# The results of the last survey

## Regarding YAG laser peripheral iridotomy?

**Where to place the peripheral iridotomy?**

**92.6%** Superior / under lid
**7.4%** Does not matter

**Does the size of the peripheral iridotomy matter? (assuming it is full thickness)**

**67.4%** Yes
**32.6%** No

**Do you pharmacologically constrict the pupil before a peripheral iridotomy?**

**96.8%** Yes
**3.2%** No

**Do you follow patients up post-laser?**

**97.9%** Yes
**2.1%** No

**If yes, when?**

**42.1%** 2 weeks
**42.1%** 4 weeks
**10.5%** 2 months
**5.3%** 4 months and over

**What drops do you give post-laser?**

**Iopidine STAT**

**91.6%** Yes
**8.4%**No

**Steroid drops**

**92.6%** Yes
**7.4%**No

**Non-steroidal anti-inflammatory**

**11.6%** Yes
**88.4%**No

**Do you give acetazolamide after laser peripheral iridotomy?**

**11.6%** Yes
**88.4%** No

## Regarding routine posterior capsulotomy?

**Do you pharmacologically dilate the pupil before a posterior capsuolotomy?**

**93.7%** Yes
**6.3%** No

**Do you follow patients up after routine posterior capsulotomy?**

**22.1%** Yes
**77.9%** No

**If yes, when?**

**42.8%** 2 weeks
**33.3%** 4 weeks
**23.9%** 2 months

**Do you give drops after YAG-laser capsulotomy?**

**41.0%** Yes
**59%** No

**What drops do you give post-YAG laser capsulotomy?**

**Iopidine STAT**

**56.4%** Yes
**43.6%** No

**Steroid drops**

**74.6%** Yes
**25.4%** No

**Non-steroidal anti-inflammatory**

**20.5%** Yes
**79.5%** No

**Do you give acetazolamide after laser posterior capsulotomy?**

**5.3%** Yes
**94.7%** No

Firstly, my sincere thanks to those of you who responded to last edition's survey. We had a record response.

Laser was never my most exciting clinical treatment, but in this environment how I wish for even that degree of patient contact.

Again, we see variation but this time we seem to be more in agreement. We all tend to pharmacologically miose the pupil prior to peripheral iridotomy and dilate the pupil prior to posterior capsulotomy. Most of us agree that a peripheral iridotomy should go under the eyelid and two-thirds of us believe that size does matter. Consensus seems to be strong that such patients require a follow-up appointment between two and four weeks after their laser.

Regarding postoperative management we all seem to give topical Iopidine and steroids post laser peripheral iridotomy (PI). Only approximately one in 10 of us give acetazolamide post-treatment.

We are more divided when it comes to long-term follow-up. The split is almost 50:50 as to whether such patients require long-term follow-up and more than half of those who say they do would do so in the hospital setting. This means a lot of hospital appointments on a yearly basis forever. I do follow-up my narrow angle patients as I was trained that they have an approximately 15% chance of converting to chronic narrow angle glaucoma. I follow them up until they have their cataracts out and then I believe the risk of the pressure rise goes away as the drainage angle opens up widely. Challenging myself, I wonder why I need to see them in hospital and whether we could simply discharge them back to their own optometrist to measure their pressures? I think the value of guidance here is clear. If a professional body guided us as to whether such patients do or do not require hospital follow-up then we could avoid unnecessary appointments or conversely avoid the risk of avoidable harm.

I personally do not follow-up laser capsulotomy patients as I think the safety profile of this procedure does not require it. Equally, I do not give any post-procedure drops as I do not believe they get much inflammation or a significant pressure rise. I have never had problems with cystoid macular oedema (CMO) or inflammatory problems post capsulotomy.

I hope you find these results interesting and they will aid your practice reflection.

SECTION EDITOR

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# Our next survey: the current state of our practice under the COVID-19 pandemic

1. Are you currently undertaking general ophthalmology clinics?
   - ❑ Yes
   - ❑ No

2. Currently, how many of your consultations are carried out
   – Face to Face?
   0% 100%
   ❑❑❑❑❑❑❑❑❑❑❑
   – Virtually via video?
   0% 100%
   ❑❑❑❑❑❑❑❑❑❑❑
   – Virtually via telephone?
   0% 100%
   ❑❑❑❑❑❑❑❑❑❑❑

3. Do you have access to a local non-hospital / optometry or other service which can measure IOPs and feed these readings back to the hospital eye service?
   - ❑ Yes
   - ❑ No

**Assuming you are doing a telephone clinic and you telephone a 71-year-old man with mild COPD who is a driver and has established glaucoma and an MD of -14.4dB in one eye and -3.1dB in the other eye. Presenting pressure was 25mmHg. The lockdown is still active. What is your management?**

4. IOP had been stable at 15mmHg on one drop for some years but at the last attendance three months earlier the IOP was 24mmHg. No change in therapy was planned and the aim was to bring him in for a recheck of IOP.

5. Same patient as in question 4 however a second drop was added.

6. IOP had been stable at 15mmHg on one drop for some years but at the last attendance three months earlier the IOP was 34mmHg. An additional drop was added.

7. IOP had been stable at 15mmHg on one drop for some years and at the last attendance one year previously the IOP was again 15mmHg.

8. IOP had been creeping up on one drop for some years and at the last attendance six months previously the IOP was 20mmHg. A suspicion of visual field progression was raised.

9. IOP was 39mmHg at the last visit two months earlier and it was suspected this was due to poor compliance. Review was arranged for six weeks later.

10. IOP had been stable at 15mmHg on one drop for some years. At the last follow-up the IOP was 16mmHg and a follow-up in a year was arranged. This has already been delayed and is now 18 months.

11. IOP had been stable at 15mmHg on one drop for some years. At the last follow-up the IOP was 16mmHg and a follow-up in a year was arranged. This has already been delayed and is now 18 months. The patient tells you that the IOP was 24mmHg at their opticians just before lockdown.

**For each of the above:**
- ❑ Bring in for face to face appointment and IOP check before lockdown ends (less than one month)
- ❑ Reassure and bring in two months when lockdown restrictions abate
- ❑ Reassure and bring in in three months when lockdown restrictions abate
- ❑ Reassure and bring in in four months when lockdown restrictions abate
- ❑ Reassure and bring in in six months
- ❑ Reassure and bring in in nine months
- ❑ Reassure and bring in in one year
- ❑ Send to optometrist or community service for IOP check (if available)
- ❑ Change / add topical mediation by letter / contacting GP / sending out prescription.

12. Considering the above scenarios, assume the clinician did not bring the patient in for an IOP check face to face and they finally attend with a bilateral IOP of 35mmHg and progression of the visual field defects in both eyes resulting in loss of driving license. They complain that no effort was made to check their IOP at their booked appointment. Do you consider that:
    - ❑ The standard of care was reasonable regardless of the coronavirus lockdown
    - ❑ The standard of care was reasonable due to the restrictions of the coronavirus lockdown
    - ❑ There was an avoidable breach of duty in not attempting to measure the IOP or delaying the follow-up
    - ❑ There was an unavoidable breach of duty in not attempting to measure the IOP or delaying the follow-up.

(multiple answers allowed)

**You can complete the survey online here:**

**www.eyenews.uk.com/survey/**

**Deadline 30 June 2020**

Results of previous surveys are also available on the website: www.eyenews.uk.com/education/medico-legal/