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HealthHarmonie Limited

Minor Eye Conditions Services Guide

2017

Contents

Introduction

This document is a guide for the delivery of Minor Eye Conditions Services (MECS) within the Community. Guidance is based on information from Royal College of Ophthalmologists.

Experience, Qualifications and Competencies

Any optometrists delivering MECS services must hold the following:

- Wales Optometry Postgraduate Education Centre WOPEC/LOCSU (PEARS) Distance Learning modules (Part 1) and
- The associated Practical Skills Demonstration (Part 2).

In order to progress to the second element of the accreditation process, a candidate must have successfully passed the first.

An optometrist who has a relevant higher qualification and experience may be exempt from the PEARS Distance Learning and/or the Practical Skills Assessment at the discretion of the Clinical Lead. Participating optometrists will also be expected to keep their knowledge and skills up to date.

Required Equipment

Optometrists should have suitable core competencies for the delivery of this service and should have access to the following equipment:

- Means of binocular indirect ophthalmoscopy
- Slit lamp
- Tonometer
- Distance test chart (Snellen/logmar)
- Near test type
- Equipment for epilation
- Threshold fields equipment to produce a printed report
- Amsler Charts
- Equipment for FB removal
- Appropriate ophthalmic drugs
  - Mydriatic
  - Anaesthetic
  - Staining agents

Clinical assessment

The optometrist should assess the patient's clinical condition, undertaking appropriate examinations and testing. The following conditions can be seen and managed as part of the community ophthalmology service

- ✓ Corneal abrasion
- ✓ Episcleritis
- ✓ Hordeloum
- ✓ Ocular rosacea - meibomianitis
- ✓ Pinguecula
- ✓ Pterygium
- ✓ Sub conjunctival hemorrhage

- ✓ Sub tarsal foreign body
- ✓ Dry eyes
- ✓ Trichiasis
- ✓ Floaters
- ✓ Ocular motility disorders – adult
- ✓ Chronic squints – adult
- ✓ Ocular migraine
- ✓ Epiphora
- ✓ Lid twitch
- ✓ Corneal endothelial dystrophies
- ✓ Raised IOPs
- ✓ Lens opacities
- ✓ Vitreous opacities
- ✓ Posterior vitreous detachment
- ✓ Dry AMD
- ✓ Epiretinal membrane
- ✓ Visual field anomalies
- ✓ Myelinated retinal nerve fibres
- ✓ Contact lens related issues
- ✓ Peripheral retinoschsis
- ✓ Pigment dispersion syndrome
- ✓ Keratoconus
- ✓ Suspicious disc cupping
- ✓ Blepharitis

Management of Flashes and Floaters

History and symptoms

A full and thorough history and symptoms is essential. In addition to the normal history and symptoms, careful attention must also be given to the following:

History:

- Age (over 50 year olds more likely to develop breaks)
- Myopia (over -3D)
- Family history of retinal break or detachment
- Previous ocular history of break or detachment
- Systemic disease (e.g. Diabetes, Marfan syndrome)
- History of recent ocular trauma, surgery or inflammation

Symptoms:

- Loss or distortion of vision (a curtain / shadow / veil over vision)
- Floaters
- Flashes

For symptoms of floaters these additional questions should be asked:

- Are floaters of recent onset?
- What do they look like?
- How many are there?
- Which eye do you see them in?
- Any flashes present

For symptoms of flashes these additional questions should be asked:

- Describe the flashes?
- How long do they last?
- When do you notice them?

For symptoms of a cloud, curtain or veil over the vision these additional questions should be asked:

- Where in the visual field is the disturbance?
- Is it static or mobile?
- Which eye?
- Does it appear to be getting worse?

