SightLine Laser Eye Center

PRK POST-PROCEDURE GUIDELINES

VISIT	VISION	MEDS	FINDINGS	COMMENTS
DAY 1	VARIES	➢ TOPICAL ANTIBIOTIC AND STEROID ➢ ORAL PAIN MED (NEURONTIN) ➢ TOPICAL ANESTHETIC	➢ EPITH. DEFECT ➢ VARIABLE PAIN ➢ CL IN PLACE ➢ POSSIBLE CORNEAL EDEMA/FOLDS ➢ WATCH FOR INFILTRATES	➢ QUIET & COMFORTABLE ➢ IF PATIENT IS IN SIGNIFICANT PAIN OR VISION IS POOR, REASSURE ➢ FREQUENT ARTIFICIAL TEARS ➢ IF PAIN IS SEVERE, TOPICAL ANESTHETIC q 2HRS
DAY 3-5	VARIES (POORER)	➢ TOPICAL ANTIBIOTIC AND STEROID ➢ ARTIFICIAL TEARS	➢ EPITH. INTACT ➢ PATIENT COMFORTABLE ➢ CL INPLACE ➢ WATCH FOR INFILTRATES	➢ REMOVE CL IF EPITH. INTACT ➢ CONTINUE CL IF EPITH. DEFECT PRESENT ➢ D/C ANTIBIOTIC WHEN EPITH. INTACT ➢ VISION MAY BE WORSE AFTER CL REMOVAL. REASSURE PATIENT
WEEK 1	20/40 TO 20/20 EXPECT 20/30 CORRECTED	➢ STEROID QID & TAPER OVER 4-8 WKS DEPENDING ON TX AND OUTCOME	➢ EPITH. INTACT BUT MAY BE IRREGULAR ➢ EYE QUIET ➢ CHECK IOP	➢ IF > +2.00 D/C STEROID ➢ IF > +1.00 DECREASE STEROID TO BID AND MONITOR CLOSELY (Q 1-2 WEEKS) ➢ IF –0.50 TO +1.00 CONTINUE STEROID QID ➢ IF > -0.50 CHANGE STEROID TO *PRED FORTE* QID AND MONITOR Q 1-2 WEEKS ➢ IF INCREASED IOP CONSIDER TREATING W/ ANTI-GLAUCOMA MEDS
WEEK 3-4	20/40 TO 20/20 EXPECT 20/25 CORRECTED	➢ STEROID	➢ EYE QUIET ➢ CHECK IOP ➢ WATCH FOR HAZE (FAINT HAZE IS NORMAL)	➢ INCREASE OR DECREASE STEROID BASED ON REFRACTION & HAZE ➢ TAPER STEROIDS ➢ TREAT INCREASED IOP IF NEEDED
MONTH 2-3	20/40 TO 20/20 EXPECT 20/20 CORRECTED	➢ POSSIBLE STEROID	➢ VISION STABILIZING ➢ EYE QUIET ➢ WATCH FOR HAZE AND REGRESSION	➢ IF HAZE IS PRESENT: ➢ TRACE TO MILD: NORMAL ➢ MODERATE: CONTINUE LOW DOSE STEROID ➢ SEVERE: INCREASE STEROID (PRED FORTE QID) ➢ IF REGRESSION, INCREASE STEROID & TAPER SLOWLY
MONTH 6	20/40 TO 20/20	➢ NONE	➢ QUIET & CLEAR CORNEA ➢ WATCH FOR LATE HAZE & REGRESSION ➢ CHECK IOP	➢ SAME AS THREE MONTH ➢ CONSIDER ENHANCEMENT IF CLEAR CORNEA & RESIDUAL CORRECTION. CYCLOPLEGIC REFRACTION REQUIRED PRIOR TO ENHANCEMENT ➢ REFRACTION USUALLY STABLE

PLEASE NOTIFY SIGHTLINE IF THERE IS ANY DEVIATION FROM NORMAL POST-PROCEDURE FINDINGS.

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MANAGEMENT OF THE PRK PATIENT

Patients have PRK because they either choose this procedure or because LASIK was not an option for them. PRK has a slower vision and comfort recovery even though the eventual outcome is as good or better than LASIK. It is therefore important to prepare the patient adequately prior to the procedure and to continue to reassure them afterwards. Also, doctors need to be reminded about how to manage the PRK patient because there are fewer of these than LASIK patients.

Initially, we tell each patient that there will be a period of discomfort the first few days following the procedure. We are currently managing this with the oral pain mediator, Neurontin, and a diluted version of topical anesthetic. The Neurontin (300 mg capsules) is taken three times daily for four days. The proparacaine .125% may be used in the first 48 hours if needed for pain relief. Only a small amount of this medication is given to the patient and they do not receive any additional amount if they run out of that supply.

With regards to vision recovery, expectations should be set up prior to surgery. Overall visual satisfaction following PRK is actually greater than LASIK once the healing is complete. We can expect that the vision will initially be variable. It will get worse once the epithelium comes together at the suture line centrally. When it appears that there is no defect, the bandage contact lens is removed (this is usually at day 3-5). When the lens is removed, there is a mild decrease in vision for a day or two, and then it will gradually continue to improve as the cornea continues to heal and the epithelium thickens and smoothes. The antibiotic may be discontinued as soon as there is no epithelial defect present. At the one week visit the patient is usually 20/30 or better, but can be worse. This is the time where we need to think about adjusting their dosage of steroid medication.

The steroid is typically tapered over a period of 4-8 weeks based on the amount of treatment and the post-operative refraction. The dosage of the steroid is adjusted based on 1)corneal haze and 2)refractive outcome. If a myopic refractive treatment was performed and the refractive error at one week is greater than 2D of hyperopia, the steroid may be discontinued completely to allow the cornea to regress and heal on its own. If after a myopic treatment the refractive error is between 1.00-2.00 D of hyperopia, the steroid may be decreased to BID. If it is between -0.50 to +1.00 D, you may continue the steroid at QID and watch the patient's refractive error closely over the next 1-2 weeks and taper accordingly. If the patient is more than 0.50 D myopic, it is best to continue the steroid QID and even consider changing to Pred Forte 1% QID and monitor closely. In summary, stronger steroid dosing is used when the patient is more myopic and weaker steroid use is indicated when on the hyperopic side for a myopic-treated patient. *This is opposite for hyperopic treatments (ie: stronger steroid dosing is used when treatment on a hyperope is still on the hyperopic side and the steroid is decreased when on the myopic side).* Keep in mind that anti-glaucoma meds may be used at any time if you feel that your patient is a steroid responder.

With regards to corneal haze, we should keep in mind that mild haze is normal when present during the first few months and should eventually go away. In the rare event of significant corneal haze, consider increasing the steroid doseage and monitor. ***Be sure to warn patients to wear sunglasses and avoid extreme sun exposure during the first post-operative year as there is a direct link between UV exposure and increased corneal haze following surface ablation.***

In summary, setting the patient's expectations early and continuing to reassure your PRK patients will help make them more content as they await the final results. As always, please feel free to contact us at Sightline if you have any further questions or concerns.