Late-Onset Keratoconus In a LASIK Patient

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CASE PRESENTATION

A 23-year-old male presented for a LASIK evaluation in October 2000. Preoperatively, he had manifest refractions of -5.00 +0.75 X 90 OD and -5.25 +0.75 X 85 OS, and his pachymetry measurements were 525 µm OD and 520 µm OS. Computed topography was normal (Figure 1). LASIK surgery was uneventful.

The patient's last follow-up visit to your practice occurred in 2002. Computed topography was normal. His UCVA measured 20/15 OU. He had manifest refractions of plano +0.25 X 140 = 20/15 OD and -0.25 D spherical equivalent for a visual acuity of 20/15 OS.

In 2007, the patient returned with a complaint of decreasing vision in his right eye during the past several months. His UCVA measured 20/70 OD, and he had a manifest refraction of -4.25 +3.50 X 142 OD. The UCVA and manifest refraction for his left eye were unchanged. Figure 2 shows the results of computed topography.

Several refractive surgeons that the patient consulted confirmed your diagnosis of keratoconus rather than classic LASIK ectasia. After you discuss with the patient the options of Intacs (Addition Technology, Inc., Des Plaines, IL), riboflavin treatment, a computed topographic-guided laser enhancement with riboflavin, and penetrating keratoplasty, he decides to see a specialist for the implantation of Intacs, because you presently do not perform the procedure. He asks you to refund the price of his original LASIK surgery to help defray the cost of Intacs surgery. How would you proceed?

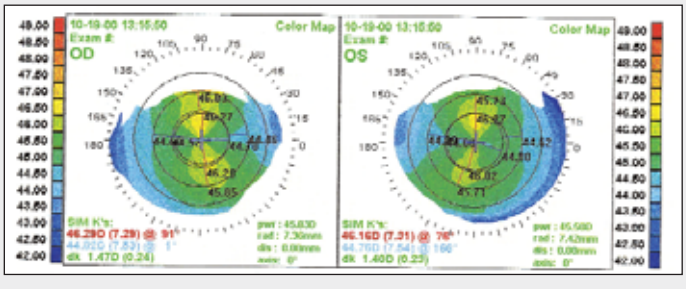

Figure 1. Computed topography (EyeSys Vision, Houston, TX) showed normal, symmetric, astigmatic bowties in both of the patient's eyes preoperatively.

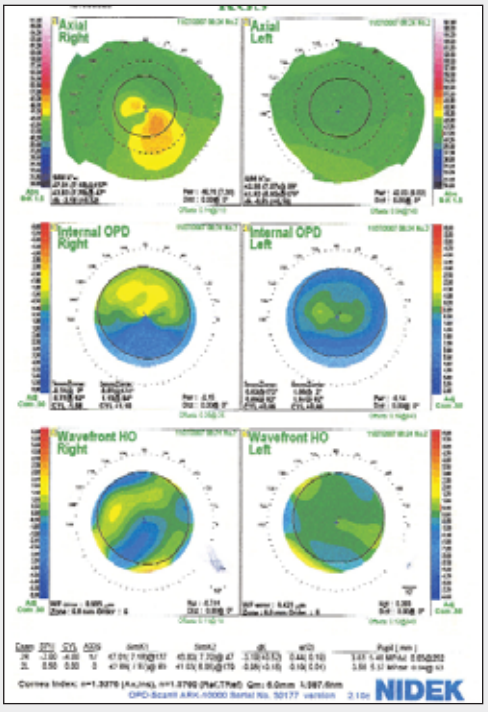

Figure 2. Topography showed a normal postoperative LASIK result in the patient's left eye. His right eye, however, exhibited classic topographic patterns consistent with corneal ectasia as typically seen in cases of keratoconus.

CHARLES R. MOORE, MD

This is clearly a straightforward case of uncomplicated LASIK in an appropriate candidate. Any refund to this patient would be a catastrophic mistake that I believe could be interpreted by an attorney as a partial admission of guilt. It might be worthwhile to see if there is any family history of keratoconus.

> "The surgeon should understand the situation completely before choosing any action."
> —John Potter, OD

ALAN FAULKNER, MD

Obviously, the outcome for this patient is unfortunate, and I think how a physician responds is incredibly important. When we surgeons choose to operate on a patient, we all recognize that—despite our best efforts—the results may not be as we envision. To that extent, we always share some degree of the risk.

In this case, most would agree that there were no significant risk factors for or warning signs of the outcome, so the physician is not really responsible or liable. It is likely that ectasia would have occurred to some degree even if the LASIK procedure had not been performed. That stated, I would refund the patient's money to assist him in attaining visual recovery. After all, our mission in life is to preserve and maximize vision!

I would not ask this patient to sign a release to obtain the refund, although I do not think it would be wrong to do so. My reason is that the refund is offered based on empathy and concern, not as compensation for damages. In the past, risk managers have advised me that refunds do not constitute an admission of wrongdoing, that requesting a release is optional, and that refunds often diffuse the likelihood of litigation.

In a case like this, I think taking the high road is good for the patient and our profession!

JOHN POTTER, OD

The answer to a difficult question such as "How would you proceed?" is "It depends." First, I would gather the facts. Implied but not stated is the issue of whether this patient could file a complaint of medical malpractice against the operating ophthalmologist. The surgeon should therefore know with reasonable certainty what the statute of limitations, statute of repose, and continuing-care considerations are in his state. His medical malpractice insurance provider should be able to assist with that inquiry, and the surgeon should understand the situation completely before choosing any action. It is prudent to discuss any risk of a malpractice claim with the medical malpractice insurance provider.

The next step is a matter of emotional intelligence. Regardless of the circumstances, this is the ophthalmologist's patient. If the physician wants to help, he should. If he does not, he should not. Because this patient will be under the care of another surgeon, the original ophthalmologist should secure a release for any refunded money, if possible.

RICHARD L. VANORE, ESQ, AND NORMAN F. KLICK, JR, ESQ

In North Carolina, where we practice law, and in most other jurisdictions, any claim by the patient in this case would be barred by the applicable statute of limitations/repose. Nonetheless, North Carolina, like many other jurisdictions, has a specific rule of evidence that provides that apologies for adverse outcomes, offers to undertake corrective or remedial treatment or actions, and other gratuitous acts to assist the patient shall not be admissible to prove negligence or culpable conduct. Regardless, the physician should be very careful in making any statements that could be construed as admissions of fault. If the surgeon in this case is not practicing in such a jurisdiction, any such communication or act could be used against him in a lawsuit.

The interaction should be carefully and immediately documented, including notation of all disclaimers communicated to the patient and statements by the patient acknowledging that the physician was not at fault. In addition, the physician's professional liability insurance carrier should be notified immediately.

In the event that any payment/refund is made, it would be best to obtain a full and complete release of all claims from the patient. If this also includes a termination of the patient from the practice, the physician should first consult with the applicable licensure/medical board. In North Carolina, patients must be given 30 days' advanced written notice, and it must be made clear whether the individual physician and/or the entire practice is terminating the patient. In addition, the practice must provide emergency care during the 30-day period. ■

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