Royal United Hospital Bath NHS
NHS Trust

Ophthalmology Referrals Guidance

RUH

Bath & North East Somerset

January 2012

Contents

EMERGENCY REFERRALS TO RUH

All referrals must be booked by phone or fax. "Walk-in" patients are no longer accepted without a telephone referral, even with a letter.

During working hours (8.30-5pm Monday-Friday):

- For advice, or for patients who may need to be seen within 48 hours, contact the **Triage nurse** on 01225 824403

- For urgent patients who may need to be seen within 2-21 days, **fax** referral to 01225 825038. Faxes are read within 2 hours between 8.30-5pm Mon-Friday. (Please supply the patient's home and mobile phone numbers).

Out of hours evening and weekends

Call RUH switchboard and ask for Ophthalmology doctor on call - 01225 428331 (Mon-Thurs 5pm-8pm, Fri & Sat 24hrs, Sun up to 3.30pm)

Overnight and Sunday evening

Call the Bristol Eye Hospital (0117 923 0000) **ONLY** if the patient needs treatment before the next morning (Mon-Thurs 8pm to 8.30am, Sun 3.30pm-8.30 Mon am)

Bristol Eye Hospital, Lower Maudlin Street**,** Bristol BS1 2LX
Tel: 0117 923 0000

Temporal artery biopsies

With visual problems → eye department phone (01225) 824403

Without visual problems → vascular surgeons phone: (01225) 825491 or 824761, then fax urgent letter to: (01225) 821908.

Common Emergency Conditions

RED EYE

Uveitis (Iritis)

- Symptoms – Red eye, pain, photophobia, blurred vision, some epiphora
- A possible recurrent problem. Patients become very good at differentiating their uveitis symptoms from other conditions.
- To help relieve the patients symptoms treat with g. Cyclopentolate 1% tds until their review. If patients have had it before and symptoms are the same treat with g. predforte 1-2 hourly
- Patient should be seen within 24 hours – phone/fax

Angle Closure Glaucoma

- Symptoms – Severe pain, nausea and vomiting, blurred vision, photophobia, coloured halos around lights, frontal headache.
- Signs – Red eye, cloudy cornea, fixed pupil
- Please refer urgently by phone

Herpes Zoster Ophthalmicus

- Eye Involvement – red eye, blurred vision, possible pseudodendrite with fluorescein.
- Hutchinson sign – Rash involving the tip of the nose, may predict higher risk of eye involvement.
- Treat PO Acyclovir 800mg 5 x day 1/52
- Use ocular lubricants
- ONLY refer if eye involvement

Other red painful eye - refer urgently if:

- In contact lens wearers (risk of microbial keratitis)
- Corneal graft patient
- Corneal or subtarsal foreign body suspected
- Scleritis (“toothache-like” pain)
- Had cataract surgery in last 2 weeks

FLOATERS

Retinal Detachment

- Sudden onset floaters, flashes and/or loss of peripheral vision (described as an increasing curtain). Possible photopsia.
- More common in myopes and younger adults
- Please refer urgently by phone

Posterior Vitreous Detachment

- Floaters – few in number, centrally/paracentrally placed, commonly described as a fly or circle.
- New onset flashes commonly only in dull illumination – caused by vitreous pulling on retina
- Typical age 45-70
- Risk of retinal tear or hole approx. 1%
- Risk of retinal detachment approx. 0.2% (higher in myopes)
- High risk features – large numbers of floaters, myopes, loss peripheral vision
- If no high risk features ask patient to see their optometrist or refer by fax
- If high risk features refer by phone

TRAUMA

Possible Penetrating Injury / Globe Rupture

- High velocity impact eg hammering at stone or metal

Blunt trauma eg a punch

- Please refer urgently by phone if visual loss, double vision

Chemical Injury

- Wash out eye immediately with saline/bottled water or just tap water if nothing else available
- Please send to RUH main casualty or phone for further irrigation

