





Risk-Stratified Postoperative Follow-Up After Uncomplicated Cataract Surgery: Real-World Outcomes and Implications for Remote Care

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Background: To evaluate the clinical value of postoperative examinations at 24 hours and 30 days following uncomplicated phacoemulsification, and to identify subgroups who may safely benefit from remote or simplified follow-up pathways.

Methods: A retrospective observational study was conducted, including all patients who underwent uncomplicated phacoemulsification at a high-volume tertiary public hospital during September 2024. Demographic data, ophthalmologic history, surgical characteristics, day-1 and day-30 findings, visual outcomes, and emergency visits were extracted from electronic medical records. Postoperative complications associations were evaluated using bivariate tests and multivariate binomial logistic regression.

Results: Of 296 patients, the most common 24-hour complication was transient intraocular pressure elevation (13.2%). Overall, 20.9% showed a postoperative finding on day 1, and 14.2% required unplanned reassessment. At 30 days, complications occurred in 6.7% of cases, mainly cystoid macular edema (3.6%). In multivariate analysis, 24-hour complications ($P=0.028$) and ophthalmologic comorbidities ($P=0.010$) independently predicted 30-day complications. Patients without ophthalmologic history, without 24-hour complications, and with early visual improvement had a markedly lower risk of adverse outcomes. Applying a risk-based follow-up strategy could reduce approximately 50% of routine 30-day in-person reviews and relieve up to 300 hours of annual clinical workload.

Conclusion: This risk-stratified postoperative model may improve service efficiency in high-volume public hospitals, support the sustainability of ophthalmic care, and may be transferable to other public health systems. Low-risk patients could be safely monitored remotely without compromising clinical outcomes. Prospective studies are required to confirm these findings.

Keywords: cataract, phacoemulsification, postoperative complications, follow-up, telemedicine, risk stratification

Introduction

Cataract surgery is one of the most frequently performed surgical procedures worldwide. The increasing prevalence of cataracts associated with demographic ageing has intensified the workload of ophthalmology departments, particularly in public healthcare systems such as Spain's. Advances in phacoemulsification techniques have substantially improved surgical safety, reduced recovery times, and minimized the incidence of severe postoperative complications. Nevertheless, postoperative follow-up protocols remain variable and resource demanding.^{1,2}

International clinical guidelines show considerable heterogeneity. The *American Academy of Ophthalmology (AAO)* recommends an early examination within the first 48 hours, followed by refractive evaluation during the first postoperative month.³ Conversely, the *European Society of Cataract and Refractive Surgeons (ESCRS)* and the *Royal College of Ophthalmologists (RCOphth)* consider that a mandatory in-person review at 24 hours is not always necessary in the absence of intraoperative complications and may be replaced by structured telephone calls or telemedicine-based

assessments conducted by ophthalmologists, optometrists, or trained nurses.⁴ Likewise, the second monthly follow-up visit may be performed in person or remotely and does not necessarily require the direct participation of a specialist.⁵

The growing adoption of telemedicine across multiple medical fields, together with the need to alleviate clinical burden, has stimulated interest in alternative follow-up strategies after cataract surgery.⁶ However, evidence supporting these approaches is limited, particularly in patients with pre-existing ocular disease or other risk factors, who are often excluded from clinical trials.^{7,8} Although the absence of ocular comorbidities and intraoperative complications is generally considered indicative of a low-risk profile, this definition relies mainly on expert consensus and trial exclusion criteria, with limited evidence supporting structured risk-stratified follow-up pathways.^{3,8} Real-world data from tertiary hospitals are therefore essential to determine whether a risk-stratified postoperative pathway can maintain patient safety while optimizing resource allocation.

This study evaluates the utility of 24-hour and 30-day postoperative examinations after uncomplicated phacoemulsification, identifies predictors of early and late complications, and explores whether selected patient profiles could be safely managed with remote or simplified follow-up strategies. We hypothesized that absence of ophthalmologic comorbidity, absence of 24-hour complications, and early visual improvement would identify a low-risk group in whom routine 30-day in-person review could potentially be simplified or replaced by remote follow-up.

