Eye Doctors OF WASHINGTON

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Informed Consent for Phototherapeutic Keratectomy with the Excimer Laser

This information is being provided to me so that I can make an informed decision about having phototherapeutic keratectomy (PTK). This procedure with the excimer laser has been recommended because I have a corneal scar, opacity or irregularity, and/or because I have recurrent erosion syndrome, a disorder which causes episodes of pain in my eye.

Nature of the Procedure

In phototherapeutic keratectomy (PTK) the laser is used to remove tissue from the surface of the cornea (the clear front surface of the eye). This procedure smoothes the corneal surface and removed superficial opacities and irregularities of the cornea.

Expected Benefits

I understand that the possible benefits of PTK are an improvement of vision and/or an alleviation of pain and avoidance of complications of alternative treatment. However, I understand that the results in my case cannot be guaranteed.

Alternative Treatments

For the improvement of my vision, I understand that the alternative to PTK is keratectomy performed with a knife or an electrical burr. This technique involves removal of the surface of the cornea. The main disadvantage of this procedure is that it leaves a rough corneal surface. Another alternative treatment to improve my vision is corneal transplantation (full thickness or partial thickness) which carries the risk of rejection and infection in the eye.

If I have recurrent episodes of pain in my eye, alternative treatments may include micropuncture of the surface of the eye, a bandage contact lens, hypertonic saline ointment, or corneal scraping.

Like all surgical procedures, PTK has risks. I understand the following are possible complications of the laser treatment: pain or irritation, cloudiness of the cornea, infection of the eye, ulceration of the cornea, excessive thinning of the cornea due to tissue removal, decreased vision, inability to wear contact lenses, persistent epithelial defect, and glare or halos around lights. It is possible that the laser treatment itself could cause scarring or irregularity in my cornea, with impairment of my vision.

Please initial after reading: _____

I understand that an additional drug called Mitomycin C may be placed on my cornea during the procedure. The use of this drug is not approved by the FDA; however, it is commonly used by ophthalmic surgeons for this condition. Mitomycin C has been demonstrated in the medical literature to reduce the risk of recurrent cornea scarring. Mitomycin C does have risks including corneal melt (thinning), cornea perforation, and inability for the corneal epithelium to heal. Other less common risks are also possible.

I understand the procedure is not intended to decrease the dependency on glasses or contact lenses, and that there may be some permanent change in the refractive power of the eye, which could require a change in my spectacle prescription or the wearing of a contact lens to achieve optimal vision.

I understand that, even if the laser treatment is initially successful, the condition which caused my problem may recur. I understand that, if I have had episodes of herpes virus infections in my eye in the past, the laser treatment may increase my risk of having a reactivation of the infection.

I understand that this list does not include every possible complication that may occur as a result of this procedure. I also understand that the long term effects of the laser are not known.

I understand that I will be sedated and agree not to drive a car until the next day after the procedure.

In signing this consent form for Phototherapeutic Keratectomy, I am stating that I have read this informed consent (or it has been read to me) and I fully understand it and the nature, purpose and possible complications of this laser procedure and use of medications such as Mitomycin C. Furthermore, I have had all my questions answered to my satisfaction.

I give permission to Dr. _____ to treat my _____eye.

PATIENT NAME (Please print)	**DATE**
PATIENT'S SIGNATURE	**DATE**
PHYSICIAN'S SIGNATURE	**DATE**
WITNESS' SIGNATURE	**DATE**