



Bristol Eye Hospital

Referral Guidance

2020



University Hospitals Bristol
NHS Foundation Trust

Introduction

This guide has been produced by the Bristol Eye Hospital's Service Leads to provide clarity to our colleagues in the community who refer to our service. It is a guide for optometrists and general practitioners with regards to the urgency of referrals. This guidance is hoped to mean that patients can be referred to the correct service in the correct timeframe.

It is worth remembering if your patient has long-term follow-up by a provider for a condition that may also be affected by your referral, please consider referring to the same provider for continuity of care

This guidance will be updated in the future, however, if there is feedback or clarity required please do not hesitate to contact in the interim.

Efforts are made to ensure the accuracy and agreement of these guidelines, but BEH cannot guarantee this. This guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, in accordance with the mental capacity act.

Practitioners are required to perform their duties in accordance with the law and their regulators and nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

Information provided is continually updated so please be aware any printed copies may quickly become out of date.

Rhys Harrison
Consultant Ophthalmologist
Bristol Eye Hospital
2020

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Age-Related Macular Degeneration Service

Background

Medical Retina Department,
Level 2, Zone H,
Bristol Eye Hospital,
Lower Maudlin Street,
Bristol BS1 2LX

Medical Retinal Secretaries Fax: 0117 342 3402

Miss S Salvatore (Service Lead)
All Medical Retina Consultants treat AMD

Neovascular AMD

Patients presents complaining of sudden onset of distortion/scotoma/ sudden drop in visual Acuity with examination showing macular haemorrhage and/or intraretinal; or subretinal fluid, pigment epithelium detachment and BCVA of up to 6/96 may be suitable for anti-vascular endothelium growth factor (Anti-VEGF) treatment.

SSame day referral to Bristol Eye Hospital: Fax Referral to Medical Retina Secretaries at 0117 342 3402 or e-mail referral via secure nhs.net account to ubh-tr.amdbeh@nhs.net.

If an extensive sub-macular haemorrhage exists with an acute onset (<3 weeks) causing BCVA worse than 6/96, then the patient may benefit from a

gas bubble and TPA injection to clear the haemorrhage followed by anti-VEGF treatment. If the history suggests a longer onset, still refer immediately but with a guarded prognosis.

Instruct the patient to attend BEH Emergency Department on the same day, if out of hours please consult the on-call doctor

Dry AMD

Dry AMD - Referral for Low Vision Clinic assessment at BEH if warranted, otherwise at least annual sight test with patient self-monitoring with Amsler Chart.

Dry AMD patient who might be interested in either a follow-up observational study, or interventional study (usually where there is some evidence of geographic atrophy) refer by letter to: F.A.O. Assistant Trial Coordinators, Clinical Research Unit, Level 2 BEH, Lower Maudlin Street, Bristol BS1 2LX or contact 0117 342 4770 if any questions or queries.

Cataract Surgery

Background

The Bristol Eye Hospital offers cataract surgery in line with the [BNSSG Criteria Based Access](#) (see below).

The Eye Hospital offers a full range of services for complex cataract surgery, secondary intraocular lens surgery, toric lens insertion and cataract surgery combined with other surgical procedures (e.g. corneal and retinal surgery). Operations are performed under topical, local and general anaesthetic.

Criteria Based Access

The following criteria apply:

Primary Care and Community Optometrists

The patient understands that referral is for assessment for surgery

And

The patient wishes to have surgery if deemed appropriate
(please indicate this on referral letter)

Secondary Care

The proposed surgery will likely improve the visual acuity

And

A recorded vision of 6/12 or worse

Or

Vision is better than 6/12 but the patient has significant functional impairment attributable to their lens capacity (e.g. Glare, affecting work and driving)

Slight opacification of the lens is a normal part of ageing, surgery isn't necessary if the vision or patient isn't significantly affected. Consider using a Cataract Shared Decision Aid prior to referral

<https://bmjophth.bmj.com/content/bmjophth/2/1/e000100/DC2/embed/inline-supplementary-material-2.pdf?download=true>

If the patient has long-term follow-up by a provider for a condition that may also be affected by your referral, please consider referring to the same provider for continuity of care

e.g. Glaucoma and Secondary-Care Diabetic Services

If immediate treatment isn't necessary because the patient does not meet the above criteria, or they wish to postpone treatment other measures may be helpful, such as:

- New Glasses
- Brighter Lighting
- Anti-glare Sunglasses
- Magnifying Lenses

Referrals

As of **06/01/2020** all referrals should be submitted in eRS to:

"Speciality - Ophthalmology", "Clinic Type - Not Otherwise Specified", "Search Primary Care" and select "Ophthalmology Pathway - BNSSG CCG - 11H" This applies to **ALL** Cataract referrals from **ALL BNSSG Practices**.

Additional information should also be included in the referral including:

History of current and previous ophthalmology problems/procedures

Computerised summary including:

- Past medical history - if diabetes then please give details of management.
- Medication - including use of anti-coagulants/ anti-platelets
- Allergies
- Investigations - include most recent BMI, BP, eGFR, HbA1c (if diabetes)

There is a new cataract referral form which is available on the BNSSG remedy website (<https://remedy.bnssgccg.nhs.uk/adults/ophthalmology/cataract/>) which is now compulsory for cataract referrals.

