CARDIFF REFERRAL GUIDELINES FOR ABNORMAL OCULAR CONDITIONS

URGENT - SAME DAY PRIOR TELEPHONE/Arrange appt Send patient WITH LETTER TEL: 029 2074 3191

Chemical injuries
Unexplained sudden loss of vision
Penetrating injuries

ANTERIOR
Dacryocystitis
Hyphaema
Hypopyon
Corneal ulcer with red eye
Periorbital inflammation with pain and swelling
Pulsating proptosis
Corneal foreign bodies (if unhappy to remove/suspect IOFB)

VITREOUS
Acute flashes and floaters with tobacco dust
Vitreous haemorrhage

POSTERIOR
CRAO within 24 hours, ideally 6 hours
Retinal breaks and tears
Retinal detachment
Suspected temporal arteritis
Uveitis
Papilloedema/3rd nerve palsy – urgent to neurosurgery

ACUTE GLAUCOMA
Acute red eye with raised IOP (suspect angle closure)

DIABETES
Vitreous haemorrhage in patient who has not had similar previously

SOON - PRIOR TELEPHONE/ARRANGE appt- send patient WITH LETTER TEL: 029 2074 3191

Acute diplopia
Herpes Zoster ophthalmicus (start anti-viral as appropriate same day)

ANTERIOR
Rubeosis with V/A hand movements or better
Scleritis
Rust ring (GP removed corneal FB)

VITREOUS
Floaters with 3 months onset
Vitritis

FUNDUS
Amaurosis fugax

Wet maculopathy – Amsler Metamorphosia especially if sole eye and V/A 6/24 or better

ARMD with recent Amsler defects/symptoms of distortion
CRAO more than 24 hours old
CRVO (within 3 months)
Direct blunt trauma to eyeball
Maculopathy with recent change in V/A
Optic disc pallor (suspected compressive lesion)
Pre-retinal haemorrhage
Retinitis

GLAUCOMA
IOP greater than 30 mmHg (white eye, clear cornea, pain free)

DIABETES
New vessels at disc or elsewhere
Recurrent vitreous haemorrhage in patient already under named consultant (patient will generally ring consultant's secretary themselves)

EYE CASUALTY AT UHW IS ON 029 2074 3191. RING BEFORE REFERRING Please only use in urgent cases

ALL URGENT REFERRALS MUST BE ACCOMPANIED BY A REFERRAL LETTER

PLEASE NOTE: *The ocular conditions listed in this document are intended to reflect those that might be encountered in community practice and is not intended to be exhaustive. The suggestions for referral have been devised for general GUIDANCE only. It does not remove from practitioners their professional responsibility to each patient, who should be dealt with on an individual basis. Conditions marked *GP* may be managed by the patients' General Practitioner.*

IN TURN – BY LETTER (priority assessed upon receipt)

Cataracts
Variable non-specific field defects (no other signs)

LIDS & AREA
Acquired ptosis
Basal cell carcinoma
Changed melanosis of lids or conjunctiva
Entropion/Ectropion
Episcleritis (not clearing in 4 weeks)
Exophthalmos/Proptosis (good/ stable VA)
Inflamed pingueculae
Persistent blepharitis
Persistent cysts of the glands of meibomian, zeis or moll
Persistent hordeolum
Suspected malignant lesions

CONJUNCTIVA & AREA
Conjunctival cysts or inclusions giving rise to discomfort
Conjunctivitis with abnormal V/A
Persistent epiphora
Severe dry eye

CORNEA
Keratoconus
Pterygium threatening visual axis
Corneal dystrophy and reduced V/A

IRIS
Pupillary defects
Rubeosis with no sight
Suspected iris melanoma
Incidental finding of unequal pupils

VITREOUS
Floaters greater than 3 month onset with good vision

FUNDUS MACULAR
ARMD with no acute symptoms of distortion
Macula hole

FUNDUS VASCULAR
Hollenhurst plaques
Retinal haemorrhages (non-diabetics)

FUNDUS GENERAL
Optic disc pits
Retinitis pigmentosa
Suspected choroidal melanoma
Other unusual pigmented lesions
Optic disc pallor (no obvious cause)

GLAUCOMA
Glaucoma suspect (with IOP <30mmHg) based upon:
- disc appearance,
- field loss,
- IOP greater than 5mm difference between eyes,

DIABETES
More than 5 haemorrhages, exudates or circinate lesions within the vascular arcade

OPTOMETRIST and / or GP MANAGED

Refractively managed squint

ANTERIOR
Chronic blepharitis *GP*
Hayfever and allergic conjunctivitis (mild with normal V/A) *GP*
Hordeolum
Ingrowing lashes (up to 3 epilations performed)
Meibomian gland dysfunction
Pingueculae
Sub-conjunctival haemorrhage *GP* OR OO
Superficial foreign bodies *GP*or OO
Disgnosed episcleritis *GP*

CORNEA
Diagnosed corneal dystrophy with good V/A
Chronic dry eye *GP*
Pterygium not threatening visual axis
Superficial corneal abrasions *GP* OR OO

VITREOUS
Asteroid hyalosis

FUNDUS
'Dry' macular changes and stable amsler with good VA
Follow-up hospital diagnosed flat choroidal naevus can be managed by O.O.

GLAUCOMA
Cases with features such as IOP <26mmHg and normal discs that have been seen and discharged by the HES and assessed stable/not glaucomatous and not changing

DIABETES
No significant changes *GP* (Consider referring all diabetics to the Diabetic Screening Clinic)

HEADACHES
Refer if orthoptic problem otherwise to GP if no optometric explanation

UNIVERSITY HOSPITAL OF WALES – EYE DEPARTMENT