Corneal foreign body – grinding at metal, blown in by the wind

- Refer by phone/fax

Corneal foreign body – grinding at metal, blown in by the wind

Corneal Abrasion

- History of scratch to eye
- Instillation of fluorescein elicits an area of green fluorescence under blue light.
- Treat with oc Chloramphenicol 1% qds for 5/7
- Use oral analgesia and g Cyclopentolate 1% tds 2/7 for comfort if required

Orbital cellulitis

- Refer urgently if:
- reduced vision, diplopia, unable to open one eye.
- or if a child

PAINLESS SUDDEN LOSS OF VISION

- Onset less than 24 hours ago - Refer urgently by phone
- Common causes
    - Macular degeneration
    - Retinal vein occlusion
    - Retinal artery occlusion
    - Ischemic optic neuropathy
    - Retinal detachment

GIANT CELL ARTERITIS

- Risk <u>increases</u> with age, very rare below 55 yrs
- CRP or PV raised (CRP >25, PV>1.9) in >96% of cases
- Systemic symptoms usually occur
- Vision affected?
    - If vision affected or fluctuating GIVE steroids immediately 60-80mg prednisolone orally or 500mg - 1g IV methylprednisolone
    - BUT TAKE BLOOD FIRST!
    - Phone eye triage nurse
- Vision not affected?
    - - wait for blood test results and probably for a biopsy result BEFORE steroids, <u>refer to vascular surgeons</u> for a temporal artery biopsy asap (phone their secretaries (01225) 825491/824761; fax referral (01225) 821908
    - Temporal artery biopsy can wait, but should be done within 2 weeks of starting steroids
- Uncertain diagnosis of GCA and no visual problems?
    - consider referral to rheumatologists or neurologists

ELECTIVE REFERRALS

1 BLEPHARITIS

Should be mainly managed by GPs and Optometrists

Background:

Blepharitis describes chronic inflammation of the eyelid margin.. Blepharitis frequently leads to associated ocular surface inflammation and tear deficiency and can predispose to keratitis. It can also exacerbate preexisting aqueous tear deficiency, worsening symptoms of dry eye. So there is a strong association between blepharitis and dry eye.

Diagnosis:

- Symptoms of blepharitis are often intermittent and typically bilateral.
    - Sore eyelids, slightly sticky eyes
    - Dry eye symptoms – blurred vision, contact lens intolerance
- Signs of blepharitis include:
    - Inflamed lid margins crusts on lashes and inflamed conjunctiva
    - Eyelid margins may be scaly, oily or greasy
    - Styes and chalazions are much more common in people with blepharitis
- Visual acuity should be normal, although dry eyes may cause intermittent blurring
- Swabs for culture and sensitivity are not routinely indicated

Management:

- Advise eyelid hygiene twice daily until symptoms resolve and then once daily indefinitely
    - Gently press on the eyelids with a cloth soaked in very warm water for 5-10 minutes
    - Massage and express meibomian gland contents when there is posterior blepharitis
    - Cleanse lid margins using any of the following – sodium bicarbonate: a teaspoonful in a cup of boiled water; baby shampoo diluted with warm water, or commercial eyelid scrubs (not available on FP10)
- Treat underlying conditions that may be causing or exacerbating blepharitis, eg rosacea
- Artificial tears are recommended for people with dry eyes or an abnormal tear film

- Choice of formulation should generally be guided by individual preference. Hypromellose 0.3% eye drops or Carbomer gel are the cheapest and most commonly used formulation in the UK
- Initially use artificial tears as required, at up to 30-minute intervals if symptoms are severe. Decrease the frequency as symptoms improve
- Use preservative-free drops if more than six applications per day are necessary or if the person uses soft contact lenses
- Consider prescribing a paraffin eye ointment eg Lacrilube at bedtime to provide prolonged lubrication

- Contact lenses must not be worn during any eye infection and when eye drops or ointment are being used

Where there is marked infection:

