

PERIOCCULAR (SUBTENON) STEROID INJECTION

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A. INDICATIONS:

Periocular steroid injection involves placement of steroid around the eye to treat intraocular inflammation or swelling of the reading center known as cystoid macula edema (CME). Intraocular inflammation and/or CME if untreated may cause irreversible visual loss and damage the eye. Periocular steroids are active for a period of time (weeks to months) and can cause resolution of CME and intraocular inflammation. The effects of periocular steroids are localized to the eye and do not result in the major systemic side effects sometimes associated with oral steroids.

B. BENEFITS:

The benefits are resolution of CME and/or intraocular inflammation with visual preservation or improvement. However, there are no guarantees or assurances of treatment effect with some cases demonstrating continued deterioration even in spite of treatment.

C. RISKS AND COMPLICATIONS:

Risks and complications include common side effects such as redness, irritation, subconjunctival hemorrhage or mild to moderate intraocular pressure elevation. Uncommon complications include ptosis, lid hemorrhage/ischemic necrosis, marked elevation of intraocular pressure/steroid glaucoma, corneal abrasion, infection, retrobulbar hemorrhage, vaso-occlusion (artery or vein occlusion), optic nerve injury, or inadvertent globe perforation. These uncommon risks may result in loss of vision, need for further surgery, or rarely loss of the eye. Other potential risks and complications not listed here may occur and be discussed as well.

D. POST-TREATMENT CARE

Post-treatment care includes follow-up appointment to monitor the intraocular pressure and treatment response to the periocular injection. Additional injections or intraocular surgery (removal of the vitreous gel or vitrectomy) may be recommended depending on the treatment response.

INFORMED CONSENT

I, _____ have been given the brochure(s) on: PERIOcular (SUBTENON) STEROID INJECTION.

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

Operative Procedure Note Subtenon Kenalog Injection

Patient Name: _____

Date: _____

Procedure: Subtenon Kenalog Injection _____ Eye

Diagnosis: Macula edema _____ 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 anesthetic 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 stated 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 away from the operative eye toward their nose. Topical, local 4% lidocaine was applied with two q-tips and direct pressure over the superior temporal fornix of the operative eye for two minutes. Using a "Nozik" technique of localizing a 25 gauge 5/8" needle in the subtenon's space in the superior temporal quadrant, 1cc or 40 mg of Kenalog (triamcinolone acetonide) was injected in the subtenon's space after confirming the needle was not intravascular by the absence of any blood return upon aspiration. Indirect ophthalmoscopy performed immediately following the injection confirmed no inadvertent globe penetration/perforation or intraocular injection of steroids. Visual inspection of the fornix confirmed no steroid vehicle anterior to the septum. The patient tolerated the procedure well and left the procedure room without complication.

Post-operative Management:

The patient was instructed to return in follow-up in _____. If the patient had been using topical anti-inflammatory drops postoperative instructions/schedule for use of the drops were given to the patient. The patient was instructed again as had been done preoperatively not to drive a motor vehicle for 24 hours and to return immediately upon any pain, decreased vision, or symptoms of retinal tears or detachment, which were reviewed.

**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)
PERIOCLAR (SUBTENON) STEROID INJECTION _____ 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): PLACEMENT OF STEROID AROUND THE EYE TO TREAT INTROCLAR INFLAMMATION OR SWELLING OF THE READING CENTER KNOWN AS MACULAR EDEMA.
 - 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: REDNESS, IRRITATION, SUBCONJUNCTIVAL HEMORRHAGE, PTOSIS, LID HEMORRHAGE/ISCHEMIC NECROSIS, HIGH INTRAOCULAR PRESSURE/STEROID GLAUCOMA, INFECTION, RETROBULBAR HEMORRHAGE, VASO-OCCLUSION (ARTERY OR VEIN OCCLUSION) OPTICE NERVE INJURY, OR INADVERTENT GLOBE PERFORATION. THESE UNCOMMON RISKS MAY RESULT IN LOSS OF VISION, NEED FOR FURTHER SURGERY OR RARELY LOSS OF THE EYE.
 - c. All reasonable alternative treatment, including risks, probable effectiveness of each and consequences if this proposed treatment is not received: ALTERNATIVE TREATMENT WOULD BE USE OF TOPICAL STEROIDS, INTRAVITREAL STEROIDS AND/ OR VITRECTOMY

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