Optimisation Prior to Elective Surgery

BEH wishes to optimise the patient's general health to ensure as safe as surgery as possible. All patients undergo a pre-operative assessment and include the following which will postpone surgical intervention.

Antithrombotic Therapy

- | | |
|--|---|
| • Aspirin/Clopidogrel/Dipyridamole | Continue |
| • Heparin | Continue |
| • Warfarin | INR within range 48hrs prior to surgery |
| • Direct Oral Anticoagulants
(<i>Rivaroxaban, Apixaban, Dabigatran, Edoxaban</i>) | Continue |

Hypertension Therapy

Blood pressure control needs to be below:

- | | |
|----------------------------|----------|
| • Systolic Blood Pressure | 180mm/Hg |
| • Diastolic Blood Pressure | 100mm/Hg |

Diabetic Control

This is based on long term diabetic control through HBA₁C.

- HBA₁C >100mmol/L will require optimisation prior to surgery. This is due to the increase risk of complications from cataract surgery. This is not an absolute contraindication and will be reconsidered in special or urgent cases.

Capacity Consent

If the patient lacks capacity, please highlight this on referral and suggest that the patient attends the clinic with a family member who is able to assist with consent or with the patients nominated power of attorney.

Cataract Special Cases

Toric Lenses

Toric lens insertion is performed in the Bristol Eye Hospital and are based on the following criteria:

- Regular Astigmatism
- Corneal Astigmatism >2.5D
- Patient related factors apply

Selection of cases for Toric Lens insertion is based in BEH and do not need to be identified at referral.

Multifocal Lenses

These are not commissioned for treatment of cataract in BNSSG. Requests to fund multi-focal lenses for children with rare cataract conditions will be considered through an independent funding request. Funding approval must be secured by the primary care treatment prior to referring patients for assessment. On limited occasions the CCG may approve funding for an assessment only in order to confirm or obtain evidence demonstrating a patient meets the criteria for funding.

Posterior Capsular Opacification and YAG capsulotomy

Bristol Eye Hospital performs YAG capsulotomies for Posterior Capsular Opacification (PCO). If the referral highlights the indication for YAG capsulotomies the patient will be booked to a one-stop laser clinic where they receive treatment on first visit.

Information regarding the procedure will be sent to the patient with their appointment letter.

Useful Links

<https://bnssgccg.nhs.uk/library/policy-for-cataract-referral/>
<https://bnssgccg.nhs.uk/individual-funding-requests-ifr/individual-funding-requests-directory/multifocal-lenses/>

Corneal Service

There have been primary care advice guidelines produced which is available for many anterior segment diseases. It is advisable to check the BNSSG Remedy website referral for many conditions which can be managed in primary care.

Consultants:

Mr Kieren Darcy – Service lead

Mr Derek Tole

Mr Philip Jaycock

Emergency same day referral

- Corneal ulcer
 - All corneal ulcers need urgent referral
 - These may be due to bacteria, fungi, parasites, or viral infections
 - They are more common in contact lens wearers

- Contact lens wearer with;
 - Red painful eye
 - Sudden blurring of the vision
 - Acute photosensitivity
 - Always consider acanthamoeba keratitis – early in the disease the symptoms (pain and photosensitivity) are often far worse than the signs. Significant risk factors – water contact with the lens (i.e. swimming / showering), overnight wear, poor CL hygiene, continuous wear CL > monthly CL > Dailies CL > RGP

- Chemical injury
 - Before referral please immediately irrigate the eye with copious amounts of tap water

- Suspected corneal graft rejection
 - Patients may complain of reduced vision, photosensitivity, red eye, or pain.
 - All corneal graft patients with any of these symptoms must be considered to have a graft rejection until proven otherwise.
 - Graft survival directly correlates with speed treatment is instigated

- Peripheral ulcerative keratitis
 - This usually presents with a red, painful, photosensitive eye, with or without a drop in vision.
 - It may be associated with other systemic inflammatory conditions such as, Rheumatoid arthritis, inflammatory bowel disease, or infections such as Tuberculosis, Hepatitis C.

Urgent outpatients (within 6 weeks)

- Allergic conjunctivitis
 - All patients should be started on mast cell stabilisers in the community and an attempt to find the allergen
 - Referral is indicated if;
- Failure to control symptoms with mast cell stabilisers
- Corneal epithelial defect (urgent same day referral)

- Iris lesions
 - All newly identified iris lesions should be referred urgently.
 - Please clearly state the referral is for a new iris lesion and they will be filtered into our UBM clinic for comprehensive imaging assessment

- New conjunctival lesions
 - New conjunctival pigmentation, or long-standing with a change in size
 - Non pigmented, new lesion or long standing with change in size
 - Any lesion with a white crusted surface (keratin)

Routine referrals to corneal service:

- Pterygium
 - The following criteria determines whether surgery and referral is indicated;
 - Recurrent episodes of inflammation or irritation,
 - Signs of growth. Pterygium are ideally removed before they affect the visual axis
 - Recurrent pterygium (previous surgical excision) should be referred

- Conjunctival lesion
 - Pinguecula
 - These do not need referral unless they cause significant irritation or cause recurrent bouts of inflammation. Surgery is only very rarely indicated.
 - Topical lubrication is usually sufficient to settle any inflammation

- Fuch's Endothelial dystrophy
 - Patients with corneal guttae do not need referring unless they are suffering from;
 - Diurnal variation in vision with blurring in the mornings
 - Visually significant starbursts, halos, glare or difficulty with night driving
 - Visually significant cataract – performing simultaneous cataract surgery with endothelial keratoplasty is believed to be associated with a favourable graft survival rate.

