# The New Normal

EUROCOVCAT is a group of cataract and refractive surgeons that has met on Zoom several times to discuss how to get back to practising ophthalmology in the most safe, efficient manner in the months and years ahead. This article, written exclusively for *EuroTimes*, provides an insight on how to rethink cataract care, not only for the current COVID-19 situation, but for the "new normal" following a global pandemic.

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## INTRODUCTION

Countries are at different starting points with regard to COVID-19 epidemiology and response, availability of personal protective equipment, testing requirements, current cataract patient pathways (some have overnight stay), economic situations and patient demographics.

Clinic settings for cataract surgery also vary from standalone private practices, ambulatory surgical centres to large specialised clinics and departments located within the general hospitals.

Financing of cataract surgery differ too, quite significantly: though standard cataract is publicly reimbursed throughout Europe, some interventions, such as Advanced Technology IOLs, are covered by private insurance or co-payment.

Therefore, guidance on cataract surgery recovery needs to be quintessentially local and adapted to the specific clinical setting.

However, there are important overarching considerations that span across all practices:

COVID-19 patient and medical staff safety protocols will be here to stay, at least well into 2021.

Risk/benefit assessments will be crucial in determining when and how to restart cataract procedures.

This also provides an opportunity to critically reframe the patient pathway to future-proof cataract care.

**Why we need to put a spotlight on Cataract in the next phase of COVID-19 recovery?** The development of cataract is an inevitable fact of ageing. Cataract surgery is therefore among the top three most commonly performed surgical interventions across Europe. In many countries, waiting lists are already long; and suspension of all interventions due to the outbreak of COVID-19 has further affected patients' access to care.

While the evidence suggests that the impact of cataract surgery on a patient's quality of life is overwhelmingly and compellingly positive, in some countries, health authorities are tempted to deprioritise cataract surgery in recovery planning as it is considered as a less urgent elective surgery.[1,2,3]

Patients on prolonged waiting lists for cataract surgery may experience negative outcomes during the waiting period, including vision loss and ultimately, poorer health-related quality of life (HRQoL).[4]

Untreated cataract also increases the risk of falls and with it the incidence of hip and knee fracture and head injuries. Conversely, cataract surgery decreases the risk: in a cohort of US Medicare beneficiaries aged 65 years and older with a diagnosis of cataract, patients who had cataract surgery had lower odds of hip fracture within one year after surgery compared with patients who had not undergone cataract surgery.[5]

At the same time, cataract surgery is a safe procedure typically performed in an outpatient setting and with local or topical anaesthesia. Compared to most other elective surgeries, it can be performed efficiently even with COVID-19 safety protocols.

**What needs to be considered when re-starting Cataract Surgery?** Due to the high volume of patients now on cataract waiting lists, there are pressing questions if and how to prioritise patients.

There is agreement in this group that a pragmatic stance should be taken to patient triaging to facilitate the restart. We propose a number of considerations:

1. **Consider patients** in chronological order of those already scheduled prior to the COVID-19 surgical suspension and assess their willingness for surgery.
2. **Quality of life:** Strong consensus that priority should not be based on visual acuity alone, but on Quality of Life vs. Risk. Therefore, simple questions on quality of life, daily function and personal preferences should be asked to ascertain readiness.
3. **Age:** Must consider age when triaging patients and speaking of Quality of Life, as any delay of surgery is significant for a septuagenarian and octogenarian relative to life expectancy.
4. **Patient condition (comorbidities):** We should also consider the conditions that place patients in the group of higher risk for COVID-19 outcomes: Older people and people of all ages with pre-existing medical conditions (such as diabetes, high blood pressure, heart disease, lung disease, or cancer) appear to develop serious illness more often than others.[6] If chronic health issues and comorbidities can meaningfully be improved, there is a rationale to wait.
5. **Ocular priorities (other concomitant ocular disease):** Poor vision, narrow angles or other risk factors, anisometropia or high refractive errors should be considered. Operating on the second eye may be lower on the list if the anisometropia is not reducing the quality of life and increasing the risk of falls for example.

Consequently, we should aim for quality rather than quantity, and accept the fact that the number of cataract surgery procedures per day prior to COVID-19 may not be reached in the near future.

How will the cataract surgical pathway need to change to best protect patients and staff? We agree that the clinic is actually in most cases the highest risk area, not the operating arena itself, so there is a strong need to completely rethink the consultation protocol.[7]

No setup can guarantee complete COVID-19 safety, but control measures need to become standard.

We have highlighted some overarching considerations:

- The new reality calls for a one-stop clinic setup.
- Consistently reduce human contact to a minimum – this applies to number of staff in clinic as well as accompanying family members.
- Specific pathway for COVID-19 positive patients. There is no need for a specific diagnostic pathway, but rather the "red room" where the patient can be consulted about the deferred surgery.
- New waiting room configuration and methods (i.e. in-car waiting and patient distancing).

