Continuous Cataract Complications Log Book

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| Year of Training(total cataracts per year of training) | Date | Hospital | R/L eye | Co-morbidity | Supervised/Independent | Complications | Management | Pre-op VA | Post-op Va | Reflection |
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| ST7(89) |
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 | 11/04/17 | SHH | R PHACO  | Short eye/ shallow AC/ dense cataract/ Advanced AMD/ Dementia | Supervised | Dropped Nuclear Fragment | Managed self with supervision | CF | 6/36 (Ref +1.75/-1.00x90) | Short AL 20.1MM, PATINET WITH ALZHEIMERS - UNDER GA WOKE UP MID SURGERY AND LIFTED HEAD WHILST PHACO PROBE IN SITU. 1/8 FRAGMENT DROPPED. ANTERIOR VITRECTOMY. EYE CLOSED. REFERRED TO VITREORETINAL SERVICES.Patient explained about the complication and why surgery took longer than planned. Explained that second surgery is necessary by another team.Day 3 post op underwent lensectomy and secondary IOL insertion into sulcus. At 6/52 stable, eye quiet; VA 6/36 (advanced AMD).Unexpected complications do occur and one must be prepared to deal with them if they occur. It is important to monitor the patient’s iop and ensure they are taking oral diamox in order to keep the corneal oedema to the minimum so that there is a good posterior segment view for subsequent VR surgery. |
| ST7(89) | 12/10/17 | MREH | L PHACO | Dense/brunescent cataract | Supervised | Dropped Nuclear Fragment | Managed self with supervision | CF | 6/9(Ref -.0.5/+1.00x135 | Dense/brunescent cataract. Inferior zonular dehiscence towards the end of phaco. 1/8 fragment dropped. Patient referred to VR service.Patient explained about the complication and why surgery took longer than planned. Explained that second surgery is necessary by another team.I observed and helped with the lensectomy and secondary IOL insertion into the sulcus. 6/52 patient eye is stable and VA is 6/9.Extra care should be taken with brunescent cataracts and potential zonular weakness. At the stage when zonular dehiscence was noted, it was felt that CTR would have not been helpful. Balance between increasing PHACO power and weakening zonules. Patient was counseled before surgery of potential complications as brunescent cataract was noted. |
| ST7(89) | 07/12/17 | MREH | L PHACO | Narrow angles/ glaucoma | Supervised | Zonular dialysis | Managed self with supervision | 6/18 | 6/18 (not refracted yet) | Hypermetroipa and narrow angle glaucoma. Very high posterior pressure and shallow AC. On IOL insertion into the bag, 2 clock hours of zonular dehiscence noted with some vitreous prolapse. Anterior vitrectomy. Miochol. AC stable and pupil round at the end of procedure.Patient explained about the complication and why surgery took longer than planned. Day 1 post op VA 6/24 unaided. IOP 14. No inflammation. Dilated fundoscopy – flat retina/no tears.Day 7 post op. Comfortable. VA 6/18. IOP 13. Eye quiet and settling nicely. Suture slightly tight likely causing astigmatism but reassured as vicry it will dissolve. Due to previous high post pressure, hopefully the vitrectomy should help with long term pressure.  |
| ST6(75) | 07/01/16 | Burnley (BGH) | L PHACO | Dense cataract | Supervised | PC rupture and vitreous loss | Managed self with supervision | 6/18 | 6/7.5(Ref -0.25/+0.00) | PC tear noted after last fragment removed. Managed vit loss without supervisor taking over. Sulcus IOL inserted. Approach dense cataract with care. Balance between increasing phaco power (but risk of PC rupture) and using lower phaco power but causing zonular dehiscence. Patient explained why surgery took longer. F/U day one - sl corneal oedema VA 6/12 unaided. IOP 12. Week 1 post surgery VA 6/9-1. Stable. Week 4 post op VA 6/7. All settled nicely. |
