Point of No Return: To Remove a Seeing Eye

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INTRODUCTION

Enucleation and evisceration are surgeries to remove an eye when all other treatment options have failed or are not possible. The most common indications for removal of an eye are infection, a painful non-light perceiving eye, trauma, and malignancy.[1]

Eyes with visual potential are not ideal candidates. The decision to enucleate or eviscerate can be difficult in light-perceiving eyes with treatment-resistant pain, particularly in patients with an already guarded visual prognosis.[2] It is imperative to consider the acuity of the condition, psychosocial influences, and both visual and non-visual prognoses when discussing these surgeries with patients.[3]

CASE PRESENTATION

Mr. Smith is a 40-year-old Male with Past Ocular History of oculofacial injury via bicycle accident (1998) S/P Frontalis Sling with autologous Fascia Lata graft OS (1999), Lagophthalmos OS S/P Lateral Tarsorrhaphy (2016) with subsequent release (2017), Exposure Keratopathy with Corneal Thinning OS, and Recurrent Corneal Ulcers OS who presented to clinic with complaints of 1 week of pain and redness OS. He had frequently painful flare-ups for several years' duration and scheduled the appointment with hopes to have OS removed.

CASE PRESENTATION (CONT'D)

	OD	OS
L/L	Normal	**S/P tarsorrhaphy with release. 3 mm lagophthalmos. 1+ mucoid discharge.**
C/S	W&Q	1+ Injection
K	Clear	**Inferior stromal scarring with corneal neovascularization and iris/cornea touch. Dense central scarring with epithelial defect. Scattered superficial punctate keratopathy. 360-degree pannus.**
A/C	D&Q	**2+ Cell**
Iris	Round and Reactive	**Inferior iridodialysis. Iris with synechiae to defect.**
Lens	1+ NS	1+ Nuclear sclerosis. Anterior capsule pigment dusting.
Vit	Clear	Clear

Table 1: Anterior Segment Exam. Abnormal findings OS.

VAs were 20/20 and 20/600 PHNI. Anterior segment exam described in **Table 1**. Posterior segment exam was unremarkable. He was diagnosed with Iritis secondary to Exposure Keratopathy and sent home with Pred Forte QID OS x 14 days and Cyclopentolate BID OS x 14 days. Protective polycarbonate lenses were recommended. The patient repeatedly voiced his wishes to proceed with surgical removal OS.

Mr. Smith returned to clinic 3 weeks later. He had been incarcerated in the interim. Exam appeared stable with improvement of acute inflammatory changes (**Figure 1A and 1B**). He wished to pursue alternative options to enucleation or evisceration, as he understood he has useable vision OS.

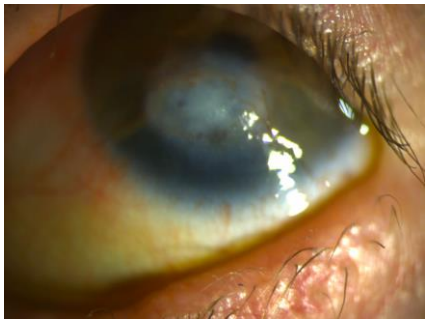

Figure 1A: Slit Lamp Photo OS. Dense corneal scarring.

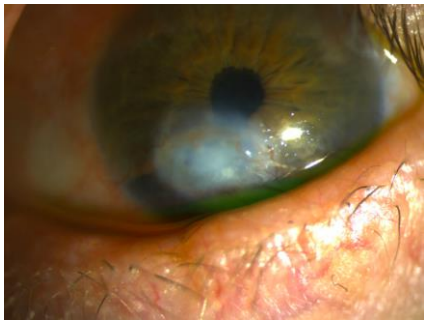

Figure 1B: Slit Lamp Photo OS. Clear view of corneal neovascularization.

DISCUSSION

This case highlights the importance of extensive discussion with patients regarding removal of a seeing eye. The patient was treated with conservative measures, ultimately changing his mind regarding surgery. In an acutely painful eye, patients may be willing to utilize extreme therapies to obtain relief.

It is imperative to exhaust all treatment options prior to proceeding with an irreversible surgery. Impromptu decision-making to please patients in the present may have lasting effects that are not in their best interest.[4]

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