Managing Patients' Expectations of Glaucoma Surgery

Our duty extends beyond the informed consent process.

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In the Internet age, our patients have access to information on eye surgery right at their fingertips. They have likely heard about current procedures that their friends and relatives have undergone and feel they know what to expect from eye surgery. Because the most commonly discussed ocular procedures are cataract and refractive, however, our patients' expectations of glaucoma surgery are often unrealistic. Resetting their expectations is therefore important, but it can be a challenging process.

EDUCATING PATIENTS

A 63-year-old hyperopic female has a visual acuity of 20/60 OU and worsening cataracts. She also has pseudoexfoliation, small pupils, loose zonules, and narrow angles. Recently, she received laser peripheral iridectomies in both eyes. The patient has central visual field loss in both eyes (Figure 1). Her IOPs are uncontrolled, despite eye drops, and glaucoma filtering surgery is recommended. The patient wishes to undergo cataract surgery as well, and she expects to have perfect vision afterward. During the discussion, she mentions her 73-year-old husband, who was also hyperopic and recently had cataract surgery with the implantation of multifocal IOLs. He reportedly had perfect vision 2 weeks after surgery and is able to use the computer and read without glasses. She asks, "If my husband can see perfectly after eye surgery, why can't I?"

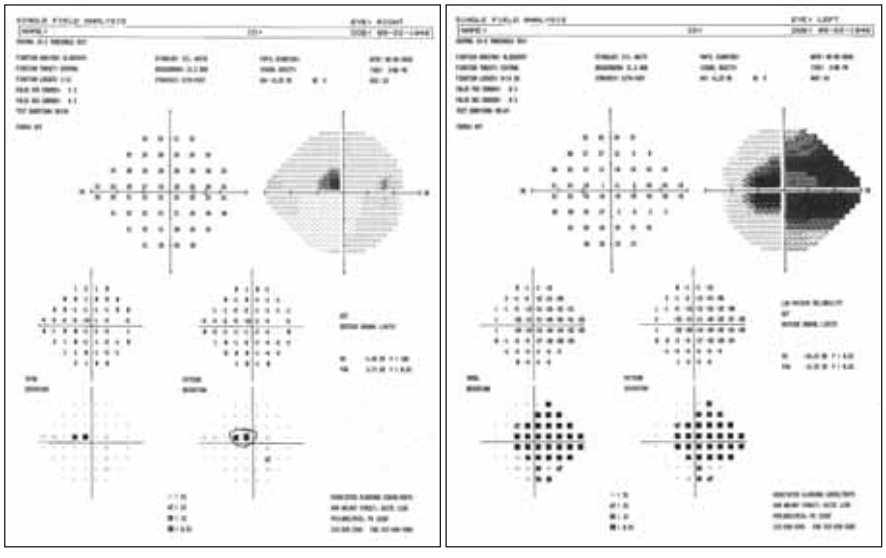

Figure 1. The patient has sustained some central visual field loss in both eyes.

As illustrated in the case presented, patients often expect a complete cure when they visit a doctor for the treatment of a problem, whether a sinus infection or ocular disease. If surgery is performed, they expect it to restore their predisease state. Unfortunately, we cannot meet this expectation in glaucoma. Our efforts to educate patients should therefore begin at their initial evaluation—not when we recommend surgery. Upon the diagnosis of glaucoma, patients need to learn that any vision loss and nerve damage from the disease is irreversible. We must explain that medications, laser therapy, and surgery cannot revive what is lost to glaucoma and that we can only try to prevent more damage. A basic understanding of the disease sets the framework for patients' expectations of glaucoma treatment in general. When recommending surgery, show-

ing patients their visual fields may be helpful. We can point out the areas of their vision that are already irreversibly affected by their glaucoma, and we can indicate the areas that can be saved by further lowering of the IOP. Patients who continue to insist that glaucoma surgery will improve their vision may not be good surgical candidates or may require further counseling.

Excluding emergency surgery, patients should be given time to consider and prepare for the intervention. In the interim, we can manipulate their medications and schedule patients for close observation while warning them that they will likely need surgery if the change in drug therapy does not sufficiently lower their IOP. The goal is for patients to feel that they have had enough time to think about the surgery and have all of their questions answered.

DESCRIBING SURGICAL COMPLICATIONS

A 75-year-old family internist recently underwent surgery elsewhere for a dense 3+ to 4+ cataract. The eye had pseudoexfoliation and little zonular support. The end result was the implantation of an anterior chamber IOL and epinuclear fragments in the vitreous. When he comes to us for a second opinion, he earnestly asks us, "How is it possible that this can happen to me? Tell me what my surgeon did wrong."

A poor understanding of the surgery and its complications can lead to poor patient-doctor relationships at best and, at worst, litigation. As surgeons, it is natural for us to want to reassure patients and make them feel confident about our abilities. When obtaining informed consent for glaucoma surgery, however, it is imperative that we be honest with patients about the procedure's potential complications. We must mention the devastating potentialities such as suprachoroidal hemorrhages as well as the common, but less disturbing, problems like astigmatism and ptosis. Patients need to realize that complications can happen, even to them. This information is particularly important for individuals with risk factors, such as those on blood thinners.

The more patients understand, the more they accept. Thus, we should explain the general mechanisms of the surgery. Patients may be exposed to all of the potential problems of surgery, but they may not hear or understand what is being said. Pictures, diagrams, and models are certainly helpful. Studies have examined the utility of distributing written handouts with information regarding the recommended surgery and its complications in addition to the standard informed consent. This written information does not appear to improve patients' understanding of the risks and complications of the procedures. Neither does it improve their understanding of the operation or its complications. It does, however, seem to increase their satisfaction with the surgical process.[1,2]

EXPLAINING SURGICAL RESULTS AND THE POSTOPERATIVE COURSE

The postoperative course can be more troublesome for patients than the glaucoma surgery itself. We must forewarn them that blurry vision is likely after glaucoma surgery unlike cataract surgery. This information is particularly important for monocular individuals, who may need extra time to prepare for additional support in the home. Patients should expect to return to the clinic on postoperative day 1 and to have follow-up appointments at least twice more during the first 6 weeks after surgery. We should caution patients to avoid bending, lifting, or straining. They need to plan accordingly if they are avid athletes or if their job requires strict hours or strenuous activity. Often, we can assist patients by completing forms for health care transportation or for excused time from work.

Patients are anxious to know whether or not their surgery was successful. Although a majority of them will achieve a significantly lower IOP, it is prudent for us to advise patients before surgery that their postoperative pressure depends partially on how their body heals. For example, we should warn younger patients and those with a history of prior surgeries or ocular inflammation that scarring after surgery can lessen surgery's efficacy. Otherwise, they may feel shocked and horribly disappointed to learn that their IOP has returned to baseline values 6 to 8 weeks after surgery.

CONCLUSION

It is not enough for us to list the risks, benefits, and complications of as well as the alternatives to the recommended surgical procedure. The benefit of surgical intervention is not always noticeable immediately postoperatively, and the recovery time and follow-up may be long and rigorous. Educating patients about their disease as well as the mechanisms of the surgery helps them to understand the goal of the procedure and what they may reasonably expect. Allowing them time to consider the surgery and the healing process permits them to make the necessary preparations. ❑

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1. Stanley BM, Walters DJ, Maddern GJ. Informed consent: how much information is enough? *Aust NZ J Surg.* 1998;68(11):788-791.
2. Edwards MH. Satisfying patients' needs for surgical information. *Br J Surg.* 1990;77(4):463-465.