

Challenges In Practising Ophthalmic Anaesthesia in a Stand-Alone Ophthalmic Set-Up

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Introduction

Ophthalmic anaesthesia practice ranges from free-lancing to a full-time exclusive presence. The role of an ophthalmic anaesthesiologist is challenging one and has evolved from simply being present during a surgery to the extent of being more involved in the technical aspect as well as the day to day working and management of the Operating Theatre (OT). Author's centre is a stand-alone, day-care ophthalmic multispecialty facility with a single anaesthesiologist.

Challenges in a stand-alone centre

A. Pre-Anaesthesia Check Up

Even though ophthalmic surgeries are generally considered low-risk surgeries, the patients requiring ophthalmic surgeries may have a host of comorbidities.

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Some practitioners believe that preoperative testing will not contribute to the final clinical outcome, while others get all patients tested before surgery. In certain cases, such preoperative testing helps to uncover certain conditions which heretofore were not identified.^{1,2} This hold true for countries like India, where yearly health check-up is not mandatory.

Typically, the preoperative evaluation has always been a challenge for the ophthalmic anaesthetist. Most of us, see the patient for the first time on the day of surgery. At some centres, patients are worked up and evaluated by the surgeons alone.

In the stand-alone day-care facility, evaluation of all patients before surgery is a team work of optometrists, counsellors and doctors (surgeons and anaesthesiologist). In author's centre, most primary preoperative evaluations are done by the optometrists (the first point of contact for most patients into the clinic) and the counsellor (who facilitate surgical appointments for patients and give them patient-specific preoperative instructions) on the basis of investigation reports.

Key words

Challenges, Stand-Alone Clinic, Non-Technical Skills

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This team is regularly and continually trained to recognize certain red flags and to warn us about them. The following are some of the examples of red flags:

- Hearing difficulties/ Language barriers/ Deaf and mute patients
- Geriatric patients
- Paediatric patients
- Parkinsonism/ dementia
- Patients with mobility issues
- Mentally challenged
- Syndromic (Down's Syndrome)
- Obese patients
- Breathing difficulty at rest or on history
- Obstructive sleep apnoea
- Claustrophobic/ anxious patients

Anticoagulants are commonly prescribed to elderly patients with comorbidities; but it becomes an issue of concern in patients for vitreoretinal surgeries, oculoplasty or glaucoma surgeries. In most routine cataract surgeries, anticoagulants are not discontinued and delay or postponement of surgery is done only if optimisation of the patient prior to surgery (for example an uncontrolled hypertensive patient posted for a vitreoretinal surgery will benefit in terms of the surgical outcome.¹

B. Intraoperative Period (Non-Technical Skills [NTS])

In the intraoperative period, apart from the surgical/ anaesthetic skills, it's the behavioural aspects or the non-technical skills that play a major role.³ These constitute: Team working, Task management, Situation awareness and Decision making, See Figure 1.⁴



Figure 1. The ANTS System

C. Paediatric Ophthalmic Surgeries

Conducting paediatric general anaesthesia (GA) has always been a challenging proposition, especially for a single anaesthesiologist in an ophthalmic OT with staff who have no training in crisis management and no ICU back up close by. These factors have prompted us to be very stringent about patient selection. Over the years, we have learned to utilise every human resource available in the OT, to train and form our team for paediatric surgeries. We have recently started using simulation scenarios to train the OT staff for crisis management, in preparation for a paediatric GA and to communicate certain core learning objectives for surgeons.⁵

A few examples, common in our working, how NTS helps with the following:

- Patients with mobility issues: Being warned about these patients (communication from Counsellor/ Optometrist) helps us plan the mobilization of patient into the OT, by allocating resources at the right time. Be prepared to earmark some time to interact and reassure the patients and their attendants before the surgery (Situation awareness, Task management).

- Patients with anxiety / claustrophobia: Being informed about anxious or claustrophobic patients ensures that we can plan to premedicate patients or administer sedation where necessary. Most times simply holding the patient's hand and verbally reassuring them during the surgical process does the trick. For claustrophobic patients, lifting the eye-drape on the contralateral side works wonders, Figure 2. (Situation awareness, Communication).
- Mentally Challenged patients: We often have patients who are mentally/ intellectually challenged. During the preoperative evaluation; we rely on inputs from the relatives and identify the one relative with whom the patient shares a special rapport. At times, we request relative to be present inside the OT during the surgery (Team work, Situation awareness, Decision making).
- Paediatric GA in an Obese child: Apart from meticulous planning and dry runs with team about various options, better to have second anaesthesiologist to help on the day of surgery (Team work, Task management, Decision making).



Figure 2. Eye drape lifted up for claustrophobic patient

- Kyphoscoliotic geriatric patient: Broken back, but unbroken spirit!. Always do a trial of drapings in the pre-anaesthetic clinic for positioning and counsel the patient thoroughly. This will make them mentally strong. Communication with the patient and including his/her in the decision-making process will save the day (Decision making, Communication, Team work), Figure 3.



Figure 3 a & b. Elderly female with Kyphoscoliosis and her positioning difficulty

For challenging cases, everyone in the team contributes as per their capability and training, keeping in mind our common goal: "Safe and good clinical outcome" for the patient. Though the ophthalmic surgeries may be considered low risk, the anaesthesia practice surrounding it never is low risk. It has its own unique challenges and rewards. The onus lies on us, as perioperative physicians, to bring about an awareness of this fact to not only among patients but also within the medical community.

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