

OPHTHALMIC ANESTHESIA SOCIETY

- [Welcome](#)
- [Membership](#)
- [Info](#)
- [OAS Annual Meeting](#)
- [Newsletters](#)
- [Letter from the President](#)
- [Board of Directors](#)
- [Related Links](#)
- [Contact OAS](#)
- [2005 Program Archive](#)

O A S I S

OPHTHALMIC ANESTHESIA SOCIETY IN-SIGHT • SPRING 2006
NEWSLETTER • Page [1](#) | [2](#) | [3](#)

President's Message

By Richard Rivers, MD, PhD

Issues in ophthalmic anesthesia persist, and they remain the foundation of the society. Bringing varied practitioners from varied backgrounds and varied training together makes for fruitful discussions and presentations. If the practice of medicine were by formula, and if there were adequate research to perform all tasks based on clear scientific evidence, then there would be little room for discussion and little reason to have our annual meetings. However, we haven't quite arrived there yet, so here we are, doing what we can to be excellent practitioners based on shared knowledge and experience.....and, hopefully, some evidence-based practice as well.

The year marches on and there has been much recent activity regarding the program for the 2006 meeting. This will be our 20th annual event, and it will be a very well-rounded program. We will continue to present our annual refreshers on block techniques, bring in consultants to discuss pacemakers, sleep apnea, and nausea, and offer new topics from our membership about pediatric problems, control of intraocular pressure, and the cardiac patient. This will all be accented by nice discussions about the history of ophthalmic anesthesia and how to handle your administrators.....plus even more talks, and Anesthesia Jeopardy. Need I say more? We will see you there!

IN THIS ISSUE

- [President's Message](#)
- [Food For Thought](#)
- [You Asked for It!](#)
- [Editor's Message](#)
- [Under the Covers](#)

Newsletter Archives

- [Winter 2005 Newsletter](#)
- [Fall 2005 Newsletter](#)
- [Summer 2005](#)

[Newsletter](#)

- [Fall 2004 Newsletter](#)

Food For Thought: OAS Role in Credentialing or Curriculum Formation?

By Gary Fanning, MD

Last fall some e-mail discussion occurred among members of the Scientific Advisory Board of OAS as to whether or not it would be appropriate for OAS to offer a certification process in ophthalmic anesthesia. The intent, of course, is to try to improve the training in and the practice of ophthalmic anesthesia.

Basically, I think most agreed that there are many problems associated with trying to be a certification organization. There are already perfectly good organizations performing certification in the areas of anesthesiology, ophthalmology, and nurse anesthesia. The questions also arise as to what good such certification would do and how much liability it would produce.

Perhaps a more productive and acceptable approach would be for OAS to write a curriculum in

Employment Opportunities

Gary Fanning wants to retire, and the Hauser-Ross Eye Institute is in the process of recruiting his successor. We are looking for an experienced physician anesthesiologist who is interested in ophthalmic anesthesia and would like to live in a beautiful, growing Midwest city located 60 miles west of Chicago. If you have an interest in this opportunity, please contact either Chris Frankovich at (815) 756-8571 or by e-mail at cfrankovich@kishhospital.com. You can also contact Gary at gfanning@aol.com.

**Certified Registered
Nurse Anesthetist, Flying
Eye Hospital
ORBIS International**

Nearly 37 million people worldwide are blind, and 28 million of them do not need to be. As a nonprofit organization, ORBIS

ophthalmic anesthesia for training programs in anesthesiology, ophthalmology, and nurse anesthesia. It would have to be a very detailed document, including things like anatomy, physiology, pharmacology, and pathology as they pertain to ophthalmic anesthesia. Other clinically pertinent details include things like patient assessment, documentation, specific techniques, and complications. Also included should be an inclusive reading list that covers all of the above areas and more. Issues of clinical teaching should also be addressed, such as how to teach, when in a training program to teach, how many blocks are considered adequate for teaching purposes, and how is the trainee supervised during this experience. If the project were done well, we might be able to enlist the aid of ASA, AAO, and AANA to distribute the curriculum to teaching programs across the country.

If any of you have thoughts or suggestions regarding these issues, write to me so that we can share them in the next issue. If enough interest exists, perhaps we should work toward appointing a curriculum committee at the next annual meeting.

International strives to eliminate avoidable blindness and restore sight in the developing world, where 90% of the world's blind live. ORBIS is a founding member of Vision 2020, a global initiative led by the World Health Organization and the International Agency for the Prevention of Blindness, which aims to end avoidable blindness by the year 2020.

