

The Reluctant Patient

BY STEVEN DEWEY, MD

Evelyn was an 83-year-old rather matronly lady who visited me in 1994. She presented with a posterior subcapsular cataract plaque, dense brunescens nuclear sclerosis, and 20/200 vision in her right eye. Her left eye had a white cataract, a 3-mm bound pupil, and hand-motions vision. Her primary complaint was that she simply could not wait any longer. She could no longer see well enough even to do the knitting that had kept her occupied.

Evelyn's history immediately endeared her to me. She had been a patient of Tullos Coston, MD, from the 1940s through the 1960s in Oklahoma City, Oklahoma. He had repaired a retinal detachment in her left eye sometime during those years. I explained that I had met Dr. Coston, and I asked her what specifically he had done to make this repair. She explained that she had never understood it entirely but that her sister, a retired nurse, did. Her sister had essentially cared for her through the process.

As I performed the A-scan, I invited Evelyn to have her sister call me to discuss the treatment on the left eye. It appeared to have good visual potential (ie, good four-quadrant light projection and normal contours on ultrasound). I told Evelyn that it should be easy to extract the cataract from her left eye and restore her vision.

"My sister doesn't know I'm here," she explained. "She'd be upset with me to no end if she knew I was having my cataract removed."

I was astonished to hear her remarks and learned that her experience with the retinal detachment repair had left her with painful memories. Apparently, the fear of any future surgery was worse. She said that Dr. Coston had advised her never to have the cataract removed from her left eye and that a retinal detachment would probably result from cataract surgery on her right eye.

I tried to offer her a slightly different perspective. I asked her when she had last seen Dr. Coston, and she told me it had been at least 25 years. With the most gentle tone I could use, I described how both cataract surgery and retinal detachment surgery had changed during that time. I suggested that it would be appropriate to move forward with surgery on her left eye first, and I offered to send her to a local retinal specialist for a second opinion.

Evelyn responded that she did not know that I had trained in Oklahoma City but that I had taken good care of two of her friends. Nevertheless, my negotiations were not successful. Although her left eye was virtually blind due to

the mature cataract, I was not to touch it. Surgery on her right eye was scheduled within the next couple of weeks.

THE OKLAHOMA CITY CONNECTION

I interviewed in 1986 for a residency position to begin in 1988. My visit to the Dean McGee Eye Institute (DMEI) was on the final day of interviews, and I was the last candidate waiting outside the fifth-floor conference room for my name to be called. I was already amazed by the program and the facility, and I was not feeling confident about my chances.

During my wait, the elevator doors opened, and out walked Dr. Coston. He met my uncertain gaze with a confident, grandfatherly smile, came over, sat down next to me, and started a conversation. He was obviously proud of the institute, the role he had played in its development, and its future. He was masterful at relaxing nervous medical students such as myself. I mentioned that, during my interviews at other programs, I had never met a chairman emeritus, let alone knew that one remained on the faculty. He nodded, smiled, and pointed out that DMEI was special that way.

I started my residency at DMEI in July 1988, and Dr. Coston passed away in October of that year. Unfortunately, the conversation we had as I interviewed was the longest I would have with him. Although I did not get to know him personally, as I would have liked, his spirit permeated the faculty and the facility during my tenure.

Ironically, Evelyn was the first patient whom I could identify as having been treated by Dr. Coston, despite my 3 years in Oklahoma.

SURGERY

I had planned to have Evelyn receive general anesthesia so that I could avoid patching her only sighted eye. I discussed this approach with Evelyn, but she wanted to avoid any pain after surgery, even if that meant patching her right eye. I agreed and performed a lid-sparing retrobulbar block, with a Honan balloon placed for the requisite time.

This was the era, for me at least, of 6-mm PMMA lenses implanted after phacoemulsification. I created a Langerman hinged incision about 1.5 mm posterior to the superior limbus and entered the anterior chamber with a keratome appropriate for a 19-gauge beveled needle. After completing the capsulorhexis, I started making the central grooves in anticipation of normal divide-and-conquer surgery.

