Informed Consent for Cataract Surgery
Patient Information, Risks & Benefits; Is Cataract Surgery Right for You?

Dr. Wandzura and the team at the LAKELAND VISION INSTITUTE present this information in order to educate you regarding your decision on whether or not to have cataract surgery.

A clear understanding of the proposed surgery, including risks & benefits, is part of the medical consent process.

This information is not meant to frighten or alarm you, but rather to educate you so that you can make an informed decision.

Please review this information at home with your family. Keep this information in your cataract surgery folder with your other instructions and documents. If you have any questions or concerns, please contact Dr. Wandzura’s office @ 306-764-2020 or by email @ eyemd@sasktel.net.

We will have a LAKELAND VISION consent form based on this booklet & a separate VICTORIA HOSPITAL consent form for you to sign at the office before your surgery is booked.

Thank you for trusting Lakeland Vision, the office of Dr. Wandzura, for your eye surgery needs. We look forward to serving you.

Section 1: Basic Eye Anatomy

Light enters the eye through the cornea and then passes through the lens. The lens of the eye works like the lens in a camera. The lens focuses light from your world onto the retina (the retina is like camera film). The incoming image is then transmitted by the optic nerve to your brain where the image is processed, allowing you to “see”.

The lens is made up of protein fibers that are optically clear. The lens fibers are held in place by a very thin membrane, called the capsule. The capsule in
turn is attached to the eye by very thin “ropes” called the zonules. The lens sits behind the iris (the colored part of the eye) and the black central hole in the iris is called the pupil.

When you are young, the lens is clear and you enjoy clear, crisp vision. As you age, the lens protein fibers harden and become progressively opaque, which causes the image to become slowly dimmer and less clear.

Section 2: Refractive Errors

A CATARACT is the natural lens of the eye that has become cloudy and opaque, resulting in reduced vision, clarity and brightness.

PRESBYOPIA, or “old-eye”, means that as humans get older, the natural lens hardens and cannot focus on near objects as easily. Presbyopia symptoms (eye strain when reading, blurry objects that are close) start to occur to people in their mid-40’s (this is why people wear reading glasses or have to get bifocals in their glasses).

MYOPIA, or “near-sightedness”, means that incoming light is focused too much, in front of the retina, so that the image is blurry. Myopia is corrected with glasses or contacts to “push the image back” onto the retina (minus lenses do this). Incidence of myopia is estimated to be 20 – 25 % of the world’s population.

HYPEROPIA, or “far-sightedness” means that the incoming light is not focused enough, and creates a blurry image. Plus lenses in glasses or contacts “pull the image forward” onto the retina so that it can be seen. Incidence of hyperopia is estimated to be 5 - 10 % of the world’s population.

ASTIGMATISM means that the front of the eye (the cornea) is not round in shape (like a soccer ball or grapefruit cut in half) but rather is shaped more like a football or watermelon cut in half. Astigmatism can be corrected with glasses or contact lenses. Up to 70 % of the population has significant (more than 1 diopter) of astigmatism.
Section 3: Cataract Diagnosis & Testing

Cataracts usually develop slowly in most cases. Many patients are not even aware that they have cataract. The vision loss is generally slow & insidious. However, sometimes cataracts can occur rapidly, usually associated with trauma, steroid medications, diabetes or other genetic or ocular diseases.

The common cataract symptoms & signs are:

- Blurred vision; vision that is “not clear”
- Difficulty with bright lights; “glare”
- Trouble seeing clearly at night and/or difficulty driving at night
- Rings of light around bright lights; “halo”
- Multiple images of one object (double, triple or more images)
- Complaints of “my glasses don’t work anymore” having to frequently change glasses that work seem to help only temporarily
- Dim vision, especially in low light situations
- Darkened or reduced color vision, difficulty distinguishing colors

When your vision becomes reduced enough that you are having difficulty with activities of daily living, then you are usually referred to an ophthalmologist who specializes in cataract surgery. Cataracts are traditionally diagnosed after a complete eye exam, which does include measurement of visual acuity, contrast and glare acuity if applicable, intraocular pressures & dilated eye exam of the lens and retina.

