Nottingham University Hospitals NHS
NHS Trust

NOTTINGHAM GUIDELINES FOR THE REFERRAL OF PATIENTS TO THE DEPARTMENT OF OPHTHALMOLOGY, QUEEN'S MEDICAL CENTRE.

These guidelines have been produced in consultation with consultant ophthalmologists at the Queen's Medical Centre. In common with all guidelines, they should be considered as aids to good practice, and not as rigid protocols. Each patient needs individual treatment in the light of his or her needs and the clinical judgment of their doctor.

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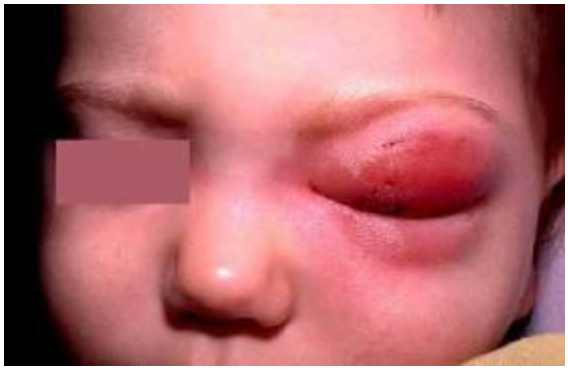
OPHTHALMOLOGY GUIDELINES

Eyelids

Urgent referral:

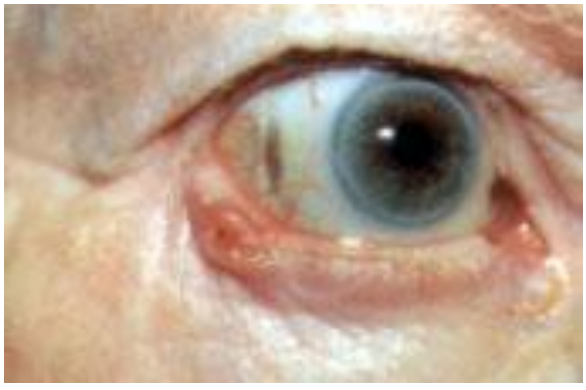
1. Orbital cellulitis: Children with diffuse erythematous swollen lids and raised body temperature with or without proptosis or reduced eye movements – urgent referral to Eye Casualty as this can be sight and even life threatening, for admission, investigation, and intravenous antibiotic administration.



Orbital cellulitis

2. Preseptal cellulitis in adults: (diffuse lid swelling with erythema, but no proptosis or reduced eye movement): Treat with broad spectrum oral antibiotics and review after 24 hours if no improvement or deterioration: urgent referral to Eye Casualty.

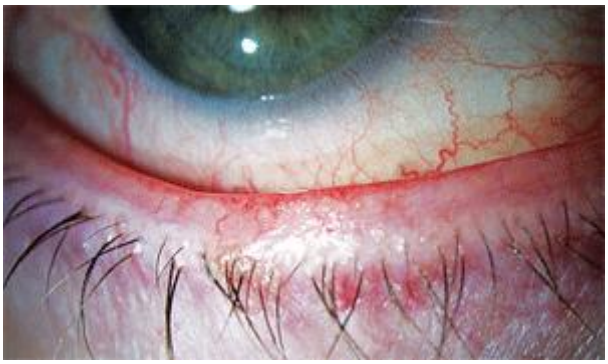
3. Suspected periocular skin cancer: Basal Cell Carcinoma (BCC), Squamous Cell Carcinoma (SCC), malignant melanoma (MM).
    a. Look for evidence of growth, ulceration, pearly borders, altered pigmentation, bleeding, history of previous skin cancer, immunosuppression, exposure to UV rays –refer to dermatology 2 week wait (may require Moh's surgery).



BCC

Community management or observation:

1. Blepharitis – bilateral



Blepharitis

Symptoms: watery eyes outdoors, gritty, foreign body sensation, crusting at medial canthus on waking in the morning, itchy eyes. History of rosacea.

Signs: red lid margins, skin scales base of eye lashes, dry eyes, white discharge.

a. Leaflet provided- lid hygiene and lubrication. (appendix 1)
b. Consider oral Tetracycline or Doxycycline for a 3 to 6 month course, if unresponsive to lid hygiene and lubricants or if the patient has multiple recurrent chalazia.

