LASIK Post-Procedure Doctor Guidelines

Day 1: Confirm that the flap is properly aligned, there is no infection or inflammation, confirm good vision, and re-assure the patient.
Baseline uncorrected vision will depend on the pre-operative Myopia or Hyperopia, usually better than 20/40 but blurry. A baseline Retinoscopy/auto refraction is usually easier to get than a Manifest Refraction. Some overcorrection (amount depends on the initial prescription and the patient's age) is ideal to allow for regression. Reassure your patient accordingly, the refraction will fluctuate and change over the next few weeks/months.

Assess the corneal flap position and clarity. A dislodged corneal flap is associated with corneal striae (which is best observed in retroillumination) and must be referred back immediately. It is important to note that the epithelial defects and dislodged flaps carry an increased risk of epithelial in-growth and these patients should be followed more closely during the first month.

Subconjunctival hemorrhages are common and patients should be reassured. Interface opacities (debris/fibers) are occasionally observed despite irrigation of the interface intra-operatively and do not have any clinical significance. Patients should be carefully checked for Diffuse Lamellar Keratitis (DLK), which can occur on day 1 with no pain, redness, or decreased vision. Post operative eyes are often dry. Encourage frequent lubrication.

Pain is uncommon unless an epithelial defect occurs or the corneal flap has been displaced. Epithelial defects along the corneal flap margins are related to poor patient epithelial adherence and heal within 24-48 hours. DO NOT pressure patch but the eyelid can be taped shut for 24 hours, if painful.

Day 5-7: Confirm there is no sign of infection or inflammation and re-assure the patient.
A thorough Biomicroscopy exam is required to search for infiltrates, and/or any sign of infection or increased inflammation. If any infection is suspected, the patient should return to the SEI Center for culture and fortified medications. Although infections are rare, aggressive medical treatment is needed. If you have any questions about infectious or inflammatory post operative conditions, please contact SEI at (800) 551-7347.

If a refractive error is observed, the patient may be fit with disposable contact lens at week one, pending enhancement after 3+ months. As noted above, overcorrection is ideal as regression is still expected over 1-3 months. Patients may resume full activities including swimming and wearing makeup after the first week.

Month 1: Confirm that vision is progressing normally, there is no inflammation or in-growth, and re-assure the patient.
Best corrected visual acuity is usually restored. Epithelial in-growth may develop within the first month. Pearls or nests of epithelium are visible along the corneal flap margin and may sometimes appear as an advancing line and may be white or gray in color. Erosion or rolling of the corneal flap edges may result. Monitor weekly until epithelial in-growth appears stable (usually week 4-6). Patients with epithelial in-growth should be referred back immediately for interface cleaning if; a) in-growth rapidly growing or >2 mm; b) in-growth affects vision; or c) in-growth affects flap integrity.

Month 3: Confirm the uncorrected visual acuity and perform manifest refraction for best corrected visual acuity. If needed, consider enhancement if refractive error has been stable. (Please fax to the SEI Affiliate fax line)
Enhancements are performed ideally after 3+ months for Myopic patients, and 6 + months for Hyperopic patients. The Corneal flap can often be lifted easily for up to 6 months. If lifting is not possible or recommended, a PRK enhancement may be considered. Excellent stability is typically achieved after 4+ months.

Enhancements are performed after the cornea has adequately healed, but early enough to enable the corneal flap to be raised. By 4-6 months, the need for an enhancement is typically determined and may be scheduled. So that the benefits of the procedure outweigh the risks, criteria for an enhancement are UCVA 20/40 or worse and refractive error of $\geq$ -1.00 D.

Months 6 & 12: Confirm vision is stable, perform normal eye health testing.
Night glare is usually dissipated. The patient's best corrected visual acuity is usually restored by 1 year. A faint white line along the corneal flap edge is a normal late clinical finding.

Enhancement: Consider enhancement only if there is adequate Stromal tissue available. Enhancements are performed after 3+ months. If there are any questions regarding a patient's eligibility for enhancement, please contact SEI's Refractive Coordinator at (866) 399-1790.