

Post-trichiasis Surgery Follow-up: Experiences and Lessons Learned

Session Date:	Saturday, November 4
Session Time:	9:00am – 12:00pm
Session Location:	Loch Raven I
Session Description:	Discuss the global recommendations for TT surgery follow-up, hear from those who have conducted follow-up using different strategies, including how the exercise was carried out, the results to date, and how the findings have been incorporated to strengthen trichiasis surgical programs, and end with a discussion on research needs regarding post-operative follow-up of TT patients.
Session Chairs:	Whitney Goldman, Helen Keller International Chad MacArthur, Global Health Consultant
Session Rapporteur:	Julie Kenyon

KEY DISCUSSION POINTS

Introduction & Background

The goal is to have a population free of blindness due to trachoma by reducing the burden of trichiasis to less than 1 case per 1000 population. Quality assurance through post-operative follow-up 3-6 months after surgery can detect and potentially resolve post-operative trichiasis (usually due to surgical failure) and other complications: granuloma, over-correction and abnormal lid contour. Outcome assessment is patient-focused looking at clinical outcomes and ideally all patients receive follow-up. The 3-6 month follow-up also provides an opportunity to further examine and counsel those who did not receive surgery. Currently there is no literature on follow-up strategies and impact on outcomes.

Surgical audits should also be conducted during the 3-6 month post-operative period. Audits focus on the quality of surgery by individual surgeons through the examination of a subset of a surgeon's patients, and are therefore, programmatic. The findings from both outcome assessments and surgical audits should be used for decision making on patients, surgeons and the program.

Experience of Outcomes assessment in Ethiopia, Nigeria, Tanzania, Kenya, Uganda, Chad, Malawi, Mozambique, Zambia, and Cameroon

The Federal Ministry of Health (FMOH) of Ethiopia estimates there are 700,000 people with trachomatous trichiasis. The FMOH Fast Track Trichiasis Initiative has led to 88% of the target endemic districts and 79% of targeted health centers currently providing TT services. Following the WHO recommendation, post-operative follow-up is to be conducted by the operating surgeon at 1 day, 1-2 weeks and 3-6 months. It is believed that most patients are seen at 1 day and 1-2 weeks but evidence indicates a severe drop off for 3-6 months. In the regions of Tigray and SNNP, of the 8,379 patients only 1,827 (21.8%) presented as requested to have their surgical outcome assessed. To counter this low rate of follow-up, it is recommended to: a) strengthen post-op counselling, b) provide patients with appointment cards, c) improve coordination to allow follow-up to be combined with outreach services, d) get better buy-in from surgeons, e) have clear guidelines on follow-up developed by the FMOH.

Nigeria has an estimated TT backlog of 222,000. With funding from the Queen Elizabeth Diamond Jubilee Trust, a fast track initiative has been established. Data from the state of Kano, indicates that

the 3-6 month follow-up only reached 45% of the people operated on. This low-turnout was despite community based strategies being implemented including working with community leaders, providing the leaders with the contact information of patients, utilizing town announcers, and enlisting case identifiers to mobilize patients to present at the given time and place. Factors that were cited as contributing to the low turnout were: a) death of some patients, b) travel or relocation, c) follow-up being conducted during farming periods, d) satisfied patients not presenting for further assessment.

In Tanzania, Kenya, Uganda, Chad, Malawi, Mozambique, and Zambia, supported by either DFID or Trust, programs also found a sharp drop off between patients presenting for the 7-14 day follow up and the one at 3-6 months. Among four countries, the turnout for 7-14 day follow-up was 77%, while only 58% were seen at 3-6 months. Similar to the experience in Nigeria, patient satisfaction was mentioned as one reason for low turnout at the 3-6 month time period. It was also found that among the four countries, active follow-up reached more people. The strategy of providing patients with incentives such as soap to present did not seem to increase turnout. Challenges of follow-up included: not all programs did the 1st day follow up, nor the 7-10 day follow up and when post-operative trichiasis was reported there was little evidence on how it was managed. Also, there are inconsistent reports on the follow-up of epilating patients that chose not to receive surgery; and the question was raised of whether more needs to be done on their behalf. As with Nigeria and Ethiopia, the outcome assessments showed a very high level of good outcomes ranging from 89.4%-100% in the four countries supported by DFID and Trust; 70-94% as reported in Kano, Nigeria and 99.3% as seen in the Ethiopia presentation. The question posed by all the presenters were how much these figures could be trusted and if there will be a bias if the operating surgeon is the one assessing and reporting on surgical complications, including post-operative TT.