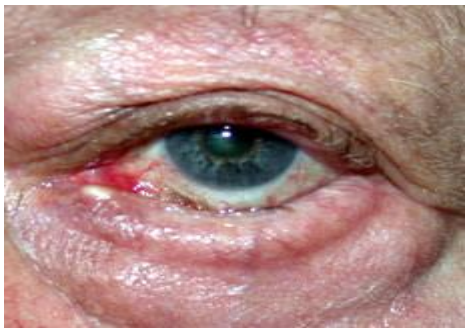
If unilateral blepharitis, blepharitis unresponsive to treatment or recurrent chalazion consider lid tumours –eg: Basal cell carcinoma, sebaceous gland carcinoma – refer urgently (2 week pathway) to the oculoplastic clinic for biopsy and histologic confirmation of diagnosis

2. Lid cysts-

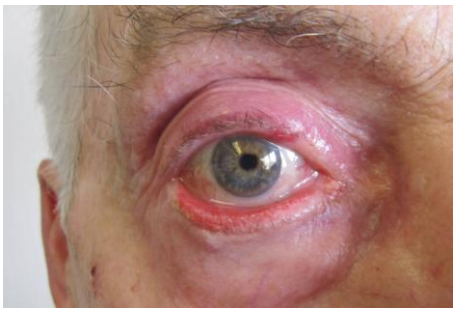
a. Chalazion / Meibomian cyst
    i. Treat with hot spoon bathing, topical antibiotics, and lid hygiene – leaflet provided (appendix 2)– if persistent for more than 3 months and if there is significant discomfort/ visual disturbance/inflammation- refer for incision and curettage directly to minor operations clinic (Principia – Dr McCulloch community service).
    ii. Chalazia in children have the potential to cause visual loss in the form of amblyopia due to corneal distortion or refractory errors and hence should be referred to the paediatric ophthalmology clinic if no improvement with warm compresses and topical antibiotics for 2-3 months.

Chalazion

3. Entropion: in-turned lower lid with lashes rubbing on eye can cause irritation and discomfort and has the potential to cause corneal ulceration: temporary taping of eye lid to relieve symptoms till corrective surgery.

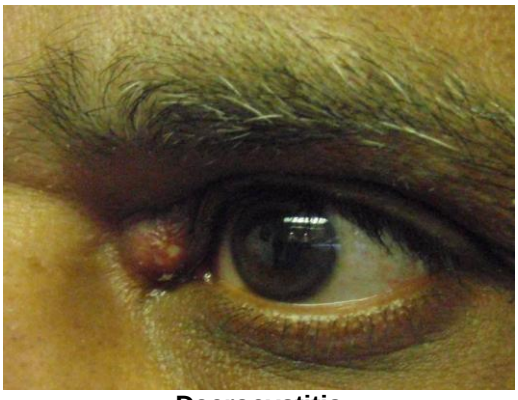


Entropion



Ectropion

4. Acute dacryocystitis: Treat with broad spectrum antibiotics and refer routinely to occuloplastics as a small number may be complicated by corneal perforation from mucopus production and require surgical intervention. If abscess develops refer to Eye Casualty.



Dacrocystitis

<u>Routine referral:</u>

1. Ptosis, entropion and ectropion.
2. Blepharitis: unresponsive or unilateral.

3. Trichiasis (misdirected lashes towards the globe, causing irritation, redness and discomfort) treated by epilation (lash avulsion) for temporary relief and electrolysis for permanent destruction of the misdirected lashes.

Other:

Blepharoplasty. Small visually insignificant sebaceous cysts, papillomas and benign periocular skin lesions – observe commissioning policy for cosmetic plastic surgery May 2008.

Watery eyes

Community management or observation:

Refer to Hospital Eye Service (HES) if the patient complains of visual disturbance, mucopurulent discharge or inflammation of the periocular skin and wishes to consider a surgical treatment.

Watering that is most prevalent out-doors is more likely to be due to blepharitis and can be treated with lid hygiene and artificial tear substitutes.

Those complaining of watering in an air-conditioned environment or with prolonged exposure to VDUs (computer screens, etc) are likely to respond to artificial tear substitutes.

