



Closed Claim Study

Disclosure of Risks, Complications, and Adverse Outcomes

By Anne M. Menke, RN, PhD
OMIC Risk Manager

Allegation

Loss of vision following cataract surgery.

Disposition

Defense verdict on behalf of insured ophthalmologist.

Case Summary

A 77-year-old female presented to the insured ophthalmologist with complaints of being unable to read, drive, or watch television and vision in the left eye of light and dark sensation only. Visual acuity was 20/25 OD and 20/80 with refraction OS. Past ocular history included peripheral iridectomies OU for intermittent angle closure glaucoma and pseudophakia OD. Medical history was significant for atrial fibrillation treated with aspirin, COPD, and hypertension. The patient had a dense cataract, grade 3-4+. The ophthalmologist recommended phacoemulsification with IOL placement under topical anesthesia and a clear corneal incision. After removing the extremely dense cataract, the insured detected a large rent in the posterior capsule and performed an anterior vitrectomy with removal of the remaining cortex. He attempted to place the IOL in the sulcus but resorted to anterior chamber placement due to instability. No bleeding was noted.

The patient's postoperative course was complicated by the development of a full eight-ball hyphema with loss of vision on day 3; treatment consisted of bed rest in a recliner at 30 degrees and 1% ophthalmic Atropine. The ophthalmologist later testified that he recommended but the patient refused hospitalization; he did not document this or any pre- or postop discussions regarding the possible effects of the patient's aspirin therapy. IOP, slightly elevated at 28 on postop day 1 and treated with topical agents, rose to 62 on day 4 when the patient experienced a rebleed, prompting an anterior chamber paracentesis and hospitalization. An anterior chamber washout was needed the next day to control the pressures. Blood staining of the cornea and IOP of 30 was noted on day 13. The retina specialist to whom the patient was referred performed another anterior chamber paracentesis and found no posterior bleeding on B scan. The patient requested a second opinion; the consultant explained the treatment options but told the patient there was little chance for visual improvement.

Analysis

The plaintiff's expert was critical of the insured on several accounts. First, the insured should have considered the impact of aspirin therapy on the development of the hyphema or rebleed and advised the patient to discontinue taking aspirin once bleeding developed. Second, the insured did not recognize the early readings as falsely low in the face of edema and hyphema. Third, had systemic agents been used to control the patient's elevated pressure, optic nerve damage and the resulting loss of vision might have been prevented. Fourth, the hyphema should have been washed out earlier with care taken to remove the clot.

While noting the insured's lack of documentation regarding aspirin and recommended hospitalization, defense experts supported the accuracy of the IOP measurement and felt he had appropriately recognized and managed the intraoperative and postoperative complications. The jury returned a verdict in favor of the insured ophthalmologist.

Risk Management Principles

The ophthalmologist disclosed the potential complications to the patient and responded each time to the patient's complaints by promptly examining her, even on Christmas. This responsive care no doubt contributed to the jury's defense verdict. Like many patients, the plaintiff was angry about experiencing two rare complications and about learning the permanent nature of her vision loss from a consultant she herself had asked to see. Had the ophthalmologist explained that she had two risk factors that might lead to rupture of the posterior capsule (the dense cataract and the fragile condition of the capsule), the patient might have been better prepared to deal with her poor outcome.

When anticoagulants are medically necessary for surgical patients, the surgeon should explain the need and risks to the patient and choose the most appropriate anesthesia and operative technique. Instructions to stop medications, especially anticoagulants, and recommendations for hospitalization must be documented. When there is significant loss of vision, the patient should be kept informed of treatment options and prognosis for recovery. If a poor outcome is final, the patient should be assisted in adapting to a low vision status.