Cameroon has a low burden of TT (4,000) confined to the three northern regions. Case finding is difficult and surgical productivity is low. Cameroon, in the past, has conducted follow-up on a subset of patients similar to how a surgical audit is conducted, though done by the operating surgeon. Due to the low numbers needing to be followed-up and to the fact that follow-up was conducted by going to the homes of the patients, 86% of the targeted patients (218/343 in four districts) were assessed for surgical outcomes. Cameroon, however, will move to targeting 100% of patients operated on but will need to shift to asking patients to come to a central site rather than the more pro-active strategy of visiting patients' homes.

KNOWLEDGE GAPS IDENTIFIED

1. Is the WHO 2010 target $\leq 10\%$ PTT at 1 year an achievable target for success? Could it be lower; should it be higher? Is 1 year the best time for this benchmark, as programs don't usually see patients at this time point?
2. How do we assess outcomes in the most effective manner and who should conduct outcome assessments and audits? What new approaches can be introduced? Who should be prioritized for audit?
3. Can immediate post-operative photos help predict who is most at risk of PTT?
 - a. What strategies can improve follow up for all patients- including those who have opted out of surgery and are epilating?
4. How will strategies for outcome assessment/surgical audit approaches evolve in increasingly lower burden districts?
5. Management of children with TT: Are we following them properly after surgery? Should 100% of children be followed?
6. How are referrals for PTT and other complications managed when seen at 3-6 months?
7. What management is needed for lid contour abnormalities? Functional vs. cosmetic issues

8. Intersection between what countries feel they can/should achieve vs. what international programs monitor
9. Patient self-assessment (including services) vs programmatic assessment at 3-6 months
 - a. Do they agree? If so, could we do assessments via phone?
 - b. Is there training for patients? Do the patients understand what is being asked of them to report?
10. Various methods to achieve objective of quality surgery with quality outcomes.
 - a. If patients don't return because of good outcomes, do we need high follow-up rates?
 - b. Should we collect severity information at baseline to be able to prioritize who needs follow up and to provide information for adjusting expectations for PTT and eyelid contour abnormality rates?
11. Literature review of level of follow up achieved after any surgery and what the outcomes are of those (also looking at patient comprehension of medical suggestions).
12. Understanding who comes back for follow up and who does not (must be done in several countries to make it generalizable) and why
13. Comparison of follow-up approaches (house to house, central location, phone calls). How does this change based on surgical volume and context in which surgery is provided?
 - a. Approaches to monitor outcomes (phone calls, photos, HEAD START (all compared to in person follow up))
 - b. Framework for follow up in the context of varying stages of program evolution.
14. Tools for monitoring and assessing all relevant outcomes (no programmatic system in place)
 - a. Using smart phones
15. Operationalize what is a good outcome
 - a. Necessary scenarios for developing OR
 - i. What we need to do for follow up (still scaling up or need to scale up)
 - ii. Develop tools/guidelines through OR to advise national programs

RECOMMENDED NEXT STEPS

Outcomes assessment and the surgical audit should be distinguished and both should be budgeted and planned for in advance. Potential strategies to improve the number of people seen for outcome assessment (target 100% of operated people) include counselling patients about the follow-up at all touch points, scheduling a specific time and date, conduct follow-up at gathering places (mosques, markets, etc.), provide an appointment slip, and having town criers and case finders remind patients. Apps can capture patient information and keep in contact with them. The relative success of different strategies to improve follow-up numbers should be documented.

Audit findings should be used to make programmatic decisions. Findings from outcome assessment and audits should be compared.

There is a need to review the most appropriate time for TT surgery follow-up. Surgeons should receive refresher training and be encouraged to use their findings from outcome assessment and audit to improve their surgical technique. There should be support and SECU/TECU supervision provided after trainings (e.g. ICTC monitoring, Preferred practices guidelines and SOPs checklist, design National TT surgery supervision framework, etc.).