Routine referral:

Watering which is frequent, often with a medial spillage, occurring indoors as well as outdoors, with or without episodes of infection is likely to be secondary to primary nasolacrimal duct obstruction and should be referred to the oculoplastic service for consideration of dacryocystorhinostomy (DCR).

Blepharospasm, hemifacial spasm, aberrant regeneration after 7th nerve palsy:

If visually significant, causing discomfort or inability to open eyes, refer to HES for botulinum toxin injections.

Cornea:

Urgent referral to casualty:

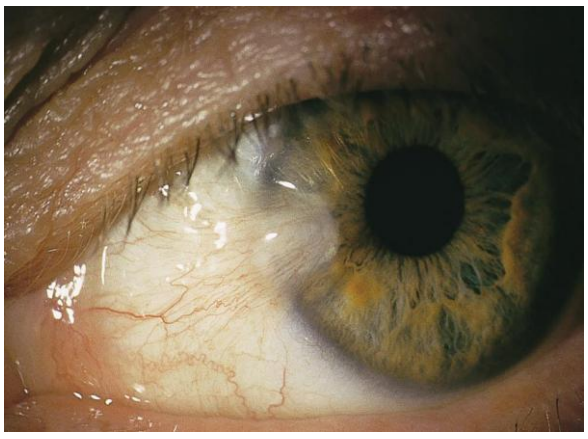
1. Contact lens wearers with symptoms of red eyes, photophobia and pain -?keratitis / corneal ulcer

Corneal ulcer stained with fluoroscine

2. Patients with systemic immune mediated disorders eg Rheumatoid arthritis, presenting with grittiness, pain and photophobia - ?keratitis / corneal ulcer / corneal melt

Non urgent referrals

1. Pterygium: can cause reduction in vision either by causing astigmatism or by encroaching on the visual axis (over the pupil). It can also cause discomfort if the pterygium is inflamed or if it is causing Dellen (dry patch on the cornea). Do not refer unless encroaching on the pupil as surgery is not indicated before this.



Pterygium

2. Suspicion of corneal dystrophy – opacities in the cornea observed by the opticians by slit lamp. They can cause reduction in vision or recurrent corneal erosions and pain and discomfort.

If the patients have no symptoms with either, no treatment is specifically indicated.

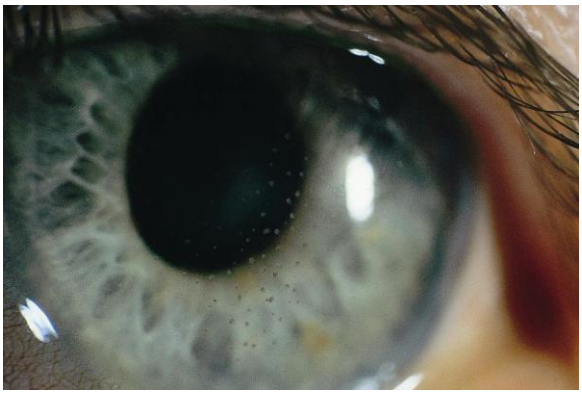
Red eye;

Urgent referral to eye casualty:

1. Anterior uveitis (inflammation of the iris and ciliary body, resulting in inflammation in the anterior chamber):

Symptoms: red eye, ocular pain, photophobia, blurred vision

Signs: circumciliary congestion, no or minimal discharge, small pupil, KPs (keratic precipitates)



KPs in anterior uveitis

2. Keratitis (corneal inflammation):

Red eye with history of foreign body, contact lens, cold sores.

Symptoms: red eye, pain, photophobia, blurred vision

Signs: foreign body on cornea, fluorescein staining reveals corneal abscess/ulcer

3. Angle closure glaucoma:

Symptoms: Acute red eye, severe eye pain, head ache, nausea, vomiting, marked reduction in vision, haloes, photophobia

Signs: Hard eye ball, fixed mid dilated pupil, cloudy cornea, shallow anterior chamber

4. Ophthalmia neonatorum:

Any infant (birth to 1 month) with sticky red eyes.

