

Ophthalmic Referral Guidance

Optometrist and GP notes

General advice on urgency of referrals

Queen Mary's ophthalmology department has requested that routine referrals include a detailed history and full clinical findings in order for them to decide upon the urgency. Suggesting a specific time interval until assessment can cause anxiety amongst patients and may waste scarce hospital resources if secretaries have to spend time talking to anxious patients on the phone.

CATARACT

Just because a patient has a cataract (which can be considered as part of the ageing process) does not mean that they need to be seen by the hospital. It is most important that patients are only referred for cataract **if they are having problems caused by their cataracts bad enough for them to want to have surgery**. A number of patients are being referred with relatively good VA's (6/12 or better) who decline to have the operation when the risks are fully explained to them. It may be that these patients are having symptoms from their cataract, but if these are not bad enough for them to wish to accept the risk (albeit small) of surgery then they should not be referred. Please can you ensure that you make it clear to the patient that – although it is unlikely (1:1000) – there is a risk that they may be left worse off after the operation. Those patients with better VA's may be referred if they meet the criteria below BUT there needs to be full supporting history and symptoms documented in the referral letter.

A Cataract Assessment enables accredited optometrists to perform an anterior eye and dilated fundal examination to exclude other pathology. NB only Tropicamide to be used for dilation. If a patient is found to have other minor pathology this should be highlighted on the referral form. The assessment enables discussion of cataract surgery with the patient and explanation of the risks involved. This can then be weighed up by the patient and they can decide whether or not they wish to be referred for surgery depending on their degree of visual difficulty and their attitude to the surgery.

Patients with some cataract present, but symptoms not being caused by the cataract should be examined (and referred for other co-morbidity if appropriate) in the normal way.

Patients should only receive an assessment if a decision to refer is being considered and then should only be referred following assessment if they are:

- **symptomatic of cataract AND**
- **have some impairment of lifestyle** (typically involving a reduction in visual acuity) **AND**
- **willing to have surgery** (following counseling and discussion with the optometrist).

Patients with uncomplicated cataract are to be referred through the Choose and Book (C&B) pathway after assessment by an accredited Optometrist. When possible, non-accredited Optometrists should refer patients for assessment to accredited practitioners within the same practice.

Patients with complicated cataract requiring treatment (eg damaged pupil, previous injury) should be referred in the normal way and NOT through the C&B pathway. Again, a full history is required.

Patients with co-morbidity found during the assessment which then forms the major reason for referral (eg ARMD) should be referred in the normal way and NOT through the C&B pathway.

Patients meeting the above criteria who are unable to make an informed decision (eg Alzheimer's) should NOT be referred through the C&B pathway.

If patients are taking Flomax or Tamsulosin (for prostate problems) or similar drugs, please can you highlight this on the referral form? This can cause Floppy Iris Syndrome, which makes cataract surgery more complicated.

Patients requiring second eye procedures will normally discuss options and be counseled by their consultant. However, if a patient was treated for their first eye and discharged, they can be regarded as a new referral under the scheme. For full details of Cataract Choice scheme, please refer to SEL Cataract guidance (2005).

GLAUCOMA

The numbers of patients who are referred for suspect chronic open angle glaucoma and then found to have no glaucoma can be around 30%. These false positive referrals are not without risk as they can cause unnecessary anxiety to the patient as well as paperwork for the practitioner and a waste of local hospital resources. Practitioners are encouraged to use the **Bexley refinement scheme** to recheck suspicious findings. Please note that the scheme only applies to **patients who are registered with a Bexley Care Trust GP**.

The aim of this scheme is to enable optometrists to refine their own referrals prior to deciding whether or not a patient should be referred. This can be done by repeating suspicious IOP measurements, preferably at a different time of day, using an applanation method (Perkins or Goldmann) and repeating visual field tests in the darkened, quiet room on a separate occasion. Evidence based criteria for repeating measurements is documented in the protocol (revised Feb 2006)

The framework does not abrogate your professional judgment and if you are in any doubt you should refer the patient. It does not cover every case and is intended as a guide only. There are other factors to be taken into account such as the previous clinical appearance, symptoms (if any), disc size and risk factors such as race and family history. The aim of the framework is to enable you to refine your referrals for the benefit of the patient. Part of the scheme is to encourage full and adequately documented referrals, so please remember to complete all the relevant clinical details (such as cup/disc ratio, IOP including method and number of readings and include a visual field plot where relevant).

NB A fee for repeat fields/IOP can only be claimed once per patient per year. This scheme is designed to reduce the number of inappropriate NHS referrals and so can be used for both NHS and private patients.

Indications for referral

Acute glaucoma should be referred to eye casualty

All chronic glaucoma's should be by referral letter NOT direct to eye casualty. The decision to refer should be based on all your clinical findings and the patient's risk factors and these should be recorded in the referral letter.

