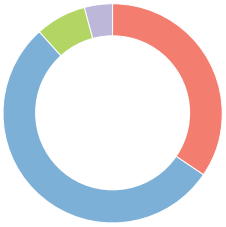
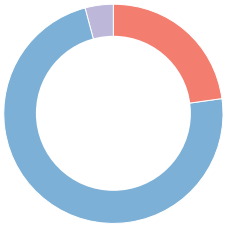
The results* of the last survey

1. A patient is referred in from their optometrist with potentially occludable drainage angle. Gonioscopy performed by you confirms occludable angles. The intraocular pressure is normal, there is no cataract, and the optic disc is entirely healthy. What do you do?



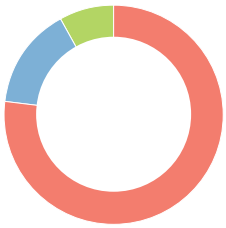
34.5% Discharge to own optician
54% Recommend a YAG peripheral iridotomy
7.5% Recommend lens extraction
4% No response

2. If you had occludable drainage angles and no cataract with normal pressures, would you have:



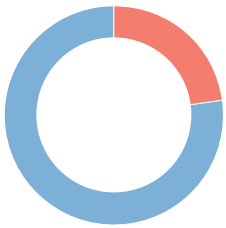
23% No treatment
73% Peripheral iridotomy
4% No response

3. Where do you place your YAG peripheral iridotomy?



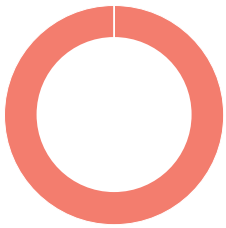
77% Superior
15% Temporal
8% Does not matter where

4. If you were found to have glaucoma with pressures of 24mmHg in each eye would you have:



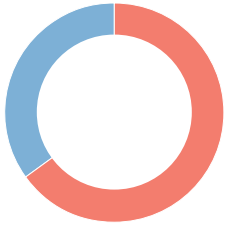
23% Drops
77% SLT

5. A patient is listed for cataract surgery and has an uncomplicated procedure. They have a refractive surprise, and it transpires that they had had laser refractive surgery 10 years prior. This was not asked / detected at the initial consultation or the pre-assessment. Was there a breach of duty?



100% Yes

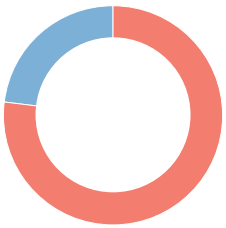
6. Who was at fault?



65% Doctor in clinic
35% Operating surgeon

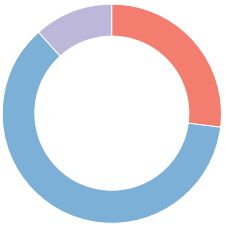
*Please be aware that this data does not form part of a peer reviewed research study. The information therein should not be relied upon for clinical purposes but instead used as a guide for clinical practice and reflection. The sample size for the August 24 survey was: 26 respondents.

7. A patient has second-eye cataract surgery and ends up with a refraction of -2.5 in the first eye and +0.5 in the second eye. Refractive outcome was discussed with the patient at the initial clinic attendance, and it was decided to leave her -2.0 so she could read without spectacles on. She is now suffering with anisometropia. Is there a breach of duty?



77% Yes
23% No

8. Who was at fault?



27% Doctor in clinic
61.5% Operating surgeon
11.5% No response

I have recently had a couple of medico-legal cases involving narrow angles and the management of those patients. I have also recently seen a run of them in clinic.

The first question refers to a patient with no signs of a problem except potentially occludable drainage angles on gonioscopy. Historically I would have immediately arranged for them to have bilateral YAG peripheral iridotomies (PIs) as a prophylactic measure. I would say to them that clinically the angles could become blocked off but it is not an exact science. The risks of angle closure are low but if they develop it, it can be sight threatening. The risks of YAG PI are low so it is worth undertaking the laser. Now we have evidence and guidance, the decision is less clear cut.

We have discussed this issue previously and indeed a very similar question was asked before and almost two thirds of you would still undertake YAG PIs. This increased dramatically to 91% when the patient was symptomatic. Now the figure is closer to 50%.

I refer again to the Royal College of Ophthalmologists' *Clinical Guidelines: The Management of Angle-Closure Glaucoma* [1]. In primary angle-closure suspects they recommended PI only if they have additional risk factors such as an 'only eye'; a family history of significant angle-closure disease; high hypermetropia; diabetes or another condition necessitating regular pupil dilation; use of antidepressants or medication with an anticholinergic action; and those people either living or working in remote locations (such as foreign aid workers, armed forces stationed overseas or oil rig workers), where accessing emergency ophthalmic care is not possible.

Laser PI is not advised for most people who are primary angle-closure suspects without additional risk factors, and yet 50% of us would still recommend it and indeed 7.5% would take their lens out.

What is fascinating is that when you are the one who has the occludable angles more than 70% of you would elect to have the iridotomy. This goes against the evidence base and guidelines. It also raises an ethical question of why we would have it ourselves and yet would not recommend it for patients? I explain to my patients the pros and cons of treatment and then they make an informed choice as to how they wish to proceed. I have been asked on many occasions what I would do and I answer that I would have the laser. Maybe seeing the misery and pain endured by patients who have had acute angle closure I am swayed into avoiding that scenario at all costs.