Community management or observation:

1. Conjunctivitis:

a. Bacterial – conjunctival injection, mucopurulent discharge

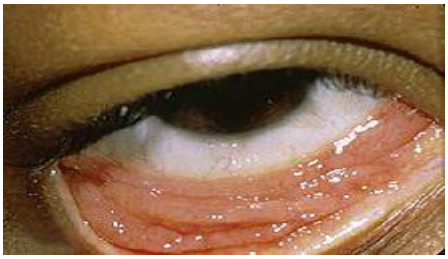
Rx – Chloramphenicol drops QDS, information on prevention of cross infection.

Bacterial conjunctivitis

b. Viral - conjunctival injection, watery discharge

Rx – no treatment required

c. Chlamydial – Persistent red eye, inferior conjunctival follicles, ptosis, chronic mild to moderate discharge.



Chlamydial conjunctivitis

Rx – Oral erythromycin and penicillin eye drops, on microbial confirmation and refer to GUMedicine, for counselling and investigation of sexually transmitted diseases.

d. Allergic – itchy, red eyes with mucoid discharge and watering.

Rx – Anti allergic drops: mast cell stabilisers, H1 receptor antagonists. (Opatanol)

2. Recurrent anterior uveitis:

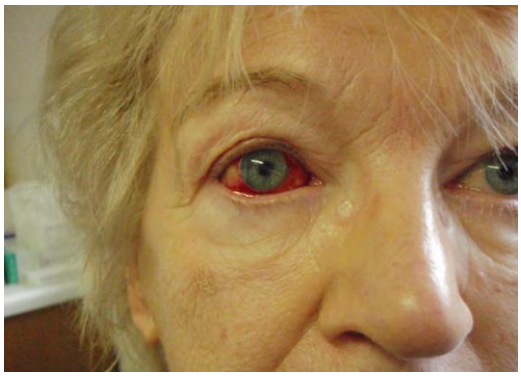
Patients who have been 'previously' diagnosed with idiopathic acute anterior uveitis, can be given a repeat prescription of G Predforte 1% to be put into the affected eye QDS for one week and to be tapered by one drop per week for a further 3 weeks. Suitable patients will have this recorded in the consultant discharge letter. (Topical steroids are contraindicated if the patient is known to develop steroid induced glaucoma or to have suffered from HSV (Herpes Simplex Virus) associated uveitis). If there is no improvement in symptoms in 3 days the patient should be referred urgently to the Eye casualty.

3. Subconjunctival haemorrhage:

Wait and watch, should clear in 7-10 days

If recurrent check - BP, full blood count

Refer to eye clinic routinely if recurrent as the subconjunctival haemorrhage may be due to local causes like haemangiomas, embedded foreign bodies, etc which can be treated.



Subconjunctival haemorrhage

Chronic Glaucoma

If chronic glaucoma is suspected refer to an optician in the first instance unless visual loss is profound.

Most patients are directly referred by opticians to the hospital glaucoma service for the following signs of glaucoma.

- IOP (intra ocular pressure) > 21 mmHg or suspicious optic discs.
- Repeatable visual field defect
- Afro-Caribbean or young patients and family history of glaucoma with raised IOP or suspicious optic discs.

If IOP greater than 35 mmHg refer to Eye casualty.

Cataract

New best practice guidelines

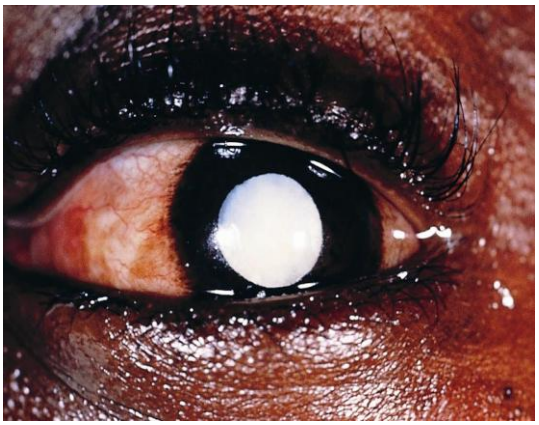
New PCT guidelines

Opticians and GPs to refer patients with no comorbidity directly to cataract clinic.

Vision 6/12 or worse in the first eye

Vision 6/24 or worse in the second eye if VA in the first operated eye is 6/9 or better.