EXAMPLES OF CONDITIONS NOT REQUIRING REFERRAL TO THE EYE CLINIC –

Optometrist / GP managed. (Letter to GP to inform or if required to recommend further treatment)

Asymptomatic ARMD	Contact lens problems not involving corneal infections
Asymptomatic Fuch's Dystrophy	Contact lens fitting problems
Asymptomatic map-dot fingerprint dystrophy	Dry eye
Asymptomatic peripheral retinal degeneration	Keratoconus improvable with spectacles
Asymptomatic flat retinal lesions	Meibomium Gland Dysfunction - hot compress etc
Asymptomatic hypertensive retinopathy (refer to GP only)	Non-specific field defects – can use refinement scheme.
Vertigo	Pterygium not Threatening Visual Axis
Headaches	Sub-Conjunctival Haemorrhage – Normal BP
Blackouts	(letter to GP if suspect BP)
Mild Blepharitis	

Practitioners are reminded that in dilation, the risks factors increase with the duration of the drug. Therefore, it is recommended that only Tropicamide/ Phenylephrine are used.

AGE RELATED MACULAR DISEASE

Age related maculopathy (ARM) - 'dry' is the commonest form – signs: drusen and focal pigmentary changes. Patients with AMD but no distortion do NOT usually require referral, except for other reasons eg. partial sight registration, LVA's or cataract. These patients can be referred via the usual route (not fast track). However, patients may just require increased reading additions, advice on lighting, diet and to stop smoking, if appropriate.

Age related macular degeneration (AMD) – the 'wet' form is characterised by the development of new blood vessels beneath the retina (choroidal neovascularisation). This can further divided into classic, occult or a mixture. This requires urgent referral for consideration on PDT (subject to referral guidelines)

Which patients to refer?

Patient's symptoms are very important – a recent onset of symptoms such as distortion scotoma, shadow or patch in the central vision is more likely to represent wet AMD, than simply a gradual worsening, blurring or difficulty with vision which is more likely to be related to the dry form, or cataract etc. If the VA is unchanged, it is unlikely that the patient will have wet AMD.

Fluorescein angiography remains the mainstay for the diagnosis of wet AMD, but in primary care, the **Amsler grid** is a useful screening tool. Unfortunately, it has a significant high false positive rate.

Useful tips to avoid false positives are:-

1. Do not use bifocals or varifocals when testing – single vision reading lenses are better
2. Do not use after having examined the maculae with fundus lens or ophthalmoscope.
3. Ask the patient to blink a few times.
4. Rotate the Amsler grid 90 degrees to see if the distortion persists in the same area.
5. If in doubt, repeat the test after a few minutes, maybe in different lighting conditions.

You may consider giving the patient an Amsler grid sheet to take home; with instructions to return if they notice any distortion.

Kings College Hospital is the regional centre for PDT. Nice guidance states that PDT treatment should be available to patients who have a VA of 6/60 or better in the affected eye and have classic but no occult choroidal neovascular membrane (CNV) as determined by Fluorescein angiography. In addition, patients with predominantly classic CNV with VA 6/60 or better will be entered into a research programme.

Referral Guidelines for Wet AMD (urgent – 2 weeks)

VA in affected eye – 6/60 or better

Recent sudden onset of central distortion (usually less than 6 months)

Fundal appearance suggestive of choroidal neovascularisation.

If VA <6/60 - non-urgent referral to local eye department.

Referrals using the Fax reporting form to include the following information:-

Patient's details and telephone number

Patient's refraction and VA

Affected eye and duration in weeks

Optometrists name and address

FAX 0207 346 3738

A copy of the referral to be sent to the patient's GP..

DIABETES

As from January 2007, a community based retinal camera screening scheme will be in place in Bexley.

- Patients with diabetes should be regularly screened and be encouraged to attend their screening. However, it needs to be reinforced that this does not replace the need for regular eye examinations as they can be more prone to ocular complications.
- If patients are not under regular screening review or attending a HES diabetic clinic, the patients GP should be **informed** if any retinopathy is found during an eye examination. This is useful even if the retinopathy does not require referral to the HES to enable the management of the condition to be reassessed. However, it should be clearly stated when referral to the HES is NOT required. At present, Optometrists who see diabetic patients under the GOS have a duty to notify the GP of their findings.

Non sight threatening (Mild and Moderate Non-Proliferative) retinopathy does not require referral.

New gradings for camera scheme

No retinopathy R0 - - - - require annual screening

Mild and Moderate Non- proliferative retinopathy R1 require annual screening, inform diabetes care team

- The National Screening Committee has made recommendations for how quickly patients with referable retinopathy should be seen by the Ophthalmologist.

- The minimum time recommended between screen positive and consultation with an Ophthalmologist is:

1 Maculopathy 1 ie clinically significant macular oedema, ischaemic maculopathy - less than 13 weeks.

NB outside the camera screening scheme and in the absence of any other adverse signs, referral for a few microaneurysms within one disc diameter does not constitute maculopathy.

2 Severe Non-Proliferative R2 - microaneurysms, hard exudates, blot hemorrhages, CWS, venous beeding or loops - less than 13 weeks.

3 Proliferative Retinopathy/Advanced Diabetic Eye Disease R3 - new vessels on the disc (NVD) high risk or elsewhere (NVE) less risk, pre-retinal hemorrhage, vitreous haemorrhage – 2 weeks.

- Referral decisions will depend on whether the patient has been seen for regular screening or is already under the HES. It will also depend on the time since the last screening or examination along with any history and symptoms. Again, please avoid referring patients unnecessarily to the hospital when they are already being seen.

These referral notes have been devised for general GUIDANCE only. They do not remove from practitioners their professional responsibility to each patient, who should all be dealt with on an individual basis.

PATIENTS WHO ARE MONOCULAR OR HAVE OTHER RISK FACTORS MAY CONSTITUTE A HIGHER RISK