Pre-operative testing for cataract removal: Don’t let cardiac risk prevent fall prevention

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Story from the Front Lines:

A 74 year old man with multiple medical co-morbidities including CAD and prior MI, falls, hypertension, type 2 diabetes, cataracts, and ESRD presented to clinic requesting a referral for cataract removal. He expressed concern about falling due to his poor vision, and after repeated requests to his nursing home physician he was referred to a community ophthalmologist for evaluation for cataract surgery. At the time of referral the patient proudly reported self-discontinuing all medications – he simply didn’t want to take them - except for nightly long-acting insulin. He reported otherwise feeling perfectly well, denying any chest pain or shortness of breath at rest or with exertion.

His ophthalmologist felt uncomfortable performing cataract removal due to perceived excess risk of a cardiac event. The patient was referred to a cardiologist and advised he would need a stress test prior to cataract surgery. Upon seeing the cardiologist the patient refused the test. The ophthalmologist declined performing the procedure and the patient followed up with his primary physician to again pursue cataract removal.

Teachable Moment:

It is understandable to desire certainty and reassurance prior to performing an elective surgical intervention. Our patient was at risk for coronary events, and it is natural to desire optimization of this risk prior to operating. However, high-quality evidence and the guidelines for pre-operative testing indicate that this is not helpful. No professional society recommends cardiac evaluation prior to cataract surgery. Furthermore, the patient himself was unwilling to consent to stress testing or take risk-lowering medications. On the other hand, he took appropriate steps to mitigate fall risk by using assistive devices and seeking care for his vision impairments.

All of the cardiac testing in the world would be unlikely to change the outcome of cataract removal for this gentleman. He was able to delineate the risks and benefits of an invasive procedure in the setting of his known cardiac risk. A patient-centered approach, clearly documenting his understanding of these risks should allay our fears about performing this procedure, even if optimal coronary status was warranted for his safety.

Alas, it was not. Per 2007 ACC/AHA guidelines “there is evidence and general agreement that exercise or pharmacological stress testing prior to non-cardiac surgery is not useful for evaluation of patients scheduled to undergo low-risk non-cardiac surgery.” There is evidence from a large RCT with broad inclusion criteria published in NEJM in 2000 demonstrating no safety benefit from pre-operative CBC, electrolytes, and EKG, let alone stress testing. Lastly, we know from the CARP trial that even for high-risk vascular surgeries, pre-operative coronary
revascularization for patients with stable CAD does not significantly alter cardiovascular outcomes.

In conclusion, our patients preferences were not adequately considered and were trumped by a common practice that persists in spite of high quality evidence showing that routine testing before cataract surgery is not helpful. Indeed, he may have experienced harm had he undergone a stress test or fallen again before he could proceed with cataract removal. A review from JAMA in 2012 indicated lower risk of hip fracture within 1 year after surgery compared with those who had not undergone cataract surgery. After a long discussion with the patient, he agreed to resume low-dose aspirin therapy and was seen in our ophthalmology clinic 1 month later to arrange his cataract repair.

References:


