



Latest cornea news from the Cornea Society

Introduction

Welcome to the 19th issue of Cornea Society University (CSU). This month's CSU VideoEd will focus on "Step-by-step DMEK." We will also feature an article on "Surviving your first surgical complication."

✓ Surviving your first surgical complication

"There are two types of doctors who never have surgical complications: those who don't operate and those who aren't truthful." (Read more)

✓ Step-by-step DMEK

Endothelial keratoplasty (EK) has evolved greatly over the last decade. (Read more)

✓ Stay in touch

Since fellowship recently ended, please be sure we have your updated contact information on file so you can continue to receive the *Cornea* journal and other Society publications and mailings. (Read more)

✓ Save the date: CSU Dinner Program upcoming event

Plan to attend the CSU Dinner Program taking place on Friday, October 26 in Chicago during the AAO annual meeting. (Read more)

✓ CSU booth at AAO annual meeting Chicago

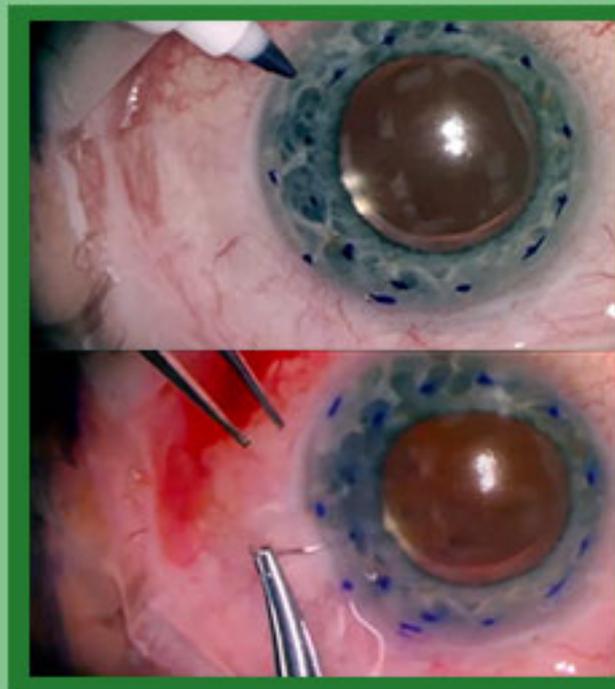
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"There are two types of doctors who never have surgical complications: those who don't operate and those who aren't truthful." This is one of my favorite quotes because it is completely accurate. Complications may occur because of a faulty instrument, a surgical mistake, or because the patient has abnormal anatomy. No matter how skilled of a surgeon you are in residency and fellowship, you are bound to experience a surgical complication in your first few years on your own.

Operating on your own, without the safety net you were accustomed to in residency and fellowship, can be a scary experience in and of itself. If you then encounter a surgical complication, this can turn into a terrifying experience. Even the most confident, prepared surgeon struggles with their first surgical complication, and their second, and likely every one that occurs after that. Surviving your first surgical complication is truly a rite of passage and hopefully an important learning experience.

Handling intraoperative complications starts preoperatively. Another one of my favorite sayings is: "Anything you tell patients about beforehand is their fault, and anything you tell them about afterward is your fault." I see a lot of patients for second and third opinions with complications that aren't unexpected such as a patient with Fuchs' dystrophy who has corneal edema after cataract surgery or a patient with pseudoexfoliation who had zonular instability during cataract surgery. One of the most common questions patients ask me in these situations is "Why didn't my surgeon tell me about this ahead of time?" It is imperative to perform a thorough examination preoperatively and inform patients of any increased risks with surgery based on preoperative findings. I also discuss increased risks with any patient who is difficult to examine or patients who have had previous surgery as there are often unexpected findings intraoperatively.

The other crucial preoperative step is to prepare. You need to know every detail about your procedure before you go into the operating room. Even if you've done the same procedure many times as a resident or fellow, you always had someone to back you up if something went wrong. When you are operating on your own, there isn't a similar back-up. I like to have a contingency plan for every possible complication when I go to the operating room. Before my first solo cataract surgery, I watched surgical videos and read many cataract complication books to prepare. I went to the operating room knowing multiple ways to save an abnormal capsulorhexis or a posterior capsular tear. I also made sure that my operating room had the appropriate materials and equipment ready in case an unexpected complication occurred. At our institution, we have a contingency tray filled with necessary instruments for these situations.