Materials and Methods

This retrospective observational study was conducted at a tertiary public academic center in Madrid, Spain. All consecutive patients who underwent cataract surgery between 1 and 30 September 2024 were screened. Eligible cases were those in which standard phacoemulsification with intraocular lens implantation was completed without intraoperative complications. Intraoperative complications included posterior capsule rupture, vitreous loss, zonular dialysis, or other unplanned events requiring deviation from standard phacoemulsification. Combined glaucoma or retinal surgery and procedures with any intraoperative complications were excluded. Patients lacking complete postoperative evaluations at 24 hours or 30 days were also excluded.

Data were obtained from the hospital's electronic medical record system and anonymized before analysis. The study received approval from the Institutional Review Board and the Institutional Ethics Committee. The study was conducted in accordance with the Declaration of Helsinki. Extracted variables included demographic characteristics, systemic comorbidities, and relevant ophthalmologic history such as glaucoma, pseudoexfoliation, pathological myopia, age-related macular degeneration, or previous vitreoretinal or glaucoma surgery. Surgical details included the operated eye (first or second), cataract density according to the LOCS III classification, level of surgeon experience (resident or attending), and intraocular lens type and power. Standard practice at our center includes postoperative examinations at 24 hours and 30 days, along with a regimen of topical antibiotics and a tapering course of topical corticosteroids. Postoperative information included reported symptoms at 24 hours and 30 days, intraocular pressure (IOP) measurements, best corrected visual acuity before surgery and at both follow-ups, incision integrity, and documented complications. The need for unplanned reviews, emergency visits, surgical re-intervention, and the final postoperative status (discharge, continuation in routine follow-up, or referral to specialized clinics) was also recorded. Clinically significant complications were defined as those requiring a change in postoperative treatment. Early IOP elevation was defined as IOP >26 mmHg at 24 hours and late IOP elevation as IOP >21 mmHg at 30 days, based on our institutional protocols and current literature;⁹ cystoid macular edema was diagnosed based on OCT findings.

Descriptive statistics were used to summarize the dataset. Categorical variables were expressed as absolute numbers and percentages, while continuous variables were described using means and standard deviations. Associations between clinical variables and postoperative complications were evaluated using chi-square tests for categorical variables and Student's *t*-test or one-way ANOVA for continuous variables, depending on distribution normality determined by the Kolmogorov–Smirnov test. Multivariate binomial logistic regression was conducted to identify variables independently associated with 30-day complications, incorporating those clinical factors most likely to influence postoperative outcomes based on univariate results ($P < 0.05$) or strong clinical rationale. Statistical significance was set at $p < 0.05$. All statistical analyses were performed using SPSS (IBM Corp., Armonk, NY).

Results

A total of 296 patients fulfilled the inclusion criteria (Table 1). The mean age was 75.5 ± 8.3 years, and 65.8% were women. Systemic hypertension was the most prevalent comorbidity. Among male patients, 28 individuals (9.5%) were receiving treatment for prostatic disease. Regarding ophthalmologic conditions, 6.4% had glaucoma, 6.1% had pathological myopia, 3.7% had exudative age-related macular degeneration, and 3.5% presented pseudoexfoliation syndrome. Seven operated eyes had undergone previous vitrectomy, and two had previously undergone non-penetrating deep sclerectomy. Surgical activity was balanced between the first and second eyes, and residents performed 44.6% of the cases under direct supervision. Cataract density was predominantly nuclear, with a mean LOCS III scale density of 2.76, and the mean intraocular lens power implanted was 20.9 diopters.