As in all walks of life, technology has significantly advanced the practice of ophthalmology. A complete eye exam is often enough to diagnose cataract, but far more advanced technology is now used and recommended to maximize outcomes and minimize complications. Advanced diagnosis technology includes, but is not limited to:

The 4 types of refractive errors are myopia, hyperopia, astigmatism & presbyopia.
1. **OCT imaging of the retina**
   - OCT (Optical Coherent Technology) uses scanning lasers to measure microscopic structures inside the eye that sometimes cannot be seen with a standard eye exam. OCT evaluates the retina for unsuspected or unseen retinal diseases like macular degeneration, macular holes, macular traction & macular cysts.
   - **This test is covered by Sask. Health.**

2. **Determination of intraocular lens (IOL) power**
   - The cataract is actually the lens of the eye. Without a lens, the light cannot be focused and you cannot see. Prior to IOL development, people were left without a lens after cataract removal (called aphakia) and had to suffer with very thick glasses and poor vision. Today the standard of care is a intraocular lens (IOL) in every cataract surgery case, unless unexpected complications have occurred, preventing the placement of the IOL in the eye.
   - There are 2 ways to measure the eye, one way is to use ultrasound measurements and the other way is to use laser measurements. Ultrasound measurements have been used for 30 or more years and are still considered an acceptable standard of care.
   - **Ultrasound measurement of the eye is covered by Sask. Health.**
   - Laser measurements are a newer & the best way to measure the eye. The laser measuring machine is called the “ZEISS IOL-MASTER”. The IOL Master test is quicker, easier and operator independent, which means that laser measurements are 10 -20 times more precise and accurate than standard ultrasound measurements.
   - LAKELAND VISION is pleased to provide the latest IOL MASTER 500 series for the benefit of our patients and IOL calculation excellence.
   - **This test is not insured by SK Health and is optional but is very HIGHLY recommended if you wish to have the best refractive results.**
g. The data from the ultrasound or IOL Master is then used in lens calculation formulas to determine which IOL power will be used for each patient.

h. **Standard formulas are used in cases where IOL selection is not as critical and are free of charge.**

i. One of the world’s leading ophthalmologists has developed a “Fourth Generation Formula” which is known to provide more accurate and precise calculations, especially in “challenging eyes”, such as very far-sighted or very near-sighted eyes.

j. **The 4th Generation “Halliday 2 Formula” is used in combination with IOL Master 500 data. The cost to use this formula is included in the IOL Master Fee, and is not insured by SK Health.**

3. **OCT imaging of the front of the eye**
   a. This test measures the size, structure and configuration of the front of the eye where the cataract is located. This test is important to detect unsuspected weakness or disturbances in the normal tissue of the eye.
   b. Complications are more likely when the eye tissues are weak or abnormal in some way. If the surgeon is prepared, complications can be anticipated & risks can be minimized.
   c. **This test is not insured by SK Health and is optional but is recommended.**

4. **Corneal topography**
   a. This test measures the front of the eye called the cornea, in order to detect any corneal diseases or irregularities and to measure the corneal power. The topography results also help the surgeon plan the type & location of the surgical incision during the surgery.
   b. **This test is not insured by SK Health and is optional but is recommended.**

5. **Wavefront analysis**
   a. Wavefront analysis measures the complete optical system of the patient’s eye. Lakeland Vision Institute is proud to offer the Tomey iTRACE system, a state-of-the-art
wavefront analyzer and one of the few such systems in Canada. The wavefront analysis measures higher order aberrations of the eye and is used to optimize the intraocular lens selection for each patient. Using wavefront analysis is like buying a “tailor-made suit”.

b. This test is not insured by SK Health and is optional but is recommended.