An exciting opportunity exists to join the ORBIS team as Certified Registered Nurse Anesthetist (CRNA) on its unique Flying Eye Hospital, a DC-10 wide-body aircraft converted into an innovative teaching facility and ophthalmic surgical center. The ORBIS Flying Eye Hospital and its international medical team have conducted treatment and training programs in more than 70 countries since 1982. Many of the world's leading surgeons donate their time to perform surgery and teach aboard the aircraft, in programs specifically designed to suit the needs of host countries.

ORBIS International is looking for a Certified Registered Nurse Anesthetist to be

**20th Annual
Meeting
October 13-
15, 2006
Westin
Michigan
Avenue
Chicago,
Illinois**

scheduled in conjunction
with the annual meeting of
the American
Society of
Anesthesiologists; make
your plans now to attend!

responsible for administering anesthesia to patients and teaching anesthesia practices and protocols to other health care professionals who participate in the Flying Eye Hospital programs. For this opportunity, we are seeking an experienced CRNA (minimum 4 years) who is a graduate from an accredited school of nursing and has a current RN license and Nurse Anesthetist certification. The ability to interact with people of diverse cultural backgrounds and to work effectively in a team-driven environment is a must. The candidate must have a willingness and ability to travel internationally up to 75% of the time, and excellent communications skills.

For further information, visit our website at www.orbis.org. To apply, forward your resume to CRNA@ORBIS.org.

Member Spotlight:

The Spokane Eye Surgery Center

The Spokane Eye Surgery Center was founded in 1986 by the physicians of the Spokane Eye Clinic. Seeking to take advantage of the new Medicare emphasis on outpatient surgery, the ophthalmologists built a 3-room facility next door to the main building of the Spokane Eye Clinic. Spokane is the hub of the Inland Northwest, lying 280 miles East of Seattle, and is the largest city between Seattle and Minneapolis. We are therefore a referral center for parts of Montana, Idaho, and Oregon.



Dan Simonson



Mary Lawlor

Originally, there were 7 ophthalmic surgeons operating- Drs. O.W. Jones III, Don Ellingsen, Bruce Ellingsen, Lance Olson, John Van Gemert, Steve Maher, and Jerry LeClaire. Dan Simonson, CRNA was the first anesthetist, and he continues there today as Chief CRNA and managing partner of the facility.

Today we have 11 surgeons, having lost a few of our founders to retirement and gained some partners – Drs. Jeff Snow, Steve Day, Randall Jacobson, Jason Jones, F. Jane Durcan, Erik Skoog, Nick Ranson, Barb Smit, and Rob Wirthlin. In addition to Dan Simonson, our current anesthesia staff consists of Mary Lawlor, CRNA, with Heidi Ritz-Stephens, CRNA and Lori Olander, CRNA. Mary, Heidi, and Lori are all members of the OAS as well.

The Surgery Center performs approximately 3400 surgical procedures and another 2500 laser procedures per year. In addition to cataract

surgery, we cover all of the major subspecialties – our surgeons have fellowships in retina/vitreous, anterior segment/cornea/refractive, glaucoma, strabismus, and oculoplastic. We are open 5 days per week, and our surgeons have become so reliant on our facility that we cover them on weekends for emergencies as well.



Pre-Op



Retina Surgery

In addition to our physicians and CRNAs, we employ 18 Registered Nurses, 4 surgical technicians, 4 nursing assistants and one anesthesia tech as clinical staff and an office manager and 3 additional employees as administrative staff.

A majority of our cases are performed under IV conscious sedation and retrobulbar block. Dan has performed in excess of 50,000 retrobulbar blocks in his twenty years at the Surgery Center. We also do topical and general anesthesia. Most of our general anesthetics are for oculoplastic procedures such as Dacryocystorhynostomy, tear duct probing, and enucleation. We also employ general anesthesia for our adult strabismus procedures and the occasional pediatric patient.

Each of our surgeons is allocated one ½ day for their surgical block time, and with our 3 rooms this means we can accommodate 1 cataract surgeon who employs two of the rooms as well as an additional retina surgeon who used the “Vit” room. In addition, if the retina surgeons are not working, we can also put oculoplastic cases in the third room.

We do not require our patients to be NPO for conscious sedation cases, and ask diabetics to take their insulin and eat normally on the day of surgery. Patients remain in their own clothes, while a gown, and hat are put on over them. IV access is established and sedation and blocking takes place out in the pre-operative area, where patients are monitored

for a complete block and satisfactory response to sedation before being transported to the operating room, where they are subsequently hooked up to monitors as well.



Cataract Surgery



Nurses

After surgery, patients are returned to the post-op area, given a snack and instructions, and are soon on their way. We have found that RNs provide us the most flexible staffing, and our nurses are trained to scrub and circulate as well as work in the pre- and post-op area.

