



COLOR VISION CHANGE LEADS TO AN IRATE PATIENT IRATE PATIENT

Sometimes clinical experience outweighs scientific evidence.

BY TOBIAS H. NEUHANN, MD, FEBOS-CR

Ten days after a straightforward cataract procedure to implant a clear, glistenings-free, one-piece IOL in a 71-year-old man with an almost mature, dark-brown cataract, the patient presented for his scheduled postoperative follow-up visit. He would not agree to sit still for automated measurements such as noncontact tonometry or autorefractometry and instead demanded loudly to speak immediately to the surgeon who had destroyed his life. In an extremely harsh tone, he complained to me about a dramatic change in his color vision.

I acknowledged his complaint but did not pursue it straightaway, attempting first to check the postoperative findings on the slit lamp and measure his refraction. Not a chance. The patient stood up and shouted about what I had done to him. He was a professor at the Bavarian Academy of Fine Arts, and he had lectured for decades on the theory of colors dating back to Johann Wolfgang von Goethe and the theory of color types originally developed by Bauhaus master Johannes Itten. He reported that he was seeing all his specially produced color pigments, which are extremely expensive and complex to produce, far too intensively, and all his paintings

were now unusable. I had destroyed his career. He was ruined.

Fortunately his wife had accompanied him to the appointment. Although she was able to calm him somewhat, he refused to engage in any discussion or listen to explanations on my part, and he exited the examination room cursing loudly.

ANOTHER ENCOUNTER

Three months later, his wife made him another appointment. At first, I wondered whether I should refuse the examination, but, in the end, I decided to see him. Not a good idea. Again he started with insults and threats. I let him rage for about 10 minutes, until I also made it clear very loudly that I'd had enough. I said he should tell me what he thought should happen next.

That was too much for him. He stood up and made as if to strike me. His wife intervened, leading him out of the practice and asking if they could return in the afternoon. Okay, I said, one last attempt. Why I let myself be taken in, I no longer recall.

When he again appeared with his wife, I asked two colleagues to join us in the consulting room. The professor had totally changed, apologizing for his rough nature. It's just the way he

is, he said. He explained that his visual acuity through the operated eye was fantastic, but up close everything was out of focus, and the color difference was simply unacceptable.

When I tried to explain the color difference, he immediately interrupted me again, raising his voice. I rose and left the room without a word, assuming he would storm out once again. On the contrary, he remained seated while my colleagues calmly explained to him the reasons for the color difference and the other factors he had noted, like seeing poorly at near. He still refused to be examined. My colleagues therefore let him leave without an examination.

A YEAR LATER

One year later, he came to the practice again. He had sought advice elsewhere, where his surgical outcome was praised. He had by now become accustomed to the new color spectrum, which he said would require him to make a few changes in his work. He then told me that art history was full of similar experiences with famous artists such as Vincent van Gogh, Claude Monet (Figures 1 and 2), and William Turner. But, he said, we should have warned him of the change before surgery.

When I mentioned that I had personally explained the change in colors to him before surgery—that I had talked about a choice of a clear or a yellow-tinted lens, and that he had decided very clearly for farsightedness—then he claimed it was his memory that had let him down. Only the copy of the written informed consent could prove it to him. His response, still, was that I should have made these changes much clearer to him.

But now, he said, his second eye was disturbing his vision tremendously. He was aware that only an operation could change that, but he was concerned that surgery would have the same effect as the first procedure. The other eye, his left, the eye I had already operated on, had always been his better eye anyway. The refraction in the second eye was $-4.50\text{ D} = 20/200$.

I made an attempt to explain the options to him, such as a blue-light-filtering IOL, an extended depth of focus IOL, blended vision or monovision, or even emmetropia, such as he previously had. When he said he had no interest in listening to “all this nonsense,” as he described it, I asked him to find another surgeon. I felt that he had no trust in me and was not willing to listen, and I did not want to endure more of the insults I received after his first operation. I got up and left the room, as did he.

Four weeks later, the patient appeared with his wife, unannounced. The staff at reception told him that we had noted our unwillingness to treat him again due to his lack of trust in the practice. His wife then asked for an appointment for herself, as she was also a patient with us.

At this appointment, the husband and wife again came in together. I examined and treated her while her

husband remained in the waiting room. At the end of her examination, she asked me very politely to kindly operate on her husband’s other eye. They had consulted several other clinics, she said, but her husband did not under any circumstances want to go to any of them. She understood my reluctance, but her husband was really very agreeable and sensitive, a teacher who was popular with his students. She explained that it was difficult for him to teach at present because of his uneven vision, and therefore he was also now depressed. His aggressive behavior was a thing of the past.

So now what should I do? Continue to stand my ground and refuse to treat, or jump over my own shadow and accept the situation? What if the operation on this mature cataract failed, despite use of a femtosecond laser? What if there was a capsular tear? What if there was endothelial damage, the postoperative IOP was elevated, or the postoperative refraction was not right? What if something else unforeseen happened? I asked for time to consider the request, as I wanted to discuss the issue with my colleagues, including my son Raphael, who has been my partner for several years.