- Posterior Polymorphous Dystrophy
 - These do not need referral unless associated with a deterioration in vision
- Epithelial Basement Membrane Dystrophy
 - These do not need referral unless associated with recurrent episode of sudden pain (usually upon waking)
 - Referral to a corneal specialist should be considered before cataract surgery
- Other corneal dystrophies
 - These should be routinely referred
- Keratoconus
 - All newly suspected cases
 - Please clearly document the patients age, visual acuities, speed of any visual deterioration and the reason for concern (I.e scissoring light reflex, Vogt striae, obvious cone, obvious thinning)
- Dry eye
 - All dry eye patients should initially be treated with topical lubricants +/-blepharitis management before being referred to secondary care.
 - We accept referrals for;
 - Ongoing symptoms despite intensive topical lubrication
 - Ongoing signs despite intensive topical treatment

Emergency Department

Background

The Bristol Eye Hospital offers an Ophthalmic Emergency Department. Doors open 08:30 and last patient admitted is 16:30. Outside of these hours, there is an ophthalmology on-call team, however referral needs to be directly with the on-call team. If you are unsure whether your patient needs to be seen out of hours, please discuss with the on-call team. Please refrain from sending ophthalmology referrals to the general Emergency Department outside of opening hours without discussion with the on-call team; this leads to patients waiting in main BRI Emergency Department several hours before discussion with the on-call team.

The BEH Emergency Department runs like any other Emergency Department. We aim to see 95% of patients within four hours. It is intended for Emergency patients only and patients are seen in order of urgency, not arrival. It is not a clinic. Please advise all referrals of this.

Service lead is Mr Rhys Harrison.

Useful numbers:

BEH Emergency Department: 0117 342 4613 (08:30-16:30 only)
On-Call (via switchboard): 0117 923 000

Please be aware that the BEH ED is not funded to operate a phonenumber for triage or guidance. This means that when we are busy, we do not have the staff to adequately answer this phonenumber. Please do not call us about conditions detailed below, just send them to the department. If wishing to arrange for urgent review of a patient out of hours, please liaise with the On-call team.

The Emergency Department is intended for patients within the BNSSG CCG (Bristol, North Somerset, South Gloucester). Eye Casualties are available at:

- Bath 01225 824403
- Cheltenham/Gloucester 08454 223578
- Newport 01633 238856
- Swindon 01793 604868

Please be aware that the following list is not exhaustive...

Anterior Segment

Broken/Loose corneal sutures
Chemical Injury
Corneal Graft Rejection
Corneal Trauma (Abrasion, Laceration, Foreign Body)
Hyphaema
Infective Keratitis of any cause
Peripheral ulcerative keratitis
Sight threatening complications of Allergic Eye Disease
Stevens-Johnson Syndrome
Suspected Chlamydial/Gonorrhoeal Conjunctivitis
Suspected Open Eye Injury

Glaucoma

Suspected Bleb-related Infection
Intraocular Pressure >35mmHg (of any cause)

Medical Retina

Acute retinal artery occlusion
Amaurosis Fugax
Hypertensive Eye Disease (Grade IV)
Subretinal bleed with reduced vision

Neuro-Ophthalmology

Acute loss of vision
Acute Onset of Nystagmus
Acute Onset of Anisocoria (with or without additional symptoms)
Suspected Optic Neuritis
Sudden Onset Diplopia (suspected Third, Fourth or Sixth Nerve Palsy)
Sudden Onset of Visual Field Defect suggesting a neurological cause (hemianopia, quadrantanopia, altitudinal defect).
Suspected carotid cavernous sinus fistula
Suspected Giant Cell Arteritis with eye symptoms (*see below*)
Suspected Unilateral/bilateral optic disc swelling or papilloedema
Transient Loss of Vision (Amaurosis fugax)

Oculoplastics

Acute onset ptosis
Eyelid/Canalicular Lacerations
Orbital Inflammation
Orbital pathology leading to optic nerve dysfunction or corneal exposure.
Peri-Orbital/Orbital Infection
Suspected orbital bony injury

Paediatric Ophthalmology

Suspected non-accidental injury
Sudden onset of diplopia
Sudden onset of squint with restricted movements
Suspected papilloedema

Uveitis

Acute uveitis of any cause

Vitreoretinal

Acute onset of flashes and floaters
Positive Shafer's sign
Retinal Detachment (Macula on or off)
Retinal tear
Subretinal bleed with reduced vision
Vitreous haemorrhage

Glaucoma Service

Background

The Bristol Eye Hospital offers a full range of glaucoma services including surgery for peripheral iridotomies, selective laser trabeculoplasty, transscleral cyclo diode, trabeculectomy, drainage tube implant and deep sclerectomy.