| ST6(75) | 06/01/16 | Burnley (BGH) | L PHACO+goniosynechiolysis | AACG | Supervised | Aqueuous misdirection | Managed self with supervision | 6/12-3 | 6/6(Ref -0.25/+0.5x137) | PREVIOUS AACG; SHALLOW AC (AL 20.76); HAELON GV USED FOR GONIOSYNECHIOLYSIS; DURING I/A EYE BECAME ROCK HARD - LIKELY AQ MISDIRECTION. EYE COSED WITH 10.0 NYLON; TREATED WITH STAT DIAMOX AND SCHEDULED FOR SECONDARY IOL UNDER GA THE FOLLOWING WEEK.Patient explained about the complication and why we could not insert IOL at the time. Explained re secondary IOL implant and agreed it would be safer to do under GA.Secondary IOL under GA. Nil complications.1 week post op VA 6/7.5 unaided. IOP 10mmHg. Eye quiet.4/52 post op VA 6/6 post refraction. IOP 12mmHg. Eye stable. In retrospect it might have been better to do this surgery under GA +/- on the table Diamox to minimise IOP and reduce the risk of aqueous misdirection.  |
| ST5(60) | 10/1/2011 | Oldham | R PHACO | Dense Cataract | Supervised | PC rupture and Vit loss | Managed self with supervision | HM | 6/9(Ref-0.5/+1.25x105) | Dense cataract. Elderly patient. Small PC tear with vitreous loss noted at the end of phaco. Limited IA and anterior vitrectomy. IOL in sulcus. Patient explained about the complication and why surgery took longer than planned. 6/52 eye stable. VA 6/9. Approach dense cataracts with care. Balance between increasing phaco power (but risk of PC rupture/corneal damage) and using lower phaco power but causing zonular dehiscence. |
| ST4 (26) | No complications |  |  |  |  |  |  |  |  |  |
| ST3(76) | 1/12/2008 | MREH | R PHACO | Densenucleus | Supervised | Ant rhexis run out  | Senior surgeon took over and converted to ECCE. | 6/60 | 6/9 unaided 2/52 post surgery. (ref not available) | Always take care of capsulorhexis – take your time (feedback from senior surgeon). In this case as the nucleus was dense it was decided to convert to ECCE. Conversion went well. Nil further complications. Patient was explained what had happened and that they had sutures which will have to be removed at 2-3 months post surgery. Patient was understanding of this. At 2/52 patient was very pleased as the vision had improved to 6/9 unaided. Eye was settling nicely. Plan was to remove sutures at 2/12.  |
| ST3(76) | 1/12/2008 | MREH | R PHACO | Nil | Supervised | PC rupture/Vit loss | Anterior vitrectomy managed by self | Not available | 6/6 ph 2/52 post surgery. | Initial surgery went well. After IOL insertion rhexis split leading to post capsular rupture. Vit loss was noted. Ant vitrectomy performed by myself. IOL stable in bag. Next day eye stable. No corneal oedema. IOP 14mmHg. 2/52 post surgery VA 6/6 ph. All settled. Patient explained about the complication and why surgery took longer than planned. Senior surgeon supervised and gave instructions for the management of anterior vitrectomy. I was pleased that I was able to managed this complication by myself. I followed up the patient closely post op and in this case patient ended up with good post-operative outcome.  |
| ST3(76) | 1/12/2008 | MREH | L PHACO | Soft nucleus | Supervised | PC rupture/Vit loss | Anterior vitrectomy managed by self | 6/12 | 6/9+2 6/52 post surgery after secondary IOL insertion. | Soft nucleus. Small PC hole noted at the end of IA. Ant vitrectomy by myself. IOL for secondary insertion.Patient explained about the complication and why surgery took longer than planned. Feedback: Extra care with soft nuclei. Protect PC with second instrument at all times. Gentle aspiration and minimal PHACO. I followed up the patient closely post op and secondary sulcus IOL was inserted. VA 6/9+2 6/52 post surgery. |
| ST2(124) | 2/10/2007 | Burnley (BGH) | L PHACO | Iris atrophySmall pupilNS+++Poor red reflex | Supervised | Zonular dialysis/ No vit loss | CTR inserted by myself. IOL in bag. Stable. | 6/36-2 | 6/7.5 4/52 post surgery | Care must be taken with dense nuclei. Beware of associated zonular weakness. It was a good choice to insert CTR. IOL was then inserted into the bag and all was stable. 4/52 patient had finished all post op drops. IOL was well centered and eye had settled nicely.  |
| ST2(124) | 15/10/2007 | Burnley (BGH) | R PHACO | Dense nucleus | Supervised | Anterior capsular split | Senior surgeon took over and converted to ECCE. | 6/18 | 3/12 post surgery 6/6-3 | As soon as central puncture made in the rhexis with a cystotome there was a horizontal split in the anterior capsule extending to the pupil edge with dense nucleus pushing forward. Senior surgeon took over and converted to ECCE. PCO was dealt with at 3 months post surgery. Patient ended up with good vision. Beware of unexpected complications. Know your limitations and when to ask a senior surgeon to take over. |
