OPHTHALMIC HOSPITALIST INTEREST GROUP

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OPHTHALMIC HOSPITALIST INTEREST GROUP NEWSLETTER

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Announcements

Join the Community!

Have a question or topic about inpatient/ER consults? Share on the AAO/OHIG community! Log in with your AAO username.

OHIG Round Table Discussion at AAO Meeting 2024

Save the date for the OHIG Round Table Discussion at **AAO 2024** in Chicago , **Sat 10/19/24 @ 4:00-5:00pm**, Society Relations Office. More details to come. We hope to see you there!

OHIG Topic Wishlist

Have a case you would like to feature in an OHIG newsletter? We welcome your ideas and expertise. Email ohig@ohig.org.

Welcome New Members!

Thanks for joining OHIG! Please verify your information on the OHIG website.

Photo Link

Articles

Enucleation vs Evisceration in Ocular Trauma: A Review of the Literature, Orbit 2013

Surgical decision making in ocular trauma is often based on surgeon preference with minimal evidence to support either enucleation or evisceration. These authors recommend evisceration in cases of reliable patient follow up due to the low incidence of SO.

Evisceration vs Enucleation From The Ocularist's Pespective, OPRS, 2003

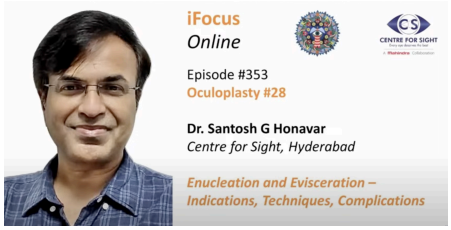
Board certified ocularists feel that evisceration is superior to enucleation in terms of ocular motility, complications, and best overall cosmesis.

To Implant or Not To Implant: Emergency Orbital Eviscerations with Primary Orbital Implants, Eye, 2021

Traditionally, orbital implants are discouraged following evisceration for endophthalmitis. This series suggests acceptable implant exposure/extrusion rates for infected/inflamed eyes.

PEARLS

Enucleation and Evisceration: Indications, Techniques, and Complications



A lecture provided by Dr. Santosh Honavar from Centre for Sight in Hyderabad on enucleation vs evisceration.

Click here to view.

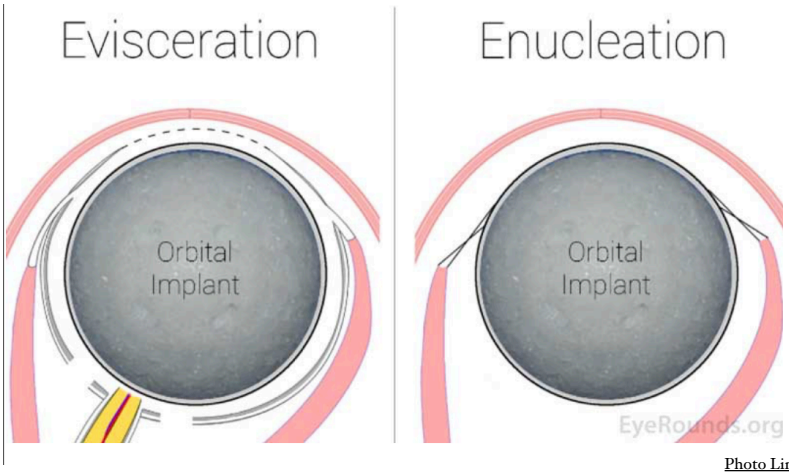
Ophthalmic Hospitalist Positions

Check out these awesome job openings for ophthalmic hospitalist positions across the US listed on the OHIG website.

If you have a position you'd like to advertise please let us know!

Click here to view.

CONSULT ROUNDS



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It is a busy day on consults and you find yourself rounding on several inpatients who unfortunately need to have their eye removed.

Patient #1 – 19-year-old male with facial injury after a fist fight in a bar. Vision is NLP. There is a large corneal scleral laceration with marked posterior extension. The globe could not be fully closed in the OR. On POD1 he remains NLP and wishes to have his eye removed.