The Ophthalmic Anesthesia Society

Dan is a founding member of the Ophthalmic Anesthesia Society, joining (although not able to attend) for the first meeting held in Dallas, TX in 1987. He has been active in the Society ever since. He finds the annual meeting of the Society the most productive and informative of all the meetings he attends, and has encouraged many of his fellow CRNAs to join as well. He believes that every anesthetist involved in ophthalmic anesthesia has a duty to their patients to keep up with the latest in the field, and ophthalmic anesthesia is so specialized that the best way to do that is through the Society and its meetings.

He has used information derived from the meetings to improve his practice and better understand the complications and best practices inherent in the field. It has given him the opportunity to make friends with numerous CRNAs and anesthesiologists who specialize in ophthalmic anesthesia, and he consults with many of them in the course of the year via email or telephone. They comprise a hugely valuable resource to help with clinical problems that come up during the year.

©2005 Ophthalmic Anesthesia Society

OPHTHALMIC ANESTHESIA SOCIETY

- [Welcome](#)
- [Membership Info](#)
- [OAS Annual Meeting](#)
- [Newsletters](#)
- [Letter from the President](#)
- [Board of Directors](#)
- [Related Links](#)
- [Contact OAS](#)
- [2005 Program Archive](#)

O A S I S

OPHTHALMIC ANESTHESIA SOCIETY IN-SIGHT • SPRING
2006 NEWSLETTER • Page [1](#) | [2](#) | [3](#)

You Asked for It!

By Gary Fanning, MD

IN THIS ISSUE

- [President's Message](#)
- [Food For Thought](#)
- [You Asked for It!](#)
- [Editor's Message](#)
- [Under the Covers](#)

Newsletter Archives

- [Winter 2005 Newsletter](#)
- [Fall 2005 Newsletter](#)
- [Summer 2005 Newsletter](#)
-
- [Fall 2004 Newsletter](#)

Question #1: We are in the process of revising our policy and procedures manual. Can you tell me what your policies are for diabetic patients regarding how much insulin they should take, whether or not they should take their normal oral hypoglycemic agents, and whether or not they should be kept NPO?

--OAS member

Answer #1: Here is our routine, and it is entirely empiric and not scientific. Diabetic patients are brought in from 8:45-9:45 AM and instructed to take their regular morning meds including Insulin or oral hypoglycemics, and to have breakfast three hours before arrival time. For example, an 8:45 arrival time = meds and breakfast at 5:45AM, or a 9:45 arrival time = meds and breakfast at 6:45AM. This includes insulin and PO meds at regular doses. With this admission time they are released before lunch, and it does not disrupt their routine. It is not scientific, but it has worked very well for many years.

--Randy Cole, MD, Boozman-Hof Eye Center, Rogers, Arkansas

Answer #2: At our institution we approach diabetic patients with physician's orders rather than policies so that they may be

individually tailored as necessary. This reflects my belief that medicine should not be practiced in a “cook book” manner. That being said, the orders do not usually vary.

Our orders for diabetic patients are influenced by the fact that we keep our patients for cataract surgery NPO for six hours for solid foods and at least two hours for clear liquids. We also check pre-operative blood glucose on each diabetic patient. If this is above 300mg/dl we consider postponing the case after consultation with the surgeon and the patient’s medical doctor. We have done cases on brittle diabetics with glucoses far in excess of 300mg/dl as long as a medical doctor was aware and actively following the case.

We have insulin-dependent diabetics scheduled for morning surgeries hold their morning insulin dose, and we schedule them for the first cases of the day. In our setting we are fortunate to be able to get these patients out in time for breakfast, and they can resume their usual morning insulin dose after they eat.

We have insulin-dependent diabetics scheduled for afternoon surgeries eat an early breakfast and take half their usual morning insulin dose.

For patients on oral hypoglycemic medications, we have them skip their medication for the day of surgery.

In cases with patients on a combination of both oral hypoglycemic medication and insulin, and in cases with patients on insulin pumps I consult with the medical doctor or endocrinologist prior to surgery to get their recommendations on how to proceed and also to make sure the patient will be followed closely postoperatively.

In Tampa we have followed this approach for many years with thousands of patients with good outcomes.

--Gary Cass, MD, Tampa Eye and Specialty Surgery Center,
Tampa, FL

Answer #3: In 2005, we implemented a new policy for NPO, insulin and oral hypoglycemic medications. Historically, we had allowed all our patients for conscious sedation with Orbital

Epidural Blocks to have a “lite meal” the day of surgery. We had them continue their usual medications including insulin and oral hypoglycemics the day of surgery. This practice worked very well from 1985 to about 2000.

