SOMERSET NHS Foundation Trust
Musgrove Ophthalmology Referral Guidance

Emergency	Urgent		Low risk – ACES
HIGH RISK <24 hours	MEDIUM RISK - Px will be triaged following receipt of referral by Specialty teams	IP within 24 hrs (ACES protocol)	GP or Optometrist managed HES referral via GP
acutereferralclinic@SomersetFT.nhs.uk Phone 01823 344662 8.30am-5pm	acutereferralclinic@SomersetFT.nhs.uk	https://www.somersetccg.nhs.uk/your-health/aces/aces-participating-practices/	

CORNEA AND EXTERNAL EYE

▪ Microbial keratitis/PUK. ▪ HSK/HZO – severe. ▪ Foreign body deep/rust ring. ▪ Chemical injury – immediate irrigation up to 30mins as first action. ▪ Corneal trauma with sight loss. ▪ Broken/loose corneal sutures. ▪ Corneal transplant rejection. ▪ Hyphaema/ Hypopyon. ▪ Endophthalmitis. ▪ Unexplained painful red eye with sight loss.	▪ Adenovirus with sight loss. ▪ Vernal conjunctivitis with corneal involvement. ▪ Chlamydial/gonorrhoeal conjunctivitis – suspected (Conjunctival swabs to be conducted in the community) **2 week Referral:** • Changed melanosis of conjunctiva • Suspected conjunctival neoplasm	▪ Marginal keratitis. ▪ HSK/HZO – mild. ▪ Foreign body – superficial. ▪ Rust ring. ▪ Corneal abrasion/epithelial defect. ▪ Recurrent epithelial erosion. ▪ Severe/persistent episcleritis. ▪ Acute dry eye/keratitis. ▪ Conjunctivitis - infectious/allergic. ▪ Unexplained painful red eye.	▪ Acute/chronic dry eye. ▪ Foreign body superficial. ▪ Rust ring. ▪ Photo keratitis – Arc eye. ▪ Corneal abrasion. ▪ Corneal dystrophy. ▪ Episcleritis. ▪ Conjunctivitis – infectious/allergic. ▪ Pingueculae/pterygium. ▪ Blepharitis. ▪ Chalazion/hordeolum. ▪ Trichiasis/Ingrowing lashes. ▪ Sub-conjunctival haemorrhage. ▪ Unexplained Painless red eye.

OCULOPLASTICS

▪ Orbital blow out fracture. ▪ Orbital/pre-septal cellulitis. ▪ Eyelid lacerations – esp. canalicular. ▪ Dacrocystitis- cellulitis concern. **Oculoplastics – within 2 weeks** ▪ Rapidly growing eyelid tumour – suspected squamous cell carcinoma or melanoma. ▪ Proptosis with reduced vision, diplopia or pain. ▪ Facial Palsy with evidence of corneal exposure. ▪ Changed melanosis of lids.	▪ Active thyroid eye disease. ▪ Basal Cell carcinoma. ▪ Entropion with persistent discomfort or evidence of corneal changes. ▪ Suspected **new** Thyroid eye Disease with symptoms (longstanding/stable/burnt out does not need routine review). ▪ New proptosis. ▪ Facial palsy with no corneal concern. *Patient may have video consultation for medium/low risk conditions.*	**HES referral – low risk** ▪ Socket problems. ▪ Trichiasis/ingrowing lashes – recurrent. ▪ Blepharospasm. ▪ Chalazion > 6 months. ▪ Ectropion. **Artificial Eye Referrals** ▪ For patients requiring a replacement artificial eye (AE) or review of an AE, the GP should refer to the National Artificial Eye Service. Please contact the NAES on 01253 951131 or naes.naesinfo@nhs.net	▪ Trichiasis / ingrowing lashes. ▪ Epiphora - is FDDT delayed? Consider blepharitis or allergy prior to referral to HES. ▪ Suspected Thyroid eye Disease- manage with GP (thyroid function test). **Conditions requiring exceptional funding** ▪ Xanthelasma – ask GP to check Cholesterol. ▪ Ptosis > 16 years age. ▪ Dermatochalasis. ▪ Chalazion/ Hordeoleum. ▪ Naevus/ freckle. ▪ Benign lesions of the skin including skin tags, papilloma, sebaceous cysts (even if causing visual difficulty). ▪ Cosmetic surgery requires a private referral and is not eligible for NHS treatment.

