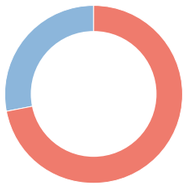
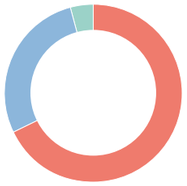
The results* of the last survey

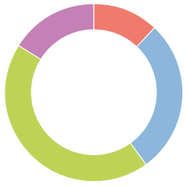
1. Do you routinely check blood glucose in a diabetic patient having cataract surgery on the day of surgery?
   - 72% Yes
   - 28% No



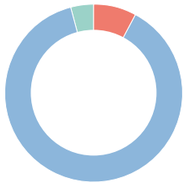
2. Do you routinely check blood pressure on a patient having cataract surgery on the day of surgery?
   - 68% Yes
   - 28% No
   - 4% No Response



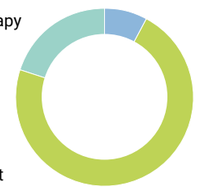
3. In a patient having cataract surgery on Warfarin, do you check their INR?
   - 12% On the day
   - 28% At pre-assessment
   - 44% A week before
   - 16% Do not check it



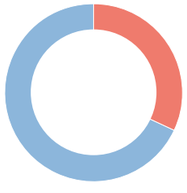
4. Do you have any restrictions on timings to vaccinations either before or after cataract surgery?
   - 8% Yes
   - 88% No
   - 4% No Response



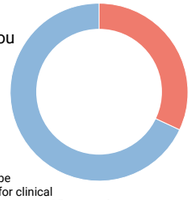
5. In a patient on immunosuppressive therapy undergoing cataract surgery, would you:
   - 0% Temporarily stop it prior to the procedure
   - 8% Liaise with their GP about stopping the drug
   - 72% Liaise with their physician about stopping the drug
   - 20% No Response



6. In a patient with a haematological disorder undergoing cataract surgery, would you:
   - 32% Proceed with cataract surgery without an issue
   - 68% Liaise with their haematology consultant about the procedure



7. In a patient who has had a splenectomy due to undergo cataract surgery, would you give prophylactic systemic antibiotics?
   - 32% Yes
   - 68% No



* 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 April 2025 survey was: 25 respondents.

The first question refers to whether we check blood glucose levels prior to cataract surgery. Almost three quarters of you do which was interesting. We know that poor glycaemic control (manifesting as a raised HbA1c) has implications for wound healing for other forms of surgery but there is no evidence to suggest that it has any implications for cataract surgery.

Getting it Right First Time (GIRFT) released guidance on high-flow local anaesthetic cataract surgery in October 2022 [1]. The recommendation is that there is no requirement to measure HbA1c preoperatively for cataract surgery in patients who have diabetes. There is currently no evidence to support a harmful outcome in patients undergoing cataract surgery with a raised HbA1c. They recommend that blood sugar measurements are not required on the day of surgery unless the patient is unwell or reports that they have not taken their medication or eaten and drunk as instructed.

> *'As patients are not starved for the procedure and don't have diabetic medications altered, the risk of blood glucose instability is reduced; furthermore, patients will be awake throughout and able to report symptoms relating to blood glucose irregularity. The Royal College of Ophthalmologists supports the view that diabetic patients undergoing cataract surgery should have their blood sugar controlled but does not consider there is enough evidence to cancel cataract surgery above any one level of blood sugar or HbA1c. There is no published evidence on the adverse effects of high intraoperative blood glucose on outcome after cataract surgery. If the patient is feeling unwell, this should trigger blood sugar measurement that will guide further management aimed at preventing cancellation wherever possible'* [1].

The Royal College of Ophthalmologists has also released some guidance on this issue [2]. It states:

> *'There is evidence to show that good long-term control of blood glucose will reduce the likelihood of long-term complications such [as] retinopathy / maculopathy, infections, and the need for cataract surgery. However, there is no published evidence on the adverse effects of high intraoperative blood glucose on outcome after cataract surgery. The data collected by the NOD national cataract audit is not sufficient currently to robustly answer this question.'*

They point to the fact that there is no blood glucose level which should result in a cancellation or postponement of the procedure and therefore, unless the patient is obviously unwell there is no need to check the blood glucose levels. It seems that the standard practice of checking blood glucose in all diabetics having surgery persists and indeed in my unit it is still checked.

