



Closed Claim Study

Orbit Compartment Syndrome Leads to Poor Outcome Following Blepharoplasty

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ALLEGATION

Failure to monitor and treat bleeding following an upper lid blepharoplasty, resulting in complete vision loss OS.

DISPOSITION

Claim was settled prior to litigation.

Case Summary

A male patient in his late forties presented to an OMIC insured with a complaint of eyelid swelling after a minor injury. The patient was refracted to 20/20 OU, and a visual field test was performed, taped and un-taped, revealing severe superior defects, which were completely relieved by taping up the eyelid skin. This confirmed the ophthalmologist's impression of severe dermatochalasis and the need for a non-cosmetic upper lid blepharoplasty. Prior to surgery, a platelet function test revealed abnormal EPI and ADP platelet function. The surgical procedure was unremarkable, but the patient needed treatment with several medications for elevated blood pressure in the post-anesthesia recovery room. An hour-and-a-half after surgery, the nurse notified the physician of ongoing bleeding and swelling. Detained in surgery, the ophthalmologist instructed the nurse to apply iced saline gauze and pressure dressings, which stopped the bleeding. Ninety minutes later, the insured examined the patient, found moderate lid edema and chemosis OS, and ordered an orbital CT scan. Three hours later, he reviewed the CT report of a hematoma on STS lateral to the globe with medial and some inferior displacement of the globe but no compression or displacement of the optic nerve. The patient's left orbit was extremely tense with proptosis. Seven hours after he was first notified of the bleeding, the insured performed a left lateral canthotomy and lysis of the inferior crux of the lateral canthal tendon in the operating room, and transferred the patient to a hospital. While the edema had decreased by the following day, the patient's vision was LP to NLP and never improved.

Analysis

When the insured ophthalmologist reported the claim, OMIC asked two oculoplastic experts to review it in light of the severity of the injury. The first expert felt that even though the patient had undergone previous surgical procedures without excessive bleeding, the abnormal platelet functions warranted a

consultation with a hematologist before proceeding with the blepharoplasty. Both experts raised concerns about the postoperative management of the patient. While the insured's decision not to perform bedside canthotomy and cantholysis when he first saw the patient in the recovery room was acceptable, his failure to closely monitor the patient over the next four to six hours fell below the standard of care. He was faulted for not adequately instructing the nurses on which symptoms to monitor and report to him. Noting that the insured was concerned enough to order a CT, the experts criticized the two-hour delay in reviewing it. Finally, when the insured examined the patient for a second time after surgery, he did not take immediate action to reduce the orbital pressure, such as a bedside canthotomy and cantholysis. Both experts felt that the insured's failure to recognize and treat an evolving orbit compartment syndrome led to the patient's poor outcome. Notified of the review, the insured ophthalmologist agreed to settle the claim within his policy limits and avoid the expense and risk of a trial.

Risk Management Principles

Hemorrhage during or following blepharoplasty is a significant vision-threatening risk that warrants prudent preoperative planning and postoperative management. Ophthalmologists should carefully evaluate any aspect of the patient's condition that increases a particular risk (e.g., hypertension and bleeding disorders), obtain preoperative clearance from the appropriate specialist, and disclose the added risk to the patient during the informed consent discussion. When patients develop a complication, all members of the health care team (and family members if appropriate) should be advised of what to watch for and when and how to notify the surgeon. To avoid allegations of failure to diagnose, ophthalmologists should use the WIT-D approach.¹ "W," the worst case scenario, is helpful in establishing a prioritized differential diagnosis (here, compartment syndrome); "I" represents the information needed to rule the diagnosis in or out; "T" stands for telling interested parties so they can help monitor the patient; and "D" is, of course, for documentation.

1. Carolyn Buppert, "A Witty (WIT-D) Approach to Avoiding Mistakes," *Gold Sheet* 4(6), 2002, www.medscape.com/viewarticle/438381.