

Member Spotlight

Practice Profile: The Hauser-Ross Eye Institute



The Hauser-Ross Eye Institute (HREI) in Sycamore, Illinois, opened in 1987, founded by a wife-husband team of ophthalmologists, Dr. Lynn Hauser and Dr. Neil Ross, who dedicated themselves to the practice of excellence in eye care and especially in cataract surgery. Lynn and Neil sought to improve the ophthalmic anesthesia part of their practice and were fortunate enough to hear a lecture by Dr. Robert Husted at an AAO meeting. Bob became their consultant and encouraged them to become members of OAS, which they did. In 1991, wanting to be able to offer general anesthesia at their facility, they hired Dr. Gary Fanning to become the Director of Anesthesiology and Medical Director of the surgery center. There were two absolute requirements Gary had to meet before being hired: he had to attend a meeting of the Ophthalmic Anesthesia Society (held that year in Banff, Alberta, Canada) and he had to spend a day with Bob Husted in Wichita, Kansas. There were two CRNAs at Hauser-Ross when Gary arrived: Larry Larson (who retired in 1999 and passed away this year) and Norma Peterson (who moved to Oregon and is still a member of OAS).



Charles Ahn



Tom Tilton



Adam Cohen



Gary Fanning

Sycamore, Illinois, lies in the north-central part of the state, about 60 miles directly west of Chicago. Its sister city is DeKalb, noted historically as the home of barbed wire. Today DeKalb is known as the home city of Northern Illinois University, one of the state's major institutions of higher education. The two cities are very close, their lines of demarcation freely interdigitating. HREI lies about equidistant from the downtown areas of both cities. The area is growing rapidly as more people move west from Chicago looking for new housing at affordable prices.

While its area of influence has been infiltrated by a number of competing surgeons over the years, HREI still considers all of north-central Illinois to be its main drawing area, along with southern Wisconsin and eastern Iowa. With a branch office in west-suburban Downers Grove, we also see a number of patients from the western suburbs of Chicago. We see many patients from areas to the south, especially the LaSalle-Peru area along the Illinois River. We have a transportation system and send cars out to bring patients to the Institute from very distant areas.

There are currently four surgeons active at the Hauser-Ross Surgicenter. Dr. Thomas Tilton and Dr. Charles Ahn are the cataract surgeons, performing

approximately 1800 cataract procedures a year. Dr. Ahn is also a fellowship-trained anterior segment surgeon and performs corneal transplants, pterygium surgery, and other anterior segment procedures. Dr. Adam Cohen, the newest member of our team, is our oculoplastic surgeon with a busy practice of oculoplastic, orbital, and facial surgery. He has been here a year, and his practice is developing nicely. Dr. Kathy Anderson, our pediatric ophthalmologist, furnishes our practice with kids needing tear duct probings, exams under anesthesia, and strabismus surgery. Dr. Steven Tichy is our retinal specialist, but he has retired from the surgical aspect of his practice. He still sends Dr. Fanning many patients for blocking prior to major panretinal photocoagulation procedures and for orbital blocks to relieve pain. Dr. Christina Miller has just joined the practice. She is a residency-trained optometrist who is doing primary care. We are currently looking for another retinal surgeon and for a glaucoma surgeon.



Karen Rouse



Peg McMaster



Kathy Perkins



Chris Frankovich

The nursing staff in the Hauser-Ross Surgicenter is headed by Karen Rouse, RN, our nurse manager. Karen started with Lynn and Neil in the very beginning and has been the rock upon which the Institution rests. The staff of nurses and techs are an extremely affable group who work well together and are very competent in their jobs. Most of them are cross-trained in case of special needs due to absences, and all are dedicated to the mission of

providing excellent care to our patients. They make this a wonderful place to work and to be a patient. Our patient-comment cards attest to the loving and competent care given by our staff.

Anesthesia at Hauser-Ross is a one-person show. Gary Fanning has been here since 1991, providing both blocks and general anesthetics (although more than 95% of our cases are done under regional). About a third of the cataracts are performed under topical anesthesia with sedation, two-thirds under block with sedation. He has performed about 22,000 blocks in his 14 years at HREI. As he is planning to retire from Hauser-Ross in 2006, any of you who might be contemplating a move might want to give him a call.