At the 24-hour assessment, eleven patients reported symptoms such as ocular pain, blurred vision, or foreign body sensation (Table 2). Seven of the symptomatic patients exhibited postoperative complications, with a mean intraocular pressure of 37 mmHg. Transient IOP elevation was the most frequent objective finding. IOP spikes >26 mmHg occurred in 13.2% of eyes ($n=39$). The overall mean IOP at the 24-hour visit (including uncomplicated cases) was 20.75 ± 1.8 mmHg. Corneal incision leakage occurred in 5.7% of eyes; all were managed conservatively and showed good clinical evolution. Altogether, 20.9% of eyes presented at least one postoperative finding at 24 hours, and 14.2% of patients required a scheduled unplanned in-person reassessment, most commonly due to IOP spikes. Two patients

Table 1 Baseline Characteristics and Surgical Details

Category	Variable	N/Mean	%/SD
Population	Age (years)	75.5	± 8.3
	Male	101	34.1%
	Female	195	65.8%
Systemic Comorbidities	Diabetes	72	24.3%
	Dyslipidemia	126	42.6%
	Hypertension	149	50.3%
	Prostate treatment	28	9.5%
Ophthalmic Comorbidities	High myopia	18	6.1%
	Exudative AMD	11	3.7%
	Glaucoma	19	6.4%
	Pseudoexfoliation	10	3.5%
	Corneal guttata	5	1.6%
	Acute anterior uveitis	5	1.3%
Surgical Details	First eye operated	145	48.9%
	Second eye operated	148	50.0%
	Simultaneous bilateral surgery	3	1.0%
	Surgeon experience <4 years	135	45.6%
	Surgeon experience ≥ 4 years	161	54.4%
Surgical History	Previous vitrectomy	7	2.4%
	Non-penetrating deep sclerectomy	2	0.6%
	Other surgical history	3	1.0%

Table 2 Postoperative Reviews

Early 24-Hour Review		
Symptoms	N	%
Pain	5	1.7%
Foreign body sensation	2	0.7%
Poor visual acuity	4	1.4%
Total	11	3.7%
Clinically significant complications		
Intraocular pressure spikes	39	13.2%
Positive Seidel	17	5.7%
Corneal edema	9	3.0%
Others (Epithelial defects, haptic displacement, herpetic queratitis, etc)	13	4.4%
Need for re-evaluation	42	14.2%
Mean IOP at 24 hours	20.8	±1.8
Monthly Review		
Clinically significant complications	N	%
Macular edema	10	3.6%
Ocular hypertension	2	0.7%
Persistent inflammation	4	1.5%
Others (Dry eye syndrome, herpetic queratitis, diplopia)	4	1.5%
Follow-up		
Scheduled for contralateral eye surgery	72	26.0%
Referral to specialty clinic	20	6.7%
Routine follow-up	98	33.1%
Discharged	106	37.7%

required surgical re-intervention: one for haptic reposition and the other for retained cortex removal. Pseudoexfoliation syndrome was the only preoperative factor significantly associated with higher intraocular pressure at 24 hours ($p = 0.046$). No statistically significant differences in early complications were observed between surgeries performed by residents and those conducted by attending surgeons.

At the 30-day evaluation, postoperative complications were observed in 6.7% of eyes. Cystoid macular edema occurred in 3.6% of cases and was the most frequent late complication, followed by persistent inflammation in 4 eyes and elevated IOP in 2 eyes. By this time point, 37.7% of patients were discharged from follow-up, 33.1% continued routine care, and 6.7% were referred to specialized ophthalmology clinics. Visual outcomes were favorable overall: at 24 hours, more than two Snellen lines of improvement were already achieved in 37% of patients, and by 30 days, this improvement exceeded 60%. Twelve percent of patients experienced no visual improvement, primarily due to pre-existing retinal or optic nerve pathology.

Unplanned emergency visits occurred in 2.7% of cases, most commonly due to superficial punctate keratitis. One patient required surgical removal of retained cortex.

We conducted a univariate analysis and identified a significant association between ophthalmologic comorbidities and 30-day postoperative complications ($p = 0.009$) (Table 3). Complications detected at 24 hours were strong predictors of 30-day complications ($p = 0.002$). Early visual improvement was inversely associated with late postoperative complications ($p = 0.038$), suggesting its potential role as a marker for risk-stratified follow-up.