| ST2(124) | 23/11/2007 | Burnley (BGH) | L PHACO | Soft nucleus/unstable AC | Supervised | PC rupture and vitreous loss.  | Senior surgeon took over Anterior Vitrectomy and IOL in bag.  | 6/12 | 6/9 at 3/52 post surgery | Soft nucleus/unstable ACSmall PC noted at the end of i/a. Vitreous loss. Senior surgeon took over - Anterior Vitrectomy and IOL in bag.Patient explained about the complication and why surgery took longer than plannedNext day review by myself showed small vitreous wick in the AC, peaking the pupil and choroidals. This settled 2 days post oral Diamox treatment. YAG laser was performed successfully to the vit wick. At 3/52 VA was 6/9. |
| ST2(124) | 23/11/2007 | Burnley (BGH) | R PHACO | IHD, previous CVA, Aspirin, HTNS+++Deep set eyes. | Supervised | Iris prolapse  | Senior surgeon took over after rhexis completed by myself as patient moving/coughing/ difficult communication | 6/60 | 6/12 at 3/12 post surgery with aphakic correction.  | NS+++, difficult communication, coughing ,deep set eyes hence temporal incision made. Rhexis completed by myself with no problems. However, patient soon became restless with coughing and moving so senior surgeon took over. Top up anaesthesia. During phaco by senior surgeon patient moved again. PC rupture and vit loss noted. Converted to ECCE. IOL expressed. Loss of red reflex noted temporally and nasally indication SCH. Wound closed immediately. Close post op follow up. IOP was 24mmHg the following day on oral Diamox and topical therapy. SCH settled gradually. Corneal oedema and inflammation also settled. Patient was left aphakic as it was decided not to go ahead with further surgery. Importance of choosing suitable patients as junior surgeons. Elderly with communication difficulties best handled by senior surgeons from the start. However, we did not predict that the patient was going to become restless with coughing during the surgery and initial stages went well. Senior surgeon did take over immediately after I felt there was too much movement by the patient and that proceeding myself would not be safe. Unfortunately in this complications occurred despite the senior surgeon taking over.  |
| ST2(124) | 27/11/2007 | Burnley (BGH) | L PHACO | Amblyopia/ previous trauma/weak zonules | Supervised | PC rupture and vit loss | Senior surgeon took over – anterior vitrectomy | 6/24 | VA 6/12 after secondary sulcus IOL | Dark fundus, amblyopia/previous trauma/weak zonules.CCC and hydrodysection routine. As soon as the phaco probe inserted AC deepened due to weak zonules. Very mobile bag. Case supervised closely by senior surgeon. PC rupture noted with ¼ nucleus left. Senior surgeon took over. Difficult to rotate the fragment as vit loss at this stage. Fragment lost to post segment. Ant vitrectomy. Referred to VR service.Patient explained about the complication and why surgery took longer than planned.PPV and lensectomy with secondary sulcus IOL. 6/52 all stable with VA 6/12.Previous blunt trauma was not noted at pre-assessment or in the notes. However in younger patient question the reason for cataracts as notes may not be reliable. Inserting a hook into the capsule after the rhexis and/or CTR might have helped with zonular weakness associated with trauma. |
| ST2(124) | 8/1/2008 | Burnley (BGH) | L PHACO | nil | Supervised | Zonular dialysis/no vit loss | CTR inserted by myself.  | 6/18 | 6/6 unaided 4/52 post surgery | Inferior zonular dialysis. No vit loss. CTR inserted. IOL in bag – stable. 6/6 unaided 4/52 post surgery. |
| ST1(55) | 31/5/2007 | MREH | PHACO | Previous vitrectomy/ dense nucleus | Supervised | PC rupture/vit loss | Senior surgeon took over | 6/24 | 6/9 | Difficult case. Previous vitrectomy/ dense nucleus. Deep AC. Small strand of vitreous noted at 1 o’clock in AC post IOL insertion. PC rupture must have occurred during the I/A. Strand was removed with cutter by a senior surgeon. IOL stable. Care with I/A / polish post vitrectomised eyes as lens cortical matter is often stuck to the capsule and can be very difficult to remove. Therefore best to do minimal I/A/polish and deal with PCO (if occurs) at later stage.  |
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