The upshot was that one of my colleagues who was present at the earlier consultation offered to perform all the preoperative examinations on this difficult patient and explain everything to him. He would present the information so clearly that, if the patient agreed, there would be no option for recourse or he would not come for the operation. If I was involved at all, I would only perform the surgery.

LESSON LEARNED

And that’s how we did it. Fortunately, everything went smoothly. A clear lens from the same manufacturer as for

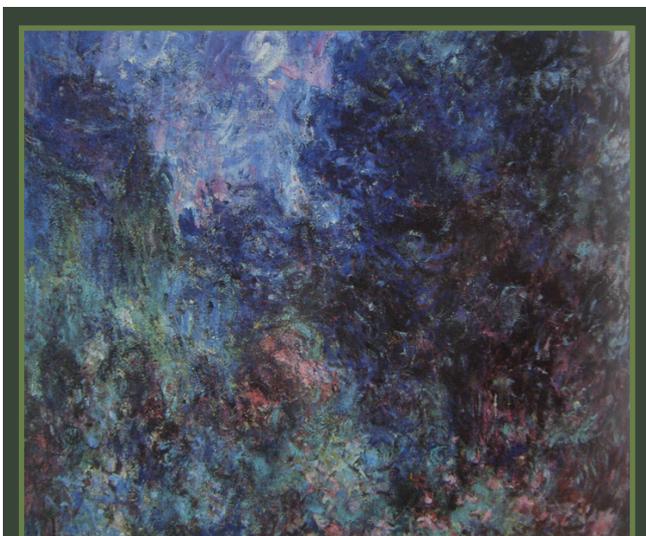


Figure 1. An example of Claude Monet’s work before cataract surgery: “The Artist’s House, View From the Rose Garden,” 1923; Musée Marmottan Monet, Paris. (Photo taken by the author while visiting Musée Marmottan Monet.)

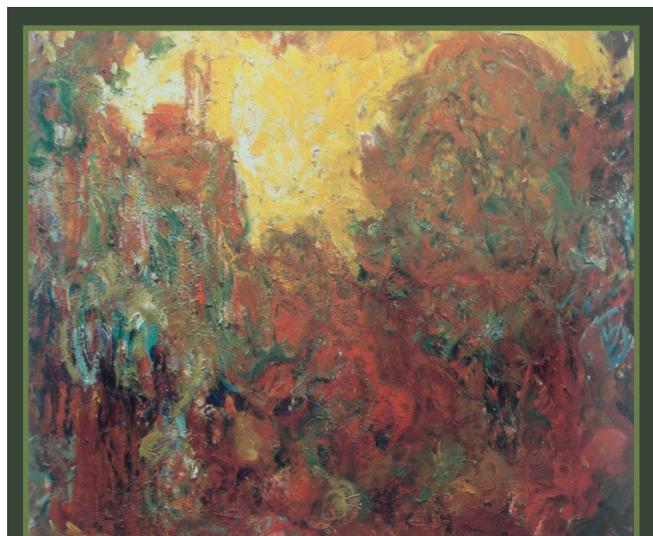


Figure 2. An example of Claude Monet’s work after cataract surgery: “The Artist’s House, View From the Rose Garden,” 1923; Musée Marmottan Monet, Paris. (Photo taken by the author while visiting Musée Marmottan Monet.)

the first eye was implanted with the aim of a postoperative refraction of -1.00 D. I could not judge the postoperative outcome, as the patient did not return for follow-up.

The response to my colleague's telephone inquiry as to why he did not attend the scheduled follow-up appointments was rather succinct: His eyesight was fine, he had no pain, he was using the eye drops as prescribed, and he simply did not have the time to come in again. He still needed to get used to his new sense of color, but he was currently working on refining Goethe's theory of colors.

In retrospect, I have discussed this patient with my colleagues for some time. A generalized lesson cannot be drawn from the experience, as fortunately we encounter people of such a nature rarely. However, we recently

had another patient—an esteemed expert in medieval copperplate engravings—who reacted just as angrily and aggressively to the change in postoperative color vision after clear IOL implantation.

In light of these two difficult cases, we have discussed the idea of giving preference to blue-light-filtering lenses if there is any doubt about a patient's reaction to color vision change, in addition to conducting thorough preoperative explanations and gaining knowledge about our patients' professions.

The reason for this may be pragmatic and at the same time highly unscientific: Simply, we have not yet experienced any similar complaints from patients after implanting blue-light-filtering lenses. The current scientific literature

does not suggest that either clear or blue-light-filtering IOLs offer any significant advantage, but published studies emphasize that there is slightly reduced contrast sensitivity and a slightly modified color spectrum with blue-light-filtering lenses.

However, if patients experience a postoperative change in color vision like that of our two patients with a clear IOL, those study findings are rendered null and void. Sometimes clinical experience still outweighs scientific evidence. ■

TOBIAS H. NEUHANN, MD, FEBOS-CR

- Ophthalmologikum Dr. Neuhann, Munich, Germany
- tneuhann@web.de
- Financial disclosure: None