In about 2000 the concept of a “lite meal” took on new proportions with the “Breakfast Sampler” from Cracker Barrels, “Fajitas luncheon special” from Chili’s, and of course the “Bacon Double Cheeseburger and Large Fries” from Burger King. Needless to say, it became necessary to redefine a “lite meal”. We limited it to include ONLY toast, juice and clear fluids. Our patients continued to amaze us with their loose interpretation of toast. For example: “I had toast, you didn’t tell me I couldn’t put something on the toast”. I even considered placing Webster’s definition of “ONLY” on the pre-op instructions. However, the last straw came when a patient, in our ASC waiting room for an afternoon procedure, pulled out a Ham and Cheese sandwich and starting eating, after all it was lunch time.

Alas, it was time to re-evaluate our age old practice of a “lite meal” the day of surgery. I considered the following factors:

1. Aspiration risks with emergent airways
2. The increasing number of patients treated for GERD
3. Management of the patients with difficult airways
4. New anesthesia staff members who were not comfortable with food on the day of surgery
5. Florida’s litigious atmosphere

Our present revised policy:

We give the patients a list of clear fluids and encourage them to drink until they leave for the ASC. No food. Diabetics hold their insulin and oral hypoglycemics medications. We request they bring all their prescribed medicines in their original containers to the ASC. Brittle diabetics, who are knowledgeable about managing their blood sugars, may decide if they need insulin in conjunction with the clear fluid regimen.

Oral Intake Instructions:

Conscious sedation (awake) with orbital epidural block:

- 2-hours clear fluids

- 6-hours milk/solid food

Deep sedation:

- 2-hours clear fluids
- 6 hours milk
- 8 hours solid food

We monitor blood sugars as clinically indicated the day of surgery.

--Randy Harvey, CRNA, Florida Eye Clinic/ASC, Altamonte Springs, FL

Answer #4: I'll answer your question by giving you a couple of scenarios and describe what my policy for diabetics is in each one with some rationale (right or wrong) for each policy.

Routine cataract patient having topical or orbital block: Take your usual insulin dose and have a normal breakfast. For NIDDM patients, take usual medications, have a light breakfast (toast and juice, coffee or tea). Measure blood sugar on all diabetics (using a CLIA-waived hand-held glucometer) when the IV is started. Rationale: I do not sedate these patients to the point of loss of consciousness or loss of reflexes. I want the diabetics to stay on their usual regime as much as possible. I wouldn't mind letting the NIDDM folks eat a normal breakfast, but hyperglycemia is a much more frequent finding than hypoglycemia. I have treated hypoglycemia using IV dextrose only a few times (certainly less than a dozen) in over 14 years. I do not treat hyperglycemia, and we do not have an absolute level at which we cancel because of a high sugar. It doesn't seem right to take on someone with a sugar of 400, as something else might be going on that needs to be addressed before elective surgery. Some people cancel if the sugar is over 250. We see that level of hyperglycemia enough that it would inconvenience a lot of people. I have combed the literature looking for scientific evidence of what level of hyperglycemia has been shown to compromise results of cataract surgery, and I have found nothing definitive. We have never been able to correlate any specific complication or poor result with blood sugar level.

Oculoplastic surgery patients or patients having general anesthesia: Try to schedule IDDM patients early in the day, keep them NPO and tell them not to take insulin. After surgery we tell the patient to take about 1/2-2/3 of their normal insulin dose on arriving home and resume a normal diet. For NIDDM, we keep them NPO, tell them to hold off on oral hypoglycemic agents until arriving back home. Rationale: I sedate these oculoplastic patients heavily, including 3-4 minutes of loss of consciousness at the very beginning while the surgeon injects the local anesthetic around the lids, face, etc., so I need them to be NPO. Again we measure the glucose when starting the IV so that we know where we're starting. We've had no problems with this approach.

To be honest, I am shocked that someone hasn't performed a large study of diabetics having cataract surgery to see if it really makes much difference how you manage them. It may simply be that no one has seen a high enough incidence of complications in these folks to make such a study worthwhile, and there are many ways to achieve acceptable results. This must particularly be true for hyperglycemia, because I can find no real agreement on how such patients should be handled. As a result, I approach each one individually and try to find out what their sugars normally run in the morning. In folks who are off the scale (350-400 and up), we ask a few more questions, consult with the surgeon, and sometimes consult with the patient's usual physician.

--Editor

Question #2: I am in the process of writing a policy with regard to criteria for the performance of surgery and monitored sedation by a CRNA on patients who are morbidly obese. We are a single-specialty ASC, performing only eye surgery with the exception of posterior chamber procedures. We do not perform general anesthesia. We would like to create a policy that gives us patient selection criteria with respect to weight, especially if there are other co-morbidity factors present. Do other OAS members have any information or recommendations on this issue?