Symptoms of less concern:

- Long term stable flashes and floaters
- Symptoms >2 months

Clinical examination

All patients presenting for a MECS examination with symptoms indicative of a potential retinal detachment should have the following investigations (in addition to such other examinations that the optometrist feels are necessary):

- Tests of pupillary light reaction including swinging light test for Relative Afferent Pupil Defect (RAPD), prior to pupil dilation
- Visual acuity recorded and compared to previous measures
- Tonometry, noting IOP discrepancy between eyes
- Visual Field examination at discretion of optometrist
- Slit lamp bio microscopy of the anterior and posterior segments, noting:
  - Pigment cells in anterior vitreous, 'tobacco dust' (Shafer's sign)
  - Vitreous haemorrhage
  - Cells in anterior chamber (mild anterior uveitic response)
- Dilated pupil fundus examination with slit lamp binocular indirect ophthalmoscopy using a Volk or similar fundus lens (wide field fundus lens optimal) asking the patient to look in the 8 cardinal directions of gaze and paying particular attention to the superior temporal quadrant as about 60% of retinal breaks occur in that area. Noting:
  - Status of peripheral retina, including presence of retinal tears, holes, detachments or lattice degeneration
  - Presence of vitreous syneresis or Posterior Vitreous Detachment (PVD)
  - Is the macula on or off (i.e. does the detachment involve the macula or not)
- Alternatively, if the optometrist is familiar and confident then a dilated pupil fundus examination with headset binocular indirect ophthalmoscopy using a 30D lens with scleral indentation or a fundus contact lens could be used.

Management

Local hospital arrangements may vary for dealing with retinal problems. It is vital to be aware of the local arrangements as this may affect the management of patients.

Symptoms requiring assessment within 24 hours:

1. Sudden increase in number of floaters suggests blood cells, pigment cells, or pigment granules (from the retinal pigment epithelium) are present in the vitreous. Could be signs of retinal break or detachment present

2. Cloud, curtain or veil over the vision. Suggests retinal detachment or vitreous haemorrhage – signs of retinal break or detachment should be present

Signs requiring referral within 24 hours:

1. Retinal detachment with good vision unless there is imminent danger that the fovea is about to detach i.e. detachment within 1 disc diameter of the fovea especially a superior bulbous detachment, when urgent surgery is required.
2. Vitreous or pre-retinal haemorrhage
3. Pigment 'tobacco dust' in anterior vitreous
4. Retinal tear/hole with symptoms

Signs requiring referral ASAP next available clinic appointment:

1. Retinal detachment with poor vision (macula off) unless this is long standing
2. Retinal hole/tear without symptoms
3. Lattice degeneration with symptoms of recent flashes and/or floaters

Require discharge with SOS advice (verbal advice and a leaflet):

1. Uncomplicated PVD without signs and symptoms listed above
2. Signs of lattice degeneration without symptoms listed above

Explain the diagnosis and educate the patient on the early warning signals of further retinal traction and possible future retinal tear or detachment:

- Give the patient a Retinal Detachment warning leaflet
- Instruct the patient to return immediately or go to A&E if flashes or floaters worsen

Management of Red eye

History and Symptoms

A full and thorough history and symptoms is essential. Careful attention must be given to thefollowing as appropriate:

History

- Previous ocular history
- Systemic disease, especially diabetes, thyroid dysfunction and inflammatory disease e.g. rheumatoid arthritis, ankylosing spondylitis, inflammatory bowel disease
- Recent cold, flu or infections
- Acne rosacea
- History of contact lens wear
- History of recent ocular trauma, pay particular note to hammer and chisel i.e. risk of penetrating injury and to possible chemical contamination
- History of recent ophthalmic surgery
- History of recent UV exposure e.g. sunlamp, welding
- Atopia e.g. hayfever, asthma, eczema
- Recent foreign travel
- Instillation of any eye drops, if so what are they?
- Systemic medication
- Allergies to drops, preservatives, medications
- Family history

Symptoms

- Discomfort, gritty sensation
- Itchiness
- Pain - sharp or aching on a scale of 1-10
- Discharge - watery, purulent, mucoid
- Unilateral or bilateral
- Duration of onset
- Acute, recurrent or chronic
- Photophobia
- Reduced vision
- Any predisposing factors