After consultation with Dr. Wandzura, the appropriate additional diagnostic tests will be recommended. Retina OCT and ultrasound measurements ARE insured services. Laser measurement of the eye & 4th generation IOL formula calculations ARE NOT insured but BOTH ARE highly recommended. Anterior OCT, topography, wavefront analysis are NOT insured services and are optional.

Section 4: Benefits of Cataract Surgery

Cataract surgery is the most commonly performed surgery in the world. In Canada, over 250,000 cataract surgeries are performed annually. Many of you will know friends or family that have benefitted from cataract removal with IOL implantation. Clinical outcome studies have shown 95% of patients experience an improvement in their vision and reported being satisfied with their visual result.

Cataracts affect your vision and can also impair your normal everyday tasks called “activities of daily living”. Several studies have shown that reduced vision also means reduced quality of life. Elderly patients with visual
impairment but are otherwise well are more likely to experience functional decline. Reduced vision is also associated with reduced independence.

Studies have also shown an association between reduced vision and falls resulting in hip fractures. Reduced contrast sensitivity that occurs with cataract formation is associated with decreased driving performance and an increased risk of accidents. One study has shown reduced vision to have a greater negative impact on elderly patients than the impact of high blood pressure, diabetes, acid reflux and even angina.

**Section 5: Risks of Cataract Surgery**

Physical function, emotional well-being and overall quality of life can be enhanced when visual function is restored after cataract surgery. Improved visual function means less risk of injury, less risk of accidents and reduces overall disability, especially in the elderly “at-risk” patients.

Cataract surgery is a quick, minimally invasive and successful surgery in the vast majority of cases.

However, **ALL SURGERY HAS RISKS**. The overall risk of complications in cataract surgery is very low, reported at 1% of all cases. This means that cataract surgery is actually the safest surgery that you can ever have.

**HOWEVER, THE INCIDENCE OF COMPLICATIONS IS NOT ZERO.**

A guarantee of surgical results is NEVER promised. Complications are rare, but when they do occur, they are usually unexpected.

**Major complications**

1. Death
   a. Death is not usually discussed when considering modern cataract surgery. There is no complication of the surgery itself
that would cause mortality, however there could be complications arising from general anaesthesia, for instance.

b. Most cataract patients are elderly and many of these patients are diabetic, may have high blood pressure and/or high cholesterol and other medical health issues. This means that these patients are at risk of higher morbidity & mortality rates based on their overall health status alone.

c. Surgery can also invoke stress in different individuals to different degrees. Patients could suffer heart attack or stroke if they are ill and susceptible to stressors. HOWEVER, IN THIS SITUATION, THESE PATIENTS ARE LIKELY TO SUFFER THE SAME MORBIDITY AND MORTALITY WITH TIME EVEN IF THEY DO NOT HAVE EYE SURGERY.

2. Post-operative Infectious Endophthalmitis
   a. Infectious endophthalmitis means a bacterial or fungal infection in the inside of the eye after cataract surgery.
   b. This is one of the most serious complications after surgery.
   c. The bacteria usually come from the patient’s own skin and eyelashes. The most common time for endophthalmitis is day 3 to day 5 after the cataract surgery.
   d. Fortunately, this complication is very rare, reported in the medical literature at 1 in 1000 cases.
   e. The infection can be treated if caught early and treated aggressively, but despite treatment, up to 50% of cases have reduced vision or blindness.

3. Suprachoroidal hemorrhage
   a. This complication is due to a blood vessel bursting inside the back of the eye during the surgery. This is due to hardening of the arteries combined with blood thinners in most reported cases.
   b. This complication almost always results in complete blindness. Fortunately, with modern cataract surgery, this complication has become even more rare, reported at 1 in 10,000 to 1 in 50,000 cases.

