Cataract Pre-assessment Standard Operating Procedure (SOP)

The aims of the pre-cataract referral pathway:

- To present the option of cataract surgery to the patient (who has reached the visual threshold)
- To assess the patient for co-morbidities (limiting visual prognosis) and causes for an increased risk of complicated cataract surgery
- To reduce the number of inappropriate cataract referrals to the HES
- To discuss the risks and benefits of surgery such that the patient is able to make an informed decision of whether to proceed with cataract surgery
- To offer the patient a choice of surgery providers

FAQs

What clinical examinations need to be undertaken during a cataract pre-assessment?

Patients will have already undergone a sight test which will identify them as reaching the visual threshold required for cataract extraction (best corrected VAs will have been established along with current refraction). The patients then need to undergo a detailed anterior and posterior ocular examination.

What are we looking for during the clinical examination?

Anterior segment examination (consider the following):

- Blepharitis - severe blepharitis can increase the chance of post-operative endophthalmitis. Blepharitis needs to be treated upon referral. Patients should commence lid hygiene measures then referred.
- Fuchs endothelial dystrophy – look for endothelial guttata. These patients can undergo cataract removal, but it must be undertaken using the softshell viscoelastic technique to minimise loss of endothelial cells (already compromised in these patients). Post-operative corneal oedema and corneal decompensation is a risk. Treating post-operative corneal oedema may involve a corneal graft in severe and persistent cases.
- Pseudoexfoliation syndrome (PXF) – look for ‘moth eaten’ appearance of pupil in transillumination. Examine the anterior lens surface (with patient dilated) for protein deposits in a ring appearance. These patients have a wobbly lens due to weaker zonular fibres and therefore are at greater risk of complications during surgery.

- Poorly dilating pupil – A poorly dilating pupil impedes full view during surgery and increases the risk of posterior capsular rupture and IOL dislocation. These patients may need hooks or intracameral drugs during surgery.
- Previous glaucoma surgery (trabeculectomy) – cataract surgery after a trab can increase the risk of trabeculectomy failure (due to inflammation or scarring).

Posterior examination (consider the following):