Lynn Hauser and Neil Ross have retired from the practice. In 1999 they sold the Institute to the local healthcare system, and HREI is now a part of the Kishwaukee Community Hospital. The transition period was a bit difficult for all of us, but a new system administrator has helped turn things around and, to a degree, time has helped heal our sadness over losing Lynn and Neil. We have also been fortunate in acquiring an excellent administrator for the Institute, Mr. Chris Frankovich, who has helped bring stability. We recently underwent a survey by the AAAHC and performed well.



Wendy Boylen



Sue Simon & Marti Moon



Scott Jones



Jeri Wethington



Connie Froelich



Rhonda Joiner

The Ophthalmic Anesthesia Society has played an enormous role in the success of the Hauser-Ross Eye Institute. Gary Fanning was blessed to have worked early on with Bob Hustead and Roy Hamilton, both of whom taught him so much. Over the years

the association as been fruitful in numerous ways, helping us to offer excellent care to our patients. Few societies impact their members as directly and as positively as OAS. We form a family to whom we can turn whenever we have problems, an important connection for so many of us who practice alone.

The Hauser-Ross Eye Institute survives beyond the professional lives of its founders, exactly as they had hoped. Their care and hard work survives in those who remain here and provide care to patients just as the founders taught them. Lynn and Neil are special people, and it is rewarding to see their dream, which was brought to reality by so much hard work, continue in their absence. An important part of their legacy is membership in OAS, something that hopefully will live on.

Under the Covers

by
Gary Fanning, MD

Lateral Canthotomy Technique: Two ophthalmologists from the Department of Ophthalmology and Visual Sciences at the University of Wisconsin-Madison published a brief, nicely illustrated report of the technique of lateral canthotomy and inferior cantholysis for the treatment of sight-threatening retrobulbar hemorrhage. Their description of the surgical technique was preceded by a short case report of a woman who received a deep, intraconal block prior to laser photocoagulation. The surgical technique involved entering the orbit at the inferotemporal corner and dissecting posteromedially behind the globe to open the connective tissue septa to allow escape of the retrobulbar hemorrhage. The patient did well and underwent repair of the canthotomy four days later.

Editor's Note: This is a paper worth reading and a technique worth knowing. The disturbing parts of the paper are the descriptions of the block technique and the anesthetic mixture. The needle used was a 1.5 inch, 25G blunt needle. I postulate that use of a shorter needle (1-1.25") would have prevented the complication. These authors are aware of Koornneef's work, but they obviously are not aware of the work of Katsev et al who tried to warn ophthalmologists of the dangers of long needles as

far back as 1989. This message seems impossible to communicate to practitioners. I spoke twice at the recent AAO convention, and I asked both audiences if they were familiar with Katsev's work. Not a single hand went up. Don't use 1.5 inch needles! The fact that a blunt needle was used should also raise an eyebrow or two. Long, blunt needles do not protect against this complication (or any other) in my opinion. Equally disturbing is the anesthetic mixture used, which was 2% lidocaine with 1:100,000 epinephrine. This is an outrageous concentration of epinephrine to be injecting in the orbit. You don't need more than 1:300,000-1:400,000 if you use it at all. I was shocked to read that such a concentration is still being used. It's too bad that this otherwise interesting and useful paper was tainted by two such unfortunate practices.

References: Burkat CN, Lemke BN. Retrobulbar hemorrhage: inferolateral anterior orbitotomy for emergent management. Arch Ophthalmol 2005; 123:1260-1262.

Katsev DA, Drews RC, Rose BT. An anatomic study of retrobulbar needle path length. Ophthalmology 1989; 96:1221-1224. (This paper is a must read for anyone who puts needles in orbits!)

Restless Leg Syndrome: Can we stop it? From the Medical University of South Carolina comes an interesting case report that may have great value to us in ophthalmic anesthesia. The authors describe a 77-year old man scheduled for an MRI who had a history of restless leg syndrome (RLS) starting at age 58. He had been treated for RLS with anti-Parkinson drugs and oral methadone, with incomplete relief. He was given deep sedation for the MRI, but RLS and leg pruritis continued despite rather impressive doses of Propofol, midazolam, hydromorphone, and diphenhydramine. When at last he was given glycopyrrolate 0.2mg and physostigmine 1.0mg IV, all leg movement stopped.