Suddenly, the lens just did not seem right. The anterior chamber seemed deeper—not too shallow, just unstable.

This was not the densest cataract I had removed, but it quickly appeared to be one of the more challenging. I enlarged the scleral tunnel and enlarged the capsulorhexis by converting it to a can opener. I prolapsed the lens into the anterior chamber using a J-cannula and, with a lens loop, delivered the hemisections created by sculpting.

As I removed the second half of the lens, out came the capsule. Right behind the capsule was a large, dark grey mound that replaced the bright red reflex. Surprisingly, there was no vitreous at the wound, the pupil remained round, and the iris remained in position. I pressurized the globe to try to suppress what I perceived to be a choroidal hemorrhage. I called my retina colleague, who recommended sclerotomies, but nothing drained. I dutifully closed the primary incision and the conjunctiva over it.

POSTOPERATIVE COURSE

The postoperative discussion was one of the worst I can recall. Here was a patient waking from sedation with her sighted eye patched to hear how her surgery did not go at all as planned, with no implant placed and another surgery likely necessary to try to restore or preserve her limited vision. I had no answers for Evelyn. I cannot imagine how difficult that night must have been for her given her history and circumstances.

When I was alone, I mentally replayed her surgery in an effort to identify the problem. Had I missed pseudoexfoliation? Should I have insisted on general anesthesia without a block? My only solace was that her presenting vision had been so poor and her left eye had unknown visual potential.

I can still picture Evelyn's right eye on the first day after surgery—aphakic with a yellowish serum where the aqueous would otherwise be clear. Her choroidals were low but obviously hemorrhagic. The appearance of the eye improved considerably after vitrectomy and drainage, but the anatomical success did not yield a good visual outcome. Her right eye now had hand-motions vision. She could not even tell if I held a +13.00 D lens in front of her eye.

About a week after her vitrectomy, I decided to discuss the cataract in her left eye. Obvious to me was the potential for improvement, and I felt that, at this point, it would be obvious to her as well.

When I broached the idea of cataract surgery on her left eye, I did not get anywhere. No, Evelyn replied, Dr. Coston had told her never to have the cataract removed from that eye. He had obviously been correct about it all along, she said. Then, she told me that she had finally called her sister to tell her what had happened. Evelyn could no longer live alone, so she had been forced to reconcile with her sister and would be moving in with her. After all, she said, her sister could understand the medical issues far better than she could.

PERSPECTIVES

I will never know if Dr. Coston actually told Evelyn never to have the cataract removed from her left eye. Given the time frame of their interaction, I would not be surprised if he did; intracapsular surgery on an eye at risk begged complications in that era. Unfortunately, Dr. Coston's effort to prevent a catastrophic result undoubtedly contributed to the problem by influencing Evelyn to wait so long for the cataract extraction. Given the innovations that Dr. Coston himself brought to Oklahoma, I cannot help but think that he would have advised her differently along the way and that her cataract surgery would have been successful at an earlier stage.

I never shared this line of thinking with Evelyn. It certainly would not have changed the outcome. I did offer to discuss her case with her next ophthalmologist, but I never heard from or about her again.

LESSONS LEARNED

My experience with Evelyn helped direct me to treat all patients as if they are monocular. I continued briefly to use general anesthesia for truly monocular individuals, but I quickly converted to subconjunctival and then to topical anesthesia for all patients. Today, it is only in unusual circumstances and with extreme reluctance that I will use a retrobulbar block for a presumably straightforward cataract procedure. My current approach does not necessarily produce normal vision immediately, but at least the patient is capable of maneuvering with the aid of his or her freshly operated eye.

The need for a large incision to accommodate a large lens is well behind US surgeons. To what extent the unstable chamber in Evelyn's case was the result of a problem or the cause of the problem I will never know. I did not videotape my cases at the time, and video overlays were not available to assist in the review. Although the quest for smaller incisions has focused primarily on improving their sealing and decreasing astigmatism, smaller-gauge needles reduce fluctuations in the anterior chamber simply by restricting flow. Undoubtedly, such technological advances will continue to improve surgical outcomes by reducing the potential for similar problems. ■

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