Operative Procedure Note
Pneumatic Displacement of Subretinal Hemorrhage

Patient Name:_____

Date:_____

Procedure: Pneumatic Displacement of Subretinal Hemorrhage ____ Eye

Diagnosis: Subretinal Hemorrhage _____ Eye

Indication: _____ Eye

Informed Consent:
In an extensive discussion, Dr. Mann candidly reviewed all the risks, benefits, alternatives, nature and intent of the above-proposed procedure. The patient understood that the ocular and anesthesia risks might result in loss of all vision, need for further surgery, and loss of the eye as well as life threatening and disabling complications. The patient states they had a good understanding of their clinical situation and wished to proceed nevertheless citing that the benefits outweigh the risks. Sufficient time was provided for the patient to ask questions and to have their questions answered to their satisfaction by Dr. Mann.

Procedure Performed:
Topical anesthetic drops were instilled into the operative eye. The patient was placed in the supine position and instructed to gaze in the primary position while a retrobulbar anesthetic block was performed. Indirect ophthalmoscopy performed immediately following the injection confirmed no inadvertent glove penetration/perforation or vascular occlusion. The operative eye was then prepped and draped in a standard fashion. Using a 30 gauge needle and 3cc syringe, _____ml of 100% filtered _____ gas was injected 3.75 mm from the limbus through the pars plana in a sterile fashion and under direct visualization with the indirect ophthalmoscope. An intraocular pressure measurement was performed and a therapeutic paracentesis was done in a standard fashion using a 30 gauge needle and a TB syringe entering the anterior chamber parallel to the iris plane at the limbus to allow egress of aqueous fluid and lowering of the intraocular pressure to a normal range. Antibiotic eye drops were then used every 5 minutes times four and the intraocular pressure rechecked 30 minutes postoperatively prior to discharge. The patient tolerated the procedure well and left the procedure room without complications.
Post-operative Management:
The patient was instructed to return in follow-up the next day and maintain postoperative positioning near face down for five days. Topical antibiotic and anti-inflammatory eye drops for four days with postoperative instructions/schedule for use of the drops were given to the patient. The patient was instructed to return immediately upon any pain, decreased vision, or symptoms of retinal tears or detachment, which were reviewed.

INFORMED CONSENT

I, _____, have been given the brochure(s) PNEUMATIC DISPLACEMENT OF SUBRETINAL HEMORRHAGE AND RETROBULBAR ANESTHESIA. I have had the opportunity to read, understand, and ask questions regarding this procedure(s). Dr. Mann has explained this procedure to me in depth. I have been informed with regard to the potential benefits, complications,risks, and alternatives of the procedure. Sufficient time was allowed for me to ask questions and these questions were answered to my satisfaction.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

RECEIPT OF POST-OP INSTRUCTIONS

I _____ have been given postoperative instruction information. I have had the opportunity to read, understand and ask questions regarding my planned surgical procedure(s). Dr. Mann has explained this procedure to me in depth. I have been informed in regard to the potential benefits, complications, risk and alternatives of the procedure. Sufficient time was allowed for me to ask questions and these questions were answered to my satisfaction.

_____ _____

Patient signature Date

_____ _____

Witness signature Date

PERIBULBAR & RETROBULBAR ANESTHESIA

Absence of pain (anesthesia) and immobilization of the eye (akinesia) are often necessary to allow effective laser and cryotherapy treatment or intraocular surgery. Both anesthesia and akinesia can be obtained to a variable degree by injection of anesthetic (Lidocaine and/or Marcaine) around and behind the eyeball prior to treatment or surgery.

The following are **common** effects of the anesthetic injection but are usually temporary:

1. Blurring of vision
2. Numbness and swelling around the eye
3. Ptosis (drooping of the eyelid)
4. Diplopia (double vision)

The following are **uncommon** complications of the anesthetic injection:

1. Retrobulbar or periorbital hemorrhage (bleeding behind or around the eyeball)
2. Globe perforation (puncture of the eyeball by the needle used for anesthetic injection)
3. Optic nerve injury or vascular damage (central retinal artery or vein occlusion)
4. Allergic reaction to the anesthetic
5. Seizure
6. Cardiorespiratory arrest (death)
7. Bilateral akinesia

These uncommon complications may result in permanent loss of vision, need for further surgery or treatment, or loss of the globe. Other less common complications may be discussed as well.

Post treatment care may include applying ointment to the eye and wearing a patch for 24 hours.

The Retina Group LTD. P.C.

Eric S. Mann, M.D., Ph.D.

Diseases & Surgery of the
Retina Macula & Vitreous

POSTOPERATIVE INSTRUCTIONS FOLLOWING EYE SURGERY

ACTIVITY:

Avoid driving, bending, heavy lifting, vigorous coughing and/or sneezing, straining with bowel movements, vomiting, and any other activity that increases intra-ocular pressure. No exercise or physical exertion for 4-6 weeks.

WOUND CARE:

1. Avoid squeezing eyelids shut or touching eye.
2. During the day, keep operated eye covered with eyeglasses or shield.
3. At night, always wear shield to prevent rubbing eye and causing injury.
4. Wear dark glasses if photosensitivity occurs.
5. Crusting on the eyelids may be removed with a **clean** washcloth run under warm tap water.
6. DO NOT PRESS ON THE EYE.
7. Call your surgeon if you develop any signs and symptoms of infection: eye pain, decreased vision, itchy/watery eyes or increased redness/swelling/discharge.
8. Wash your hands before giving eye drops.