Editor's Note: Here's a paper that might be worth more than the annual subscription to the journal! RLS is a horrible condition (I suffer it myself from time to time) which is devilishly difficult to manage. I see it most often when a patient has received the usual small amount of sedation I use before a block, a level of sedation that often puts the patient right at that boundary between being awake and being asleep. In my own case, when I do experience RLS, it is always at that point where I am just about to fall asleep. My

treatment for patients has always been to allow the sedation to wear off completely before sending the patient to the OR. Almost invariably the RLS will have resolved. Now we have a possible treatment to use should RLS occur in the OR: a small dose of physostigmine coupled with a small dose of glycopyrrolate. Many of you may remember using physostigmine in the past to reverse delirium in the recovery room. That delirium was often caused by the central effects of atropine or scopolamine, and physostigmine reverses it well. How interesting it was to learn that it may be effective against RLS as well. Use of glycopyrrolate instead of atropine during surgery prevents delirium, because glycopyrrolate does not cross the blood-brain barrier (neither does neostigmine).

Reference: Alpert CC, Tobin DP, Dierdorf SF. Physostigmine for the acute treatment of restless leg syndrome. *Anesth Analg* 2005;101:726-727.



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You Asked for It!

by
Gary Fanning, MD

Question #1: A colleague in my facility inadvertently blocked the incorrect eye. Apparently the patient and family were very understanding, as was the surgeon. Since the patient had 20/400 or worse in both eyes, they decided to go ahead and block the correct eye and do the procedure. I was taught that if and when this happens, you should cancel the case and send the patient home; however, it's hard to argue that my colleague's decision wasn't sound in light of the patient's visual acuity. What are your thoughts?

--OAS Member

Answer #1: I hate to say it, but I have had this happen to me more than once. I finally instituted a policy that has helped me—so far. I now first check the permit with someone else and say the side out loud to both the patient and the person I'm checking the permit with. It's a lot like the "time out" procedure that has been recently instituted by JCAHO, but I've been doing it for six years.

In the cases in which I did block the wrong eye, the surgeon and I discussed the situation with the patient and their families and gave them the option of what to do, and in every case they chose to continue with surgery. I have done bilateral blocks on rare occasions when the clinical situation called for it, without untoward effects.

I don't see the rationale or benefit of an "automatic" response. It seems to me to be something that should be delicately explored with the patient and family, allowing them to have a choice in the matter.

--A longstanding, stalwart OAS member who chooses to remain anonymous

Answer #2: If the reason for poor vision in the eye that was blocked was a cataract, why not just take the cataract out of that eye and come back another day for the other? It's such an obvious question that there must be another facet to it, which would be interesting to know. I personally would not be very comfortable blocking the other eye on the same day. You may call it gut reaction if you wish. If the

block of the first eye has gone smoothly and there's no noticeable problem, in theory it would be OK to block the second eye, hopefully after an hour or so has gone by. This would give enough time to evaluate for any serious problems (retrobulbar hemorrhage, brainstem anesthesia, etc.). If the surgeon is swift and doesn't anticipate any unusual problem doing the case, I would definitely use a very short-acting agent, such as 2% or 3% Nesacaine. This would allow the patient useful vision in less than 3 or 4 hours.

In terms of prevention, anesthesia providers are the most important step. In our institution the patient is given a color-specific dot over the operative side (just above the eyebrow) on admission. I check the schedule, the orders, and the permit and ask the patient which eye we're to operate on. I also ask the afternoon before when I make my phone call to the patient. I have witnessed misses and near-misses by others in my career, but none since I've been doing ophthalmic anesthesia. It's a lot like stopping for red lights—being sure of the proper side is simply something we must do.

--Editor

Question #2: A 5-month old baby was scheduled for cataract surgery. As a murmur was heard by the pediatrician, an echocardiogram was performed which showed an ejection fraction of 55% and a suggestion of "metabolic cardiomyopathy." The baby was cleared for surgery by a pediatric cardiologist. The baby underwent successful cataract surgery using sevoflurane induction, a small dose of thiopental after establishment of an IV, and atracurium for intubation and maintenance of muscle relaxation. The baby did well clinically and one week later underwent surgery for the second cataract using an identical anesthetic technique. About two hours after surgery the baby was given an oral feeding, at which time he turned blue. He was transferred immediately to a nearby children's hospital, but died of cardiac failure the next morning in spite of intensive therapy. Should this baby have been seen again by the pediatrician and possibly have had a repeat echo before the second procedure, in spite of being well clinically?

--OAS Member in India

Answer: This was certainly a very unfortunate occurrence. We don't know exactly how the baby

died: cardiac failure or the results of aspiration. If the baby was well enough two hours after surgery to have been fed, it seems unlikely that complications of the anesthetic technique per se were an issue, unless the feeding was attempted prematurely. With regard to a repeat work-up, I cannot say that with an intervening week of clinical wellness I would have asked for a repeat evaluation. If the baby was examined immediately preoperatively and felt to be in his usual state of health (i.e., like he was the week before), what would have been the indication for a repeat work-up? It would have been nice to know the exact results of an autopsy in this case.