- Generally prescribe a topical antibiotic and continue for 1 month after the inflammation has settled:
  - Chloramphenicol ointment applied to the lid margins with a finger or cotton bud (after attending to lid hygiene or just at night) is recommended
  - Fusidic acid eye drops are an alternative
- Prescribe an oral antibiotic for recalcitrant staphylococcal blepharitis, severe secondary infection of the meibomian glands, and local cellulitis
  - Flucloxacillin is recommended first-line
  - Erythromycin or azithromycin is recommended if penicillin is contraindicated
- Chronic blepharitis may be helped with a 6-week course of Doxycycline 50-100 mg daily

Referral to Secondary Care Services:

- Referral for advice will not routinely be commissioned
- Refer urgently if orbital cellulitis is suspected (cellulitis of lids and the person is systemically unwell, tender sinuses, restriction of eye movements).
- Refer in the following instances:
  - To exclude malignancy if there is:
    - Persistent localized disease, ulceration or resistance to treatment
    - Marked eyelid asymmetry
  - If there is evidence of corneal disease
  - If vision deteriorates
  - If there is moderate or severe pain

- If the diagnosis is uncertain
- Associated disease, for example Sjögren's syndrome or eyelid deformities, requires specialist management.

References:

CKS (Prodigy guidance): Blepharitis
http://www.cks.library.nhs.uk/blepharitis/in_depth/management_issues

Quick reference guides:

Blepharitis: non infected
http://www.cks.library.nhs.uk/qrg/blepharitis_non_infected.pdf

Blepharitis: infected
http://www.cks.library.nhs.uk/qrg/blepharitis_infected.pdf

Further information - CKS (Prodigy guidance): Blepharitis
http://www.cks.library.nhs.uk/blepharitis/in_depth/management_issues

2 CATARACTS

The agreed criteria for referral are:

- The patient complains of significant visual impairment, which adversely affects their quality of life where the reduction in vision is primarily due to cataract.
- Blurred vision with a corrected monocular distance visual acuity of 6/12 or worse.
- Where the distance visual acuity is better than 6/12 but the patient is suffering from significant visual impairment such as;
  - Disabling glare in sunlight or at night restricting their ability to
  - Disabling monocular diplopia.
  - Difficulty with reading or specific visual tasks
  - Intolerance to significant anisometropia due to nuclear sclerotic changes or induced by earlier cataract surgery of the other eye.
- The patient is willing to undergo cataract surgery provided by the NHS.

Current pathway for Cataract Patients

1. Cataract is established as the main cause of the reduction of vision by an optometrist and the decision has been made to refer for cataract surgery.
2. The patient is told they have a choice of where they can have the operation. The patient is given an information sheet on cataracts and an explanation of the principles of “Choice.”
3. There will be two types of centre providers will work from
   - Provider from an Acute Centre e.g. the Royal United Hospital Bath, Bristol Eye Hospital, Salisbury Hospital, Great Western Hospital Swindon.

- Provider from a non-Acute Centre eg Circle Bath, Bath Clinic' Emersons Green, Devizes and Shepton Mallet Treatment Centre.

  The optometrist indicates on the referral form if an acute provider is more suitable for the patient.

4. The optometrist fills in and faxes the 'Direct Cataract referral' form to the referral centre and to the patients GP (for information). The patient's GP must be within the PCT's boundary and the PCT must be one which is involved in the direct referral scheme.
5. After the procedure a letter will go to the referring optometrist either by post or via the patient, indicating that surgery has taken place and whether refraction or a follow-up and refraction is required. If it is not clear on the form or letter the optometrist is instructed to do a follow-up.
6. If the patient requires refraction, a GOS eye examination is completed and the optometrist fills in step 3 on the "Post-operative refraction/follow-up" form and faxes it to the provider and forwards a copy to Bath and North East Somerset PCT for payment either by fax or post.
7. If the patient requires a post-op follow-up and refraction, a GOS eye examination is completed. A "Post-operative refraction/Follow up" form is completed and it is promptly faxed to the provider. Only accredited optometrists can do a post-operative follow-up. The optometrist must have attended the accreditation session and are on the PCT's list of accredited practitioners. They then forward a copy to Commissioning PCT for payment.
8. All forms can be downloaded from Avon LOCs website and will be changed from time to time Avon Local Optical Committee

3 MEIBOMIAN CYST / CHALAZION

This is a retention cyst of the Meibomian gland. It may become infected or may develop into a sterile chronic granuloma in which case it is called a Meibomian cyst or Chalazion.

