

Letters

Pointing Leaves Room for Error

Your “Wrong-Eye Surgery: Will It Be Your Turn Next?” (Opinion, March) reminds me of a story of my own.

A patient came to see me to have an eyelid lesion removed. She pointed to her lower eyelid, where I marked a lesion that looked benign but could possibly have been a basal cell carcinoma. I injected local anesthetic, removed the lesion and then showed her in a mirror that I was leaving the 3-mm skin defect to heal. She was surprised that I had not removed the lesion that that was bothering her—a tiny hidrocystoma in a laugh line near the lateral canthus!

The moral is that there is wisdom in having the patient mark the lesion, or at least verifying with a mirror that what we are seeing is what they are seeing.

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Shield Your Eyes

As you point out in “Wrong-Eye Surgery: Will It Be Your Turn Next?” (Opinion, March), marking the correct surgical site does not always prevent errors from occurring.

Cases like yours—in which the correct surgical site was marked by the surgeon but the incorrect

site was draped—are not uncommon. A similar incident happened last year at a major teaching hospital where a surgeon operated on the wrong knee—despite having marked the correct side himself. The Academy’s wrong-site/wrong-IOL checklist is still vulnerable to this particular error.

In addition to marking the surgical eye, we have initiated a policy of covering the nonsurgical eye with a transparent shield.

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Treating Mothers-to-Be

I found “Glaucoma Drops: Rx for Success, or Trouble?” (Feature, March) very interesting, especially the section on treating expectant mothers. While there may be a paucity of information regarding human usage of glaucoma medication in pregnancy, there is some human data that can guide clinicians.

The use of carbonic anhydrase inhibitors (CAIs) has a large pool of human data on which to base clinical decisions. The source is the National Collaborative Perinatal Project (NCPP) conducted by the NIH from 1959 through 1974. This study monitored more than 50,000 mother-child pairs and 1,024 instances of systemic usage of acetazolamide during pregnancy. In

the resulting offspring, there were 18 instances of malformations. The predicted number due to chance was 18.06. This suggests that the incidence of malformations from acetazolamide exposure during pregnancy is no greater than the natural incidence. In the same study, there were 12 documented first trimester exposures to acetazolamide. No anomalies were observed in the resulting offspring.

Prof. Fiscella’s statement that CAIs are “associated with teratogenic effects” is therefore misleading. First, the human data do not in any way support this claim. Second, the animal data support this claim only as it relates to nonprimate animals. Rats and mice do, in fact, demonstrate skeletal abnormalities when exposed to the agent in utero. Primates, however, do not. The likely cause is that primate carbonic anhydrase is a different isoenzyme than nonprimate carbonic anhydrase. As a result, the nonprimate data really do not pertain to human usage.

There are, in fact, more data to support a clinician’s decision to use CAIs than there are to support using any other agent available. Further, when you recognize that the data from the NCPP was culled from systemic usage only, the usage of topical CAIs—which can be further shielded from the



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systemic circulation with punctal occlusion—gains an even greater scientific advantage over other agents.

Regarding beta-blockers, there are many reports of its human use during pregnancy for preeclampsia and eclampsia, and the observation of significant skeletal birth defects in this class of medications is absent.

Conversely, brimonidine, which was described as the best choice by Dr. Miller-Ellis, does not have any human data supporting its usage in pregnancy. The heavily animal-dependent FDA classification may support her claim, but human data of any kind do not. The human data support using topical CAIs and beta-blockers first.

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Note: Dr. Odrich reports no related financial interests.