Aravind 2013 – Postcard 7

World Sight Day 2013

World Sight Day 2013 (WSD13) this year falls on **10** second Thursday of October). After two years witho this year IAPB has decided – on popular demand – t theme idea. WSD13 Promotional material - including a blindfold ribbon, Web banners and a document ter

Thursday 10 October 2013

Today is World Sight Day

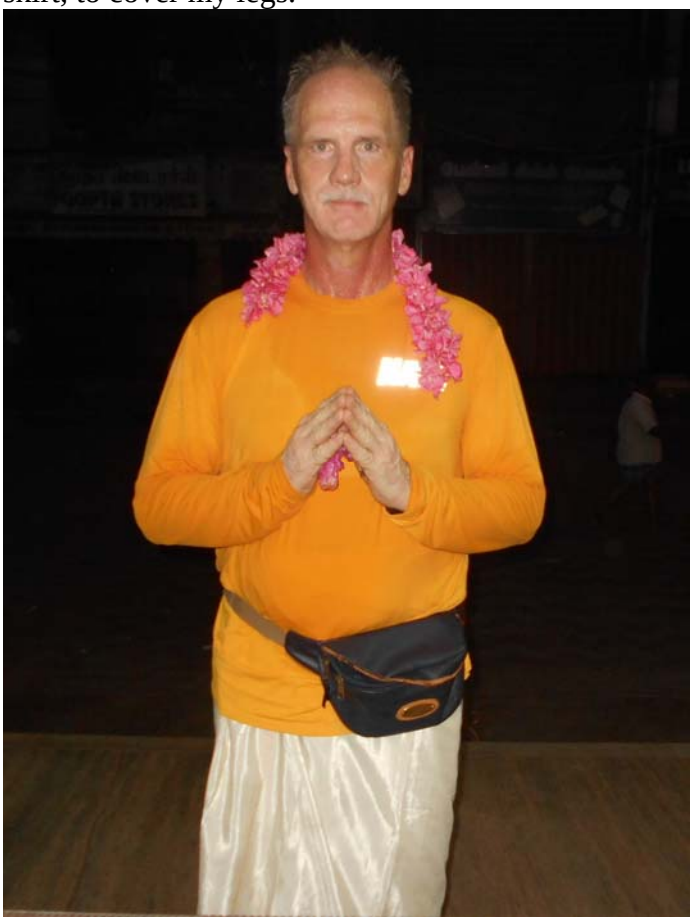
I would like to take this opportunity to thank every member of the Department of Ophthalmology and Vision Science for the work that you do to preserve the sight of those we serve. I am proud to be a part of our team, and wish that each of you could see what is done here at Aravind in our common mission.

Meenakshi Temple

The quest today was to get to Meenakshi Temple, the temple that put Madurai on the map. Meenakshi was about the only thing I knew about Madurai (other than Aravind) for the simple reason that one our nurses in PreOp at UAMC shares the name.

I had to leave while it was still dark.

On arriving at the Temple, I needed to rent Dhoti, or skirt, to cover my legs.



The temple is very busy now; a festival of several days (I believe 9) is underway. This mornings trip was just to find out where it was, and to find it by getting there on foot, wandering a little (it was dark, and while I had studied a map, I had not brought it along). The early risers were more than happy to help me find my way, and the coffee is great.

This was not a 3-Roses stand, but what was interesting was that instead of propane, charcoal was used to head the milk and coffee water.

I could not figure out how to take pictures of the inside of the temple (you can't take your camera in, unless you have a token that you by inside the temple.) Catch 22.

Patients

My first three patients are doing well. All are 20/40 or better at this point, uncorrected. Small Incision Cataract Surgery is not as easy as it sounds, even when you take this rule into account. My fourth patient did well, but it was because an IOL fellow came to his rescue.

Mr. N was a patient from the Free Hospital, who was operated on at the Paying hospital. The reason is the microscope is much better at the paying hospital. There are good reasons for the residents and fellows to train on the OPMI 1-FC, the primary being simplicity and familiarity. There is no foot pedal to fuss with, and it is the equipment that graduates will have access to when they graduate. I am used to the finest microscope we can arrange, with a stereo side scope for the assistant or instructor. Dr. Haripriya allowed Dr. Suganya, my instructor, to bring my patient to use her scope after she was done with her cases. Dr. Suganya was detained, and so Dr Haripriya (one of the finest cataract surgeons in the world; she was one of the four surgeons that demonstrated cataract surgery live at AAO in Chicago recently) simply said to go ahead. The boss was watching. Residents, this is called instant empathy. I constructed my wound, Dr. Haripriya completed the side pockets (I am still not aggressive enough in my dissection), and then was relieved by Dr. Suganya.

The death of a thousand cuts

The cloudy portion of the lens that is removed during cataract surgery is surrounded by a capsule.