Patient #2 – 43-year-old male with self-inflicted GSW to the right orbit. Vision is NLP. The right globe is visibly disorganized with frank areas of missing ocular tissue. You aren't sure if there is even anything to close. He has multiple orbital/facial fractures and scheduled for OR repair with ENT tomorrow. You wonder if you should do a globe exploration or just consult Oculoplastics for primary enucleation/evisceration.

Patient #3 – 81-year-old female with a history of severe dementia and frequent falls presents with a red eye of unknown duration. In the ED, she is HM and found to have a severe corneal ulcer with large hypoyon. She is started on aggressive topical fortified antibiotics but does not improve. She eventually develops panophthalmitis with posterior scleral involvement. CT imaging is also consistent with early orbital cellulitis. The patient becomes NLP and started on broad spectrum IV antibiotics while awaiting Oculoplastics consultation for urgent eye removal.

Case Comments: We sadly come across many patients in the hospital/ED who have severe ophthalmic conditions that warrant consideration for eye removal. How should we navigate this process? What are important things to consider for enucleation vs evisceration?

We seek expertise from OHIG member Dr. Craig Czyz who is an independent ophthalmic hospitalist and also an oculoplastics surgeon.

Craig Czyz, DO, FACOS, FACS
Professor, Chair of Ophthalmology, Ohio University
Chief, Oculofacial Plastic and Reconstruction
Ophthalmic Hospitalist

Question #1
Are there instances when enucleation is better than evisceration or vice versa? Does it matter if a patient has infectious posterior scleral involvement? What are benefits/cons of either procedure for a patient young/old?

Czyz: I typically reserve enucleation for cancerous etiologies. I will consider it for infective etiologies of the posterior sclera, but typically those cases have orbital involvement as well. In my experience eviscerations result in better cosmetic outcomes, reduced latent complications, and improved patient comfort.

As for age being a determining driver, either modality would require revision for younger patients as their orbits mature. As most pediatric cases are the result of retinoblastoma, most will have undergone enucleation.

Question #2
For cases of trauma, are there any instances when primary enucleation is reasonable in lieu of primary globe exploration or attempted repair? What if a patient is critically injured and unable to consent for surgery? Are you concerned about any legal considerations for removing an eye without a baseline subjective vision?

Czyz: It is rare for me to perform a primary evisceration, especially if the patient is not conscious for consent prior to the procedure. Obviously in cases of severe globe disruption I will perform a primary evisceration. I would guesstimate this occurs in 5% of cases. In all these cases I add photo documentation of the injury pre and intra operatively in case there are any questions regarding the severity of the injury postoperatively.

I typically like to repair the globe, even if I feel vision restoration is unlikely for two reasons. The first is so the patient can be evaluated by retina postoperatively and they can provide an opinion as to visual potential. Secondly, it gives the patient time to process the injury and the likelihood of intraocular content removal and insertion of implant. Again, I would guesstimate that 10-15% of my primary repairs will return for evisceration within 6 months.

Question #3

Recent articles have shown that a patient's risk of developing sympathetic ophthalmia (SO) after open globe injury is exceedingly low (0.6%-0.19%). In fact, comparable or even lower than the risk of developing an RD after cataract surgery (0.21%). Have you noticed any new trends or standards of care when it comes to enucleation/evisceration after open globe injury?

Czyz: I discuss sympathetic ophthalmia (SO) with all my globe rupture patients. I provide them with the estimate of SO occurring at less than 1% and that it could occur tomorrow or 20 years from now. I then let them make the decision for the elective procedure of evisceration. In my experience, in the more severely damaged globes, patients will opt for evisceration due to ocular discomfort, combined with the risk of SO.

I am not aware of any studies that compare SO rates for evisceration and enucleation, therefore I will always perform evisceration unless the case is one of the exceptions I previously mentioned.

Special Thanks: *We would like to sincerely thank Dr. Craig Czyz for sharing his insights about enucleations vs eviserations in the hospital consult setting. He wears many important hats in ophthalmology! We are grateful for his expertise and diligent care of hospital-based patients.*

AAO/OHIG Online Community Survey Question

What is the predominant eye removal procedure following open globe injury at your institution?
A) Enucleation
B) Evisceration
C) Both - depends on the Oculoplastics provider
D) Other, please comment below

Share your responses on the AAO/OHIG community page!