# Comments on: All India Ophthalmological Society (AIOS) Task Force guidelines to prevent intraocular infections and cluster outbreaks after cataract surgery

We acknowledge the wide variation of Indian ophthalmic surgical settings and applaud the All India Ophthalmological Society (AIOS) task force's efforts to reduce endophthalmitis. However, because well-intentioned opinions are subject to bias, scientific study is necessary to determine if individual measures can lower the rate of a rare complication. Our multi-society task force has previously published ophthalmology-specific guidelines for instrument processing and sterilization and is evaluating a variety of surgical practices that are potentially unnecessary and wasteful.[1] We are concerned that many of the AIOS guidelines lack scientific evidence and, in some instances, contradict guidelines from our own task force and the American Academy of Ophthalmology (AAO).[1,2] These include guidelines regarding (1) surgeon and operating room features: limiting the number of cases to 25 eyes per surgeon in a four-hour session, maximizing the use of disposables, mandating sterilized gowns and gloves for every case, leaving intracameral antibiotics to the discretion of the surgeon, (2) patient features: avoiding surgery if multiple systemic problems, fasting blood sugar of ≥140 mg/dL, random blood sugar of ≥200/mg/dL, and blood pressure of ≥160/95 mmHg.

A retrospective clinical registry study of two million cataract surgeries at India's Aravind Eye Care System reported an identical 0.04% endophthalmitis rate to that from the United States IRIS registry, despite an impressively high volume of procedures per surgeon per hour.[3] A prospective Aravind study found that changing gowns and gloves, disinfecting surgical floors, gowning patients, and operating on multiple patients simultaneously in the same operating room did not impact the endophthalmitis rate.[4]

Because failure to strictly adhere to rigid guidelines can create medical liability when a blinding complication occurs, they must be backed by strong scientific evidence. Absent this, surgical facilities should be afforded the discretion to independently develop protocols based on the best available evidence while monitoring outcomes. In our opinion, many of the opinions and recommendations presented in the AIOS document appear to lack the scientific evidence or justification to be requirements.

The AIOS should not overlook the robust evidence from Indian and US institutions for safe, efficient, cost-effective, and sustainable care. The economic and environmental cost of surgical waste and unproven practices will ultimately constrain our ability to provide sight-restoring surgery to all those in need.[5] We suggest that the AIOS reframe and revise many of these empirical guidelines as considerations rather than requirements.

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**Conflicts of interest**

There are no conflicts of interest.

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## References

1. Chang DF, Mamalis N. Guidelines for the cleaning and sterilization of intraocular surgical instruments. J Cataract Refract Surg 2018;44;765-73.
2. Miller KM, Oetting TA, Tweeten JP, Carter K, Lee BS, Lin S, *et al*; American Academy of Ophthalmology Preferred Practice Pattern Cataract/Anterior Segment Panel. Cataract in the adult eye preferred practice pattern. Ophthalmology 2022;129:P1-126.
3. Haripriya A, Chang DF, Ravindran RD. Endophthalmitis reduction with intracameral moxifloxacin in eyes with and without surgical complications: Results from two-million consecutive cataract surgeries. J Cataract Refract Surg 2019;45;1226-33.
4. Haripriya A, Ravindran RD, Robin AL, Shukla AG, Chang DF. Changing operating room practices: The effect on postoperative endophthalmitis rates following cataract surgery. Brit J Ophthalmol 2022:bjophthalmol-2021-320506. doi: 10.1136/bjophthalmol-2021-320506.
5. Chang DF. Needless waste and the sustainability of cataract surgery. Editorial. Ophthalmology 2020;127:1600-2.



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