4. Retinal detachment
a. Eyes that are very near-sighted are at increased risk in the immediate post-operative period, which is commonly said to be the first 6 weeks after surgery.

b. Overall incidence is reported to be 1 in 1000 cases, but this risk is for all patients, so the risk in near sighted patients is much higher at 1 in 50.

c. Retinal detachments can be repaired with surgery in the majority of cases (75%) but even with successful repair, some patients do not recover full visual function.

5. Cystoid Macular Edema (CME)

a. This is thought to be the most common complication after cataract surgery.

b. The incidence of clinical CME (i.e. when the patient notices some visual impairment) is reported to be 1 in 100 to 5 in 100 cases (1 – 5%).

c. The incidence of CME that is not visually significant (i.e. only seen on specialized tests) is much higher, as high as 30%.

d. CME occurs when the body produces a type of chemical (called prostaglandins) after the eye surgery as part of the healing process. Some individuals produce too much prostaglandins chemical after their eye surgery which in turn causes leakage of fluid out of the blood vessels into the center of their retina (called the macula).

e. CME is much more common in diabetics or people with previous iritis or pre-existing macular disease (like epiretinal membranes).

f. Most of the time, CME will resolve with treatment. However, it is always much better to prevent CME from occurring in the first place if possible.

g. CME that does not resolve & becomes chronic will cause permanent central visual blurring (i.e. vision that is reported by patient’s as “never sharp”) but CME does not cause complete blindness.

h. The incidence of CME is greatly reduced by combining steroid & non-steroid eye drops before, during and after cataract surgery.

i. All patients undergoing cataract surgery will be prescribed these drops to minimize the risk of CME.
6. **Toxic Anterior Segment Syndrome (TASS)**
   a. This is a new complication that has just been described in the last 5 – 10 years.
   b. TASS means that the front of the eye develops excessive inflammation like it is infected, but on microbiology tests and samples, no bacteria are ever found.
   c. TASS tends to occur in isolated outbreaks at different hospitals at different times.
   d. The cause is thought to be any piece of equipment, instrument or surgical product that is contaminated with material that is toxic to the eye (examples reported include silica, metals, endotoxins, sterile contaminants).
   e. There have been reported outbreaks in Toronto, Vancouver, Victoria & Saskatoon.
   f. At Victoria Hospital in Prince Albert, as of 2013 there have been NO TASS outbreaks.

7. **Dropped or retained cataract nucleus**
   a. In some patients, the eye tissues are weak from age, trauma or genetics.
   b. If the capsule or zonules are weak, the cataract may not be able to be removed with normal surgical techniques
      i. Additional surgery to remove the remaining cataract from the back of the eye is required from the retinal service in Saskatoon (called a posterior vitrectomy)
      ii. The visual results for patients are usually quite good after vitrectomy if the remaining cataract is managed & removed quickly and appropriately
   c. Anterior segment OCT can help predict this potential problem (see Section 3; paragraph 3a) and the surgeon can take steps to prepare and in some cases prevent this complication by altering the surgical plan
      i. This is why the additional diagnostic test anterior OCT is so important to have BEFORE the surgery

8. **Swelling of the Cornea (Corneal edema)**
   a. Transient swelling of the cornea is common after cataract surgery
i. Very dense cataracts, small eyes with little internal space, prolonged surgery time & poor patient co-operation all contribute to post-operative corneal edema

b. Corneal edema usually resolves on its own over the first 1 week after surgery
   i. During this time your vision will be “milky or blurry”

c. Certain patients have a genetic disease of their cornea, which predisposes them to long-lasting or even permanent corneal edema
   i. This condition is called Fuch’s Corneal Dystrophy
      1. Patients with this condition have a separate consent to read & sign regarding this condition before they can decide and proceed with cataract surgery

9. Dislocated intraocular lens (IOL)
   a. The IOL is supported by the remaining capsule & zonules (see section 1)
      i. If the tissues are weak, the IOL can move, tilt or displace itself out of position
      ii. The IOL can be repositioned if it is not in the capsule in uncomplicated cases
         1. Will usually occur from brisk rubbing of the eye in the first 24 hours (DO NOT RUB THE EYE)
      iii. In complicated cases, the IOL can move or dislocate days, months or years after the surgery
         1. Sometimes the IOL can be left alone if vision is stable but extensive IOL repositioning & suture fixation is required if the IOL has moved out of position too much