Diagnosis

A chalazion presents as a firm, painless lump in the lid which gradually enlarges. Initially, it may resemble a stye but lacks acute inflammatory signs. The majority point towards the conjunctival surface which may be slightly reddened or elevated. Symptoms (other than cosmetic concerns) are uncommon. Occasionally an upper lid meibomian cyst can press on the cornea and cause astigmatism. The majority of cases will resolve spontaneously and virtually all will resolve within two years.

Management

Acute chalazia can be treated with a warm compress and massage and topical antibiotics e.g. chloramphenicol ointment or fusidic acid eye drops. If there is localised cellulitis oral antibiotics such as Flucloxacillin or tetracycline may be required. Blepharitis should be treated, see above. Chronic recurrent chalazia and Rosacea may be treated with low dose oral doxycycline. Small, inconspicuous, asymptomatic chalazia may be ignored

- Conservative management with eyelid hygiene (see Blepharitis section) and topical lubricant drops or gel

- If infection present:
- Acute therapy with oral Augmentin, flucloxicillin or tetracycline (e.g. doxycycline 100 mg qds for 10 days)
- Chronic therapy with low-dose oral tetracycline frequently prevents recurrence. If tetracycline cannot be used, metronidazole has been used in a similar fashion.
- Topical antibiotics e.g. chloramphenicol ointment or fusidic acid eye drops
- Small, inconspicuous, asymptomatic chalazia may be ignored.

Referral to Secondary Care Services

Incision and curettage will not be routinely commissioned until it has been present for 6 months and it affects vision.

Referral of patients with meibomian cysts or chalazia which are symptomatic (eg, infection resistant to treatment, astigmatism, rosacea or sebaceous dysfunction). Please obtain PRIOR APPROVAL from PCT before referral.

References

Emedicine
http://www.emedicine.com/oph/topic243.htm

GP notebook
http://www.gpnotebook.co.uk/simplepage.cfm?ID=-234487777

4 DIABETIC RETINOPATHY

All Diabetic patients should now have routine screening as per the National Screening Council guidelines and then be referred to the Diabetic Eye Service at the RUH if they have potential sight threatening retinopathy.

5 EXCISION OF BENIGN LID LESIONS

Will not be routinely commissioned unless there is concern about malignancy or they are so large that they are affecting vision. This includes cysts of Moll and Zeis, Xantholasma, papillomas and skin tags. These are interventions not normally funded INNFs. Please obtain PRIOR APPROVAL BEFORE referral to the eye department.

6 EXCISION OF PINGUECULUM

Will not be routinely commissioned. Try topical lubricants or non steroidal anti inflammatory eyes drops such as Ketorolac if there is irritation.

7 EYELID ECTROPION

This is where an eyelid turns outwards away from the eye. This is rarely harmful and can be left untreated if the patient wishes. Try Carbomer gel or lubricant ointments for comfort if required. **Refer to secondary care if significant irritation, watering, redness and conjunctivitis are present.**

8 EYELID ENTROPION

This is a condition in which the lower eyelid rolls in against the eyeball. **Most patients should be referred for treatment in secondary care**. If a patient is very elderly, infirm or suffering from senile dementia, then entropion can be observed and treated with lubricants. If the eye becomes red or if there is any sign of corneal ulceration refer urgently.

