at the same issue regarding a stroke, there was again variance, but three months seemed to be the magic number again.

Getting it Right First Time (GIRFT) has issued some guidance [8], which states: "Elective cataract surgery should be postponed for three months following myocardial infarction, cardiac therapeutic intervention (e.g., stent or angioplasty), stroke or transient ischaemic attack (TIA). Patients who have experienced one of these conditions in the last three months are American Society of Anaesthesiologists (ASA) physical classification grade IV and are at high-risk of a subsequent event in the immediate post event period. Patients with angina should be advised to bring their usual angina medication and have this available to use throughout their admission including in theatre. Any patient with new or un-investigated chest pain should be sent for immediate review prior to elective cataract surgery."

Therefore, it seems that three months is a consensus and certainly a timescale I will seek to adopt in my practice.

The follow-up of cataract patients or the lack thereof has been a matter of debate for some time. Historically, patients were routinely brought back on day one however the evidence for this was weak and gradually, as the safety profile of cataract surgery has improved, this is no longer standard practice. Many patients are now discharged to community follow-up services or back to their own optician. Since the Covid-19 pandemic there has been a drive to minimise hospital attendances unless required. Arguably glaucoma patients are a special group who may warrant closer attention in the postoperative period. The survey results show there is still some variance in what clinicians do with such patients. Two thirds felt that some sort of hospital follow-up was required but the timescale varied from 1–6 weeks. In the following question, one third felt that it was safe to discharge from hospital care with only community follow-up.

The last question sought to get a feel of where we are in the recovery post-Covid-19. It was upsetting and concerning to see that more than half of you felt that the delays to follow-up for glaucoma patients was worsening.

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### Our next survey

1. In a patient with a shellfish allergy, do you still use Povidone-iodine for prep prior to cataract surgery?  
 Yes  
 No
2. In a patient with shellfish anaphylaxis, do you still use Povidone-iodine for prep prior to cataract surgery?  
 Yes  
 No
3. In patients listed for bilateral cataract surgery, do you obtain consent for both eyes at the same time? I.e. the patient signs a consent form for both eyes at the same time at the initial attendance?  
 Yes  
 No
4. What do you consider a good refractive outcome following cataract surgery aiming for emmetropia with minimal pre-existing corneal astigmatism?  
 70% within +/- 1D of emmetropia  
 80% within +/- 1D of emmetropia  
 90% within +/- 1D of emmetropia  
 100% within +/- 1D of emmetropia
5. In a post-laser refractive surgery patient, what do you consider a good refractive outcome following cataract surgery aiming for emmetropia with minimal pre-existing corneal astigmatism?  
 70% within +/- 1D of emmetropia  
 80% within +/- 1D of emmetropia  
 90% within +/- 1D of emmetropia  
 100% within +/- 1D of emmetropia
6. When undertaking cataract surgery, do you place your corneal incision...  
 Always superior  
 Always temporal  
 On the steepest axis
7. Do you discuss the errors within biometry with your patient prior to cataract surgery?  
 Yes  
 No

Complete the next survey online here:  
[www.eyenews.uk.com/survey](http://www.eyenews.uk.com/survey)  
Deadline 1 March 2024