SAFETY PRECAUTIONS:

1. To avoid falls and/or accidents, remove throw rugs, clutter, cords and furniture in walking paths.
2. Turn head fully to affected side to view objects.
3. Use up and down head movements to judge stairs and oncoming objects. MOVE SLOWLY.

POSITIONING:

_____NONE _____SIDE DOWN _____FACE DOWN _____SIT UP _____DAYS

1. Do not lay prone or flat on back if special positioning is necessary.
2. Maintain special positioning as much as possible, taking a 5 minute break every 120 minutes.
3. Do not ascend altitudes greater than 2000 feet; do not fly in an airplane; no non-ocular surgery unless both the surgeon and anesthesiologist know you have gas in your eye.

MEDICATIONS:

1. Avoid over-the-counter medications unless discussed with your doctor.
2. Shake eye drops before applying; shake Pred Forte 1% Eye Drops 30 times before using.
3. Avoid contaminating tip of eye drop applicator by touching eye with tip.
4. Wait three-five minutes between application of different eye drops.
5. Take Tylenol for pain.
6. Avoid aspirin, aspirin containing products such as Anacin and anticoagulants such as Heparin and Coumadin unless approved by your doctor.

FOLLOW UP CARE:

Follow up care is a critical part of a successful surgery. Your surgeon needs to assess your eye healing and see that you are recovering safely.

YOUR SCHEDULED FOLLOW UP APPOINTMENT IS :_____.

REPORTABLE SIGNS:

Call Dr. Mann immediately if any sudden eye pain not relieved by Tylenol, increased redness/swelling/discharge, or loss of vision or any systemic complaint.

EMERGENCY PHONE NUMBER TOLL FREE:	866-856-7882
OFFICE NUMBER MISSOURI:	314-835-9400
OFFICE NUMBER ILLINOIS:	618-632-8100

CONSENT SPECIAL/INFORMED TO SURGERY OR OTHER PROCEDURE

Name: _____ Date: _____

Medical record number _____

1. I hereby authorize Dr. Mann and / or such assistants, associates, or other health care providers that may be selected by him, to perform the following procedure (s)
Pneumatic displacement of subretinal hemorrhage _____eye.

2. Dr. Mann has discussed with me the procedure(s) listed above and the items of information that are briefly summarized below:
   a. The nature and purpose of the proposed procedure(s): to displace subretinal hemorrhage in an attempt to prevent further vision loss.
   b. The risks and possible consequences of the proposed procedure(s), including the risk that treatment may not accomplish the desired objective(s) and including, but not limited to: decreased vision, cataract, retinal detachment or break, infection, bleeding, pain, increased intraocular pressure, loss of vision, loss of globe or need for further surgery.
   c. All reasonable alternative treatment, including risks, probable effectiveness of each and consequences if this proposed treatment is not received:
   _____

3. I am aware that, in addition to the risk specifically described in Item 2 above, there are other risks, such as severe loss of blood, infection, cardiopulmonary arrest, respiratory difficulties, injury to proximate/adjacent blood vessels, nerves, organs or structures, unanticipated allergic reaction to substances, pressure/position related injuries and other risks related to the performance of any surgical procedure.

4. I acknowledge that no guarantees have been made to me as to the results of the procedure(s) and am also aware that complications and risks may occur despite precautions.

5. I consent to the performance of unforeseen operation(s) and procedure(s) in addition to or different from those now contemplated and describe herein that the named doctor and his associates or assistants may deem necessary or advisable during the course of the presently authorized procedure(s).

6. I consent to the administration of such anesthetics as may be considered appropriate by the physician responsible for anesthesia administration or such assistants or associates as may be selected by him. I understand that this procedure is to be performed using **retrobulbar/general** anesthesia. I understand that all types of anesthesia involve some risk. I further understand that if a regional, spinal or epidural anesthesia is planned, it may be necessary to also administer a general anesthetic during this procedure, and I consent to the administration of a general anesthetic. I understand the risk of a general, spinal, epidural or regional anesthesia include, but are not limited to, mouth and/or throat pain or injury, cardiopulmonary arrest, cardiac arrhythmias, heart attack, respiratory difficulties, stroke, brain damage, headache, backache and other sensory, nerve, focal and systemic injuries.

7. I also consent to the administration of blood or blood components, drugs, medicines and other substances considered advisable by the physician(s) responsible for this procedure and the use of x-rays or other diagnostic testing, procedures and devices, which the above-named physician or his associates, consultants or assistants may consider useful.

8. I hereby authorize The Retina Group LTD PC or staff to preserve for scientific or teaching purposes or to otherwise dispose of any tissues, parts, organs, or implants removed during this procedure.

9. For teaching or educational purposes, I consent to the admittance of students, staff or other observers to the operating and procedure rooms, and to the taking of any videos or photographs deemed appropriate or necessary by the physician in the course of the procedure(s). I also consent to the taking of photographs or videos for the purpose of documenting the condition or procedure in the medical record. I understand that if data, photographs, videos or other information are used for teaching/educational purposes or for scientific publication, that my (the patient's) identity will remain confidential unless otherwise authorized by the undersigned.

10. I certify that I have read or have had the above information read to me and that I understand the above consent to operation or diagnostic procedure, that the explanations referred to were made to my satisfaction and I hereby give my informed and voluntary consent to the proposed procedure(s) or operation(s).

Signature of patient:

_____

If the patient is unable to give informed consent because of physical or mental incapacity or is a minor (under 18 and unemancipated), complete the following:
Patient is unable to give consent because _____
_____
_____

:

_____
Witness to signature

I certify that I have explained to the above individual the nature, purpose, risk and potential benefits of the above procedure and have answered any questions that have been raised.

_____
Signature of Physician