Our Consultant Staff include:

Mr Demetri Manasses (Service Lead)

Ms Rani Sebastian (Service Lead)

Mr Jeremy Diamond

Mr Michael Greaney

If the patient has long-term follow-up by a provider for a condition that may also be affected by your referral, please consider referring to the same provider for continuity of care

Referral Guidance

Immediate Referral to the BEH Emergency Department (Same day):

- Intraocular Pressures over 35mmHg of any cause (including acute angle closure)
- Suspected Bleb related infection

Urgent Referral to the Outpatient Glaucoma Service (1-2 weeks):

- Symptoms suggestive of intermittent angle closure in the context of angles at risk of closure (intermittent pain, blurring, haloes, brow ache)
- Advanced glaucomatous visual field loss
- Advanced glaucomatous optic nerve damage
- Known BEH glaucoma patients not tolerating their eye drops
- Progression of glaucoma in any patient under the community monitoring scheme

Routine Referral to the outpatient Glaucoma Service:

- Glaucoma patients will be required to go through the BNSSG Raised Intraocular Pressure Criteria Based Access policy. Available at

<https://remedy.bnssgccg.nhs.uk/adults/ophthalmology/glaucoma/>

Referrals will be rejected if:

- IOP <24mmHg and normal optic discs and visual fields
- IOP <24 and insufficient information on disc status or visual field status
- Pigment dispersion syndrome or pseudoexfoliation without raised pressures or glaucoma (PDS/PXF do increase risk of glaucoma so should have yearly sight tests)
- Non-Bristol CCG patients will be accepted unless mild OHT (<24mmHg, as stated above)
- Suspected glaucomatous optic disc damage
- Repeatable glaucomatous visual field loss
- Suspected narrow angles without symptoms

Medical Retina Service

Background

The Bristol Eye Hospital's Medical Retina team is one of the biggest units within the hospital. The MR team works across multiple sites: Bristol Eye Hospital, South Bristol Community Hospital, Weston General Hospital and a mobile outreach unit in Cribbs Causeway. The department runs a renowned fellowship programme for doctors from across the world to experience working in the unit. The unit is also the tertiary referral centre for the southwest and has a wide array of imaging modalities and intravitreal therapies, laser and photodynamic therapies. The department works closely with the Clinical Research Unit giving patients access to new trials and new treatment options.

Our consultant staff are:

Ms Clare Bailey
Mr Tomas Burke
Ms Abosedo Cole
Dr Catherine Guly
Ms Lina Kobayter
Mr Sidath Liyanage
Mr Adam Ross (Service Lead)
Ms Serena Salvatore

Medical Retinal Secretaries Fax: 0117 342 3402

If the patient has long-term follow-up by a provider for a condition that may also be affected by your referral, please consider referring to the same provider for continuity of care

Same Day Referral (BEH Emergency Department)

Retinal Artery Occlusion
Subretinal Bleed affecting the macula
Amaurosis Fugax (Transient loss of vision in one eye)
Grade 4 Hypertensive Retinopathy

Urgent Referral (Clinic appointment in 1-2 weeks)

Untreated Proliferative Diabetic Retinopathy*
Hypertensive Retinopathy (Grade 3 or below)*
Retinal Vein Occlusion with proliferative Features or CMO*
Choroidal Vascularisation (Same-day fax, - see AMD Section)

Routine Referral

Retinal Vein Occlusion with no proliferative features or CMO*
Non proliferative Diabetic Retinopathy (Please check if patient regularly attends Diabetic Screening) *
Diabetic Macular Oedema (Please check if patient regularly attends Diabetic Screening)*
Retinal Dystrophies
Post-operative cystoid macular oedema
Macular Telangiectasia

* Please ask the patient to attend their GP for optimisation of their cardiovascular risk.

The Royal College of Ophthalmologists suggests vein occlusion patients receive BP measurement, Glucose measurement, Full blood count and Erythrocyte Sedimentation rate

Neuro- Ophthalmology Service

Background

The Bristol Eye Hospital offers a Neuro-Ophthalmology Service liaising with the Neurology, Neurosurgical and Paediatric Teams. The team triages all referrals three times a week. There are urgent clinic appointments in all clinics (which run 5 days a week) and there are dedicated urgent care clinics as well. Our consultants are as follows:

- Dr Denize Atan (Service Lead)
- Dr L Benetto
- Dr C Guly
- Ms R Sebastian

Referral Guidance

Immediate Referral to the BEH Emergency Department

- Suspected unilateral/bilateral optic disc swelling or papilloedema
- Transient loss of vision (amaurosis fugax)
- Acute loss of vision
- Acute onset of Anisocoria (with or without additional symptoms)
- Sudden onset of visual field defect suggesting a neurological cause (hemianopia, quadrantanopia, altitudinal defect).
- Suspected Giant Cell Arteritis (with eye symptoms) *see below*
- Acute Onset of Nystagmus
- Suspected Optic Neuritis
- Sudden Onset Diplopia (suspected Third, Fourth or Sixth Nerve Palsy)

Urgent Referral to Outpatients

- Suspected Pseudopapilloedema (asymptomatic patients with normal visual function)
- Asymptomatic, non-specific visual field defect detected on screening.

