

# How to Manage an Unexpectedly Uncooperative Patient During Surgery

---

---

*Advice on preparing for this  
challenge in the OR.*

BY SUMANA S. KOMMANA, MD, AND ASHLEY BRISSETTE, MD, MSC, FRCSC

**A** surgical day runs seamlessly in part because of a broad range of preparations, including preparations of the mind (preoperative plan), body (ergonomic considerations), and soul (the reason we do this job). We do our best to be well prepared for surgery, but sometimes even the best-laid plans go awry. Having the tools in our toolboxes to help address the unexpected is an essential part of being a great surgeon.



## **A MOVING PATIENT**

When a patient's arms suddenly begin moving up toward their head, it's important to act quickly to prevent them from touching their eyes and face. Common causes of movement include an itchy nose (a secondary effect of some forms of anesthesia), pain, and agitation (an unwanted effect of sedation).

If this occurs, *verbal anesthesia* may be employed. This technique allows surgeons or support staff to talk patients through the situation with positive reinforcement and helps to redirect and remind them that they are having surgery. Common examples are as follows:

- "The cataract is almost out. You are doing well."
- "No moving or talking. You are having surgery on your eye."

If necessary, remove instruments from the eye and ask patients if they are experiencing pain or have a specific concern. General anxiety can sometimes be alleviated with music (the patient's choice) or a hand to hold through the procedure (often that of a circulating nurse). These strategies usually keep patients calm until the anesthesia takes effect.





“Clear and continuous communication with the anesthesia team throughout surgery can help manage the situations that arise with unexpectedly uncooperative patients safely and quickly.”

When movement is a result of pain, the differential diagnosis spans from extra- to intraocular causes. Patients typically receive tetracaine drops and lidocaine hydrochloride ophthalmic gel 3.5% about 30 minutes before surgery begins. Additional tetracaine drops can be administered before the start of the case if a patient is noted to be more sensitive to pain and pressure. A peri- or retrobulbar block may be used for patients who are less cooperative and for complex cases that will take longer to complete.

The placement of a lid speculum can cause discomfort if the instrument is open too wide. This problem can be managed by positioning a folded 4 x 4 inch piece of gauze underneath the speculum to minimize pressure on the globe (Figure).

Conjunctival manipulation can also cause discomfort. Switching to instruments that are gentler on the conjunctiva can help. For example, a 0.12 forceps may be changed to a Weck-Cel Spear (Beaver-Visitec International) cut flush to the blue handle or a Thornton fixation ring with the teeth side up. In our experience, these changes in instrumentation tend to cause less bleeding and pain for the patient.

Lens-iris diaphragm retropulsion syndrome is caused by reverse pupillary block, which starts when there is 360° iridocapsular contact. This phenomenon leads to deepening of the anterior chamber, pupillary dilation, and significant patient discomfort. The syndrome can be easily reversed by lifting the iris from the anterior capsule with an available instrument (eg, phaco or I/A tip, Sinsky hook). This maneuver equalizes the pressure throughout the anterior chamber. Young age, myopia, and prior vitrectomy increase the risk of this phenomenon. It is important to recognize lens-iris diaphragm retropulsion syndrome early as a cause of pain in order to break the block and avoid unnecessary discomfort.



Figure. Placement of a folded 4 x 4 inch piece of gauze underneath the speculum minimizes pressure on the globe.

### POSITIONING DIFFICULTIES

Patients with significant neck pathology (eg, recent neck surgery, cervical kyphosis) often have a limited range of motion in their necks. Even if it takes more time, prioritizing patient comfort in the OR before proceeding with surgery is essential. The head/upper body may be kept elevated to decrease posterior pressure either by placing the patient in the reverse Trendelenburg position or, after the patient is positioned flat, by simply raising their head. Taping the patient's head to the headrest also helps remind them not to move. Care must be taken, however, not to tape the head too tightly, or discomfort may result.

Sometimes, it is beneficial to provide anesthesia before positioning patients if they may feel anxious or say they cannot lie flat. Anesthesia may quell some of their anxiety and allow better positioning. If the patient is claustrophobic, the drape can be propped up to create more space between it and the face.

### COMMUNICATING WITH THE ANESTHESIOLOGIST

Patients who become disinhibited under monitored anesthesia care can experience significant unwanted movement. A change in the level of sedation, if the patient's respiratory rate and blood pressure allow, usually overcomes this challenge.

Patients who fall asleep and wake up startled may move erratically if they are disoriented. If a patient falls asleep, therefore, it may be prudent to wake them in order to prevent this situation.

Clear and continuous communication with the anesthesia team throughout surgery can help manage the situations that arise with unexpectedly uncooperative patients safely and quickly. In most instances, surgical complications are avoidable. ■

#### ASHLEY BRISSETTE, MD, MSC, FRCSC

- Assistant Professor of Ophthalmology, Weill Cornell Medicine, New York Presbyterian Hospital, New York
- Member, CRST Editorial Advisory Board
- asb9040@med.cornell.edu
- Financial disclosure: None

#### SUMANA S. KOMMANA, MD

- Cornea fellow and Instructor in Ophthalmology, Weill Cornell Medicine, New York Presbyterian Hospital, New York
- sko4004@med.cornell.edu
- Financial disclosure: None