I have not received other answers to this question. If there are those of you reading this who would like to render an opinion, please e-mail me at glfanning@aol.com, and we will print your responses in the next issue of OASIS.

--Editor

Question #3: I recently had a patient who was uncooperative and whom I felt would not lie still during surgery (we don't do general anesthesia in our facility). When I confronted the surgeon, he told me he was sure he could work with her under regional anesthesia. I was able to do a block without too much difficulty, but in the operating room she winced, withdrew, and yelled at the slightest touch, even though she had an excellent block. Modes doses of midazolam didn't help. At first the surgeon decided to cancel her and reschedule her for general anesthesia at the hospital. Then he said that she would be a perfect patient for me to give a propofol drip. After explaining the dangers of heavy sedation without airway protection, he merely told me that they had done this for him once at the hospital and that it worked great. What would you have done?

--OAS Member

Answer #1: Should a Propofol drip be used in this situation in which a patient has not fasted and in a center which is not licensed for general anesthesia? In a perfect world, which is always Black and White, the answer would be "no." In the real world, full of situations which are mostly very "gray," I would say "sometimes it is appropriate to use." Our center is licensed to perform general anesthesia. Most of our regional anesthetics are done with "light" sedation on patients who have not been kept NPO. Most of the time things go just great

with this anesthetic technique. However, sometimes patients respond differently than we expect, or surgeons encounter intraoperative complications which may require a longer procedure or more extensive intervention than was planned. If the procedure is being done under topical anesthesia and a surgical crisis occurs, anesthesia is incomplete. A few times a year we are caught in a situation which requires deep sedation or "room air" general anesthesia (AWAC: anesthesia without airway control). We do a chin lift under the drapes but are always prepared to go further if necessary. In eleven years, we've never had an aspiration under these circumstances. Of course, if we have advanced notice of a potential problem, we keep the patient NPO so that all of our options are open.

--Barry Jones, CRNA, Rapid City, South Dakota

Answer #2: This is one I have done many times. Propofol drip is wonderful! If need be, I have supported the chin, and we have a quite cooperative patient. It also helps to have a surgeon who can complete the case without delay.

--Don Hirschman, CRNA, Wichita, Kansas

Answer #3: This is a fairly easy question to answer. Early in my career I confess that I very well might have gone ahead in a similar type of scenario, trying to appease the surgeon, even when I knew deep down that it wasn't such a good choice. I quickly learned that one can quickly dig a hole for oneself going that route from which it is difficult to recover.

In my experience, such a patient as described who is restless and uncooperative with light to moderate conscious sedation becomes even more so with heavy sedation. Also, if there were an untoward occurrence with a legal consequence, do you really think that the surgeon would be supportive of your decision? Now my approach is that the best way to keep the surgeon and everyone else happy is to have a good outcome, and sometimes that means refusing to go ahead in such a situation. After explaining my decision in a non-confrontational way, if anyone is upset with that (and they sometimes are), it is not my ultimate concern.

--Terry Gabrielson, MD, Rancho Mirage, California

Answer #4: Being editor does have its advantages: I get to put my two cents in last. The important part of this case to remember is that the surgeon had not started doing surgery. Your options are entirely different once the capsulorrhexis has been started. In those cases you are stuck. Some would quit and do a full formal general, endotracheal (or LMA) anesthetic at that point. I find it hard to argue with that if you have the capability of doing it. I have pulled off a few rescues with intermittent doses of ketamine and with combinations of midazolam and alfentanil. I'm never comfortable doing it, especially since we routinely allow our patients to have a light breakfast. Fortunately, it's only happened a few times in over 14 years. I am very skeptical about a propofol drip. I have used it in the past to sedate patients having long retinal procedures. Twice I have had patients who were beautifully sedated and lying very quietly suddenly sit bolt upright with absolutely no warning. That sort of thing sticks in your mind. If the surgeon has not started surgery and the patient appears to require general anesthesia, don't start surgery. I broke this rule once on a patient in his thirties who was very claustrophobic. The surgeon insisted I sedate him heavily, and we had his wife (who was a physician) hold his hand and help us talk him through it. When it was over, I told the surgeon that we had gotten away with one but that I would never do that again. After hearing the nurses' description of the patient's response to being draped the first time (he didn't believe my description and he hadn't seen it), he agreed and apologized. I still feel stupid for having been talked into doing something I felt was wrong. When we have to do what we have to do, we should do it. When we can stop and do it as we know it should be done, we should stop and do it as it should be done. Short answer: when you know you're right, stick to your guns.

