Correspondence

Auckland Cataract Study III: Refining Preoperative Assessment With Cataract Risk Stratification to Reduce Intraoperative Complications

EDITOR:

HAN AND ASSOCIATES HAVE EXPLORED THE ISSUE OF SURgical risk in the pathway for cataract treatment that is found everywhere in the world.[1] Since modern surgery for lens opacification often yields a good outcome it has become all too easy to trivialize. However, as cataract workload rises it is vital to identify the surgical landscapes that pose danger for both patient and surgeon. It is educative especially for new cohorts of ophthalmologists to understand the notion of categorizing risk in cataract patients.

In some contexts the surgeon examines the patient before surgery, does the operation, and sees the handiwork afterwards. Given the surgical volumes of today it is seldom practical to run mass-care in such a way. Cataract pathways are disjointed in many public services, with perhaps a nonsurgeon at the baseline check, the surgeon meeting the patient on the table, and an optometrist hovering over the eye after operation. Safety in these high-volume settings can be boosted through the exercising of more vigilance at the preoperative biomicroscopy.

My colleagues in New Zealand have focused on the anterior segment factors that increase the level of surgical difficulty. The rest of the eye should also be screened well at the preoperative step given the disease distribution in our era. Clinics in rich societies, for example, are teeming with diabetic retinopathy, advanced glaucoma, and age-related maculopathy. Beautiful surgery may be attainable in the anterior segment, but the vision can be eroded away afterwards, as the comorbidity in the posterior segment slowly deteriorates.

When judging the degree of risk in a cataract extraction not only does the surgeon need to be made aware of cornea guttata, shallow chamber, brunescent lens, and a pinpoint pupil, but it should be stressed that this is also a diabetic eye with retinal vein occlusion and lasered maculopathy. Details in the posterior segment can dictate whether intravitreal drug is required at surgery,[2] and can further impact on the aftercare.

What is being said is that coexistent disease in the posterior segment has to feature saliently in a cataract risk assessment.[3,4] To the reduction of troubles at surgery is added the aim of reducing undesirables after surgery, the latter as germane as the former in influencing the long-term vision.[5] The creation of subspecialties means that lens surgery typically occurs in services that are devoted to specific domains of ocular disease. Nonetheless, I receive cases from our general cataract pool where an observer has had the discernment to see that a uveitic anatomy would be suitably served on my operating list. Technicians of the anterior segment equal (or indeed surpass) the vitreoretinal fraternity in complex lens surgery—it is all about interest, ability, and active experience. It is also essential that complexity is recognized and a patient is counselled to have realistic expectations from any highly hazardous surgery.

Preoperative survey should be alert enough to sift out those cases that are at risk of a poor outcome so that they can be operated on by surgeons with the relevant expertise. Not only is it a matter of correct patient, correct eye, correct operation, but it is clearly also a matter of the correct specialist. Recall of these concepts will improve outcomes for high-risk cataract patients.

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