10. Posterior capsule rupture and/or vitreous loss
   a. The capsule of the lens is extremely thin (only 10 – 15 microns in thickness (5/10,000th of an inch))
      i. Surgeons want to preserve the capsule at the time of surgery so there is a place for the IOL to stay
      ii. A ruptured capsule means the IOL may have to be placed in a secondary location (called the sulcus) or in front of the iris (called an anterior chamber lens)
1. An anterior chamber lens is less ideal (higher risk of corneal damage and glaucoma)

b. Vitreous loss occurs in cases of posterior capsule rupture or zonule tears
   i. Additional surgical steps are required (called anterior vitrectomy) to remove the vitreous from the front of the eye where it does not belong

1. If managed appropriately, visual results after anterior vitrectomy are usually good, unless there is too much tissue damage & instability
   a. Additional surgical procedures may be required on a case by case basis

Section 5: Alternatives to Treatment

1. Cataract surgery is almost always an ELECTIVE procedure, which means that the patient has a choice as to whether or not to proceed with surgery, based on a review of the risks & benefits of surgery (the purpose of this document)

   a. Almost everyone will get a cataract if they live long enough
   b. Every patient is different and they must make their own informed decision
   c. Every eye is different and the surgical risks may be higher or lower than the average, depending on the case
   d. The patient is responsible for the final decision, based on their review of this information combined with the advice and guidance of their surgeon, Dr. Wandzura
   e. **When the patient decides that their vision is insufficient for their needs AND they wish to see better, cataract removal with IOL implantation is the treatment of choice**

2. One alternative to surgery is to do nothing & stay as you are
a. If you have no symptoms and the cataract is early, there is no need to do anything (“don’t worry about it”)
b. However the cataract will not get better with time and will slowly worsen
c. Some patients are content to leave things as they are and others are not
d. Everyone has different visual requirements and expectations

3. A second alternative to surgery is to change your glasses

a. Sometimes, changing your glasses will provide some additional help with your vision
   i. Be aware that the improvement may last only a short time as the cataract continues to progress
   ii. Your optometrist generally will not refer you to consider surgery unless they have already determined that changing your glasses will be of limited help
   iii. Nevertheless, changing glasses can be an option for some patients

You must understand that there are risks with any operation. The only way to avoid all risk is to not have the operation in the first place!

Section 6: Realistic Expectations

Medical studies have shown that 95% of cataract surgery patients are happy with their outcome. We know from the discussion above that the overall complication rate in cataract surgery is very low at about 1%.

How is it possible then, that 99% of people have no operative complications but only 95% are satisfied with their surgical result? This means 4% of cases had no complications yet the patient is unsatisfied.
This is due to what doctors call UNREALISTIC EXPECTATIONS. Patients either have not been told or do not understand the nature and expected results of the surgery. Dealing with unrealistic expectations prior to surgery is an important component of the informed consent process.

UNREALISTIC EXPECTATION # 1

Standard cataract surgery is designed to eliminate glasses

a. This is FALSE. Standard cataract surgery is designed to remove the cataract and improve vision WITH new glasses.
b. Surgery to eliminate glasses is called REFRACTIVE surgery (various laser types & surgeries involved in refractive surgery is a different topic & is beyond the purpose of this discussion)
c. However, with new IOL technology, it is possible to correct some refractive errors at the time of cataract surgery (this is a new field in ophthalmology called cataract-refractive surgery)
d. The patients who have no refractive error at all (therefore do not wear glasses) are in the minority
   i. The incidence of myopia is 20-25 % and hyperopia is 5 – 10 %
      1. On top of myopia or hyperopia people also have astigmatism in 70 % (see section 2 refractive errors)
      2. Therefore the incidence of no refractive error at all is low, only 10 – 20 %
e. Therefore with standard cataract surgery, unless something extra is done, 80 – 90 % of patients should expect to wear glasses full time after surgery
f. Advanced diagnostic testing with laser eye measurements (IOL Master) can significantly increase the number of eyes that have a reduced refractive error
   i. This is why the added expense of this test is worthwhile to most patients
g. Purchasing an “Premium IOL” decided to reduce your refractive error will give you the best result and reduce your dependence on glasses