NEURO-OPHTHALMOLOGY

▪ Suspected unilateral/bilateral disc swelling + symptomatic i.e. headache, transient visual obscuration (blurring/ loss), double vision, tinnitus, nausea/vomiting. ▪ Suspected AION (Giant Cell Arteritis /AION with Vision loss). If no visual symptoms in suspected Temporal arteritis – Refer to Rheumatology. ▪ Acute onset diplopia - 3rd nerve palsy. ▪ Acute loss of vision – unexplained and onset < 24 hours.	*Include image via secure email (if possible)* acutereferralclinic@SomersetFT.nhs.uk ▪ Suspected disc swelling – asymptomatic px with normal visual function. ▪ Retrobulbar/optic neuritis. ▪ AION – Non-arteritic, Non GCA ▪ Optic disc pallor/neuropathy – new finding. ▪ Acute onset Nystagmus – oscillopsia symptomatic. ▪ Acute onset diplopia – 4th, 6th.	▪ Acute/recent onset reduction in vision (VA, visual field). ▪ Recent onset –headache/ pain/discomfort. ▪ Recent onset diplopia. ▪ New pupil defect.	▪ Acute/recent onset reduction in vision (VA, visual field). ▪ Recent onset –headache/pain/discomfort. ▪ Recent onset diplopia. ▪ New pupil defect. ▪ Optic disc pit/coloboma. ▪ Tilted disc. ▪ Myelinated nerve fibres. ▪ Optic disc drusen – asymptomatic. ▪ Anisocoria – if pre-existing or with normal reactions.

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- Transient loss of vision (Amaurosis fugax). GP - TIA pathway.
- Acute visual field defect suggesting neurological cause.
- GP- to arrange TIA clinic appt.

UVEITIS

▪ Any uveitis with severe pain and a significant reduction in vision, or IOP > 35mmHg. ▪ Severe Anterior uveitis with Hypopyon /no posterior segment view. ▪ Viral retinitis (Acute retinal necrosis). ▪ Retinal Vasculitis involving macula (especially arterial involvement). ▪ Toxoplasmosis / Chorioretinitis. involving macula. ▪ Intermediate Uveitis – severe visual loss and poor fundal view.	▪ Acute anterior uveitis – moderate (no hypopyon, posterior segment visible). ▪ Children with Asymptomatic anterior uveitis. ▪ Acute Intermediate uveitis with good fundal view and no evidence of chorioretinitis. ▪ Acute Posterior uveitis not involving macula. ▪ Anterior /intermediate /Post Uveitis with Cystoid macular oedema.	▪ Acute anterior uveitis –mild (non-granulomatous, unilateral, no posterior segment involvement). ▪ Recurrent idiopathic anterior Uveitis (previous good response to topical steroids and investigated for cause).	▪ Old quiescent Chorioretinal scars. ▪ Previously diagnosed inactive Uveitis (transfer of care).

GLAUCOMA

▪ Suspected Acute Angle Closure Glaucoma. ▪ Suspected bleb related infection. ▪ Red eye with history of prior glaucoma surgery.	▪ IOP > 35mmHg of any cause. ▪ Intermittent angle closure symptoms (VH grade 2 or less, pain/brow ache/haloes/blurring). Patient may have phone triage initially by glaucoma team.	▪ Acute anterior uveitis with IOP < 35mmHg.	*OHT/Routine referral – include image via secure email (if possible)* ophthalmologysecretaries@SomersetFT.nhs.uk ▪ Please include IOP + device/Disc status (image if possible) / Visual field plot/family history/AC depth. ▪ OHT – IOP > 23mmHg x2 with GAT (IOP referral refinement scheme). Patient may have phone consultation with glaucoma team.