9 EYELID PTOSIS (DROOPY EYELID) AND DERMATOCHALASIS (EXCESS UPPER LID SKIN)

Surgery will not be commissioned for purely cosmetic symptoms. However, if the drooping lid or excess skin is affecting vision, then please refer patients to secondary care for consideration on a case-by-case basis. Please obtain **PRIOR APPROVAL** from the PCT for blepharoplasty where dermatochalasis (excess upper lid skin) is affecting vision **BEFORE** referral.

10 GLAUCOMA

Optometrists should follow the new agreed pathway (2011) for ocular hypertension (raised pressure only) and abnormal visual fields should be repeated on a separate occasion. The scheme is concerned with the referral of ocular hypertensive patients with pressures over 21mmHg and under 28mmHg where there are normal fields and discs. It allows the optometrist to perform Goldmann tonometry once at the time of the eye examination and one a week or two later at a stand alone appointment. There will be provision for repeat visual fields in certain circumstances and the monitoring of ocular hypertensive patients in practice after they have had an ophthalmological assessment and been issued with management

11 MACULAR DEGENERATION

Patients with possible wet age related macular degeneration should mostly be referred in by their optometrists using rapid access forms to the AMD service The criteria for referral are decreased central vision or spontaneously reported distortion and visual acuity between 6/12 and 6/96.

12 WATERING EYES

Watering eyes are extremely common with increasing age. If ectropion is present and the patient is sufficiently symptomatic to consider local anaesthetic surgery, please refer.

Patients without ectropion frequently have **hyper-lacrimation** (excess tear production and **ocular surface problems and dry eyes).** Please try all patients on Carbomer gel QID to both eyes for one month to establish whether reflex tearing from a poor tear film is the problem. If it improves the problem, continue it.

If patients are significantly symptomatic with watery eyes for six months, please consider referral. Drainage problems may be caused by punctal stenosis, lid mal position, nasolacrimal duct stenosis or narrowing.

13 WATERING EYES IN BABIES

Congenital nasolacrimal duct obstruction has a very high spontaneous cure rate in the first eighteen months of life. Therefore, please **don't refer children until they are eighteen months to two years old**.

If children have recurrent conjunctivitis and a watering eye, instruct their parents to bathe the eye with warm water and explain that topical antibiotics only give a short term benefit and should not be used continuously. Conjunctival swabs are unnecessary. These children are not infectious and can attend nursery.

Pressure over the lacrimal sac (placing a finger on the medial canthus and applying gentle pressure) occasionally pops the membrane at the bottom end of the nasolacrimal duct. Parents can be instructed to do this once a day but there is no good evidence that it makes any difference.

RUH OPHTHALMOLOGY SERVICES

Contact details

Specialty Manager: Steve.Roberts@nhs.net
Lead Clinician: Richard.Antcliff@nhs.net
Senior Nurse: Sylvia.Bishop@nhs.net

Appointments: 01225 821821
Other Enquiries: 01225 824602

Consultants:

Consultant	Special Interest	Telephone RUH	Telephone Circle
Mrs Sally Webber	Oculoplastics	Caroline Rubery 01225 824479	Jane Carpenter Tel: 01761 422280 Fax: 01761 422233
Mr Jonathan Boulton	Oculoplastics	Marijane Inches 01225 824533	Nicky Crump Tel: 01761 422265 Fax: 01761 422233
Mr Jonathan Luck	Cornea	Salvina Coccia 01225 824142	Nicky Crump Tel: 01761 422265 Fax: 01761 422233
Mr Roger M Baer	Glaucoma	Sarah Bailey 01225 824534	Helen Barnes Tel: 01761 422264 Fax: 01761 422233
Mr Richard J Antcliff	Medical Retina	Jacky Dennis 01225 821704	Helen Barnes Tel: 01761 422264 Fax: 01761 422233
Mrs Fiona Cuthbertson	Medical Retina	Victoria Moore 01225 824878	Jane Carpenter Tel: 01761 422280 Fax: 01761 422233