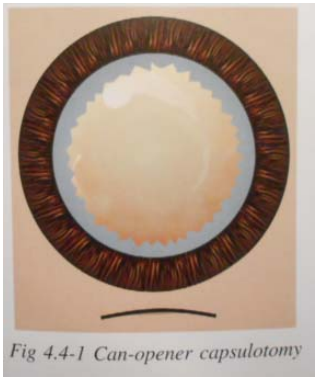


Fig 4.4-1 Can-opener capsulotomy


Fig. 4.4-4 Ripping technique

The can-opener method is what I learned as a resident, I am struggling to master the "continuous curvilinear capsulorrhexis", (CCC) the surgical advance, that when combined with the incision, is what makes SICS a great procedure. I had three weak points in my CCC. The tear started to extend, and three times my senior had to use scissors to redirect. If the circular opening is not large enough, the surgery fails. It is so large that it feels like walking on a curb instead of a sidewalk; not a tightrope but very little room for a misstep.

So fundamental error was the weak rhexis.

The second error is something I would like to share with the residents- you hear all the time it is not one thing, but a compound series of events that make things go south. As attendings it is our job to see these things before they happen. As residents it is your job to attend to the task at hand, and develop an awareness over time of the other situations that occur in surgery. In this instance, after delivering the nucleus the chamber

shallowed. I noted it and commented on it, but did not work through the reason for the shallowing. There was no change in the red reflex to speak of, and it did not feel like the abrubt change that comes with a choroidal hemorrhage. I thought perhaps I was lifting the wound too much with the Simcoe and that was why the AC shallowed.

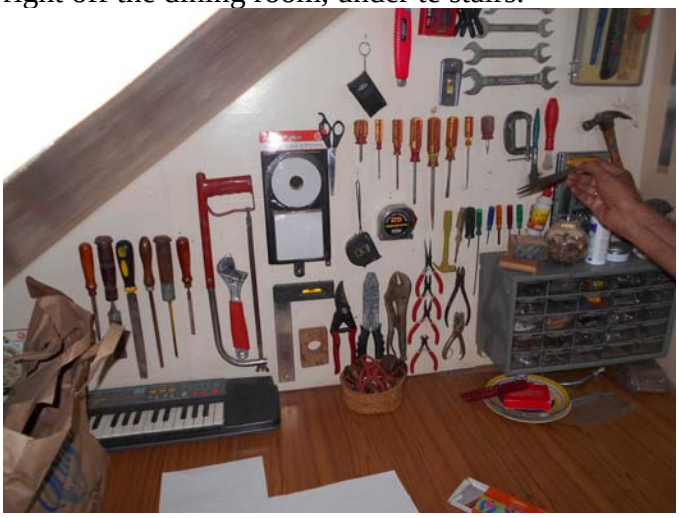
Two weak spots at 4 and 8 tore; a linear tear that did not result in vitreous. It happened slowly enough you could follow it. My resident mentor and I called for help, and an IOL fellow came. Most of the cleanup was complete at that point. We traded seats and he proceeded to evaluate; commented on the shallow AC. At that point I was away from the scope and saw the cause of the positive vitreous pressure – the lid speculum had slipped, collapsed, and was squeezing the globe near the equator (the patient had very shallow orbits).

The learning point that I failed to follow- and that each of you should try and remember – is that when you notice a problem = STOP AND FIND OUT WHY THERE IS A PROBLEM AND ADDRESS IT! If I had stopped and looked to the side of the field, and not just through the scope, I might have seen this problem and prveneted the tear.

A lens was skillfully placed by the Fellow, and the pupil came down nicely. I think that the patient will do well, but, once again, I am so grateful to be learning this procedure here at the place that does it so well, and in the hands of surgeons who recognize and treat the complications that arise in a training environment.

INTERVIEW WITH THULSI

Thulsi (Thulsi Ravilla) is the "Dan Perin" of Aravind. He likes to fix things and it shows- when visiting his home, I found that he must be good at what he does int this capacity- Chitra, his wife, tolerates a workbench right off the dining room, under te stairs.



Thulsi has an MBA who is a quantitative guy. I asked him if the MBA is the tool that will do the most good for large organizations. He became thoughtful, and then said that he thought the MBA model is probably not right for health care, in that it teaches the method of exploitation- find the opportunity and work to win. What is going on at Aravind is different – it is an organization that strives for management and a desire to optimize a function- but that optimization function is to optimize social good.

I wish that I could tell you more, but I am late already and can only say

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http://www.amazon.com/Infinite-Vision-Greatest-Business-Compassion/dp/1605099791

Sorry I'm late. I showed up sweating yesterday because I ran. My resident asked if I was OK. She doesn't know me yet. I said, "Well, I'm sweating, my fingers are tingling, I'm short of breath, and an elephant has sat on my chest… just kidding". She had the look that ophthalmologists get when they are out of their comfort zone. We all need to get there once in a while!

Regards,
Joe

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