--OAS Member

Answer #1: The one thing I always try to remember is the weight limit of the OR table. It would be wise to know it in your institution. Some are 350, some 450, and some 500 pounds.

--Marc Feldman, MD, Cole Eye Institute, Cleveland, OH.

Answer #2: The morbidly obese patient (the definition I read most is a BMI > 40 kg/meter squared) is likely to have a host of co-existing problems such as an increased risk of CAD, diabetes, hypertension, sleep apnea, Pickwickian syndrome, gastro-esophageal reflux and aspiration, restrictive lung disease, and possibly pulmonary hypertension. Airway abnormalities and difficulties have been well documented. They can also experience oxygen de-saturation with the supine position by itself, even before sedation.

Therefore, my policy concerning doing a procedure on a morbidly obese patient in a freestanding ASC, especially one that doesn't do general anesthesia, is a simple one: it shouldn't even be considered. This is a situation for an inpatient setting with the proper equipment, additional personnel, and other specialty backup handy. I also can't help but feel that if an untoward event were to occur with such a patient in an outpatient setting, it would be difficult to defend medico-legally. (As an aside, if you are considering doing these patients, you all might want to check the paperwork that came with your O.R. beds. Ours has an upper recommended limit of 400 lbs.)

--Terry Gabrielson, MD, Rancho Mirage, CA

Answer #3: I have to admit that Terry Gabrielson has a very good point. Nonetheless, I have tackled some pretty obese people in our surgicenter, including a nearly 500 pound ex-NFL linesman. I wouldn't do general anesthesia on these patients in the outpatient setting for the reasons Terry mentioned. You need help and lots of it, as well as backup. I feel comfortable doing a block, but I certainly wouldn't argue against those who don't. The points about knowing the limits of your equipment are crucial. If you can't make your patient and yourself feel comfortable about doing the procedure, don't do it. That's pretty good advice in general, come to think of it.

--Editor

Question #3: I am the VP for Ambulatory Surgery for several ASCs on the east coast. I was recently told to change our process for monitoring patients during cataract surgery. Our current practice is to have a CRNA or anesthesiologist monitor the patient, whether it is topical or block.

The Administration at one of my hospital-based centers wants to change the monitoring person to an RN in order to lower the demand for anesthesia personnel at the center so they can be used in the main hospital OR. I am concerned about this process and feel it is lowering the standard of care and is putting our patients at risk.

I would appreciate any information you could give me on the practice nationally and if you believe this is a safe practice.

--Concerned Administrator

Answer #1: This attempt by an ASC corporation to minimize the importance of anesthesiologist/CRNA/AA-administered monitoring and sedation in cataract surgery is only the beginning of the erosion of surgical care for patients undergoing outpatient procedures. It is imperative that we as the providers, including our academic colleagues, have evidence-based studies that show the importance and the need of the anesthesia providers' involvement in these surgical procedures. I certainly can give multiple anecdotes regarding potentially poor outcomes had an anesthesia provider not been present.

We are challenged by this problem as a society of professionals, and we should meet this threat to quality patient care and to our medical practices with the full force of our intellectual and political power.

--Alfie Pino, MD, Dallas, TX

Answer #2: I am sure the implementation of this practice is a direct result of the recently published articles on best practices and innovations spotlighted in ambulatory surgical periodicals. It was touted that one center replaced anesthesia providers at their ASC with RNs who "hold the patient's hand" after receiving oral

diazepam in the preoperative holding area because the anesthesia group could no longer provide coverage.

I see this as a slippery slope and a window of opportunity for certain insurance carriers. What will they do to actually provide proper care to their patients should the need arise. It also becomes an expense that the ASC must now incur, as they may not be able to bill for such services.

--Michael Cosgrove, CRNA, Livonia, Michigan

Answer #3: The following is an excerpt from a letter written by Marc Feldman to AHRQ when Marc was President of OAS. It is reprinted here with his permission along with his references.

Cataract surgery procedures should be deemed by their very nature, to justify either general, regional, or monitored anesthesia care. The surgical procedure itself justifies anesthesia care, and so there is not need for a justifying diagnosis.

