Donate eyes, not patients!

Budding out from a curriculum that was in the yesteryears clubbed along with Otorhinolaryngology (ENT), the field of Ophthalmology has made the greatest advances in the last three decades. Cataract surgery moved from an intracapsular extraction to a Femtosecond, and Glaucoma progressed toward nonpenetrating surgeries. Corneal lamellar surgeries and 27 gauge vitrectomy has made each of these procedures safer and better. Ophthalmic Plastic Surgery too, has come a long way from a blade and scissors to bloodless radiofrequency surgeries, piezo-electric technology, and navigation guided surgery. However, there is an “internal bleed” that is constantly affecting our health as a super-speciality, and I have chosen to bite the bullet and discuss it: Openly.

Ophthalmologists, unlike any other field of medicine in India, have over time developed this silently destructive art of unilateral “exodus” of our patients to allied fields of specialty. Unfortunately, it largely affects Ophthalmic Plastic Surgery, and hence our humble “squeak.”

Our epiphora patients are happily referred to the friendly neighborhood of ENT surgeons when our own oculoplastic surgeons are now well versed with endoscopic surgery. Many patients are sent simply because a dacycystorhinostomy (DCR) might block a few cases worth of phaco-time in the operation room. Others are referred for a “preoperative nasal examination,” which can be easily done by the Ophthalmologist with the over-head lamp on their slit lamp chair unit that has been patiently waiting for job satisfaction! Such generous unwarranted “donation” of patients can boomerang back as an “intrusion” of unnecessary orbital surgery techniques by our allied colleagues.[1]

The second most common martyr is our patient of spasm (essential blepharospasm and hemifacial spasm) who is sent to the Neurologist, either to rule out an “intra-cranial pathology” (which can be easily done by us), or even to treat them with Botulinum toxin. It is unfortunate that the very toxin that was invented by an Ophthalmologist is now more frequently used by nonophthalmologists for indications that belong to our specialty. So what does your spasm patient get as a result of this referral? A ptosis, or may be a dry eye. Can’t blame the Neurologists, because they have never seen the periocular anatomy from close quarters. Fortunately, it’s the oculoplastic surgeon’s home ground. In my exclusive Ophthalmic Plastic Surgery practice over last 15 years, I have seen several spasm patients who were injected with Botulinum toxin by a Neurologist, and were convinced that it does not work, until they got injected by an oculoplastic surgeon. The difference? Only the technique; not the dose.

Eyelid trauma and orbito-facial fractures are another broad sector of patients that are deflected to the “Plastic Surgery” department in many high-volume centers, and almost all medical colleges. What your patient might get at the end, is an unattended canaliculic injury, a notched eyelid margin, and a zygoma that is “fixed” often without addressing the inevitably co-existing orbital floor fracture. This patient will then be referred to you after 2 months to manage the “diplopia!” My dear (general) plastic surgeon, that diplopia would not have occurred, had you just called out for help from any oculoplastic surgeon in your neighborhood during the surgery!

Peri-ocular tumors are also mismanaged as a result of this “referral” tendency. Of particular mention is this case of a Sebaceous gland carcinoma of the upper eyelid that was managed without a systemic metastatic work-up, without a consideration of primary neoadjuvant chemotherapy, without a conjunctival map biopsy, and an eyelid reconstruction option that was ill-suited for the defect leading to a persistent red eye.[2] Any oculoplastic surgeon would feel sorry for this patient who had a mediocre, incomplete, and potentially harmful surgical result.

There has been an old tradition to refer orbital tumors to neurosurgery, and unfortunately it continues. Not surprising then, that someone with an intra-conal cavernous hemangioma, which could have come out in 15 min through a hidden conjunctival incision now receives an ear-to-ear coronal scar, and a craniotomy with an added gift of a third nerve palsy.

Last but not the least, the field of esthetic surgery is equally affected by this donation phenomenon. Most aging changes are revealed first in the periorbital region: An area that we have mastery over. Periocular Botulinum toxin, fillers, brow surgery, and blepharoplasty are the areas where an oculoplastic surgeon is most confident, and it should, therefore, be promoted.

Has a neurosurgeon ever referred an orbital mass to you? Or a plastic surgeon called you from the Operation room to help stitch an eyelid meticulously? Does your ENT surgeon ever ask you to perform an external DCR for one of their patients? These are rhetorical questions, and I know the answer. It is time for us, Ophthalmologists, to introspect. As an Ophthalmologist, it is our duty to make the patient realize, that an oculoplastic surgeon is a plastic surgeon with an added advantage of micro-surgery and extensive knowledge of ocular tissues.

Today, an aesthetic DCR can be performed by all oculoplastic surgeons via a cosmetically scarless external route, or an endonasal route.[3] In trauma setting, concurrent evaluation and management of canalicular laceration is possible only in the hands of an oculoplastic surgeon, so is the orbital floor repair. Most oculoplastic surgeons are well versed with Botulinum toxin injections for spasms as well as their cosmetic uses. The logistics of maintaining a cold chain do exist, but with your support, the oculoplastic surgeon in your city can deliver a much better and safer result. Oculoplastic surgeons do believe in cross-specialization, and
combined multi-specialty treatments along with allied specialties are always welcome. However, this should be to enhance the outcome of an occasional complex procedure, and not a passive referral of nearly all our patients to other specialties.

So how can the Ophthalmologist help our specialty of Oculoplastic Surgery grow? Well, it’s easy. Putting a stop to the “unilateral love” of referrals is the first step. The Ophthalmology Departments in medical colleges and multi-specialty hospitals should insist with the management that an oculoplastic surgeon should be involved in the management of any trauma extending from eyebrow to the inferior orbital rim (may be more!). It is not only our right; it is our area of expertise. An Oculoplastic surgeon near you would be happy to have a working relationship with your hospital or your practice: Please involve them. This would not only improve the services to the patient but also expand your horizons in Ophthalmology. Available operation room time and specialized equipment are indeed a challenge, but the beauty and expanse of Ophthalmology are growing, and we need to nurture it.

So my humble request to the Ophthalmologists is to pledge to donate their eyes to a deserving patient, and not donate the deserving patients to the lurking eyes!

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