- Progressive worsening of cranial nerve palsies or diplopia.
- Progressive worsening of visual acuity
- Progressive loss of visual field
- Ocular Myaesthesia Gravis (Urgent to Main ED if systemic weakness)

Routine Referral to Outpatients

- Longstanding Anisocoria (>6 weeks) in asymptomatic patients
- Hemifacial spasm or myokymia
- Asymptomatic, longstanding nystagmus
- Diplopia or Visual Defect following Neurosurgical Intervention
- Longstanding Cranial Nerve Palsies
- Extraocular Myopathies (E.g. CPEO)

Red Flag Symptoms with Optic Disc Swelling

Symptoms of Neurological Disease

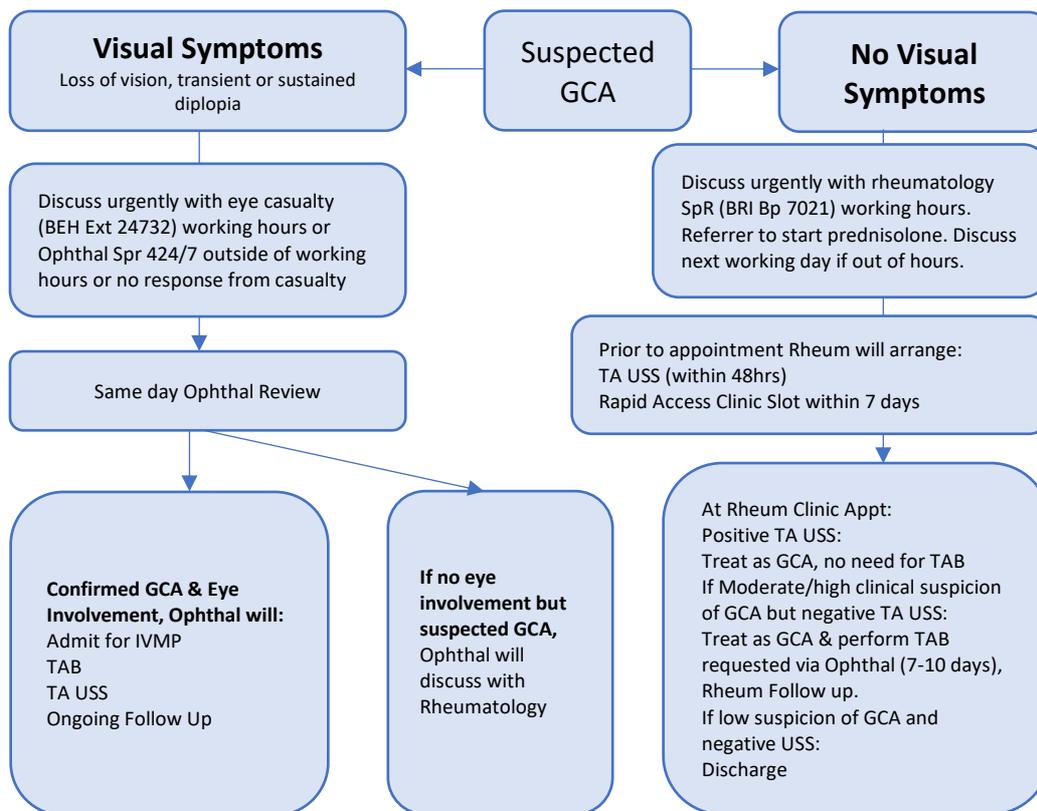
Patients with disc swelling, headache, neck stiffness and photophobia need to go to main Casualty and not Eye Casualty for treatment for meningitis/Subarachnoid Haemorrhage

- | | |
|--|--|
| <ul style="list-style-type: none"> • Headache
<i>(worse with lying down or straining)</i> • Nausea & Vomiting • Pulsatile Tinnitus • Sixth Nerve Palsy • Visual Obscuration | <ul style="list-style-type: none"> • Unilateral Dilated pupil • Drowsiness • Other Neurological Signs • High Temperature • Fever/Rigors |
|--|--|

Symptoms of Giant Cell Arteritis/Temporal Arteritis

- | | |
|---|--|
| <ul style="list-style-type: none"> • Age >50yrs old • Headache • Jaw/tongue Claudication
<i>(Pain worsens on chewing)</i> • Fatigue • Weight Loss • Loss of Vision | <ul style="list-style-type: none"> • Transient Loss of Vision • Double Vision • Associated Polymyalgia Rheumatica • Temporal Artery Abnormalities
<i>(absent pulse/beading/thickening)</i> |
|---|--|

The following is intended for Medical Clinicians seeing Patients with potential GCA



Oculoplastics

Background

The Bristol Eye Hospital offers an oculoplastic and orbital service. The Bristol Eye Hospital forms the regional tertiary referral centre for orbital care and forms part of the Regional Orbital Inflammatory Service.

