

Patients' Flow With Laser Cataract Surgery

Where do I put this device?

BY JONATHAN STEIN, MD, AND ERIC D. DONNENFELD, MD

It is always challenging for practitioners to change their behavior patterns. Adopting and incorporating new practice models presents a sometimes difficult and even unsettling situation for the average health care professional. In an increasingly competitive atmosphere, however, change will occur for most of us in the upcoming years. New practice models are emerging, and technology is expanding at an alarmingly or fascinating fast rate depending on your perspective. Laser cataract surgery as a platform is now readily available, entering mainstream ophthalmology and will likely be the standard of care at some point in the future. Adopting such technology will inevitably affect the patient flow through our outpatient consultations and our surgery center experiences.

COMPLEX CONSULTATIONS AND SURGICAL FLOW

With the advent of premium IOLs, outpatient consultations have already become more complex. If a practice is going to offer laser cataract surgery, it is extremely important for the staff to be able to explain this procedure to patients in a direct and clear manner. Too much information at once can often leave a patient more confused than educated, which in turn, leads to a suboptimal relationship regarding the upcoming surgical event. An ophthalmologist who is just starting to embrace a new paradigm should have a method in place and expect that the consultations will take slightly longer in the beginning. Patient flow through the office will potentially be affected; however, the system will become smoother with more experience and time.

WHERE DOES THE LASER GO?

Surgical flow will also obviously be affected for the individual surgeon and for the facility in general when incorporating laser cataract surgery into the practice. Different models of patients' flow have been used in different locations within the practice, and this too is continually



Figure. Dr. Stein seated at the laser.

changing with the FDA's approval of corneal flap creation on several of the units. The first issue to be considered in terms of the practice's setup is that the current FDA approval stipulates that a trained medical doctor or physician's assistant must be the one manipulating the laser. In general, unless an individual has an assistant who is a medical doctor, such as a fellow, the operating surgeon will have to perform the laser portion of the procedure. For this reason, and to make the experience for the patient as optimal as possible, the laser unit needs to be near the OR. The three main options include (1) having the unit in the OR itself, (2) placing the device in a nearby location either on the same or a different floor of the facility, or (3) putting the unit in another facility (least desirable).

When making the decision regarding optimal laser placement, multiple factors such as the OR's size and the floor's layout must be taken into account to make the transition. We suggest that if there is room in the facility, option 2 is the best, as it places the laser near the OR's rooms but does not tie up their usage.

OUR EXPERIENCE

We have operated at two different facilities with a laser cataract surgery unit since April 2011. Each facility has at least two rooms running simultaneously and one laser. Fortunately, the ORs are large enough to accommodate both the femtosecond laser unit and the standard cataract surgical equipment and microscope. Therefore, in both facilities, we keep the laser unit in one of the ORs. The patient undergoes the standard preoperative regimen in the designated area and is then brought into the OR on a mobile stretcher. He or she is placed under the laser and administered conscious sedation. The eye is anesthetized again with a topical drop such as tetracaine (no gels are used). The unit is engaged, and the 45-second laser treatment is applied. While this is occurring, the scrub technician/nurse is opening up the sterile trays to be used and priming the phacoemulsification unit. The patient is then disengaged from the laser unit, moved to the operating microscope, and prepped and draped in the usual sterile ophthalmic manner. Once the team has established a smooth routine, the surgery can be accomplished efficiently without downtime. Furthermore, additional rooms can be added if available.

CONCLUSION

We have been early adopters of laser cataract surgery and have seen the technology improve in the 2 years since it has been approved. We had the same concerns and comments as many others regarding its efficiency and superiority to a procedure that was already effective and efficient in competent hands. With advancing technology, we are convinced that this is a superior procedure, and a higher level of efficiency now exists. ■

Eric D. Donnenfeld, MD, is a professor of ophthalmology at NYU and a trustee of Dartmouth Medical School in Hanover, New Hampshire, and a chief medical editor of Cataract & Refractive Surgery Today. He is a consultant to Abbott Medical Optics Inc. and Alcon Laboratories, Inc. Dr. Donnenfeld may be reached at (516) 766-2519; ericdonnenfeld@gmail.com.



Jonathan Stein, MD, is in private practice at Ophthalmic Consultants of Connecticut in Fairfield, is a clinical assistant professor at the NYU School of Medicine in New York City, and has a Bachelors of Science degree in nutrition from Cornell University. Dr. Stein may be reached at steinjonathan@hotmail.com.

