Retina Guidelines Sussex Eye Hospital

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Retinal timetable

Monday	Tuesday	Wednesday	Thursday	Friday
AGC+VR Fellow in theatre EHH + MR Fellow in theatre	AGC + VR Fellow in theatre	EHH, VR + MR fellow in clinic	AGC, MBE, VR+MR fellow in clinic EHH + retinal OST in theatre	MBE, EHH, VR fellow, retinal OST in theatre
Lunchtime FFA meeting				
AGC, EHH (alternating) + MR Fellow in clinic MBE clinic alternating with theatre	MBE + VR Fellow in theatre EHH + retinal registar in clinic	MBE, VR +MR Fellow in clinic	EHH, VR + MR fellow in uveitis clinic	Teaching

The retinal team:

Mr A Casswell (Secretary Alison Hodge)
Mr M Eckstein (Secretary Jackie Wright)
Mr E Hughes (Secretary Tracy Powell)

VR Fellow / ASTO
MR Fellow
Retinal OST

Vitreo-Retinal Guidelines

Retinal tears

Laser treatment of retinal tears with the "green" laser is a useful skill for all ophthalmologists to possess. In most cases these patients do not need to be referred to the VR team for laser. Exceptions would be cases in which the tear is very large, very peripheral (can't be reached) or associated with vitreous haemorrhage (see later).

The laser can be used out-of-hours, bearing in mind that the laser room is located two floors away from the ward. Doctors treating such patients should inform the nursing staff on Pickford that they are taking a patient for laser. In some cases it may be appropriate to ask a nurse to accompany the patient downstairs. Keys to the Pascal laser are kept in the unlocked cupboard above the laser in the laser room at all times.

Retinal detachment

Sussex Eye Hospital is a tertiary referral centre for vitreoretinal surgery and we endeavour to provide a high-quality service to the peripheral hospitals that refer to us.

Telephone calls may be received via A+E or Pickford ward if out of hours. Depending on the presentation, patients may be asked to come in straight away, or in the following days either to the pre-operative ward round or one of the retinal clinics. Please liaise with the VR fellow/consultant if unsure.

Questions that are useful to ask the referring doctor to facilitate surgical planning:

- Duration of symptoms
- Macula on or off?
- If macula-off, how long for? (Longer history mac-off = less surgical urgency)
- Refractive status
- Age of patient
- Phakic / pseudophakic
- Location of detachment (superior progress faster)
- Visible break(s)
- Bullous or not?
- Suitability for local anaesthesia (often logistically easier to arrange out-of-hours)

- Other past ophthalmic history of note

Retinal detachments at particularly high risk of macular detachment are those with tractional flap tears, particularly if they are bullous and have superior breaks. New presentations of retinal detachment should be discussed with the VR fellow or one of the VR consultants. In general, most emergency VR surgery can be accommodated onto one of the VR lists that run on Mondays, Tuesdays Thursdays and Fridays. Exceptionally, surgery may be performed outside these times depending on the urgency of the case. If accepting a patient from a peripheral referral hospital for a VR opinion please ensure that the referring doctor tells the patient that they are being referred for an opinion and surgery will not necessarily take place on the same day. While awaiting surgery, patients in whom there is evidence of rapid progression may be advised to posture in bed with the retinal breaks dependent.

Overnight stay patients

The catchment area for the VR service extends eastwards as far as the Kent Border. As such, we have a relatively high number of patients staying on Pickford Ward overnight. Sometimes the decision to stay overnight will be offered to the patient to take or leave depending on how they feel after their surgery. Sometimes patients will be admitted the night before planned surgery. Under these circumstances it may be necessary for the on-call doctor to ensure that the patient's drug chart is appropriately completed and that any other medical issues are suitably addressed.

Vitreous haemorrhage

Vitreous haemorrhage partially or wholly obscuring the view of the fundus should be referred urgently to the VR team. In some cases (e.g. diabetics with known proliferative retinopathy) observation is appropriate. However, in cases of possible posterior vitreous detachment without a view of the fundus there is a significant risk of retinal detachment occurring that may go undetected. Such patients should not be monitored with serial ultrasound scans. Generally the VR team will manage these patients like macula-on detachments and will proceed to early vitrectomy.

Penetrating ocular trauma

Cases of penetrating ocular trauma should be discussed with the consultant on call to arrange primary repair. The registrar will need to co-ordinate the anaesthetic service and the theatre staff. Out-of-hours, the on-call theatre staff require at least one hour's notice to be called in when not on site. The nursing staff on Pickford ward will call in the theatre staff when advised to do so by the on-call registrar.

Following primary repair, if appropriate, the patient can be referred to the VR team for review.

Pneumo-displacement of centre-involving macular haemorrhage

Patients can be considered for this if presenting within 5 days of symptom onset. Please discuss these patients with the VR fellow or consultant. If the decision is taken to treat, this would generally be done as quickly as possible and certainly within 24 hours. This treatment is not suitable in every case and has limited success.

