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Advice on NICE glaucoma guidelines

The NICE guidelines provide a framework for the diagnosis and management of Chronic Open Angle Glaucoma (COAG) and Ocular Hypertension (OHT) in England and Wales. The guidelines require that OHT should be formally diagnosed using gonioscopy before continued monitoring; OHT is defined in the guidance as repeated intraocular pressure over 21 mmHg.

The representative bodies advise that, regardless of any suggested solutions made by your local primary care organisation or local ophthalmologists to continue past practice, for legal defence purposes, it is strongly advised to refer all patients with intraocular pressure over 21 mm Hg to an ophthalmologist except in the specific circumstances detailed below.

This, of course, has overwhelmed HES departments but our view is that optometrists and optical businesses put themselves at risk unless they recognise the implications of the guideline and follow this advice. It would be helpful for the referral to state that the patient is being referred in accordance with NICE guidelines as having intraocular pressure over 21 mm Hg but without any other signs eg. normal discs and fields.

In December 2009 joint guidance was published by the College of Optometrists and the Royal College of Ophthalmologists clarifying some aspects of case finding in community optometric practice. In particular two categories of patients were identified as not requiring referral and who could be monitored in optometric practice. The working group who drafted this initial guidance will continue to look at providing further advice on safe ways for patients to be managed in primary care.

Meantime we are continuing to work with the Department of Health and NHS to find a workable solution to the issues created by the guidelines both for the short and longer term. One obvious solution is for more of this work to be carried out in the community by optometrists in optical practices.

See below for FAQs

Frequently Asked Questions

Q1 What exactly is it that NICE have suggested that has caused the advice to be issued by the professional bodies?

A NICE have defined Ocular Hypertension (OHT) as untreated IOP above 21mmHg, confirmed on a separate occasion. They have also stated that OHT should be formally diagnosed using:

- Goldmann applanation tonometry (slit lamp-mounted)
- Pachymetry
- Gonioscopy
- Automated perimetry (central thresholding)
- Optic nerve assessment, with dilated slit lamp BIO

In view of this definition and these requirements, and the fact that the guidelines are now in the public domain, optometrists put themselves at risk unless they comply. Optometrists are individually responsible for their own actions and omissions and if evidence-based guidance, such as that issued by NICE, is ignored could leave the practitioner legally exposed.

Q2 What exactly does the advice issued by the professional bodies relate to?

A The advice relates to referral on the grounds of raised IOPs alone. It is still necessary to assess other risk factors for, and signs of, Glaucoma. You should continue to refer if you find other signs suggestive of Normal Tension Glaucoma (fields, discs etc). The NICE guidance does not require you change the way you assess or refer any other patient for glaucoma.



Q3 Which patients does the joint guidance from the College and the Royal College of Ophthalmologists say I don't have to refer and can monitor in my practice?

A The joint working group have identified the following groups of patients, who do not qualify for treatment under current NICE guidance and maybe advised that they should be reviewed by a community optometrist every 12 months.

- Patients aged 80 years and over with measured IOPs <26mmHg with otherwise normal ocular examinations (normal discs, fields and van Herick).
- Patients aged 65 and over with IOPs of <25mmHg and with otherwise normal ocular examinations (normal discs, fields and van Herick).

Where an OHT monitoring scheme exists locally, these patients should be referred into it, because, although NICE suggests that they should not be treated, they are still at higher risk of developing glaucoma. Where there is no such scheme, practitioners will need to use their judgement to decide whether their needs can be met through a GOS sight test. Whilst some patients maybe suitable for a GOS sight test annually, many will not and will therefore need to be referred, either into HES or into a properly funded scheme to check their OHT to NICE standards. Where a monitoring scheme does not already exist patients may either pay privately or, LOCs should work with their PCTs in setting up a suitable scheme to assess these patients annually.



Q4 The joint guidance says I have to take a mean of 4 readings with my non-contact tonometer and I have been in the habit of only doing 3, what should I do?

A The guidance states that it applies to suspected glaucoma only. Research indicates that taking 4 readings with a non-contact tonometer improves its accuracy and correlation with the Goldmann. If your results appear to be high and you are considering referring make the referral on the basis of 4 readings.

Q5 I work in Scotland/Northern Ireland, does this apply to me?

A In Scotland, optometrists are paid, as part of GOS, to repeat pressures when clinically appropriate, using Goldmann, and they should continue to do so – only referring on IOPs alone if pressures are recurrently over 21 mmHg. Practising in accordance with the terms of service will minimise the numbers of false positives referred.