Cataract surgery treats the cataract and is not performed to eliminate the need for eyeglasses. To reduce the need for glasses, refractive surgery is required.
UNREALISTIC EXPECTATION # 2

Cataract surgery will make me see as well as I did when I was young.
  a. There is no possible way that surgery can reverse the process of aging and the natural decline that occurs in all living tissues.
     i. Most people accept that they cannot run as fast, lift as much or jump as high when they age
     ii. The same is true of vision as we age

UNREALISTIC EXPECTATION # 3

I have been told that I have more than one eye disease or problem. I have poor vision but cataract surgery will fix everything & I will see perfectly again.

  1. This expectation is completely unrealistic and is dangerous to believe. This is one of the most difficult concepts for patients to understand.
     a. Cataract surgery fixes the cataract only.
     b. If you have macular degeneration, diabetic eye disease, glaucoma, previous trauma or any other ocular disease as told to you by Dr. WANDZURA, then you cannot reasonably expect to see perfectly again.
     c. Removing the cataract should, in most cases, improve your vision
        i. In some cases, removing the cataract does not help the vision very much or may not even help at all
        ii. If your disease is severe and if the condition continues to progress, then your vision will continue to worsen despite successful cataract surgery
        iii. Cataract surgery generally does NOT cause other ocular diseases to worsen
     d. The most common culprit to limit vision after cataract surgery is age-related macular degeneration (ARMD)
        i. If you have ARMD and also have cataracts, you will have to decide if cataract surgery is even worthwhile
           1. Dr Wandzura will tell you how dense the cataract is and if removing the cataract is expected to help you a lot, help you somewhat or may not help at all
ii. ARMD and any other eye disease (ocular co-morbidity) will be discussed with you and the separate applicable consent form signed prior to surgery

Standard cataract surgery will NOT replace glasses in most cases, will NOT make you see like you were young again & will NOT cure all of your eye problems

Section 7: Special High Risk Situations in Cataract Surgery

There are several important eye conditions or “ocular co-morbidities” that are associated with a higher risk for complications. These are:

a. Pseudoexfoliation Syndrome
   a. These eyes often have denser cataracts, pupils that do not dilate well and possible weak zonule support (see complications section)
   b. Narrow eyelid opening
   a. Surgical access to the eye is more difficult
b. Very dense cataract
   a. Technically more difficult and takes longer (increased risk of thermal injury & corneal edema)
c. Very far-sighted eyes
   a. These eyes are usually very small and difficult to work in as there is less space inside the eye
e. Very near-sighted eyes
   a. The opposite problem as (d), these eyes are unusually large and floppy
   b. Highest risk of retinal detachment is found here
f. Previous eye surgery
   a. Regardless of the previous surgery, there is increased risks of unexpected tissue weakness, bleeding and/or inflammation
g. Small pupil that will not dilate
   a. Very difficult to see the cataract and to remove the cataract safely
h. Adhesions in the eye
   a. Called synechiae, usually from previous iritis
i. Mature white cataract
   a. Technically more difficult as the surgeon cannot see well

j. Zonule weakness
   a. Although usually associated with pseudoexfoliation syndrome
      (see (a) above), weak or absent zonules can occur after trauma
      or in very old eyes
   i. May not be detectable until surgery is already underway

k. Flomax (Tamasolin)
   a. This medication is called a alpha-1 antagonist medication
   b. Most commonly it is given to males with enlarged prostates in
      order to help them pass urine
   c. Sometimes women can be given Flomax to help pass kidney
      stones
   d. This medication binds the muscle inside your iris even after one
      dose & the effect can be life-long
   e. During surgery, the iris will contract, flop around and want to
      push itself into the corneal incision
   i. Extra anaesthetic & a special technique (Malyugin Ring
      technique) is used by Dr Wandzura to manage this
      problem safely
   f. You must let us know if you have EVER taken Flomax