Medical Retina Guidelines

At SEH the three VR consultants also run the medical retina and uveitis services

Wet AMD

New presentations of Wet AMD should be booked for urgent FFA. The patient's notes will be tracked to the next FFA reporting meeting and treatment can be initiated from there. On Monday afternoons and Tuesday mornings it may be possible to get the FFA straight away plus a medical retina opinion on the same day. Please organise the urgent FFA from A+E to avoid unnecessary delays in treatment.

Intravitreal therapy

Patients requiring monthly Lucentis injections represent a challenge to ensure timely follow-up. Alison Hodge is the lynchpin of this. Please liaise with Alison regarding any Lucentis patient who has presented with new symptoms requiring review in clinic. Patients requiring Avastin or Ozurdex can also have these booked through Alison.

CRVO

Non-ischaemic CRVO with macular oedema should be followed up in the retina clinic. Some patients are suitable for intravitreal therapy with either Ozurdex or Lucentis. It is important to remember that this treatment is not necessarily suitable for everyone. Please liaise with retinal team.

Ischaemic CRVO without rubeosis should be followed up in the medical retina clinic to watch for rubeosis/angle neovascularization.

Ischemic CRVO with rubeosis/neovascularization should be referred urgently for PRP laser and in many cases these patients will also benefit from urgent intravitreal Avastin to control the rubeosis – please seek advice.

BRVO

If associated with neovascularisation, should be referred urgently as above.

BRVO with macular oedema and VA<6/12 – are suitable for grid laser treatment if there is no spontaneous improvement in the oedema after 12 weeks. Intravitreal therapies with Lucentis or Ozurdex are now NICE approved, please liaise with retinal team.

Diabetic patients

Sussex Eye Hospital is the base for the regional retinopathy service. If there appears to be proliferative or pre-proliferative retinopathy or diabetic macular oedema on photographs, patients will be referred for further assessment. It is important that patients with high-risk proliferative retinopathy are treated urgently. When writing to the GP about any diabetic patient under the care of the Eye Hospital please copy the letter to the diabetic screening service. The letter should include record of the best-corrected visual acuity and the retinopathy grade according to the English R / M / P system.

If discharging a patient back to the screening service, this should be explicitly stated in the letter. It is also worth reminding the patient that they should expect to be re-screened in the community in 12 months' time.

Diabetic macular oedema

Patients with diabetic macular oedema that fulfills the NICE criteria for intravitreal Lucents should be discussed with the Consultant in charge before commencing treatment.

Retinal artery occlusions

Patients presenting with any retinal artery occlusion are at risk of subsequent stroke. All patients should be referred urgently to the stroke service using the comprehensive referral proforma available in A+E and on Pickford ward. Remember to include the patient's address and telephone number. The form should then be faxed to the stroke service without delay. Please organise all the blood investigations requested by the stroke team and prescribe Aspirin according to the protocol on the form (suitable for most patients). Patients in atrial fibrillation should be discussed with the stroke team or medical registrar on-call. Adherence to the TIA/stroke protocol is audited regularly. In some cases these patients will be offered early endarterectomy.

All patients with retinal artery occlusions are at risk of neovascularization and should be followed up in clinic in 4 weeks.

Central retinal artery occlusion

There is not a good evidence base for treatment. Remember to exclude temporal arteritis in this group of patients.

If presenting after 24 hours it is unlikely any treatment can be offered for the occlusion. If presenting prior to 24 hours a trial of ocular massage can be attempted.

If presenting within four hours a paracentesis can be attempted, although the evidence for effectiveness is weak, there have been anecdotal reports of success.

These patients should also be urgently referred to the stroke service as outlined above.

GUIDELINES FOR REFERRAL TO THE UVEITIS CLINIC

The uveitis clinic runs every Thursday afternoon. This clinic is intended for patients with posterior or atypical disease or disease not responding to treatment. Classical unilateral acute/recurrent anterior uveitis should not normally be referred to the uveitis clinic for follow-up.

Children with uveitis may be referred to the uveitis clinic or the paediatric clinic.

Emergencies, to be referred urgently:
Retinitis or retinochoroiditis (ARN, CMV, PORN, sight threatening toxoplasma retinitis)
Active acute vasculitis (Behcets, SLE, etc)
Serous retinal detachment (Harada, posterior scleritis)
Necrotising anterior scleritis

Sight threatening toxoplasmosis = lesion threatening the macula, disc or a major blood vessel, or too much vitritis to adequately assess the fundus or toxoplasmosis in an immunosuppressed / immunocompromised patient.
Non sight-threatening lesions are small lesions away from the posterior pole with minimal vitritis. These cases are unlikely to require therapy and should be monitored.

As a general rule, any case of severe, sudden reduction in vision due to inflammation involving the posterior segment should be seen by a consultant or retinal fellow the same day.