FORGOTTEN RED EYE
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WHY FORGOTTEN RED EYE?

- More focus on Primary Care
- Concepts of “Hospitals Without Walls”
- Patient Access & Appointment Availability
- We will be (& already are) seeing many more cases of this type as the NHS, Primary Care & Optometry evolves

WHY FORGOTTEN RED EYE?

- In the last audit of the pre-WECS scheme 66% of all cases were managed in the community
- Of those that were referred onto HES only 75% were appropriate referrals

Br J Ophthalmol. 2009 Apr;93(4):435-8. doi: 10.1136/bjo.2008.144329. Epub 2008 Nov 21.

Novel optometrist-led all Wales primary eye-care services: evaluation of a prospective case series.

Sheen NJ, Fone D, Phillips CJ, Sparrow JM, Pointer JS, Wild JM.

WHY FORGOTTEN RED EYE?

- Refresh you of a few conditions that may just fly under the radar & I found interesting from the data
- Review Appropriate Examination Methods & Record Keeping
- Look at the things that we often forget to get done as part of the examination and to have as support in the practice

FUCHS ENDOTHELIAL DYSTROPHY

- Pseudo Dry Eye in early stages
- Prevalence of signs in 11%(f) & 7%(m)
- Guttata form on Descemets, secreted by an abnormal endothelium (dark spots on specular reflection)
- Progression to beaten metal appearance follows before there is decompensation
- Stromal thickening, blur, worse in the morning
- At 30% thickening, epithelial oedema develops with painful microcysts and bullae

TREATING FUCHS

- NaCl, lowering IOP, hair dryer
- Bandage CL's & Lubricant for bullae
- Penetrating / Deep Lamellar Endothelial Keratoplasty
- Cataract Surgery may accelerate the condition
- Often symptoms are taken for dry eye

CHRONIC ANGLE CLOSURE: SX & WHO

- Intermittent & often severe pain (especially on reading), blurring, haloes, mild limbal redness

WHO:

- Older people, females, far eastern origin, FH, refraction, axial length
- 0.5% of Caucasians and Afro-Caribbean, 1.5% of Chinese and Indian people over 40
- Though closed angle is not a prevalent as open angle it is more damaging to sight

CHLAMYDIAL CONJUNCTIVITIS

- Venereal infection caused by Chlamydia Trachomatis.
- Unilateral / Bilateral Redness, watering & mucopurulent discharge
- Causes chronic large conjunctival follicles, SPK, peripheral corneal infiltrates and lymph involvement.
- Self-limiting but recurrent. Non-treatment can lead to sterility (f)

ADENOVIRAL KERATO-CONJUNCTIVITIS

- Highly Infective, hardy virus. Transmitted via respiratory / ocular secretions via fomites such as towels, clothes & utensils
- Often causative for most URT infections
- Eyelid oedema, prominent conjunctival hyperaemia & follicles
- Severe inflammation may be associated with conjunctival haemorrhages, chemosis, membranes (rare) & pseudomembranes

ADENOVIRAL KERATO-CONJUNCTIVITIS

- Pseudomembranes or membranes may leave mild conjunctival scarring after resolution
- Epithelial microcysts (non-staining) are common during the early stage
- Punctate epithelial keratitis after 7-10 days
- Focal anterior stromal infiltrate develops under the epithelial lesion and can persist or recur for months or years

ADENOVIRAL KERATO-CONJUNCTIVITIS

- Can be sporadic, can affect more than one person in a family, can cause epidemics in workplaces, schools, hospitals etc..
- Symptoms can be mild / absent in some cases
- It is an important differentiator in CL care
- Hygiene is key in resolution (& for you)
- Steroids are used carefully in severe & prolonged cases

PATIENT EXAMINATION & DEFENSIVE PRACTICE

EMERGENCY PATIENTS

- It has been estimated that each day in excess of 5000 patients present at our practices as emergency appointments
- These comprise red eyes, flashes, floaters and a whole raft of symptoms
- As well as being a tremendous opportunity there are a number of issues to consider

WHAT SHOULD WE BE DOING?

- Training frontline staff
- Triaging patients consistently and securely
- Managing clinics & test rooms
- Practicing Defensively
- Having contingency plans & signposting

DEFENSIVE PRACTICE

- No such thing as a “quick look”
- Full responsibility for the patient is passed to the examining practitioner
- See the whole picture. Front, back & contralateral
- Record what you don’t see as well as what you’ve done and used – Negative record keeping

NEGATIVE RECORD KEEPING

- Record what you are ruling out as well as what you’ve done:

No CL fragments on eversion

No staining with NaFl

No flare or cells

Angles Grade 4 R&L

- It shows you specifically looked for those things
- Broad, brief statements (or even worse, the dreaded tick) may not be enough to defend a record card

THE RED EYE PATIENT
KEY INFORMATION & ACTIONS

THE RED EYE PATIENT

- Don't forget comorbidity
- Don't forget NaFl
- Don't forget to evert lids
- Check angles & IOP
- Look at the canthi and lid margins
- Have they had this before?
- Look for flare & cells
- Ask about photophobia
- Ask about discharge
- Do they wear CL's
- Consider hygiene
- Any systemic illness indicators or secondary factors?

KEY INFORMATION – CASE HISTORY

LOFTSEA

- Location
- Onset
- Frequency
- Type
- Severity
- Effect on Px
- Associations

THE EMERGENCY PATIENT
KEY INFORMATION & ACTIONS

ANALYSE WHAT YOU DO NOW

- How can you access more of these patients and build the practice?
- How can you assist the support staff?
- Do you have the correct protocols in place?
- How can you examine them more effectively?
- Are your records contemporaneous?
- Do you stock ancillary products that may help them and earn you revenue?