Ms Helen Garrott
Ms Rebecca Ford (Service Lead)
Mr Richard Harrad

Same Day Referral

- Peri-Orbital/Orbital Infection
- Eyelid/Canalicular Lacerations
- Acute onset ptosis
- Suspected orbital bony injury
- Orbital Inflammation
- Orbital pathology leading to optic nerve dysfunction or severe corneal exposure

Urgent Outpatient Referral

- Suspected skin cancer (other than clinically obvious BCC)- please refer urgently and we will process referrals according to the within-2-week skin cancer pathway. BCC is not included in this pathway currently but routine referrals for BCC will usually be seen within 2 months.
- Suspected orbital malignancy should be referred urgently to the Bristol service.
- Suspected orbital inflammatory disease should be sent to casualty or an urgent referral sent depending on severity.
- Active thyroid eye disease: Please state if this is suspected as we have a separate BEH orbit / thyroid clinic on Thursday mornings. We aim to see new TED patients within 4-6 weeks.

Routine Outpatient Referral

Most oculoplastics conditions can be referred routinely. However, funding is restricted for some conditions by BNSSG CCG and referrals for these may be turned down if appropriate funding has not been secured. If in doubt, please check BNSSG website for policies <https://bnssgccg.nhs.uk/individual-funding-requests-ifr/individual-funding-requests-directory/>

For all elective referrals for lid procedures, please check that the patient is symptomatic and wishes to consider surgery; in particular, some patients with ectropion are not bothered by it.

Hence if routine referral is sought by optometrists for patients needing treatments not routinely funded by the CCG, we suggest referral via the GP in order to arrange funding.

Conditions seen include:

- Ptosis (new CCG policy may come out this year restricting this surgery according to visual field involvement). Exception is ptosis associated with other neurological features such as diplopia or unequal pupils; new onset ptosis can be referred for assessment to check for neurological causes without prior funding.
- Dermatochalasis ('baggy' upper lids)- **Prior approval required** for blepharoplasty surgery. This is based on visual field results so please arrange a visual field and funding application via GP.

Blepharoplasty

Patients with the following condition may be considered:

Drooping of the tissue above the upper eyelid margin (dermatochalasis) causes persistent impairment of visual fields in the relaxed, non-compensated state where there is evidence that eyelids impinge on visual fields reducing field to less than 120° horizontally and 40° vertically. However, Group 2 PCV and LGV drivers require 160° horizontally and funding will be approved for these. (Visual fields tests are usually undertaken by an optician please see Remedy for more information:

<https://remedy.bnssgccg.nhs.uk/adults/ophthalmology/ophthalmology-guidelines-for-primary-care>)

And

Blepharoplasty will improve the vision of the patient.

Supporting evidence in the form of photographs or an appropriate visual field test result will be required. It is recommended that the patient is tested twice, first with and then without the upper lids taped up.

- Watery eyes- please try simple lubricants if any signs of dry eyes as watering may be 'reflex' due to dry eye surface. Also please try anti-allergy drops if any suggestion of allergic component.

- Chalazion: **Criteria-based access** as detailed below

Chalazion Removal

The CCG will fund excision of chalazia when the patient presents with **two or more** of the following:

- Present continuously for more than six months, verified in clinical notes
- Present on the upper eyelid and interferes significantly with vision.
- Source of regular infection (2 times within six-month time frame) requiring medical treatment
- The site of the lesion or lashes renders the condition as requiring specialist intervention within the secondary care provider.

A chalazion that keeps coming back should be biopsied to rule out malignancy.

- Ectropion / entropion. **Criteria-Based Access.** If patients with entropion have red eyes or periorcular skin please check for periorcular dermatitis and treat if possible.

Ectropion/Entropion

Ectropion

Funding approval for assessment and surgical treatment will only be provided by the CCG for patients meeting criteria set out below:

The patient is suffering from severe ectropion which is posing a risk to the health of the eye and conservative management has failed, as evidenced in either the GP's referral letter or Consultant's clinic letter.

Ectropion

Funding approval for assessment and surgical treatment will only be provided by the CCG for patients meeting criteria set out below:

The patient is suffering from moderate to severe entropion where it is posing a risk to the health of the eye as eyelashes are causing persistent and on-going irritation to the eye as documented in the patient's clinical records and it is inappropriate to manage this conservatively, as evidenced in either the GP's referral letter or Consultant's clinic letter.

Or

The patient is suffering from mild entropion, conservative management such as eye drops has failed to manage the condition and there is a significant risk to the health of the eye, as evidenced in either the GP's referral letter or Consultant's clinic letter.

Core Optometry

Contact Lens Service

The Core Optometry department at BEH offers a comprehensive NHS contact lens assessment service providing hydrogel (soft) lenses, corneal and mini-scleral contact lens fitting and aftercare, as well as full haptic lens aftercare, to people with complex eye conditions who qualify for NHS contact lens treatment.