VITREORETINAL

▪ Acute flashes and floaters with tobacco dust – complicated PVD. ▪ Vitreous haemorrhage. ▪ Symptomatic retinal breaks/tears. ▪ Retinal Detachment- record macula on/off.	*Include image via secure email (if possible)* ophthalmologysecretaries@SomersetFT.nhs.uk ▪ Macular hole – symptomatic. ▪ Vitreomacular traction – symptomatic. ▪ Commotio retinae from recent trauma.	▪ Symptomatic PVD.	▪ Symptomatic PVD. ▪ Retinoschisis – asymptomatic. ▪ Vitreomacular traction – asymptomatic. ▪ Epiretinal membrane – if symptomatic then routine referral (vision affected when px binocular)

MEDICAL RETINA

▪ Central retinal artery occlusion ideally - ARC within 6 hrs of onset. ▪ Retinal embolus - symptomatic ▪ Hypertensive retinopathy Gd 4 (swollen discs, macular oedema, exudates) – refer to medics via GP	*Include image via secure email (if possible)* ophthalmologysecretaries@SomersetFT.nhs.uk ▪ AMD (wet) – suspected /OCT confirmed with VA 6/96 or better –use rapid access referral form. ▪ Central / branch retinal vein occlusion with oedema – co-managed with GP (BP, bloods – FBC, ESR, glucose and lipids). ▪ Choroidal naevus – suspicious: use TFSOM[1] mnemonic/CMG's (link below) ▪ Macular oedema- cystoid/post-op/diabetic ▪ Proliferative diabetic retinopathy (NVD, NVE, vitreous haemorrhage)	*Include image via secure email (if possible)* ophthalmologysecretaries@SomersetFT.nhs.uk ▪ Choroidal naevus – atypical: use TFSOM mnemonic/CMG's *(link below)* ▪ Central serous retinopathy.	**Optometrist/GP co-management** ▪ Central/branch retinal vein occlusion. ▪ No oedema/reduced visual acuity – co-managed with GP (BP, bloods – FBC, ESR, glucose and lipids). ▪ Choroidal naevus – typical: use TFSOM mnemonic. ▪ Background diabetic retinopathy. ▪ Chorioretinitis – old/quiescent. ▪ Retinal embolus – asymptomatic: request GP vascular assessment. ▪ Hypertensive retinopathy – medics/GP.

[1] **TFSOM** = **To Find Small Ocular Melanoma**: Thickness >2mm, sub retinal Fluid, Symptoms, Orange pigment, Margin touching optic disc

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Useful links in relation to this guidance

The College of Optometrists – Clinical Management Guidelines (CMG's)
https://www.college-optometrists.org/guidance/clinical-management-guidelines.html

NICE – Clinical Knowledge Summaries - Eyes
https://cks.nice.org.uk/clinicalspeciality#?speciality=Eyes

The College of Optometrists and The Royal College of Ophthalmologists working together in patient management during COVID-19
https://www.college-optometrists.org/the-college/media-hub/news-listing/patient-management-during-the-covid-19-pandemic.html

Top tips for writing a good referral – Lead Optometrist at Moorfields (Bedford)
http://www.bedfordshireloc.org/CET-PDFs/Top-tips-for-writing-a-good-referral-letter-December-15.pdf

AMD – fast track referral form
https://www.rcophth.ac.uk/wp-content/uploads/2015/04/2010-SCI-048-AMD-Electronic-Referral-Form-edited.pdf

Conditions which require exceptional funding before referral – i.e. benign skin lesions/ blepharoplasty/ptosis.
This means that the patient should be advised to see their GP who may apply for exceptional funding if appropriate. A referral will be rejected from the hospital eye service without exceptional funding in place.
If there is concern that the benign lesion or dermatochalasis or ptosis is causing visual field problems, then a visual field test demonstrating this is helpful to pass on to the GP. i.e. with and without lids lifted.
https://www.somersetccg.nhs.uk/about-us/how-we-fund-services/

Out of hours contact :– Oncall Ophthalmology Specialist Registrar via Musgrove Park Hospital Switchboard 01823 333444