

Letters

Family Members in the Operating Room

Most of us would agree that having family members of our patients present in the operating room (OR) during surgery is contraindicated for a number of practical and professional reasons. However, there are rare circumstances wherein this might be appropriate, even therapeutic.

Office visit. I recently examined a 75-year-old man in my clinic for decreased vision. He had a history of dementia and hearing loss but was otherwise in good health. Best-corrected visual acuities were 20/30 in the OD and 20/70 in the OS. He had 2+ nuclear sclerotic and cortical spoke cataracts, but otherwise his eye examination was normal. The patient was accompanied by his wife.

I counseled observation, knowing that the patient retained 20/30 acuity in the OD and that it would be difficult for the patient to cooperate during monitored

anesthesia. However, I also knew that vision loss can exacerbate symptoms of dementia,¹ and I encouraged the patient's wife to contact me if his vision seemed to get worse prior to the planned one-year follow-up.

Further discussion. The patient's wife, who had power of attorney, contacted me by letter less than one month after the appointment. She was concerned that as her husband's dementia increased, completing the surgery would become more difficult. She reasoned that it would be preferable to improve the vision in the left eye now, before his dementia worsened.

She and I discussed the risks and benefits of monitored anesthesia and general anesthesia over the phone. I was concerned that even with local anesthesia, the patient would be unable to cooperate. The patient's wife suggested that she accompany him in the OR and that her presence might lessen his anxiety and increase his ability to cooperate.

Allowing family members in the OR is prohibited by our facility policies, but I discussed the situation with our head of anesthesia. He agreed that the presence of the patient's wife could potentially make the procedure safer and more comfortable.

In the OR. On the day of surgery, the wife donned a

disposable suit, mask, and hat and followed us into the operating room. I positioned her opposite to the side of surgery, so she could hold the patient's hand.

Monitors that project an image of the surgery were turned off. The patient was given 0.25 μ g of fentanyl. We customarily administer midazolam IV, but I requested this medication be withheld, fearing it might have a paradoxical effect on the patient. Although I almost always use topical anesthesia, at the beginning of the surgery I administered a sub-Tenon block to improve anesthesia and akinesia.

Other than severe intraoperative floppy iris syndrome, managed with a Malyugin ring, the surgery was uneventful. I closed the clear corneal incision with a single interrupted 10-0 nylon suture and rotated the knot into the cornea. Because the patient still enjoyed reading, I chose a target refraction of -2.00 D.

Postop. Two weeks after surgery, the patient refracted to 20/30, his eye was clear and quiet, and both the patient and his wife were pleased with the outcome. The patient had no recollection of the surgery but was



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happy to receive new glasses. Together, we decided to leave the corneal suture in place and not to proceed with surgery in the right eye for the present.

In summary, although family members in the OR should probably be discouraged, surgeons, anesthesiologists, and nursing staff should weigh the risks and benefits in selected cases. As always, communication between the care providers, the patient, and the patient's family is essential for a successful outcome.

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1 Jefferis JM et al. *Br J Ophthalmol*. 2011;95(1):17-23.

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