This is for a variety of eligible visual and therapeutic reasons. These include keratoconus, corneal distortion, scarred or white corneas. or to relieve pain or aid cosmesis if an eye has become unsightly following damage from, infection or trauma, or occlusive lenses for some types of intractable diplopia

People with very high prescriptions may also qualify for NHS contact lenses (typically over +/-15D), please note we are unable fit NHS contact lenses if normal vision can be obtained with spectacles.

The department also has a service for assessing a diagnostic best visual potential with a contact lens, (usually for people with binocular vision or past corneal/contact lens related complications) although these patients will be referred back to the General Ophthalmic Services (GOS) if longer term management is required.

Patients pay the standard NHS contact lens charges, unless they are exempt from these. (*NHS vouchers link¹*)

[Referral](#)

Referral to the contact lens service is always via the patients GP, but informal enquiries from Optometrists and Registered Dispensing Opticians may be made to the service lead Optometrist

[Helpful information for referral letters](#)

Please include most recent spectacles prescription and best corrected visual acuities

Sue Carter

Principal Optometrist and Service Lead Core Optometry Services

Susan.Carter@UH Bristol.nhs.uk

Low Vision Service

The Core Optometry department at BEH provide a comprehensive Low Vision Assessment Service to people where their vision does not correct with normal spectacles or contact lenses (typically 6/12 0.30 logMAR or worse).

As part of the appointment, functional vision is assessed (including best visual acuity for distance and near, contrast sensitivity, visual fields and colour vision where appropriate) visual aids, such as specialist spectacles, a wide variety of magnifiers, telescopes, and non-optical devices are demonstrated, and in many cases they can help people with day to day tasks. Most of these devices are available on-loan from the hospital and can be taken away to try on the day.

Electronic magnifiers are also available for demonstration, and the optometrist will also discuss optimal lighting and other problem-solving strategies to make the most of residual vision. Eligibility for sight impairment and severe sight impairment registration can also be reviewed.

Working closely with our Eye Clinic Liaison Officer (ECLO) and Specialist Nurse to provide an assessment of visual need, the low vision service also provides information, and signposting to other relevant support services, including support groups, the voluntary sector and specialist interest groups. *Include links to Vision² North Somerset and RNIB³*

[Low Vision Clinics](#)

There are weekly general Low Vision clinics, as well as specialist ones for Children, those in education and work. A small satellite service is available at Weston General Hospital, Weston-Super-Mare, the GP should be asked to refer the patient to this service if required.

[Referrals to the Low Vision clinic](#)

The service welcomes referrals of any patients struggling with reduced best corrected vision, referrals should always be made via the patients GP, however informal enquiries by Optometrists, Dispensing Opticians and other services involved in Low Vision service provision may be addressed to the service lead.

[Helpful information for referral letter](#)

Please include most recent spectacles prescription, best corrected visual acuities distance and near and specific visual needs.

Sue Carter

Principal Optometrist and Service Lead Core Optometry Services

Susan.Carter@UHBristol.nhs.uk

Updated September 2019

DOCUMENTS /Info for links

- ¹ <https://www.nhs.uk/using-the-nhs/help-with-health-costs/nhs-voucher-values-for-glasses-and-lenses>
- ² <https://visionnorthsomersex.com/>
- ³ <https://www.rnib.org.uk/>

Orthoptics & Squint

Background

The Bristol Eye Hospital offers an Orthoptic and Squint Surgery Service covering both adults and paediatrics. Referral guidance is detailed below.

Scope

Paediatric Orthoptic Services;

Orthoptic/ Optometry Clinics
 Paediatric Ophthalmology/ Orthoptic Clinics
 Paediatric Neuro ophthalmology/ Orthoptic Clinics
 Paediatric Motility Clinics
 Visual Assessment and Functional Vision Assessment for Children with SEN at BEH and Community Assessment Centres
 Children's Epilepsy Surgery Service- pre surgery visual assessments
 Community Orthoptic Service
 Orthoptic Led School Vision Screening Service for Bristol and South Gloucestershire

Adult Orthoptic Services

Motility Clinics
 Neuro ophthalmology/ Orthoptic Clinics
 Oculoplastic/Orthoptic
 Stroke Clinics
 Goldman Visual Fields
 IVT Injecting and Assessing (Extended Role)

Children in the Weston area can be referred straight to Weston General Hospital where our Orthoptists hold clinics. Adults from Weston can be referred to Weston General Ophthalmology for triage to joint ophthalmology / Orthoptic or Orthoptic only clinics

Trowbridge, Frome and Westbury Hospitals are covered by the RUH team, please refer to Bath RUH.

There is currently no myopia control service at BEH

Ms Helen McCarthy (Orthoptist Service Lead)

Orthoptic Secretary 0117 342 1441

Same Day Referral (Refer to BEH Emergency Department)

- Acute onset of a suspected third, fourth or sixth nerve palsy
- Acute onset of nystagmus
- Unexplained Loss of vision in a child
- Sudden onset incomitant squint

Paediatric Orthoptic Referrals (Routine)

For routine referrals refer to Paediatric Ophthalmology you may mark your referral “routine” and either PAEDIATRIC OPHTHALMOLGY or ORTHOPTIC/OPTOM but all will be triaged.