Exceptions: patient complaining of glare, drives for a living, sole carer and needs to drive and other criteria dependant on the patient.



Cataract

Giant cell arteritis:

Urgent referral to Eye casualty:

If diagnosis of GCA suspected. Signs and Symptoms may include: temporal head ache, scalp tenderness, jaw claudication, neck pain, weakness, loss or reduction of vision, double vision and raised ESR.

Rx: Start oral steroids 60-80mg stat or 1mg /kg body weight stat and refer to eye casualty the same or next day.

Urgent referral to rheumatology: GCA symptoms without visual symptoms:

Sudden loss of vision:

Urgent referral to Eye Casualty

1. Retinal detachment, vitreous haemorrhage

S/S (Signs and symptoms): preceding flashes and floaters, shadow in the field of vision,

2. Giant cell arteritis

S/S: temporal head ache, jaw claudication, reduced vision

3. Central retinal artery occlusion

S/S: sudden painless loss of vision over minutes (Can give immediate treatment if within 6 hours – see below)

4. Optic neuritis

S/S: sudden loss of vision over hours, colour desaturation, pain on eye movement,

5. Anterior ischemic optic neuropathy

S/S: sudden painless loss of vision, altitudinal visual field defect (loss of either top or lower half of vision)

Community management or observation:

1. Central retinal artery occlusion:

S/S: of preceding transient loss of vision (amaurosis fugax), painless, loss of vision over minutes, known vasculopath.

Treatment within 2 hours: lie flat, ocular pressure, re-breathe into paper bag.

If no improvement urgent referral to Eye casualty within 6 hours.

Routine referral to Eye Clinic:

1. Central retinal vein occlusion:

S/S: sudden reduction of vision over hours, central blurred vision – usually diagnosed by opticians and further referral to HES requested.

Diplopia

Urgent referral to Eye Casualty

Young patient < 60 years of age. History of head ache. History of trauma. New onset strabismus

These are signs of potential raised intracranial pressure secondary to a ruptured aneurysm, bleed or tumour.

Routine referral to eye clinic

Uniocular diplopia

History of previous squint

Intermittent diplopia

Age related macular degeneration

There are two basic types

WET type – needs urgent referral to the Macular Fast Track clinic (Fax no: 8754525, phone no: 8493353) as it is a treatable condition, where the deterioration of further visual loss can be halted and in some cases improved. The patient first undergoes investigation and if appropriate receives intravitreal anti-veg F injections (Leucentis).

DRY type – warrant s a routine referral to the Medical retina service for assessment of visual loss, investigations, advice on vitamin supplementation and low visual aid referral.

Urgent referral:

Sudden reduction in central vision, micropsia/macropsia (objects appear smaller or larger than their actual size) or wavy appearance of straight lines. (Macula fast track clinic Fax no: 8754525, phone no: 8493353)

Diabetic retinopathy:

Any patient who has been diagnosed with diabetes needs to undergo community photographic based annual assessment of their retinas for the diagnosis and treatment of diabetic retinopathy.

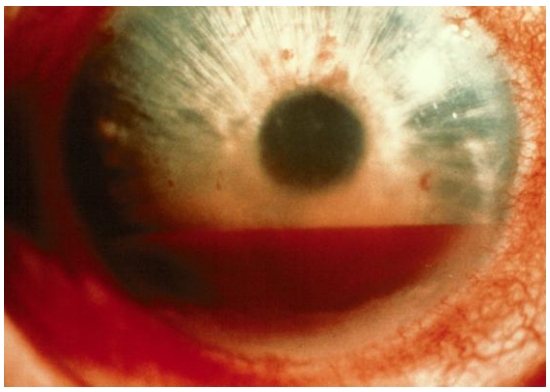
If a patient is under the care of the hospital for another non-related eye condition eg: glaucoma or corneal pathology, they will be reviewed in the hospital at their regular clinic appointment and will be taken out of the screening programme as long as they are under the care of the hospital.

If the patient is under the Hospital Eye Services for the follow-up or treatment of diabetic retinopathy they should not have their eyes screened photographically until they are discharged back to the screening service by the hospital.

