Addenbrooke's Hospital NHS
Cambridge University Hospitals NHS Foundation Trust

Addenbrooke's post-operative assessment

Complete GOS sight test if patient is eligible.

Vision and refraction
Note unaided and best corrected visual acuity **in both eyes**
Perform and record subjective refraction **in both eyes**

Slit lamp examination:

- Degree redness
- Wound
- Corneal clarity or oedema
- Degree iritis
- IOL position
- Significant posterior capsule clarity reduction
- Pupil / iris abnormalities
- IOP
- Fundoscopy – undilated unless symptoms or vision indicates

Please indicate if the fellow eye is phakic or pseudophakic

Refer for surgery for second eye if required and meets surgical threshold

Please indicate in the space provided (labelled 'List for 2nd eye Y/N') and whether there is anisometropia >2.50D

A copy of the assessment form should be returned to the hospital with your invoice

Patients should be referred back to the eye clinic if there are signs of unexpected pathology, abnormalities or unexpected poor vision.

If they need to be seen as an emergency the same day for example endophthalmitis or significant iritis then phone the eye casualty emergency phone line.

If they need to be seen within the next 2-3 days then fax the form through to the eye department for triaging (it is helpful to give the patient's contact phone number).

Addenbrooke's post-operative assessment

Potential postoperative complications in cataract surgery include:

1.Endophthalmitis.
Infection inside the globe. Presents as painful red eye with poor vision; severe iritis usually with hypopyon, opaque vitreous with poor view fundus. Very serious, emergency referral.

2. Excessive iritis. Uncomfortable, slight blurring vision; ciliary injection, lots of cells and flare in AC. Sometimes a problem as start to come off the drops. Usually requires review with 1-2 days and an increase in postop drops but can sometimes be the start of endophthalmitis.

3. Wound problems. May be asymptomatic. Wound edges may not seal together which presents as wound gape, a wound plugged with prolapsed iris tissue or may be Seidel test +ve. If severe leakage from eye, the IOP will be very low and the AC very shallow.

4. Corneal oedema. Presents as blurred vision and corneal opacity with sometimes visibly increased corneal thickness and Descemets membrane folds. Mild corneal oedema common in 1st few weeks after surgery, usually settles spontaneously with time. Must check not due to raised IOP. Rarely does not recover and requires corneal graft.

5. Raised IOP. Usually occurs 1st few days after surgery, but can persist longer. If severe, may be associated with reduced acuity and corneal oedema.

6. Drop allergy. Allergy to the neomycin component or sometimes the preservative component of the postop maxitrol drops is not uncommon. Presents as sore and itchy red eye +/- skin rash on the lids.

7. Cystoid macular oedema. Presents as blurred vision, sometimes delayed onset after surgery. VA reduced, may be Amsler distortion and swelling or cysts visible at macula. More common in diabetics even if no retinopathy.

8. Retinal detachment and retinal tear. Presents as flashes and floaters and, if a detachment, possible loss of part of visual field or reduction in acuity. May be just PVD, but all such patients should be referred if shortly after cataract surgery. Much higher risk in high myopes and those with serious operative complications.

9. IOL displacement. IOL may be partially or completely displaced from its central position across the pupil (up/down or occasionally forward/backward), can occasionally occur considerable time after surgery. Presents as reduced vision, increased astigmatism and monocular diplopia. May see part of IOL in front of pupil/iris, or iris trapped behind part of IOL. Pupil may be distorted. May be more obvious in dilated pupil.

10. Worsening diabetic retinopathy. Diabetic retinopathy can sometimes progress rapidly after surgery, even to the point of frank maculopathy or new vessels requiring laser treatment.

11. Posterior capsular opacification. The commonest complication (10%) causing reduced vision and loss transparency behind the IOL. Usually occurs after several months –years but occasionally occurs very early. Can be treated with simple YAG laser therapy if significant symptoms and opacity. All patients being discharged from care should be warned of possibility of this complication.

12. Refractive surprise. Patient's refraction does not match that expected postop or there is significant unplanned anisometropia. Anisometropia occurring in between having the first eye and the second eye done is not uncommon.

When to refer back

- ***Emergency*** referral: suspected endophthalmitis
- ***Urgent***: retinal tear/retinal detachment/flashes & floaters; significant wound closure problems; IOP > 40; marked iritis
- ***Soon***: IOP > 28; corneal oedema; unexpected IOL displacement; persistent mild-mod iritis; severe diabetic retinopathy; drop allergy
- ***Routine***: significant symptomatic posterior capsular opacification; cystoid macular oedema; refractive surprise; suspected glaucoma

Also refer back any patients with painful eyes, persistent red eye, unexplained reduced visual acuity (i.e. not if known macular degeneration, amblyopia or other such disorder limiting vision in predicted manner), diplopia, other complications or unexpected finding AND any patient unhappy with vision/care/outcome.

NB this is a guideline only and if your clinical skills tell you that there is something which needs to be seen urgently or soon please telephone and organise or discuss.

HOSPITAL LABEL

Addenbrooke's Hospital NHS
Cambridge University Hospitals NHS Foundation Trust

Consultant: Date:
Surgeon:

Right / Left: Topical / Subtenon / Peribulbar / Subconjunctival / GA

Pre-op VA (operated eye): Refractive aim:

Other conditions:

COMMUNITY OPTOMETRIST POST-OP CATARACT ASSESSMENT

Has the operation been of benefit to the patient? Yes ☐ No ☐ Comment.....

RIGHT			Eye	**LEFT**		
			Unaided Vision			
			Best Corrected VA			
			Spectacle Prescription			
Sph	Cyl	Axis		Sph	Cyl	Axis
			IOP (mmHg)			

	Cornea	
	Incision	
	AC	
	Iris / Pupil	
	Lens	
	Fundus Dilated Yes ☐ No ☐	

Actions / Recommendations:

Problems: Yes ☐ No ☐ Details:

Urgent: Yes ☐ No ☐

List for 2nd Eye: Yes ☐ No ☐

Aniosmetropia > 2.50 D: ☐

Practice Stamp / Details

Optometrist Name……..

Optometrist signature.....

GOC No..... Date……..

Return to Cataract Scheme, Box 86, Cambridge Eye Unit, Department of Ophthalmology, Addenbrooke's Hospital, Hills Road, CB2 0QQ
For urgent conditions – call Clinic 14 on 01223 216105 (9.00am to 5.00pm) and fax form to 01223 349263.
Out of hours - call 01223 245151 and ask for the on-call ophthalmology doctor.
For non-urgent advice on referral back to the HES please phone 01223 216711 (Cataract Clinic – Specialist Nurses)