1. Cataract patients are usually elderly, with a high prevalence of medical problems. Anesthesia services for preoperative evaluation and preparation are very valuable.
2. Retrobulbar blocks generally require intravenous sedation. Systemic complications including bradycardia and respiratory arrest can be quickly treated with few permanent effects if personnel with skills in resuscitation and airway management are immediately present.
3. Procedures done under topical anesthesia generally are more uncomfortable (2) and require more sedation during the procedure.
4. Cataract procedures are associated with unpredictable medical complications best treated by anesthesiologists or CRNAs in attendance.(3)
5. Microsurgical techniques require the full attention and focus of the operating surgeon. The surgeon cannot be distracted to adequately address other issues of patient comfort and safety.(4)
6. Published studies support the routine use of MAC for optimum outcome in cataract surgery.(5,6)

On behalf of the members of the Ophthalmic Anesthesia Society, I ask that the error in the draft Local Medical Review Policy be

corrected. The right of our seniors for access to high quality, skillful, and compassionate anesthesia services for cataract surgery should be protected, not eliminated.

1. Leaming DV. Practice styles and preferences of ASCRS members--2000 survey. American Society of Cataract and Refractive Surgery. J Cataract Refract Surg. 2001 Jun;27(6):948-55.
2. Katz J, Feldman MA, Bass EB, Lubomski LH, Tielsch JM, Petty BG, Fleisher LA, Schein OD. Injectable versus topical anesthesia for cataract surgery: patient perceptions of pain and side effects. The Study of Medical Testing for Cataract Surgery study team. Ophthalmology. 2000 Nov;107(11):2054-60.
3. Katz J, Feldman MA, Bass EB, Lubomski LH, Tielsch JM, Petty BG, Fleisher LA, Schein OD. Adverse intraoperative medical events and their association with anesthesia management strategies in cataract surgery. Ophthalmology. 2001 Oct;108(10):1721-6.
4. Arbisser LB. MAC for Cataracts: A question of ethics. Outpatient Surgery Magazine. March 2003.
5. Pecka SL, Dexter F. Anesthesia providers' interventions during cataract extraction under monitored anesthesia care. Journal of the American Association of Nurse Anesthetists 1997;65(4):357-60.
6. Rosenfeld SL, Litinsky SM, Snyder DA, et al. Effectiveness of monitored anesthesia care in cataract surgery. Ophthalmology 1999;106(7):1256-60.

Answer #4: According to New Jersey State Law Title 13, Chapter 35. Board of Medical Examiners, subchapter 4A, "When the administration and monitoring of regional anesthesia is being performed by a CRNA, the supervising physician shall be physically present and available to immediately diagnose and treat the patient in an emergency, without concurrent responsibilities to administer anesthesia or perform surgery, other than minor surgery."

In my view, this is one time the lawyers got it right.

--Scott Greenbaum, MD, Forest Hills, NY

Answer#5: With regard to your administration's desire to save

money by having RNs monitoring the patient without an anesthesia provider available, there are several aspects to consider. If the surgeon is going to assume all anesthesia care and have no anesthesia provider available, one should consider this scenario: any major airline could save money by using autopilot technology and having the pilot and co-pilot serve drinks and meals, thereby eliminating two stewards. In my view this is no more ridiculous than asking the surgeon to assume all the responsibilities of the anesthesia provider. Many people (even some surgeons, unfortunately) consider cataract extraction to be a minor procedure. It is not, at least not if it's my eye. If an anesthesia provider is available, he or she must be present to monitor the patient during the critical parts of surgery or Medicare will not reimburse. The most important consideration, however, is to ask yourself: do I want a qualified anesthesia provider involved in my care during cataract surgery? The answer is definitely "yes" in my case. I fully agree with Alfie Pino that the OAS ought to be in a position to fight for that concept. Marc Feldman has reinforced our feelings and opinions with data from the peer-reviewed literature.

--Editor

Page [1](#) | [2](#) | [3](#)

©2005 Ophthalmic Anesthesia Society

OPHTHALMIC ANESTHESIA SOCIETY

- [Welcome](#)
- [Membership Info](#)
- [OAS Annual Meeting](#)
- [Newsletters](#)
- [Letter from the President](#)
- [Board of Directors](#)
- [Related Links](#)
- [Contact OAS](#)
- [2005 Program Archive](#)

O A S I S

OPHTHALMIC ANESTHESIA SOCIETY IN-SIGHT • SPRINT
2006 NEWSLETTER • Page [1](#) | [2](#) | [3](#)

The Editor OPINES

by
Gary Fanning, MD

IN THIS ISSUE

- [President's Message](#)
- [Food For Thought](#)
- [You Asked for It!](#)
- [Editor's Message](#)
- [Under the Covers](#)

Newsletter Archives

- [Winter 2005 Newsletter](#)
- [Fall 2005 Newsletter](#)
- [Summer 2005 Newsletter](#)
- [Fall 2004 Newsletter](#)



Gary Fanning, MD

It has been a rather quiet winter in Northern Illinois, warmer and less snowy than usual. We've had our first tornado warnings, and I've received notice that season passes are on sale at our local golf course, so spring must be on its way. Therefore, it's not too early to begin thinking and planning for events associated with ophthalmic anesthesia.