Trauma:

Urgent referral to Eye Casualty

1. Chemical - Thorough eye wash with tap water or normal saline, at site of injury or at first contact with patient
2. Lid laceration / suspected penetrating or perforating injury to globe or suspected intra ocular foreign body
3. Hyphaema.



Hyphaema

Community management:

1. Corneal abrasion: fluoresceine stain positive, OC Chloramphenicol + eye pad refer to Eye casualty

Flashes and floaters:

Urgent referral to Eye casualty:

Uniocular:

If sudden onset of Flashes or Floaters within the last 48 hours

History of high myopia

Family history of Retinal detachment

Retinal detachment in other eye

Binocular zig-zag flashes especially if associated with aura are more likely to be migranous.

Paediatric ophthalmology

Urgent referral to eye casualty:

1. Ophthalmia neonatorum (neonates with sticky copious discharge)
2. Preseptal or orbital cellulitis
3. Accidental eye injury
4. Suspected abusive head trauma (non-accidental injury, to be referred to the paediatric casualty)

Urgent referral:

1. White reflex (leucocoria)- most common causes are cataract and retinoblastoma – both requiring expeditious treatment.

2. Capillary haemangioma (strawberry naevus) (any size) affecting the upper eyelid or a large capillary haemangioma affecting the periocular region as they grow rapidly within the first few months of life and can be amblyogenic.

Community management or observation:

1. Congenital nasolacrimal duct obstruction

Children under the age of 12 months with watery eyes : advise on massage, G chloramphenicol for conjunctivitis, refer to paediatric ophthalmology if persistent watering at 12 months of age for consideration of syringe and probe under general anaesthesia.

2. Lid cysts (chalazion)

Warm compresses, lid hygiene (leaflet attached).

Routine referral to paediatric ophthalmology

3. Squint

4. Lid cysts (chalazion)

Warm compresses, if persistent chalazion after 3 months – refer routinely to HES for incision and curettage of chalazion.

Post-operative

1. follow up

Removal of sutures following External DCR or other periocular surgery.

2. Complications

Urgent referral to Eye Casualty

Post cataract 2-5 days : reduced vision, lid swelling, pain – Endophthalmitis

Routine referral to eye clinic

Post cataract: more than 2 months: painless reduction of vision – posterior capsule opacification – treated with YAG laser capsulotomy, macular oedema treatment depends on amount of oedema.

Annex 1 – Consultants and sub specialist interests.

Annex 2 – Lid hygiene advice & Hot spoon bathing leaflet.

Annex 1

CONSULTANTS & SPECIALTY OUTPATIENT CLINICS

OCULOPLASTICS

- **Mrs LC Abercrombie** (Service Lead) Extension: 63888
  - Lid , Lacrimal, Orbit
- **Mrs KA Tambe** Extension: 64247
  - Lid, Lacrimal, Paediatric oculoplastics
- **Mr AJ Foss** Extension: 64249
  - Lid, Lacrimal
  - Medical Retina

CORNEA & ANTERIOR SEGMENT

- **Prof HS Dua** Extension: 62537
  - Corneal Disorders
  - Anterior segment disorders
  - Inflammatory Eye Disease
- **Mr SV Maharajan** Extension: 67720
  - Corneal Disorders
  - Anterior segment disorders
  - Inflammatory Eye Disease

GLAUCOMA

- **Prof SA Vernon** Extension: 67720
  - Glaucoma
  - Neuroophthalmology
  - Diabetic retinopathy
- **Mr AW King** Extension: 64247
  - Glaucoma

PAEDIATRIC OPHTHALMOLOGY

- **Mrs KA Tambe** Extension: 64247
  - Paediatric ophthalmology
  - Lid, Lacrimal, Paediatric oculoplastics
- **Mr SheryThomas** Extension: 62679
  - Paediatric Ophthalmology