In the multivariate analysis (Table 4) using binomial logistic regression, the overall model was significant ($\chi^2 = 26.28$; $p = 0.002$). The variables independently associated with the occurrence of complications were the presence of a complication within the first 24 hours (OR = 3.25; $p = 0.028$) and ophthalmologic comorbidities (OR = 4.30; $p = 0.010$). Absence of early improvement in visual acuity did not reach statistical significance (OR = 4.53; $p = 0.055$), although it showed a strong trend toward association.

Table 3 Univariate Analysis by 30-Day Complication Status

Variable	No Complications	Complications	Significance (P<0.05)
Mean VA at 30 days	0.74	0.56	P=0.030
History of ophthalmologic disease			
Yes	95	14	
No	180	6	P=0.009
Improvement of VA at 24 hours			
<0	98	6	
0–0.19	70	12	
0.2–0.39	67	1	
≥0.4	40	1	P=0.038
Complications on Day +1			
Yes	51	10	
No	224	10	P=0.002
Surgeon experience			
<4 years	126	8	
≥4 years	148	12	P=0.407

Table 4 Multivariate Logistic Regression Predicting 30-Day Postoperative Complications

Variable	OR	95% CI	Significance (P<0.05)
History of ophthalmologic disease	4.30	1.41–13.12	P=0.010
Absence of VA improvement at 24 hours	4.53	0.96–21.42	P=0.055
Complications on Day +1	3.25	1.14–13.12	P=0.028
Surgeon experience	0.813	0.29–2.25	P=0.690
Sex	1.016	0.36–2.94	P=0.977

(Continued)

Table 4 (Continued).

Variable	OR	95% CI	Significance (P<0.05)
Age (years)	1.000	0.94–1.06	P=0.996
Cataract density			
<i>Cortical</i>	1.209	0.71–2.07	P=0.480
<i>Nuclear</i>	0.984	0.57–1.69	P=0.951
<i>Posterior</i>	0.826	0.49–1.38	P=0.349

Discussion

This study provides an extensive real-world assessment of postoperative outcomes after uncomplicated phacoemulsification in a high-volume tertiary hospital. The results reaffirm the high safety profile of modern cataract surgery and underscore the importance of identifying patient subgroups who could benefit from simplified follow-up strategies without compromising clinical outcomes.^{10–13}

Transient intraocular pressure elevation was the most common early postoperative issue, consistent with the published literature. Although typically benign in eyes without glaucoma, elevated IOP may have implications for patients with pre-existing optic nerve disease. Risk factors for these hypertensive spikes include resident-performed surgeries, a history of corticosteroid use, pseudoexfoliation syndrome (PEX), an axial length greater than 25 mm, and treatment with tamsulosin.^{9,14,15} In our cohort, the only factor significantly associated with elevated IOP was pseudoexfoliation syndrome, although patients with glaucoma showed a trend toward higher IOP values. Regarding incision leakage, retrospective studies report that only about 1% of patients require incision suturing.¹⁶ In our cohort, all cases with this complication were successfully managed conservatively.

Although clinical guidelines identify refractive assessment as the main objective of the one-month visit, this task is often delegated to community opticians.^{17–19} Evidence from the United Kingdom shows that community-based optometrists can provide postoperative care safely and with high patient satisfaction, and monthly telephone assessments using validated questionnaires have also demonstrated good accuracy. These approaches may be particularly beneficial for older patients with limited mobility.^{20,21}

In our study, the most frequent complication identified at one month was cystoid macular edema, present in 3.60% of eyes, a rate similar to that reported in the literature.²² These patients also exhibited significantly worse visual acuity. This finding reinforces the value of visual acuity as an indirect clinical marker for detecting complications in a remote follow-up context.