Clinical Examination

Include the following as appropriate according to symptoms and history:

- Visual acuity
- Pupil reactions – particularly check for RAPD (relative afferent pupillary defect)
- Ocular motility
- Exophthalmos
- Eyelids – inflammation, incomplete closure, ptosis, position & size of any lumps & bumps, misdirected eyelashes, lid margin disease (blepharitis, meibomianitis, phthiriasis i.e. crab louse, punctae (normal, occluded, absent, stenosed or plug inserted)
- Tears – quality and quantity plus tear break-up time
- Discharge – serous, watery (viral toxic), mucopurulent (bacterial) or stringy (allergic)
- Bulbar conjunctiva – redness (use grading scale e.g. CCLU) note depth of vessel injection (conjunctival, episcleral, sclera) and location (perilimbal, sectoral, diffuse, localized) subconjunctival haemorrhage, pigment, raised areas
- Palpebral conjunctiva – evert upper and lower lids to look for foreign bodies, scarring, membranes, papillae, follicles & concretions.
- Corneal epithelium – note any defects (size, location, pattern e.g. superficial punctate keratitis, dendritic, geographic) FBs, infiltrates (pattern, size, location, depth), oedema, deposits (location, pattern, material e.g. iron, calcium, filaments)
- Corneal stroma – size, location & depth of opacities- infiltrates, scars, oedema. Note any vessel infiltration – ghost or active vessels
- Corneal endothelium – thickening guttatae, folds or breaks in Descemets' membrane, location, pattern & type of any deposits (KPs, pigment, blood)
- Anterior chamber – depth & Van Herrick assessment of anterior angles. Any cells, flare or blood
- Iris – heterochromia, atrophy, nodules, pigment dispersion, posterior synechiae, new vessels (note is not unusual to see vessels in light coloured irides), peripheral iridotomy

Management

Practitioners should recognise their limitations and where necessary seek further advice or refer the patient elsewhere

Symptoms requiring emergency referral

- Sudden severe ocular pain
- Severe photophobia
- Unexplained sudden loss of vision
- Painful red eye in CL wearer, unless due to FB/torn CL, (retain CLs, case and solutions for culture)
- Severe trauma

Signs requiring emergency referral (to eye casualty, ophthalmic outpatient clinic or accident and emergency)

- Circumcorneal flush
- IOP>45mmHg
- Chemical injury
- Hyphaema
- Hypopyon
- Penetrating injury or deep corneal foreign body
- Corneal ulcer unless small and marginal
- Cells or flare in anterior chamber
- Dendritic ulcer in CL wearer (possible acanthamoeba)
- Deep corneal abrasion
- Corneal abrasion contaminated with foreign material
- Proptosis, restricted eye movements, pain with eye movement, pyrexia (fever >38c)

Signs requiring urgent referral (within one week)

- Rubeosis (new iris vessels)
- IOP >35mmHg (and ,<45mmHg) unless due to acute closed angle glaucoma
- New case of facial palsy or those with loss of corneal sensation
- Pyrexia (fever >38c), with lid oedema, warmth, tenderness & ptosis