The first event to consider is the annual meeting of the British Ophthalmic Anaesthesia Society. It is being held **June 28-29, 2006**, at the Burlington Hotel in Birmingham, England. There are a number of good topics on the program, along with sessions

of papers and case discussions. This is always an excellent meeting, and the organizers in Birmingham do a superb job. Our British colleagues are cordial and pleasant, and they have a lot to offer in expertise and experience in the area of ophthalmic anesthesia. It would be wonderful to see a large contingent of OAS members at the meeting this year. England is a wonderful country to visit, and Birmingham lies right in the middle. For anyone with an interest in history, literature, freedom, and/or geography, exploring England is a must. I'll look forward to seeing many of you there. For more information about the meeting, check out the BOAS web site at www.boas.org or simply use the link from the OAS web site at www.eyeanesthesia.org, where you must already be if you're reading this!

The second event, of course, is our own annual meeting **October 13-15, 2006**, at the Westin Michigan Avenue in Chicago. Ric Rivers and Scott Greenbaum are doing a super job of organizing the meeting and have lined up many good speakers covering a variety of subjects. We've moved back to the Westin, a bit further north from last year and a venue we have enjoyed several times. This weekend corresponds with the beginning of the ASA meeting, which is also being held in Chicago this year. Many of you will want to stay on and take advantage of attending both meetings and enjoying a long stay in Chicago. This will likely be a unique happening, so plan accordingly and try to take in as much as possible. As the meeting planning continues, keep looking at the OAS web site for complete details.

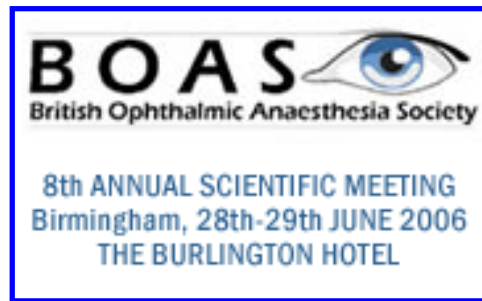
Many of you have questions from time to time, and the beauty of membership in the OAS is being able to communicate with people from all over the country when these questions arise. One excellent source of answers is the Ophthalmic Anesthesia Discussion Group located on Yahoo and initiated by Marc Feldman. There is a link to this site on the home page of the OAS web site. Of course you are always free to pick up the phone or compose an e-mail to any of your fellow members, but if you want several answers, go to the discussion group. You'll be amazed how quickly you'll get responses.

You'll note in the "Under the Covers" column of this issue that I have noted a paper authored by Don Hirschman and Lesa Morby, regarding the safety of leaving patients on anticoagulants for cataract surgery. This work was done as part of their pursuit of

their degrees of Doctor of Nursing. Don has long advocated that the members OAS work together to produce findings of clinical significance about subjects of importance to ophthalmic anesthesia, and in doing this work he and Lesa used several members to gather data for the study. We should all be proud of Don and Lesa, both long-time OAS members, for producing this work. There are many other subjects which could be addressed by members of OAS that could change clinical practice across the world. Two that I think are important are 1) oral intake practices prior to elective cataract surgery and 2) management of the diabetic patient undergoing elective cataract surgery. There are plenty of others. It might be worth considering the establishment of a permanent committee within OAS to design clinical studies and to recruit members to assist in the gathering of data. Don and Lesa's success should be an inspiration for the whole society.

This will be my penultimate effort as editor of the OASIS. I will definitely retire from doing it after the summer issue. It has been an honor to do this job as well as a certain amount of fun. I never realized how therapeutic it is to mouth off in print, knowing that colleagues around the country or the world will read your thoughts. For better or worse, being editor always gives you the last word. Of course, being editor also involves some work, as is true of all worthwhile endeavors. OAS will need a new editor starting with the fall issue. Are you interested? Let me, Ric Rivers, or Karen Morgan know if you are. OASIS must continue.

I hope you are all having a healthy, happy, and pleasant spring. I'll look forward to seeing all of you in Birmingham and Chicago.



Under the Covers

by
Gary Fanning, MD

Anticoagulation in cataract surgery: should we or shouldn't we: The authors enlisted the assistance of seven eye surgery centers across the nation to gather data for patients undergoing cataract surgery. It was strictly an observational study, no change in the patient's normal medication regimen being required. They collected data on 2,241 surgeries. 53% of the patients were on some form of anticoagulation therapy at the time of their cataract surgery. 50.5% of the patients underwent surgery having had orbital regional anesthesia, and 49.5% had topical anesthesia. The incidence of hemorrhagic complications in the block group was 0.9% (17 patients), 8 in patients not taking anticoagulants and 9 in patients taking them. These complications included bruising and subconjunctival hemorrhage, but there were no serious complications such as retrobulbar hemorrhage or suprachoroidal expulsive hemorrhages. The authors concluded that it is safe and appropriate to maintain patients on anticoagulants when faced with cataract surgery.