Next, we questioned you as to where you place your PI. Seventy-seven percent elected for the classical superior position while 15%

went temporal. Eight percent responded that it did not matter. I cannot see how a hole in the iris below the upper lid would not cause some degree of unnecessary light ingress into the eye however the evidence would suggest that it does not actually matter. In a recent systematic review [2] no significant difference was found in the incidence of any new dysphotopsia types among the location groups post-PI. Overall, the incidence of lines, ghost images, and blurring significantly increased after PI, while halos and glare significantly decreased. They concluded that the current literature suggests that the location of PI has no significant relationship to the types and rates of dysphotopsia experienced thereafter. While there is a 2–3% risk of linear dysphotopsia after PI regardless of location, PI may also resolve pre-existing halos and glare. I am still going to place my PIs at 11 o'clock or one o'clock, so I am clearly a hypocrite when I insist the readership follow the evidence.

The next question asked what readers would do if they had mildly raised intraocular pressures (IOPs) and a new diagnosis of glaucoma. More than three quarters would elect for selective laser trabeculoplasty (SLT) while the rest would prefer drops. Again, this shows that there is no definitive way to proceed and patients should be engaged in the decision-making process regarding their management.

The next question relates to a scenario which is sadly not all that uncommon. We usually aim for emmetropia and in the typical cataract age group they are unlikely to have had laser refractive surgery and most of the time we are correct. There are patients coming through now who had photorefractive keratotomy (PRK) or laser in situ keratomileusis (LASIK) many years ago and they will not automatically volunteer it. Flaps can be very difficult to see after all that time. It is vital that we routinely ask them about previous operations but also specifically ask about laser as a patient may not consider their laser to have been an operation per se, so leave no room for error and misinterpretation.

When we question who was at fault in not eliciting the history of laser refractive surgery, we are split with two thirds pointing the finger at the doctor in the cataract clinic while one third put the blame at the feet of the operating surgeon. Granted the operating surgeon has an opportunity to pick up the error when they find an emmetropic patient with an axial length of 26mm or particularly flat k's on the biometry but a full history is not taken at this point and I believe the time to pick up these issues are at the initial consultation.

Another common scenario is presented in the next question. We almost always aim for emmetropia so it is highly likely that we should aim for emmetropia again with the second eye. If we look solely at the biometry then there is no way to detect that the patient was left -2 in their other eye unless someone kindly inputs it into the biometer or writes it in. Even if we see them in myopic spectacles, we will assume that they have not had their spectacles updated. We owe a duty of care to ensure that the patient does not suffer avoidable anisometropia / visual morbidity and a duty to not needlessly put them in a situation where they need to have to have further potentially sight-threatening surgery to exchange the lens. It is a mistake, and an easily made mistake, however I consider it a breach as we should make efforts to ensure it does not happen. This time two thirds of you put the blame on the operating surgeon. I do believe it is important for the operating surgeon to check the refraction of the first eye, however it is for the team as a whole to try and supply this information and clearly document in the clinical record if the patient elects to remain short-sighted.

We will be talking about mistakes and breach of duty in the next article in response to the questions you will be receiving. Please take the time to respond.

References

1. Clinical Guidelines: The Management of Angle-Closure Glaucoma (2022). *The Royal College of Ophthalmologists.* https://www.rcophth.ac.uk/wp-content/uploads/2022/06/Management-of-Open-Angle-Closure-Glaucoma-1.pdf [Link last accessed September 2024].
2. Balas M, Mathew DJ. Dysphotopsia and location of laser iridotomy: a systematic review. *Eye (Lond)* 2024;**38(7)**:1240–5.

1. A patient with glaucoma is followed up for 10 years. The visual field in the right eye deteriorates gradually from a visual field index of 93% to 5%. Throughout this time the IOP varied between 18–21mmHg. The patient complains that he should have been offered surgical intervention and failure to do this led to his visual loss. Is there a breach of duty?
   - ❑ Yes
   - ❑ No
2. A patient has intermittent blurred vision and occasional ache in her eye. Her optician feels her angles are potentially occludable on Van Herick. Intraocular pressure is normal, optic discs are healthy and visual field is normal. The patient is referred to the hospital eye service. She should be triaged as:
   - ❑ Routine
   - ❑ Soon
   - ❑ Urgent
3. The patient in Q2 is referred into the hospital eye service and an appointment provided for two months later. During the wait, the patient suffered an attack of acute angle closure. Is there a breach of duty in not seeing her sooner?
   - ❑ Yes
   - ❑ No
4. The patient in Q2 is seen in clinic four months later as a new patient. The IOP is found to be 35mmHg in each eye and glaucomatous damage has occurred. A diagnosis of chronic angle-closure glaucoma is made. Is there a breach of duty in not seeing the patient sooner?
   - ❑ Yes
   - ❑ No
5. Do you think that a mistake resulting in visual loss is a breach of duty?
   - ❑ Yes
   - ❑ No
6. Does it make a difference if the mistake is easy to make and relatively common?
   - ❑ Yes
   - ❑ No
7. Do you think a patient who loses vision due to an avoidable clinical error deserves compensation?
   - ❑ Yes
   - ❑ No

Complete the next survey online here:
www.eyenews.uk.com/survey
Deadline 1 November 2024

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