Be sure to report any previous Flomax use and previous eye
injury or eye surgery to Dr. Wandzura BEFORE you have
cataract surgery

Section 8: Anaesthetic Choices

There are 3 ways to provide anaesthesia for cataract patients so that their
experience is reasonably comfortable and more importantly, so that the
patient can co-operate enough to allow safe, quick and successful cataract surgery.

a. Topical anaesthetic
   a. Also known as “just drops” (no needle) technique
   b. 80% of Dr Wandzura’s cataract cases are good topical candidates
   c. These patients must be able to lie on their back, relatively still and stare at a very bright light (from the operating microscope)
   d. These patients will feel pressure, water and intermittent sensations, but generally are reporting minimal discomfort during surgery
   e. No risk of eye injury; patients will feel more during and after surgery as the drops wear off

b. Local (regional) anaesthetic
   a. 25% of cases, usually patients that are very nervous, cannot hold their eye still or have other ocular co-morbidity or other high risk situations
   b. Similar to a dentist freezing a tooth, an injectable anaesthetic is given in the lower eyelid which then spreads out behind the eye in the fatty tissues
   c. The needle is NOT in the eye
   d. Eye muscles are paralyzed so the eye cannot move and vision is black so the bright light is not bothersome
   e. Surgical co-operation is better as the patient does not have to hold eye still, just lie flat and relax
   f. Patient generally feels less once the freezing is done
   g. Intravenous sedation is usually given before the injection to make the injection less painful
   h. Risks of local anaesthetic are rare but the risks are also potentially much more severe:
      i. If the injection is given too close to the eye, the eye can be perforated with resulting blindness
      ii. If the injection affects the muscles around the eye, permanent double vision can result
      iii. If a blood vessel breaks due to the injection needle, a blood clot can form behind the eye which can compress the optic nerve and result in blindness
c. General anaesthesia
   a. The least common type, only 5 % of cases
   b. Usually the very young or mentally challenged cases that cannot otherwise co-operate
   c. Can include patients who cannot hold their eye still but also refuse local anaesthetic
   d. Most comfortable for patient, easiest for surgeon as well
   e. Usually BOTH eyes are done at same time to avoid 2 General anaesthetics
   f. Takes more time, hospital not as efficient
   g. Main risk is most serious complication of all, not waking up (i.e. death)

Section 9: Conclusion

After review of this document, you should feel informed and confident about your decision to proceed with cataract surgery. Any questions that you may should be asked BEFORE your surgery. If you do not understand something in this document, be sure to ASK Dr. Wandzura and his staff for an explanation.

If you do NOT wish to proceed with cataract surgery due to your new understanding of the procedure and associated risks, or for any other reason, then we are also pleased to have helped you make an informed decision and we respect the decision that is right for you. Be sure to go over this information with your spouse and family. Educating your family will help them be better prepared when it is their turn to consider cataract surgery in their own lives.

Cataract surgery is very rewarding for both patients and surgeon alike. We love hearing stories from our patients about how cataract surgery has helped them to see better and to enjoy their lives more fully. Educated and prepared patients are better able to accept and deal with complications appropriately if any complications happen to occur in their case. The majority of complications can be dealt with satisfactorily with time, medication and additional surgical procedures.

Thank you for taking the time to read through and more importantly understand the procedure that you are considering. If you wish to proceed, please initial each page, indicating that you have read & understood the
contents and then we will prepare the appropriate consent forms for you to sign and book your surgery accordingly.