Well, do you agree or disagree with any of the above? So far as I can tell there are merits in all of the answers. Send me your comments to gflanning@aol.com and we'll print them. OASIS is an equal opportunity forum, but be prepared to suffer the slings and arrows as well as the kudos and cheers of your peers. The "right" answer is often a figment of the imaginations of those who are legends in their own minds!

--Editor•

The Editor OPINES

by
Gary Fanning, MD

Our 19th Annual Scientific Meeting is history. As always, it was nice to see so many long-time friends and to meet new members, as well. I hope everyone had as good a time and learned as much as I did. As Ric Rivers mentions in his column, plans for the 20th meeting are well underway. Many thanks to Steve Gayer and to Ric Rivers for the superb job they did in organizing this year's meeting. There were so many excellent speakers and interesting topics. Many thanks, also, to Karen Morgan and Aligned Management for all of their hard work during the entire year and especially in putting together all of the "nuts and bolts" of the annual meeting. It's a huge job, one they do very well.



Gary Fanning, MD

It was a busy fall, and many of the members of OAS were out on the circuit stumping for ophthalmic anesthesia. At the annual meeting of the American Society of Anesthesiologists in Atlanta, Steve Gayer, our immediate past president, gave an excellent refresher course on ophthalmic anesthesia that was well attended and well received. At that same meeting the third annual Workshop on Ophthalmic Regional Anesthesia was given by Marc Feldman, Ric Rivers, Steve Gayer, and myself. There were about 25 participants, including people from as far away as Finland, the Netherlands, and South America. I was honored to speak twice at the annual meeting of the American Academy of Ophthalmology in Chicago. Dr. Chandra Kumar and Dr. Timothy Dowd of Middlesbrough, England, and I gave a presentation on anatomy for orbital regional anesthesia. On the following day I helped give a course on ophthalmic anesthesia, chaired by Dr. Bruce Wallace. I was fortunate to have been joined by two other OAS members on the panel, Dr. Randy Cole and Dr. Ken Rosenthal, and we had a lovely, friendly, and wonderful discussion of multiple aspects of ophthalmic anesthesia. It is gratifying to know that the subject is not dying and that there are many who

are eager to learn more about our specialty. You may be sure that we took great pains to make everyone aware of OAS and invited them to become members.

Speaking of Dr. Chandra Kumar, a grand citation about him recently appeared in the Bulletin of the Royal College of Anaesthetists. You will recall that he has spoken at the OAS meeting on more than one occasion. He is extremely active in ophthalmic anesthesia in the UK and has given lectures on the subject in many countries. He was one of the prime movers in the creation of the British Ophthalmic Anaesthesia Society and remains one of its most active members. He was also the inspiration and organizer of the first World Congress of Ophthalmic Anaesthesia held in London in 2004. He has sponsored an annual course (videoconference) on ophthalmic anesthesia for many years, and several OAS members have been honored by being invited to speak at those courses. He has published a great deal on the subject, most recently on various aspects of sub-Tenon's anesthesia, about which he is truly a world-class expert. The Royal College of Anaesthetists recently honored him by appointing him Bernard Johnson Advisor for Overseas Doctors. Arline and I have had the pleasure of entertaining Chandra and his lovely wife Suchi in our home, and we in turn have been honored to stay with them in England. It was delightful to see him recognized so well by his peers in the UK, and our collective congratulations go out to him.

Many thanks to those members of the Scientific Advisory Board who completed their terms this year: Steve Gayer, MD (anesthesiology); Steve Charles, MD (ophthalmology); and Dan Simonson, CRNA (nurse anesthetists). We are most grateful for their service and for their loyal dedication to the society. We also congratulate those who have been elected to the Board: Randy Harvey, CRNA (nurse anesthetists); Terry Gabrielson, MD (anesthesiology), and David Markoff, MD (ophthalmology). We look forward to their service. The new officers are Ric Rivers, MD, President; Scott Greenbaum, MD, Vice-President; Randy Harvey, CRNA, Secretary; and Don Hirschman, CRNA, Treasurer. Good luck to all in the coming year.

As this will be my last year as editor of OASIS, I now have but two more editor's columns to write. In closing this one, I wish everyone a truly wonderful, happy, and healthy holiday season.