When asked about the number of you who check the blood pressure of patients on the day of their cataract surgery, two thirds of you responded that you do while almost one third do not. GIRFT has some guidance on this issue also and recommend that the blood pressure is measured before the day of surgery. If the blood pressure is reasonable then there is no need to repeat the blood pressure measure. It states:

> *'This guidance also states blood pressure does not need to be measured pre-operatively in patients who have evidence of a blood pressure less than 160mmHg systolic and 100mHg diastolic documented by primary care in the last 12 months…If this evidence is not available, blood pressure should be performed as part of the pre-operative patient assessment. On the day of surgery on-the-day measurements of blood pressure are often a reflection of patient anxiety and not a true measure of blood pressure or risk. If the patient's blood pressure recorded at pre-assessment was less than 180mmHg systolic and 110mmHg diastolic, then this does not need repeating at any point on the day of surgery. Blood pressure readings are only required on the day of surgery if the patient becomes acutely unwell'* [1].

Unfortunately, I disagree. I appreciate that the blood pressure may be artificially raised due to white-coat hypertension however the blood pressure is indeed that high, whatever the cause. If white-coat hypertension represented a falsely high reading then it would make sense to ignore it however if the blood pressure measures 220/130 then it is indeed that high. Operating on a patient with such a high blood pressure is not, in my opinion, safe. Albeit the risk of expulsive haemorrhage is exceedingly rare, there is a risk of cerebrovascular accident. Not measuring a blood pressure to avoid cancellations due to the high measurements does not make rational sense to me. I am particularly concerned about patients with a high blood pressure who are on no treatment as there is no pharmacological limit on how high their blood pressure could go on the table.

There was a variance of opinion regarding checking the International Normalised Ration (INR) of patients on Warfarin. Since the advent of other agents, this is becoming less of an issue but we do still see some patients on Warfarin. GIRFT states:

> *'Patients who are well established on warfarin will have their INR measured routinely at minimum every 12 weeks. Reasonable evidence from the patient's anti-coagulation record (yellow book) that the INR is likely to be within its therapeutic range is sufficient and no extra measurement of INR is required perioperatively'* [1].

There is evidence to support the safety of operating on patients on Warfarin and I have no concerns as long as they are within their therapeutic range [3].

The majority of you do not restrict or postpone cataract surgery in relation to vaccinations. This became a big issue during the Covid-19 pandemic and there was some evidence of worse outcomes in other forms of surgery when patients were operated upon within a few weeks of their Covid-19 vaccine. I could find no evidence in the literature to assert any issue with vaccines for eye surgery.

For patients taking immunosuppressants, guidelines generally recommend continuing their existing medication regimen during and after cataract surgery [4]. There is no strong evidence suggesting a higher risk of infection or other complications in this population, although patients on immunosuppressants should be monitored closely for any signs of infection, and those with active non-ocular infections should have these addressed before surgery. Indeed, our uveitis colleagues undertake cataract surgery on patients on immunosuppression all the time.

My feeling is that infection in eyes is an all or nothing phenomenon. The eye is immune privileged and either we get infective organisms in the eye and then we are in trouble (assuming our intracameral cefuroxime has not killed them off) or there is no infective load and we are OK. I do not believe the immune response has a significant role in preventing the onset of an infective complication and therefore the increased risk of infection is minimal.

Cataract surgery is relatively bloodless and therefore we generally have few concerns regarding haematological disorders. I would suggest caution in undertaking surgery on patients with any form of rarer haematological disorder. I have seen a handful of medico-legal cases where patients had a bleeding diathesis and had significant bleeds during cataract surgery. I think it is safer for us to consult with the patients haematology consultant before proceeding.

The splenectomy question showed a surprising split of opinion. Two thirds of you would not give prophylactic antibiotics while one third would. I could find no hard and fast evidence either way and would recommend asking the patients physician regarding it. My feeling is that it is not required based on the comments mentioned earlier about the immune privilege of the eye.

References

1. https://www.rcophth.ac.uk/news-views/ophthalmic-safety-alert-diabetic-control-and-safe-cataract-surgery
2. https://gettingitrightfirsttime.co.uk/wp-content/uploads/2022/10/Guide-1-How-to-deliver-a-high-volume-cataract-theatre-list-October-2022-FINALv1.pdf
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4. Boyce M, Massicotte A. Practical Guidance in Perioperative Management of Immunosuppressive Therapy for Rheumatology Patients Undergoing Elective Surgery. *Can J Hosp Pharm* 2020;**73(3)**:218–24.

[All links last accessed May 2025].

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