All routine referrals are via GP on ERS;

Examples of routine referrals;

- Children with vision worse than 0.2 logMAR following refractive adaption (16 weeks) and refraction under cycloplegia where possible.
- Children with manifest squint and amblyopia
- Children with decompensating symptomatic phorias

Adult Orthoptic Referrals (Routine)

For Orthoptic Adults refer to Neuro Ophthalmology at BEH via GP on ERS, referrals will be triaged by Consultant for joint appointment with Neuro Ophthalmology or for Orthoptics only.

Please be aware that the CCG operates a Prior-Approval Access for Adult Squint Surgery

Prior-Approval access as detailed overleaf:

Adult Squint Surgery

Funding Approval for surgical treatment will only be provided by the CCG for patients meeting criteria set out below:

The patient is suffering from Strabismus which is:

1. Causing intractable significant diplopia, as evidenced in either the GP's referral letter or Consultant's clinic letter.

AND

2. All appropriate conservative methods have been exhausted and have failed to resolve the diplopia, (Note – patients suffering from intractable diplopia are considered to be suffering from significant functional impairment), as evidenced in either the GP's referral letter or Consultant's clinic letter.

Patients who are concerned with their cosmetic appearance due to strabismus or connected conditions should be managed conservatively and advised that surgery to correct a cosmetic defect is not routinely available.

For more information please see: <https://remedy.bnssgccg.nhs.uk/>

The CCG does not routinely commission surgeries or treatments for other cosmetic concerns. Patients who are not eligible for treatment under this policy may be considered on an individual basis where their GP or consultant believes exceptional circumstances exist that warrant deviation from the rule of this policy.

Individual cases will be reviewed at the CCG's Exceptional Funding Panel upon receipt of a completed application form from the patient's GP, Consultant or Clinician. Applications cannot be considered from patients personally.

Vitreoretinal Service

Background

The Bristol Eye Hospital offers a full range of routine and urgent vitreoretinal surgery.

We cover Wales and the Southwest for urgent vitreoretinal surgery and provide operating facilities seven days a week, 365 days a year. Our consultants are as follows:

- Mr Sidath Liyanage (Service Lead)
- Prof A Dick
- Mr Richard Haynes
- Mr Johannes Keller
- Mr Mo Majid

Referral Guidance

[Acute onset of symptoms of Posterior Vitreous Detachment, Retinal Tear, Retinal detachment:](#)

These patients should attend the BEH Emergency Department within 24 hours.

Posterior Vitreous Detachment

- If tobacco dust, retinal tear, retinal detachment, or decreased vision patient should attend the BEH Emergency Department within 24 hours.
- If symptoms present >4 weeks (and no red flags): Routine referral.
- Any other concerns: Urgent written referral for rapid access outpatient clinic.

Retinal Detachment

Retinal Detachments require review in BEH Emergency Department, ideally the same day. If the patient will not be able to attend the department before it closes at 17:00 then please discuss with the second on-call doctor before 20:00 to discuss the best management of this patient. Please do not send patients directly to general Emergency Department. The BEH does not operate on retinal detachments in the evening or overnight. Please advise the patient to avoid significant or strenuous movement and attend the Emergency Department the next morning.

Vitreous Haemorrhage

- Unexplained or visible retinal tear: should attend the BEH Emergency Department within 24 hours.
- Untreated Proliferative Diabetic Retinopathy: Urgent Referral (*within 1 week*).
- Evidence of treated proliferative diabetic retinopathy or retinal vein occlusion: Urgent Referral (*Usually 4-6 weeks*).

Macular Bleed

Subhyaloid and submacular bleeds over the macular should be referred to the BEH Emergency Department within 24 hours.

Macular Hole

Urgent Referral (*Usually within 4 weeks*).

Epiretinal Membranes/Vitreo-macular Traction/Lamellar Macular Holes

Routine referral.

Dislocated/Opacified Intraocular Lens

Routine Referral.

Tractional Retinal Detachment

Urgent Referral (*usually within 1-2 weeks*).

Retinoschisis

Classic presentation in hyperopic patients with no retinal breaks can be referred routinely. Any other concerning features should be reviewed in the Emergency Department within 24hrs.

Optimisation Prior to Surgery

BEH wishes to optimise the patient's general health to ensure as safe as surgery as possible. In urgent cases the clinical scenario, of course, takes priority.

Antithrombotic Therapy

- | | |
|--|---|
| • Aspirin/Clopidogrel/Dipyridamole | Continue |
| • Heparin | Continue (inform surgeon) |
| • Warfarin | INR within range 48hrs prior to surgery |
| • Direct Oral Anticoagulants
(<i>Rivaroxaban, Apixaban, Dabigatran, Edoxaban</i>) | If low-risk this can be stopped 24hrs prior to surgery. |

Hypertension Therapy

Blood pressure control needs to be below:

- Systolic Blood Pressure 180mm/Hg
- Diastolic Blood Pressure 100mm/Hg

Diabetic Control

This is based on long term diabetic control through HBA₁C.

- HBA₁C >100mmol/L will require optimisation prior to surgery. This is due to the increase risk of complications from cataract surgery. This is not an absolute contraindication and will be reconsidered in special or urgent cases.