- Adult strabismus
- Neuro-ophthalmology

MEDICAL RETINA

- **Mr WM Amoaku** (Senior Lecturer) Extension: 62537
  - Medical retina
  - Macular degeneration, diabetic retinopathy
  - Uveitis
- **Mr AJ Foss** Extension: 64249
  - Medical retina
  - Macular degeneration, diabetic retinopathy
  - Lid and lacrimal disorders (oculoplastics)
- **Mr A Zaman** (Clinical lead Head and Neck) Extension: 64256
  - Medical retina
  - Diabetic retinopathy, macular degeneration
  - Surgical retina
- **Mr G Orr** Extension: 64256
  - Medical retina
  - Diabetic retinopathy, macular degeneration
  - Surgical retina
- **Miss C Lim** Extension: 68485
  - Medical retina
  - Diabetic maculopathy, macular degeneration
- **Mr D Kumudhan** Extension: 62679
  - Medical retina
  - Surgical retina
  - Diabetic retinopathy, macular degeneration
  - Uveitis

VITREO-RETINAL (SURGICAL RETINA)

- **Mr A Zaman** (Clinical lead Head and Neck) Extension: 64256
  - Medical retina
  - Diabetic retinopathy, macular degeneration
  - Surgical retina
- **Mr G Orr** Extension: 64256
  - Medical retina,
  - Diabetic retinopathy, macular degeneration
  - Surgical retina

THE DEPARTMENT OF OPHTHALMOLOGY

- Eye Casualty – 24 hours, 7 days a week ophthalmic A&E services
  - 7 am to 10 pm refer to Eye A&E, EENT Building, Queens Medical Centre.
  - 10pm to 7am (overnight) – refer to main A&E

- Macula Fast Track Clinic – Urgent ARMD patients:
  - Fax referral to: 8754525
  - Phone: 8493353 (with patient present, to offer a suitable appointment)

GENERAL GUIDELINES ON REFERRAL

- Via Choose and Book Pathway or local referral mechanism

- The following information should be supplied with each referral:
  - Age
  - Provisional diagnosis
  - Duration of symptoms
  - Past Medical and Ocular History
  - Complete list of current ocular and systemic medication
  - Any known allergies
  - Any social or medical needs which might influence prioritisation

- If immediate action is required refer directly to ophthalmic A&E with a letter.

- Outpatient appointment requests
  - Via choose and book or local referral mechanism to the appropriate clinic that is most likely to address the problem.

- Common referrals
  - Cataract – standard cataract clinic
  - Glaucoma - glaucoma clinic / general clinic
    - If acute red eye – Eye casualty
  - Macular degeneration – medical retina clinic
    - If sudden reduction in vision or distortion – Macula Fast Track Clinic

- Once the ‘choose and book referral’ has been received, the patient will be given an appointment in the general or sub-speciality clinic as requested. The appointment will be with the consultant’s team which has the shortest waiting time.

- Optometrists:
    - May advise GP’s on the need for hospital referral
    - Referral to HES is at the discretion of the GP. Minor conditions like a small peripheral retinal lesion or an asymptomatic pterigium need not be referred.
    - May refer directly to the Hospital Eye Service for conditions like cataract, glaucoma or to Eye casualty.
    - Copies of the optometrists letters to the GP (eg: white copy of the GOS18) should be provided for information with the referral letter to the consultant when referring to the Hospital Eye Department.

Annex 2

HOT SPOON BATHING

Wrap some cotton wool or a small face cloth around a wooden spoon. Dip the cotton wool in boiling hot water and squeeze off any excess water on the side of a bowl. With your eye lid closed hold the spoon close to the eye (but not touching) to feel the heat from the spoon. Bring the spoon closer to the eyelid as it cools until you can touch the back of the spoon against your eye lid without burning it. Repeat this three times twice daily for five days

BLEPHARITIS – LID HYGIENE

How is blepharitis treated?

Treatment consists of the use of warm compresses and cleaning the eyelids on a regular basis to remove the crusts and oily deposits. During flare ups, treatment should be carried out 2-4 times a day. Eye drops and ointment may also be necessary to help with the treatment. When symptoms settle down, treatment should be continued once or twice weekly. Although the condition has a tendency to flare up this can be minimised by following the cleaning regime.

Lid cleaning

1. **Soak a clean flannel or cloth in warm water and hold this against the eyelids for 2-3 minutes.**
2. **Put a few drops of baby shampoo into an egg-cup sized container of warm water.**
3. **Soak a cotton bud or dental roll into the shampoo solution and use this to clean along the edges of the eyelids and roots of the eyelashes. You may need to be 'vigorous' to dislodge the scales.**