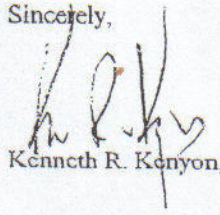
position. The tear film was stable and without irregularity despite the presence of minor microstriae centrally. There were no significant interface debris or epithelial implantation. The remainder of the anterior segment was normal, as were intraocular pressures, Schirmer tear testing and dilated ophthalmoscopy. Ultrasonic pachymetry was 405 microns right eye vs. 430 microns left eye. Eye-Sys corneal topography displayed reasonably well centered ablations with minor surface irregularities bilaterally. Orbscan topography was confirmatory and did not disclose significant posterior ectasia. Finally, with Mr. Wills' own soft contact lenses inserted, the fit and centration were adequate and could not be improved in the opinion of our contact lens specialist, Dr. Rand.

In summary, based on my review of the medical records, depositions, ophthalmic examination and discussion with Mr. Wills, it is my opinion with a reasonable degree of medical certainty that Dr. Nevyas breached the applicable standard of care by operating on this highly myopic patient with an excimer laser utilizing a treatment zone that was substantially smaller than the pupil size in dim light. Specifically, Mr. Wills' pupils measured 6.25 mm in dim light, while the laser treatment zone was only 5 mm in diameter. With this combination of high myopia and a relatively large pupil, the use of a comparatively small diameter laser treatment zone was highly predictable to cause Mr. Wills to develop the residual visual problems from which he continues to suffer. Moreover, this specific situation (ie. high myopia and large pupil diameter relative to laser treatment zone) was well known, even in 1997, to result in the likely outcome of permanent problems of glare, halo, starburst, and ghost imaging phenomena.

In addition, based on my review of the medical records, depositions and ophthalmic examination, it is my opinion with a reasonable degree of medical certainty that Dr. Nevyas failed to obtain adequate informed consent from Mr. Wills for the LASIK procedures performed on 7 and 9 October 1997. Specifically, before performing these surgical procedures, Dr. Nevyas should have advised Mr. Wills that given his clinical presentation (high myopia and relatively large pupil size) combined with the use of a comparatively small diameter laser treatment zone, it was highly likely (and a material risk) that he could develop permanent vision distortion including permanent and significant glare, halo, starburst and multiple ghost imaging problems. This aspect of the consent is particularly relevant in light of Mr. Wills' pupil size plus high myopia and the treatment zone of the laser used by Dr. Nevyas to perform these procedures. Furthermore, Dr. Nevyas failed to advise Mr. Wills that because of his high myopic condition requiring removal by laser ablation of a substantial amount of corneal tissue, that there would only be limited potential opportunity for future corrective surgeries to alleviate residual refractive error or visual distortions. Indeed, the current thickness of Mr. Wills' corneas is at the limit beyond which additional laser treatment wold be at risk to produce structural weakening with unpredictable anatomical and visual consequences. Given the extensive material risks to this patient as described above, Dr. Nevyas' testimony that he advised Mr. Wills that he was simply at "increased risk" was entirely inadequate and demonstrated that Mr. Wills was not fully informed of the risks of the intended procedures, and thus, did not give informed consent to the laser surgical procedures performed. Moreover, if as Mr. Wills testified that Dr. Nevyas assured him preoperatively there was virtually no chance of these risks occurring, then Mr. Wills was clearly not informed of the material risks of the intended procedures based on his clinical presentation and accordingly did not give informed consent to the procedures performed.

I appreciate the opportunity to review this important case.

Sincerely,



Kenneth R. Kenyon, MD

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