In theory, NICE Guidelines only apply to England and Wales; however the AOP has consulted a Scottish QC who has given an unequivocal opinion that Scottish optometrists should take account of its recommendations – not as the guidelines of a national body but as the latest, evidence-based clinical research, by a panel of experts, into the diagnosis and management of glaucoma and OHT. Optometrists, wherever they practise in the UK, who ignore the NICE recommendations may have to justify their actions in court or in front of a Fitness to Practise panel at the GOC. You should be clear of the clinical justification for this decision which should be recorded on the patient's record. You should be clear of the clinical justification for this decision which should be recorded on the patient's record. Practitioners in Northern Ireland should take note.

The CCI pathway, recommended by the Scottish Health Department, requires that, where a patient is referred on IOPs alone, the referral threshold should be 30 mmHg. The AOP has asked for the evidence base of the CCI pathway, but has not been given the references, nor had any response which suggests that such an evidence base is as robust as NICE. The AOP advises its members that it does not believe that relying on CCI in court will be sufficient to guarantee a favourable result. The SGHD's own optometric adviser has said that 30 mmHg is not a safe referral threshold.

Q6 I have a tonometer that's not a slit lamp mounted Goldmann (e.g. NCT, iCare or Perkins); what should I do if I get a reading over 21 mm Hg?

A: It is entirely appropriate to use any reliable and consistent tonometer to measure IOP and reach a decision as to the outcome of the sight test (i.e. whether to refer or not). IOP measurement is normally based on the average of more than one reading, as appropriate for the instrument, after eliminating any obviously spurious readings. If the resultant reading is over 21 mm Hg, regardless of the instrument, then the patient may be referred. If you repeat the pressure reading during the sight test and some readings are above and some are below 21mmHg, then it is a matter for your professional judgement as to whether the patient has IOP that is consistently and recurrently over 21mmHg and therefore needs a formal diagnosis of OHT as per the NICE guidelines.

Q7 Can I repeat the pressure measurements on a separate occasion?

A: Yes. If you offer referral refinement as a chargeable private procedure, then we recommend you follow the NICE standard of a slit lamp mounted Goldmann tonometer. If you repeat the pressures as a part of a funded scheme, then you should follow the protocol determined by the Commissioner, but we recommend that this should be some form of Goldmann applanation tonometry.

Q8 What happens if I have used drops for mydriasis and then taken pressures? Should I refer on pressures taken after installation or should I rely on the pressures taken before (which were under 21)?

A An increase in IOP post-mydriasis suggests an angle closure problem rather than chronic open angle glaucoma or ocular hypertension. Therefore post-mydriasis readings may trigger a referral, but it will not be for reasons of OHT

Q9 What do I do if I get a reading of 24 mm Hg with my Pulsair and get 18 mm Hg when I check it with my Perkins?

A The Perkins is the closest to the slit lamp-mounted Goldmann tonometer specified by NICE, and the more accurate of your two tonometers. In those circumstances decide whether to refer or not on the basis of the Perkins result.

Q10 Is the need to refer based on an IOP greater than 21 mm Hg in one eye or both eyes?

A: If either eye has a pressure over 21mmHg then this will constitute a reason for referral even if the other eye has lower pressure within the normal range.

Q11 Does this mean that any patient who is then confirmed to have a pressure greater than 21mmhg by a consultant would be entitled to tick the "I am considered to be at risk of glaucoma by an ophthalmologist at the hospital below" box on the GOS1?

A Yes.

Q12 What do I say to a patient with pressures slightly above 21 mm Hg whom I have been monitoring for a few years.

- A Explain that NICE have been conducting a review of glaucoma and OHT and, to be absolutely safe, have moved the threshold at which they believe additional investigations should be carried out,



Q13 There used to be referral letters I could use on your website, they seem to have disappeared. Does this mean I should stop using them?

- A The referral letters have been withdrawn as they no longer accord with the joint guidance issued by the College of Optometrists and the Royal College of Ophthalmologists. Instead we suggest you now use your normal preferred method for writing referral letters; as a minimum this should be the GOS 18 form. Ensure that the GOS 18 or referral letter is fully completed and contains all the clinical information you have for the patient; in particular include information about the appearance of the optic nerve head.

Q14 We have a number of patients whom we have seen over the last year or so whose pressures were over 21 and who we have not referred. Do we need to go through our records and identify these for referral or re-examination?

