



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 intraocular pressure over 21 mm Hg.

This, of course, could overwhelm HES departments but our view is that optometrists and optical businesses put themselves at risk unless they comply with the guidelines. 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.

We will be obtaining further legal advice on this matter and when that is available we will update you. Until that time, and regardless of any suggested solutions made by your local primary care organisation or local ophthalmologists to continue current practice, for legal defence purposes, it is strongly advised to refer all patients with intraocular pressure over 21 mm Hg to an ophthalmologist.

Meantime we are working 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 I work in Scotland/Northern Ireland, does this apply to me?

A NICE Guidelines only apply to England and Wales, however authorities in Scotland and Northern Ireland would take note of the content and vary from it only if they had a justifiable reason to do so. We do not believe that, for the moment at least, optometrists in Scotland and Northern Ireland need change their current modes of practice and can continue to apply the same clinical criteria and refer in the normal way. It would be worth checking with Optometry Scotland and Optometry Northern Ireland, who may have further information from the respective health departments.

Q4 I have a tonometer that's not a slit lamp mounted Goldmann (eg NCT, iCare or Perkins); what should I do if I get a reading over 21 mm Hg?

A IOP measurement is normally based on the average of more than one measure, as appropriate for the instrument. If the resultant reading is over 21 mm Hg, regardless of the instrument, then the patient may be referred. You should not offer the patient repeat pressures as a supplementary service unless you can use a slit lamp-mounted Goldmann tonometer for the procedure – in which case you may offer to repeat and refine the pressures and charge a fee if you wish and the patient agrees. If not, then you should refer.

Q5 I get one set of measurements averaging 23 mm Hg at the beginning of the test and a second set of measurements averaging of 18 mm Hg at the end of the test what should I do?

A For the purpose of determining whether the pressure is over 21mmHg, we suggest all measurements with the same instrument during the same test are averaged after eliminating obviously spurious readings.

Q6 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

Q7 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.

Q8 Is the need to refer based on an IOP greater than 21 mm Hg in one eye or both eyes?

A Any reading from either eye that does not meet the criteria must constitute a reason for referral, even if the other eye has lower pressure within the normal range. If the resultant measure is over 21 mm Hg, regardless of the instrument used, then the patient should either be re-booked for a measurement on a separate occasion (using a slit lamp-mounted Goldmann tonometer), on payment of an appropriate private fee if that is your preference, or referred to an ophthalmologist.

Q9 Can I offer to carry out repeat pressures for the patient whose first reading is over 21 mmHg and charge for the referral refinement?

A You can; but bear in mind that OHT is defined as pressures over 21, measured on separate occasions, using a slit lamp-mounted Goldmann tonometer. So you can only safely offer referral refinement for these patients if you have a slit lamp-mounted Goldmann.

Q10 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.

Q11 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,
- Q12 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.
- Q13 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
- Q14 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.
- Q15 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. 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 which neither the Secondary Care Trust nor the PCT will protect you from.
- Q16 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.
- Q17 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 NICE guidance.

Q18 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.

Q19 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.

Q20 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.