Editor's Note: I have already commented about this paper in my editorial column. While the study may be criticized for

relatively small numbers, many other studies have been published with significantly fewer. It is amazing how difficult a multicentered study can be, and I congratulate the authors for having done it under what must have been trying circumstances, given the time constraints and low budgets that plague all such graduate program research efforts. Their conclusions certainly ring true, and I think most practitioners of ophthalmic anesthesia would not want to stop anticoagulants, even if the patient is scheduled for orbital regional anesthesia. You have all heard my own caveats on the subject: it may be safe **if** you use short needles (1-1.25") and stay away from the vascular areas of the orbit. If you don't know where the most vascular areas are, you probably shouldn't be doing blocks in the first place. Thanks again to Don and Lesa for a good job. You should try to get a copy of this paper for your files. It has an excellent list of references. Let's hope their work will be an inspiration for the OAS to band together to do needed clinical research in the area of ophthalmic anesthesia.

Reference: Hirschman DR, Morby LJ. A study of the safety of continued anticoagulation for cataract surgery patients. *Nursing Forum* 2006; 41:30-37.

Suprachoroidal Expulsive Hemorrhage—What are the Risk Factors?: In this classic paper, the authors looked at 113 variables in 68 cases of suprachoroidal hemorrhage occurring in the years 1981-1986 at the New York Eye and Ear Infirmary. They used a control group of 217 patients randomly selected from the 35,459 patients who had intraocular surgery during the same period. The overall incidence of suprachoroidal hemorrhage was 0.19%, 0.16% in lens surgery, 0.15% in glaucoma surgery, 0.41% in retinal and vitreous surgery, and 0.56% for keratoplasty. The risk factors that were statistically significant for suprachoroidal hemorrhage were glaucoma, long axial length, elevated IOP, generalized atherosclerosis, and elevated intraoperative heart rate. In one analysis, if a patient had a history of glaucoma, an axial length greater than 25.8, preoperative IOP greater than 18mm Hg, and an intraoperative heart rate greater than or equal to 85 beats/minute, the risk of suprachoroidal hemorrhage was increased by 752-fold.

Editor's Note: I ran across this important paper while doing research on ocular compression. While fairly rare,

suprachoroidal hemorrhage is a potentially devastating complication of intraocular surgery. While we can do little about some of the root causes of this complication, anesthesia providers can help to reduce intraocular pressure and control heart rate. It is worth reading this paper and reminding ourselves everyday to pay attention to detail and to control those things which we can safely control in order to optimize operating conditions for our surgeons and patients. I highly recommend your reading and keeping a copy of this paper.

Reference: Speaker MG, Guerriero PN, Met JA, et al. A case-control study of risk factors for intraoperative suprachoroidal expulsive hemorrhage. *Ophthalmology* 1991; 98:202-210.

Ocular Surgery and Implantable Cardioverter

Defibrillators: This special article was written by an ophthalmologist associated with New York Presbyterian Hospital. He discusses the history and indications for ICDs and points out the growing list of indications which is leading to increasing numbers of patients treated with them. It is more and more likely that the ophthalmic surgical team will be faced with these patients. He discusses a number of issues associated with these devices, including the need to avoid the use of cautery and the risk of patient movement should the device fire. It appears to be most common now for the devices to be deactivated prior to elective surgery, often by a representative from the ICD manufacturer.

Editor's Note: This is an excellent article which summarizes many of the issues surrounding ophthalmic surgery patients who have ICDs. I was actually surprised to learn it was written by an ophthalmologist, and I don't mean that as a put down. He did a nice job, better than most cardiologists could do writing about retinal detachments. This is an important subject, one we'll hear even more about at the annual meeting from Dr. Marc Rozner. My current practice is to leave the ICD activated for cataract surgery and to glue my eyes to the ECG monitor. If the patient develops VT or VF, you immediately stop the surgeon. As the device needs a finite amount of time (perhaps as long as 5 seconds) to diagnose the rhythm, charge, and discharge, you should have plenty of time if you stay absolutely focused. This practice may be altered due to the drift of current practice toward turning off the device. I highly recommend your reading Dr.

Stoller's concise and interesting article as preparation for hearing Dr. Rozner at the meeting in October.

Reference: Stoller G. Ophthalmic surgery and the implantable cardioverter defibrillator. Arch Ophthalmol 2006; 124:123-125.