

Cataract surgery and the optometrist

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Abstract

Purpose To determine the outcome of discharge on the first day following cataract surgery and the feedback from patients' optometrists.

Methods Casenotes of patients who had cataract surgery between 1 April 1997 and 30 June 1998 were analysed. Patients without complications were discharged on day 1 and advised to see their optometrist at 1 month. Patients were given a form for refraction with a pre-paid envelope for their optometrist. Completed letters from the optometrists were returned to the hospital to be analysed by the principal surgeon and acted on appropriately. A questionnaire was sent out to patients whose notes did not contain any information after the first post-operative examination.

Results A total of 318 eyes from 288 patients underwent cataract surgery. Completed forms from the optometrist were received in 245 (77%) cases; no optometrist's letter was found in the remaining 73 cases (23%). Of these 73 patients, 50 (68%) had other ocular pathology requiring hospital follow-up and 9 had died. There were only 6 patients about whom post-operative information could not be obtained. There were no significant differences regarding the age and sex of those who did or did not attend the optometrist.

Conclusion Patients without complications can be discharged to the care of their optometrist on the first day following cataract surgery. With good communication between hospital and the optometrist, better use can be made of available resources.

Key words Cataract, Optometrist, Outpatients, Surgery

Cataract extraction is the most commonly performed elective procedure in ophthalmology. With the advent of small, self-sealing corneal incisions, phacoemulsification and foldable lens implantation, post-operative complications are minimal. The number and timing of post-operative appointment varies with surgeon preference. A study by Allan *et al.*¹ retrospectively analysed the clinical intervention rate during review following uncomplicated phacoemulsification. They found that in only 2.8% of routine visits were

any clinical interventions reported, many of which were trivial and avoidable.

In our study, patients without complications were routinely discharged at the first post-operative visit within 48 hours, to the care of their optometrist. Patients were informed of the 'open door' policy for immediate self-referral in the event of symptomatic problems. This study evaluated use of the optometrist as an important resource in the shared care of the post-operative cataract patient.

Methods

Casenotes of patients who underwent cataract surgery between 1 April 1997 and 30 June 1998 were analysed. Surgery was performed under a combination of peribulbar and intracameral anaesthesia. Routine phacoemulsification was performed with in-the-bag lens implantation. Information was recorded regarding patient details, type of anaesthesia, visual acuities, pre-operative morbidity, complications, and the presence of a completed report from the optometrist.

Patients without complications were routinely discharged at the first post-operative visit with a form and advised to attend their optometrist at 1 month. The form was stapled to a pre-paid envelope and an HES1 (hospital eye service) form so patients would not have to pay for refraction. Completed forms with the patient's post-operative refraction were to be returned to the hospital in the pre-paid envelope provided. All such forms were analysed by the principal surgeon and acted on appropriately.

Post-operative cataract patients were also informed of the 'open door' policy at the time of discharge.

Results

A total of 318 eyes from 288 patients underwent cataract surgery. Completed forms from the optometrist were received in 245 (77%) cases; no optometrist's letter was found in the remaining 73 cases (23%). There were no significant differences regarding the age and sex of those who did or did not attend the optometrist. Of these 73 patients, 50 (68%) had other ocular pathology requiring hospital follow-up (Fig. 1). Nine patients had died during the study period, for whom no optometrist's record was available. These patients may or may not have attended

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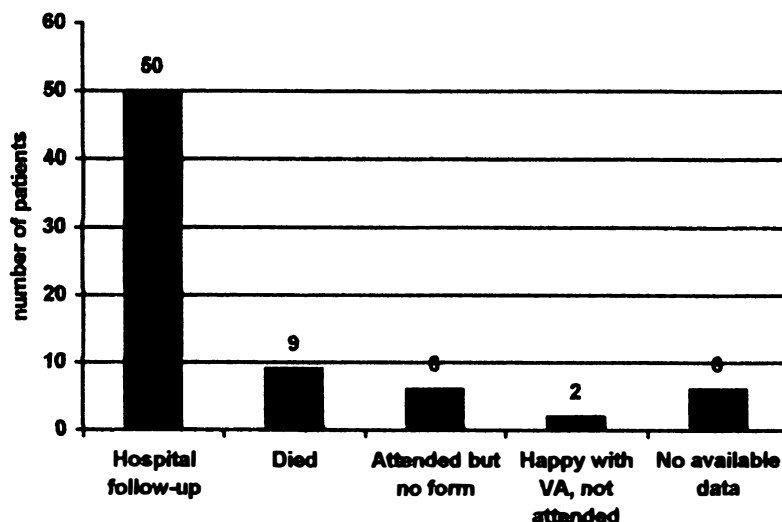


Fig. 1. A breakdown of those patients for whom no optometrist's report was available in the casenotes. The groups include those followed up at the hospital for associated ocular pathology, those who attended the optometrist with or without a form, those who died and those who did not attend because of good vision.

their optometrist. The final visual acuities recorded in the notes were 6/9 in 3 and 6/6 in 3 patients.

Of the 9 patients who died, 1 patient had pancreatitis and complications, 1 was diagnosed as having metastatic tumour a few months following surgery and 1 patient had pneumonia the day after discharge and died in hospital a few days later. In the remaining 6 patients no unusual events had taken place prior to or causing death.

The remaining 14 patients with no follow-up record were sent a questionnaire asking whether they attended the optometrist and whether they were given a form from the hospital at the time of discharge. Of the 14 questionnaires sent, 9 were returned. The results of the questionnaire revealed 6 patients had attended the optometrist but were not given a form from the hospital. They were happy with their vision. Two were happy with their vision and did not attend the optometrist. No post-operative follow-up or refraction was available for 6 patients of the total 318. The number of emergency appointments following discharge was 15 (3%). The presenting symptoms included watery eyes, red eye, light sensitivity and discomfort, with reassurance being the mainstay of treatment.

Discussion

Feedback from the optometrist was available in 77% of post-operative patients, with only 6 of the total 318 having no follow-up record. It is not possible to predict the time of onset of complications with accuracy. In the study by Allan *et al.*¹ no clinical intervention took place in 93.5% of routine review appointments. They also found that in the 7% who reattended as an emergency, 50% had some clinical intervention. In fact, patients may well delay presentation of symptomatic problems, awaiting their routine appointment.

Cohen *et al.*² conducted a study to evaluate the necessity of the first post-operative visit. They found intraocular pressures > 30 mmHg in 12 patients ($n = 201$) and cells > 2+ in 8 patients, all of which had resolved at

the 3 week review. The main purpose of the second post-operative visit was to check the patient's post-operative refraction. Follow-up practices vary widely and guidelines³ are not evidence-based. After our study period one optometrist's report revealed an unexpected hypermetropia of 4 dioptres. This patient was immediately called back and had an implant exchange.

With increasing demands for prioritisation, time and cost efficiency in healthcare provision, we propose using the services of the optometrist for the second post-operative visit following uncomplicated cataract surgery. A study by Revicki *et al.*⁴ examined the practice of co-management of the post-operative cataract patient. They found optometrists to be 99.6% specific in detecting complications with a 95.8% accuracy.

Since this study was conducted an HES1 form is no longer attached to the form for the optometrist, thus relieving the hospital of this financial responsibility. Patients have the added flexibility of arranging an appointment time, to take into account their personal commitments, and an 'open door' policy for immediate self-referral in the event of symptomatic problems.

With good communication between the cataract surgeon and the optometrist, better use of available resources⁵ can be made, to the mutual benefit of the patient and clinician.

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