A major contribution of this study is the identification of a clearly defined low-risk subgroup: patients without pre-existing ophthalmologic disease and without early postoperative abnormalities. This aligns with the multivariate findings, where ophthalmologic comorbidities and complications detected within the first 24 hours independently predicted 30-day complications. Although early improvement in visual acuity did not reach statistical significance in the multivariate model, it showed a strong trend toward association and may help identify individuals at lower risk. Overall, patients meeting these criteria demonstrated a very low likelihood of clinically relevant complications at one month and accounted for approximately 50% of the sample. This subgroup could be safely managed through remote or decentralized follow-up pathways, thereby reducing the workload of ophthalmology services.

Cataract surgery is one of the most commonly performed procedures worldwide, generating a considerable postoperative workload in publicly funded healthcare systems.²³ In this context, uniform follow-up schedules may not be sustainable in the long term.²⁴ In our cohort, approximately 50% of routine 30-day postoperative visits corresponded to patients meeting low-risk criteria. This proportion translates to nearly 150 potentially avoidable in-person reviews per month, exceeding 1800 visits per year in a high-volume tertiary hospital like ours. Assuming an average review time of 7–10 minutes, a risk-stratified follow-up model could alleviate approximately 300 hours of clinical workload annually.

This reduction has the potential to decrease pressure on outpatient services and to enable meaningful reallocation of specialist time toward higher-risk or more complex cases. Although these estimates are based on local practice and cannot be fully generalized to all settings, they serve as illustrative projections and hypothesis-generating data for similar high-volume centers. Remote or decentralized follow-up should therefore be considered a structured component of modern cataract care pathways, provided that patient selection is guided by objective clinical criteria and real-world outcome data.

Nevertheless, reducing postoperative visits entails ethical and logistical considerations. Clinicians must balance their duty to ensure appropriate follow-up with the need to allocate limited healthcare resources efficiently. In teaching hospitals, postoperative evaluations also serve as essential training opportunities for residents. Although no differences in complication rates or visual outcomes were observed between surgeries performed by residents and attendings in our cohort, previous studies have reported higher adverse-event rates among trainees;²⁵ the absence of such differences here likely reflects supervision and case selection, whereby less complex cases are preferentially assigned to residents and performed under the direct guidance of an experienced ophthalmologist.

This study has limitations. First, the relatively small number of complications observed at 30 days may have limited the robustness of the multivariate analysis, although this was partially mitigated by including only clinically or statistically relevant variables in the model. Second, exclusion of patients without complete follow-up may have introduced selection bias; however, this affected only a minimal number of cases. The retrospective design limits causal inference; nonetheless, the study accurately reflects routine clinical practice in a large tertiary hospital and provides valuable evidence to support the development of prospective trials evaluating remote, risk-stratified postoperative care models. These results represent a cohort in a single Spanish tertiary public hospital with close resident supervision, therefore results may not fully generalize to other healthcare settings.

Conclusions

Postoperative care after uncomplicated cataract surgery may be optimized using a stratified, risk-based approach. Patients without ophthalmologic history, without early complications, and with early visual improvement constitute a low-risk group that could be safely managed through remote or community-based follow-up at 30 days. In high-volume tertiary hospitals like ours, implementation of such follow-up protocols could potentially free up to 50% of postoperative visits while preserving safety and quality of care. These results support the development of multicenter prospective studies to validate remote follow-up models for uncomplicated cataract surgery.

Data Sharing Statement

The datasets generated and analyzed during the current study are available from the corresponding author upon reasonable request.

Ethical Approval Statement

The study received approval from the Institutional Review Board/Ethics Committee of Ramón y Cajal University Hospital (approval ID: 388/25).

Informed Consent Statement

Given the retrospective design and full anonymization of data, the requirement for individual informed consent was waived by the Ethics Committee.

Author Contributions

All authors made a significant contribution to the work reported, whether that is in the conception, study design, execution, acquisition of data, analysis and interpretation, or in all these areas; took part in drafting, revising or critically reviewing the article; gave final approval of the version to be published; have agreed on the journal to which the article has been submitted; and agree to be accountable for all aspects of the work.

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Disclosure

The authors declare no conflicts of interest in this work.

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