

Patient Consent and Conversations in the Age of MIGS



With more options come more questions.

BY JOHN T. LIND, MD, MS

Microinvasive glaucoma surgery (MIGS) has added new treatment options to the glaucoma doctor's armamentarium. However, with more options come more questions.

The landscape has changed in that, 10 years ago, most glaucoma surgeons performed trabeculectomy and tube shunt surgery, and a few performed just one minimally invasive procedure. Fast forward a decade, and today's graduating fellows expect to be competent in and comfortable with suprachoroidal shunting, ciliary body ablation, trabecular meshwork shunting/ablation/removal, and transscleral shunting, in addition to so-called *traditional glaucoma surgery*. Although determining the procedure

of choice can be confusing for the clinician, the level of confusion for the patient is exponential in comparison.

PATIENT EVALUATION

To achieve the best surgical results, preparation begins in the clinic.

AT A GLANCE

- ▶ Although determining the glaucoma surgery of choice can be confusing for the clinician, the level of confusion for the patient is exponential in comparison.
- ▶ Before discussing surgery, an assessment of the patient's personality, expectations, and reliability is paramount.
- ▶ It is important to communicate that any option may fail and that glaucoma treatment is a lifelong commitment by physician and patient.

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Offering targeted advice to the patient entails properly evaluating his or her eye. Questions to consider include the following:

- What is the type of glaucoma?
- What is the mechanism of increased IOP?
- What coexisting medical conditions does the patient have?
- What is the status of the lens?
- What does the angle look like?
- What is the axial length?
- What does the orbit look like?
- What are the potential postoperative risks?
- What is the current IOP?
- What is the target IOP?
- What is the status of the contralateral eye?

PERSONALITY CHECK

Before talking about surgery, an assessment of the patient's personality, expectations, and reliability is paramount. One patient might tell you, "Doc, you have one shot to get the surgery right," whereas the next patient might say, "I understand I need surgery, but I want the one with the lowest risk." These patients might have nearly identical presentations, but the surgery that is right for one patient may be wrong for the other. If glaucoma surgery is indicated with cataract surgery, a look at the patient's tolerance for refractive error may persuade you to alter your surgical plans.

EDUCATION AND EXPECTATIONS

Once you have thoroughly assessed the patient's disease and personality, the easy part is over. Then it is time to educate the patient, ensure that he or she understands the disease process, and frame your surgical discussion. Whether it is a patient I have been seeing for a decade or a patient I met 60 minutes ago, the framework of this conversation is similar. Information about the patient's disease process, disease progression, current state of damage, current IOP, and future IOP goals must all be presented. It is also important to predict, to the best of your ability, the trajectory of the patient's glaucomatous damage and to discuss options for maintaining a specific treatment regimen or altering its course. When appropriate, nonsurgical options should be outlined.

As mentioned earlier, offering more treatment options increases the complexity of the informed consent process. MIGS may offer several advantages compared with traditional glaucoma surgery, including a faster recovery time and lower risk, but each procedure carries its own unique set of potential complications. The conversation with the patient should include a thorough discussion of the benefits and drawbacks of each approach.

It is also important to counsel the patient about his or her likelihood of being free of medication after surgery. The ability to wear contact lenses postoperatively can also be high on a patient's list of desired outcomes and should therefore be addressed. Providing individualized care for the patient becomes an art.

Many patients will have a preconceived idea of what kind of surgery is best for them. Exploring their ideas and either supporting or refuting them with a logical argument is important in building a healthy patient-physician relationship. You should discuss the expected recovery period and any limitations the patient will have. Explaining that any option may fail and that glaucoma treatment is a lifelong commitment by the physician and patient are key.

CONCLUSION

Despite your best intentions and actions, you will fail at times. One distinct memory of mine is that of a patient who presented with advanced and active neovascular glaucoma, hand motion vision, and an IOP of 50 mm Hg. After discussing my recommendations of ciliary ablation or a valved glaucoma drainage device, the patient opted for laser ablation. In the preoperative holding area just a few days later, he asked me to go to the waiting room to talk with his brother. There, his brother proudly told me that, based on what he had read in *The Wall Street Journal*, he thought his brother needed a trabecular bypass shunt. Obviously, I was a poor educator in my clinic of the patient and his family! ■

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■ Financial disclosure: Advisory board member and consultant (Allergan); Lecture honorarium (Bausch + Lomb)