



Case Report

A Case of Malpractice in Ophthalmic Surgery

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Abstract

Purpose: Ophthalmic surgery requires effective preoperative disinfection with regard to the prevention of severe complications as infectious endophthalmitis.

Observation: An unofficial disinfection technique was inexplicably applied for phacoemulsification surgery. The patient left the operating room with a scratched cornea. The injury caused intense pain and increased the risk of endophthalmitis.

Conclusion and importance: The given case might point out the importance to apply correct disinfection techniques by all members of an operating room.

Keywords: Postoperative corneal abrasion; Cataract surgery; Disinfection; Endophthalmitis; Civil malpractice

Case Report

A 62-year old high-school teacher underwent phacoemulsification surgery. Having rejected preoperative sedation, he could in full consciousness observe an unusual preparatory technique. The disinfecting person drew a moistened swab of 2.5 cm side length without warning across his open eye while he was looking straight ahead. After the preceding drop anesthesia, the swab contact with the cornea was painless, but the patient felt intraocular discomfort.

Subsequently the disinfecting person in succession exerted digital traction on his upper and lower lid, ordered him to look into the corresponding opposite direction, and drew the swab again across his eye with perceptible contact to the palpebral margins. The patient was too unsettled to raise a protest against this apparently inappropriate technique.

The ensuing cataract surgery itself proceeded uneventfully. At the end of the operation, the surgeon observed and recorded a corneal abrasion, but he did not inform the patient. Intense pain and blepharospasmic unrest commenced 90 minutes after surgery when the effect of the anesthetic deposited intraoperatively in the anterior chamber faded. Advised by his family physician, the

patient started systemic antibiotic prophylaxis and analgesia with topical anesthetic drops. Signs of infection did not appear in the next few days. Informed about symptoms of a potential delayed endophthalmitis, the patient repeatedly demanded antibiotic prophylaxis in the following months whenever he anticipated the beginning of ocular inflammation. The persistent fear of vision loss led to a posttraumatic stress disorder.

Discussion

Disinfection for cataract surgery: Standard technique includes cleaning of periorbital skin and lids with iodine solution applied with a wet swab while the eye is held closed, followed by instillation of iodine solution into the palpebral slit with an allowed contact time of at least 3 minutes [1]. The patient remembered that this technique had been carried out by the surgeon himself for the same operation at his other eye in another clinic where the post-operative course was uneventful.

Perioperative abrasion: The disinfecting person had not warned the surgeon about conceivable corneal damage, so postponement of the operation was not taken into account. When the abrasion was detected postoperatively, the surgeon withheld this information which would have indicated that the damage had been done within the operating room. He later asserted that the image of an abrasion had been evoked by a rare intolerance against iodine solution and

that the lesion had been aggravated by the postoperative application of topical anesthetic drops although their short-term use has to be deemed safe according to the literature [2-4]. The ocular unrest caused by the abrasion increased the risk of endophthalmitis with regard to conceivable influx of contaminated tear fluid into the anterior chamber through the unsutured clear corneal incision [5, 6].

Disinfection technique: When the patient filed a lawsuit concerning malpractice and bodily injury, he had to be aware that it would turn out to be a case of statement against statement. A medical expert stated that no legally sane person would apply a technique as the patient had observed. However, during the legal interrogations, the disinfecting person unambiguously confirmed that the three-step technique had been applied as the patient had described it.

Disregard for the patient's safety: A justification for the technique based on ophthalmologic literature was not presented by the disinfecting person nor by the accountable clinic. It was even admitted that the technique included the risk of corneal damage when the swab was drawn across the eye with contact to the palpebral rims in an attempt of mechanical cleaning.

In the end it had to be supposed that the clinic, without information of the attending surgeon, had started an unofficial study with the intent to shorten and simplify the disinfection process. On the other hand, the disinfecting person, retrospectively not licensed for the given kind of activity in the operating room and unable to submit a manual delineating this technique, might have misunderstood verbal instructions, or she intentionally denied adequate carefulness to a patient included in an overloaded operation program.

Conclusion

The medical literature emphasizes that <prevention of postoperative endophthalmitis requires strict adherence to operating room norms, with all involved personnel discharging their assigned roles faithfully> [7]. In the given case, the careless application of an unofficial disinfection technique caused the complication of a corneal abrasion that severely endangered the patient's health and in the end evoked a disabling posttraumatic stress disorder. So if tasks in preparation of cataract surgery are delegated to assisting personnel, this personnel should be adequately educated, instructed and supervised.

Patient Consent

The patient had verbally consented to the use of his medical and legal documents under the condition of anonymisation which was done by modification of the data to his person.

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Conflicts of Interest

The author J. H. B. has no financial disclosures.

Authorship

The author attests that he meets the current ICMJE criteria for authorship.

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