- A No. Examine them as normal the next time when they are due for a sight test.

Q15 Can the pressure reading used as the basis for referral be taken by an optical assistant?

- A Yes, if adequately trained and under the supervision of the optometrist

Q16 Do the angle assessment and CTT measurements need to be performed by an ophthalmologist or could I use my OCT to do this myself?

- A Only someone with all of the competencies and a specialist qualification can diagnose OHT. You could do these assessments, as they are within your competence, but regardless of whether you do or not the patient will still need to be referred to have gonioscopy done.

Q17 I am a member of a Glaucoma Referral Refinement scheme and we refer patients with IOPs of 25 mm Hg and over. Our glaucoma specialist has told us we can continue to refer using the current criteria, it is only guidance. What should I do?

- A We now do not believe it is safe, from a defence point of view, to continue to monitor anyone who has repeated pressure of over 21 mm Hg outside the specified groups in the joint guidance. In order to protect yourself you should lower your criteria of 25 to 22, present on at least two occasions and you will be compliant with the guidelines. Whatever your glaucoma specialist says, DO NOT be persuaded or bullied into continuing the scheme as it currently stands – you will leave yourself exposed to potential legal action from which neither the Secondary Care Trust nor the PCT will protect you.

Q18 The NICE guideline says that we can work under the supervision of a consultant ophthalmologist; does this mean our referral refinement scheme can continue as it is?

A We are exploring the question of working under the “supervision” of a consultant ophthalmologist, which is allowed by NICE and will be getting a legal opinion on how far this “supervision” might extend. It is possible this could be used to cover schemes such as yours. As soon as we have more definite news we will let you know.

Q19 I am one of the few people who have the College Diploma in Glaucoma, do I still need to follow this advice?

A Our view is that your diploma constitutes a specialist qualification, includes competence in gonioscopy and, provided you undertake all of the assessments identified in question 1, you are able to diagnose OHT and comply with the guidelines. Therefore you do not need to refer. You should keep full and accurate records of all examinations undertaken as part of the NIC E guidance.

Q20 I work down the road from a colleague who has the College diploma. Can I send him all my patients to see and if so who pays?

A Yes, you can refer patients to your colleague for diagnosis. This could either be funded by your local PCT or the patients could pay a separate private fee to your colleague for this specific investigation. The patient would continue to see you for their normal optometric care.

Q21 If the patient is referred with a pressure over 21, the hospital reject the referral and the patient is returned to the care of their GP, do I still have any responsibility for that patient?

A No. Someone properly qualified will have assessed the referral in the hospital department and your responsibility for the patient has therefore ended. If the patient presents again and the pressure is again over 21 mm Hg then they will need to be re-referred.

Q22 I have referred a patient, with pressures over 21 mmHg. At HES the pressures were measured at 21 or under and the patient was discharged. At the next Sight Test, I once again measured the IOPs as over 21. What should I do?

A You should re-refer the patient.

Q23 I have referred a patient with pressures over 21 mmHg. At HES the pressures were measured at over 21mmHg, yet the patient was still discharged. What should I do?

A This patient should be monitored, either in the hospital or in an optometry-based, enhanced services, funded, OHT monitoring scheme. If there is no such scheme locally and, at the next Sight Test, the patient still has IOPs over 21 mmHg, and the situation has not changed at HES, there is little point in subjecting the patient to another fruitless visit to the hospital. Instead, write to the patient’s GP, advising them that the patient is ocular hypertensive and, under NICE, requires monitoring. Ask the GP to arrange the appropriate care for the patient. An

alternative might be a private arrangement, but be aware that OHT monitoring schemes to NICE standards require data sharing and the availability of baseline disc images. In the absence of a scheme to these standards you should use your judgement as to whether what you can offer is the best available alternative

Q24 I work as a locum and am convinced that in some of the practices I attend the tonometers are not calibrated correctly. Is this a problem?

A The issuing of the NICE guidance has highlighted the need for accurate tonometry and although the majority of optometric referral will not be based on slit lamp-mounted Goldmann tonometry, it is in our patients' interests, and the interests of local eye departments, that unnecessary referrals are minimised. It is important therefore that all tonometers are calibrated correctly and measuring as accurately as they can.

Q25 What happens if I have not followed this advice. Will the AOP and/or FODO insurances still cover me?

A The AOP and/or FODO insurances will still cover you, although our legal opinion is that your position may be hard to defend. **AOP and FODO will defend their members vigorously but that defence may not be successful.**