- Facility disinfection on a regular basis – after each patient as well in time intervals.
- Mask distribution to all those who enter – either provided by each individual or the clinic.
- Air system evaluation to possibly cut central air in clinics and hospitals to avoid spread.
- Patient and team's anxiety and safety management is crucial: clearly communicating all the procedures and protocols ahead of time to reassure them that we are taking COVID-19 seriously and will do our best to make sure that our centres are the safest place that they can be outside of their homes.

### Each critical phase of the cataract care pathway needs to be evaluated in greater detail:

**Pre-surgical assessment:**

- First assessment can be done by phone one-to-three days prior to surgery:
  - If have symptoms currently or had symptoms previously.
  - If and how much patient is bothered by their vision.
  - Understand readiness to come in for surgery.
  - Explain that risk cannot be quantified.
- Possible use of interactive history forms that can be completed on patients' phones, iPads or PCs that can include all the questions that we would normally ask in the clinic, such as reason for visit as well as visual expectations, or willingness to pay for Premium IOLs.
- Do only the mandatory in-clinic assessments (e.g. biometry, OCT, topography, tomography and specular microscopy).
- Pre-op COVID-19 testing should be integrated into one-stop pre-surgical assessment where required and possible.

Testing is a subject of debate with many unresolved questions on types of tests, availability and reliability. As cataract surgery is done under local anaesthesia and integrated in a fast-track approach, many centres will not require PCR testing and all patients are to be managed as potential COVID-19 carriers.

We agree that the following is suggested whether or not any testing is performed:

- Pre-triage by phone the day before surgery:
  - Questionnaire to assess if symptoms, risk – if yes to one question, postpone surgery if possible.
- Triage at the check-in the day of the operation:
  - Questionnaire to assess if symptoms, risk – if yes to one question, postpone surgery if possible.
  - Consent process – needs to clearly articulate that COVID-19 infection risk cannot be quantified.

**Surgical process:**

- Dilation – possible to be done by patient before coming to clinic or by intracameral injection in OR during the surgery.
- Limit communications with the patient during the surgery to strict minimum.
- Reduce number of people present in OR (i.e. one surgeon and two nurses) and consider the needs for others including anaesthetist, assistants and residents in training.
- Bilateral same-day sequential surgery now being recommended in more countries and should be considered in alignment with country legislation. However, one must be aware of the risks this can entail and inform patients about these risks. The choice to perform bilateral contemporary surgery remains the surgeon's choice.
- Staff protection: the staff should wear surgical mask[8], gloves, should be trained about wearing and taking out of personal protection equipment.
- Phacoemulsification instruments should be covered properly and single use; protecting shields for operating microscopes, 'like slit-lamp separators', should be attached to oculars.[9]

**Post-op:**

- Only phone call and video assessment one day post-surgery as this is already in place in some markets.[10]
- Limit post-op visits to only four weeks postoperative visit unless there are any issues.
- Possibility to do visits through teleconsultation if patient and caregivers agree.
- Need to evaluate current mobile apps that could be used.

We recognise that the list of recommendations is clearly not exhaustive and should be adapted and augmented locally to be fit for purpose.

## CONCLUSION

We need to get back to doing cataract surgery. Vision is a vital part of general health and cataract waiting lists have only become longer in the past few months. There is a need for cataract surgery to start again as a priority. The primary factor that needs to be considered is how the cataract is impacting the patient's quality of life. If the impact is minimal, of course surgery can wait. If the current quality of vision, however, is so that it is reducing the patient's quality of life, then the cataract surgery should be performed sooner rather than later. The surgery itself will be different to what we are used to. There will be limited access to cataract surgery slots due to social distancing guidelines and some older patients may be reluctant to come to hospital settings for cataract surgery while COVID-19 is still in the news. More intense preoperative screening, swabs prior to surgery if possible, increased use of PPE, fewer people in the operating room including in some instances working without an anaesthetist and using topical anaesthesia only, are all possible and even likely scenarios. Postoperative exams can be done virtually, either with a video call or even just a phone call, calling patients back for in-person consultations only when there are potential problems.

This text is not intended to replace local guidelines or any legislative recommendations. We had the opportunity to meet a few times using videoconferencing to discuss our main challenges and share ideas on how to face and overcome these challenges. When the discussion ended (for the moment anyhow), the final document was found to be especially useful by all of us, and hence we agreed that it may be found useful by our colleagues in the wider ophthalmological community. The decision to share the text more widely was unanimous. It is noticeably clear to us that we are all facing similar challenges in the face of this unprecedented event and we are unearthing and thinking of new ways of doing things every day. The situation is very dynamic, both from a health and an economic standpoint and we are certain that within weeks, there will be a lot to add to our collective thinking. At this point in time, there is no golden rule for exactly how cataract surgery should be restarted in Europe. However, it needs to be restarted. Each surgeon will have to consider a number of issues and then based on their experience, their local conditions and sentiment, and their patients' willingness to proceed with surgery, take the first careful steps to the new normal for cataract surgery. We hope that you find the thoughts expressed here useful and we welcome further discussion.


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