When a complication occurs intraoperatively, the first thing you need to do is stop and take a deep breath. Try not to overreact. Staying calm will help you think and will also keep your patient calm, as most of our patients are only under light sedation. It is also important to try to pick up complications as early as possible. You need to look for subtle clues and trust your instincts. Often, when I'm operating with a resident, I'll stop them and take over because "something felt wrong." In many of these situations, there isn't an obvious sign that something had gone wrong and the resident hadn't noticed any problem. With experience, you can often sense when something is impending, so I've learned to trust my instincts over time.

The steps you take postoperatively are as important as the steps you take preoperatively and intraoperatively. The first thing you need to do is tell the patient what happened. It is ideal to also talk to family members immediately after the surgery as most patients receive some sedation during surgery and may not remember or process the information. You should discuss the details again at the postoperative day 1 appointment. I think it is important to spend extra time with these patients answering questions, explaining the next steps, and setting expectations. I also make sure I'm readily available for these patients and their families and will often give out my email or phone number so they can contact me. Luckily, in our



field, even with complications, most patients do well. Regardless, it is important to forge a strong bond with your patients during this healing process to ensure a smooth road to recovery. Patients need to trust you and know that you care and won't abandon them. It is OK to refer them out if the problem is beyond your scope of practice, but stay involved even if they are seeing another physician.

Lastly, use this trying experience to grow and become a better surgeon and a better clinician. I sit down with my trainees after every operating room day to critique every case, including my own. We discuss what could have gone better and what we can do in the future to improve our surgeries. Although complications can be intimidating, they are an important part of the growing process of becoming a better surgeon. The best you can do is try to prevent them, handle them skillfully and efficiently, stick by your patients, and grow from the experience.

CSU is meant to be an interactive platform where your questions and concerns are addressed. If you have a specific area or question you want us to concentrate on in future issues, please send an email to jessciralsky@gmail.com with the subject "CSU." Additionally, CSU is designed for all young cornea and anterior segment ophthalmologists, so if friends or colleagues want to be added to the listserv, please send an email to info@corneasociety.org.

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Step-by-step DMEK

Endothelial keratoplasty (EK) has evolved greatly over the last decade. The popularity of endothelial keratoplasty has grown exponentially as the procedure has become more refined. Descemet's membrane endothelial keratoplasty (DMEK) is one of the newest EK procedures gaining popularity. DMEK provides a more anatomically exact replacement of the diseased corneal layer and therefore, produces better visual outcomes. DMEK is a challenging surgery with a steep learning curve. In this [video](#), you will hear **Christopher Sales, MD**, break it down into "Step-by-step DMEK." He will discuss preoperative and intraoperative steps. Preoperative steps include patient case selection, tissue specifications, preoperative iridotomies, and preoperative medications. During the intraoperative step discussion, he will describe tissue preparation, injector assembly, recipient preparation, tissue injection, injector withdrawal, bubble injection, and finally the DMEK dance.

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Save the date: CSU Dinner Program upcoming event



Plan to attend the CSU Dinner Program taking place on Friday, October 26 in Chicago during the AAO annual meeting. An evite was sent out earlier this month, so check your inbox. The topic for the dinner is "Financial planning for the young ophthalmologist." For more information, email Gail Albert at galbert@corneasociety.org.

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CSU booth at AAO annual meeting Chicago

Be sure to visit the CSU booth at the AAO annual meeting, October 26–30, in Chicago. We look forward to seeing you there.

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Join the leaders in cornea and anterior segment for a stimulating content and networking experience at the inaugural Cornea 360. Cornea 360 will be an opportunity for learning the most up-to-date information, collaborating with leaders in the fields of corneal research and clinical practice, and communicating with industry leaders at the cutting edge of research in these fields. The conference will emphasize interactive sessions among audience and speakers, panel discussions, and live social media feedback. Plan to attend April 4–6, 2019, at the Westin Kierland Resort & Spa, Scottsdale, Arizona. Visit Cornea360.org to register and learn more.

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CSU webinar series launching November 2018

CSU is launching a four-part webinar series on surgical procedures in November. The four-part series will feature webinars on “Tips for DMEK,” “EK complications,” “Surgical options for ocular surface diseases,” and “Surgical disasters.” Check the next CSU Update for more information.

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