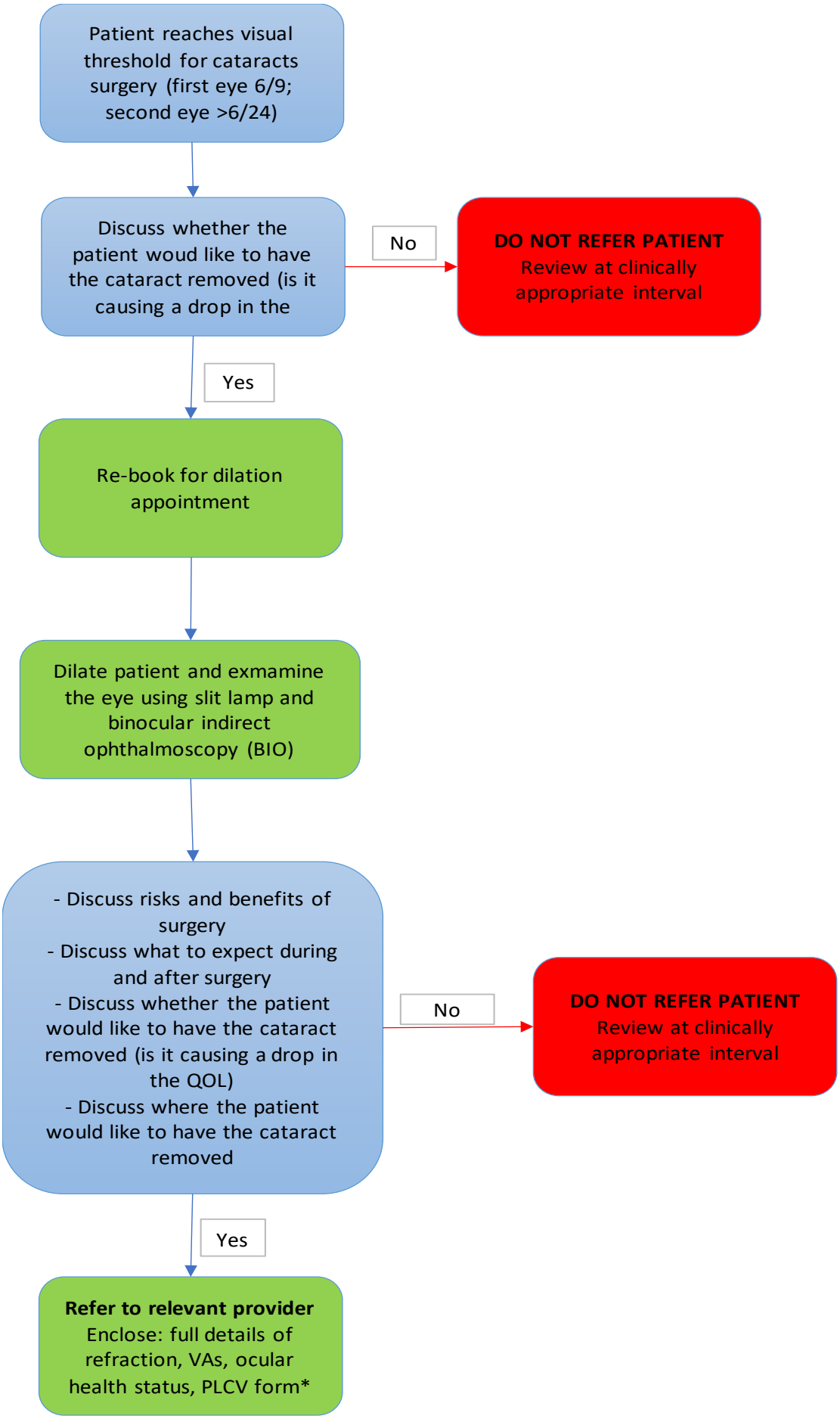
- Identify any co-morbidity which may limit the usefulness of cataract surgery for a good visual outcome. This will include macula dystrophies, AMD, previous ischaemic CRVO, CRAO, other causes for visual loss. AMD does not exclude the patient from surgery (unless the cataract is clearly not the reason for visual reduction), however these patients are given a guarded prognosis and counselled that they should not expect a full visual recovery.
- Prominent floaters – Patients will notice their floaters more after surgery. This is a problem for those with significant vitreous veils.
- Retinal detachments/tears/areas of degeneration with holes – when the lens is replaced with an IOL the physical thickness of the lens area reduces. This moves the vitreous forward and can cause traction on any existing holes/areas of degeneration. It can cause a retinal detachment.
- Pre-proliferative and proliferative diabetic retinopathy – this can get worse post operatively

What should be considered regarding the refraction?

- Consider the benefit of listing an amblyopic eye
- Consider high refractive errors – unilateral cataract extraction may result in a 3D difference between the eyes, this is not ideal, and the patient will then be listed for the second eye to avoid diplopia or binocular decompensation
- Myopic patients will need reading glasses after cataract extraction – they may not be happy with this!
- **Where there has been a myopic shift in Rx due to cataract development, include a copy of the original Rx (prior to the myopic shift) as the axial length and refraction must tally for accurate calculation of IOL power**

Are there any other things that should be considered?

- Can the patient lie flat?
- Does the patient have adequate transport?
- Allergies
- Any history of TIA or heart attack? Does the patient take aspirin or warfarin?
- Is the patient diabetic?


Patient reaches visual threshold for cataracts surgery (first eye 6/9; second eye >6/24)
Discuss whether the patient woud like to have the cataract removed (is it causing a drop in the
No
DO NOT REFER PATIENT
Review at clinically appropriate interval
Yes
Re-book for dilation appointment
Dilate patient and exmamine the eye using slit lamp and binocular indirect ophthalmoscopy (BIO)
- Discuss risks and benefits of surgery
- Discuss what to expect during and after surgery
- Discuss whether the patient would like to have the cataract removed (is it causing a drop in the QOL)
- Discuss where the patient would like to have the cataract removed
No
DO NOT REFER PATIENT
Review at clinically appropriate interval
Yes
Refer to relevant provider
Enclose: full details of refraction, VAs, ocular health status, PLCV form*

*Abbreviations used:

QOL: Quality of Life

PLCV: Procedure of Limited Clinical Value