Symptoms requiring routine referral

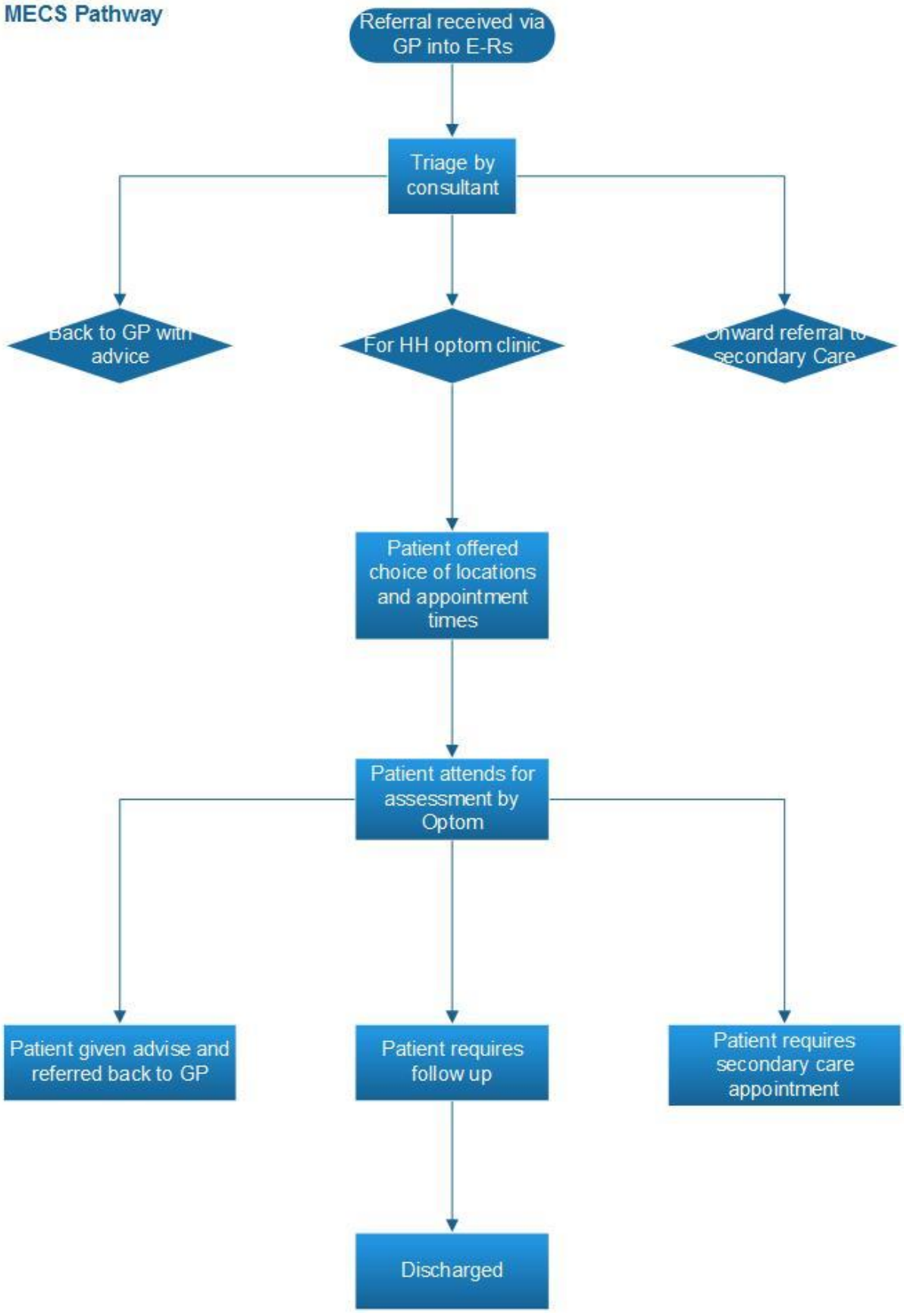
- Slow developing, non-resolving lesion of eyelid skin
- Epiphora causing symptoms

Signs requiring routine referral

- Non-resolving lid lump
- Severe ectropian with symptoms
- Entropian
- Obstructed naso lacrimal duct
- Pterygium threatening vision or associated with chronic inflammation

Guidelines courtesy of the Local Optical Committee Central Support Unit (LOCSU) Issued December 2008, Revised March 2016

Pathway


MECS Pathway
Referral received via GP into E-Rs
Triage by consultant
Back to GP with advice
For HH optom clinic
Onward referral to secondary Care
Patient offered choice of locations and appointment times
Patient attends for assessment by Optom
Patient given advise and referred back to GP
Patient requires follow up
Patient requires secondary care appointment
Discharged