FORGOTTEN RED EYE
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WHY FORGOTTEN RED EYE?

- More focus on Primary Care
- Concepts of “Hospitals Without Walls”
- Patient Access & Appointment Availability
- We will be (& already are) seeing many more cases of this type as the NHS, Primary Care & Optometry evolves
In the last audit of the pre-WECS scheme 66% of all cases were managed in the community. Of those that were referred onto HES only 75% were appropriate referrals.

Novel optometrist-led all Wales primary eye-care services: evaluation of a prospective case series.
Sheen NJ, Fone D, Phillips CJ, Sparrow JM, Pointer JS, Wild JM.

- Refresh you of a few conditions that may just fly under the radar & I found interesting from the data
- Review Appropriate Examination Methods & Record Keeping
- Look at the things that we often forget to get done as part of the examination and to have as support in the practice
**Pseudo Dry Eye in early stages**

- Prevalence of signs in 11%(f) & 7%(m)
- Guttata form on Descemets, secreted by an abnormal endothelium *(dark spots on specular reflection)*
- Progression to beaten metal appearance follows before there is decompensation
- Stromal thickening, blur, worse in the morning
- At 30% thickening, epithelial oedema develops with painful microcysts and bullae

**TREATING FUCHS**

- NaCl, lowering IOP, hair dryer
- Bandage CL’s & Lubricant for bullae
- Penetrating / Deep Lamellar Endothelial Keratoplasty
- Cataract Surgery may accelerate the condition
- Often symptoms are taken for dry eye
### CHRONIC ANGLE CLOSURE: SX & WHO

- Intermittent & often severe pain (especially on reading), blurring, haloes, mild limbal redness

**WHO:**
- Older people, females, far eastern origin, FH, refraction, axial length
- 0.5% of Caucasians and Afro-Caribbean, 1.5% of Chinese and Indian people over 40
- Though closed angle is not as prevalent as open angle it is more damaging to sight

### CHLAMYDIAL CONJUNCTIVITIS

- Venereal infection caused by Chlamydia Trachomatis.
- Unilateral / Bilateral Redness, watering & mucopurulent discharge
- Causes chronic large conjunctival follicles, SPK, peripheral corneal infiltrates and lymph involvement.
- Self-limiting but recurrent. Non-treatment can lead to sterility (f)
**ADENOVIRAL KERATO-CONJUNCTIVITIS**

- Highly Infective, hardy virus. Transmitted via respiratory / ocular secretions via fomites such as towels, clothes & utensils
- Often causative for most URT infections
- Eyelid oedema, prominent conjunctival hyperaemia & follicles
- Severe inflammation may be associated with conjunctival haemorrhages, chemosis, membranes (rare) & pseudomembranes

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**ADENOVIRAL KERATO-CONJUNCTIVITIS**

- Pseudomembranes or membranes may leave mild conjunctival scarring after resolution
- Epithelial microcysts (non-staining) are common during the early stage
- Punctate epithelial keratitis after 7-10 days
- Focal anterior stromal infiltrate develops under the epithelial lesion and can persist or recur for months or years
ADENOVIRAL KERATO-CONJUNCTIVITIS

- Can be sporadic, can affect more than one person in a family, can cause epidemics in workplaces, schools, hospitals etc..
- Symptoms can be mild / absent in some cases
- It is an important differentiator in CL care
- Hygiene is key in resolution (& for you)
- Steroids are used carefully in severe & prolonged cases

PATIENT EXAMINATION & DEFENSIVE PRACTICE
EMERGENCY PATIENTS

- It has been estimated that each day in excess of 5000 patients present at our practices as emergency appointments.
- These comprise red eyes, flashes, floaters and a whole raft of symptoms.
- As well as being a tremendous opportunity there are a number of issues to consider.

WHAT SHOULD WE BE DOING?

- Training frontline staff
- Triaging patients consistently and securely
- Managing clinics & test rooms
- Practicing Defensively
- Having contingency plans & signposting
DEFENSIVE PRACTICE

- No such thing as a “quick look”
- Full responsibility for the patient is passed to the examining practitioner
- See the whole picture. Front, back & contralateral
- Record what you don’t see as well as what you’ve done and used – Negative record keeping

NEGATIVE RECORD KEEPING

- Record what you are ruling out as well as what you’ve done:
  No CL fragments on eversion
  No staining with NaFl
  No flare or cells
  Angles Grade 4 R&L

- It shows you specifically looked for those things
- Broad, brief statements (or even worse, the dreaded tick) may not be enough to defend a record card
THE RED EYE PATIENT

KEY INFORMATION & ACTIONS

- Don’t forget comorbidity
- Don’t forget NaFl
- Don’t forget to evert lids
- Check angles & IOP
- Look at the canthi and lid margins
- Have they had this before?
- Look for flare & cells
- Ask about photophobia
- Ask about discharge
- Do they wear CL’s
- Consider hygiene
- Any systemic illness indicators or secondary factors?
KEY INFORMATION – CASE HISTORY

LOFTSEA
- Location
- Onset
- Frequency
- Type
- Severity
- Effect on Pxn
- Associations

THE EMERGENCY PATIENT
KEY INFORMATION & ACTIONS
How can you access more of these patients and build the practice?
How can you assist the support staff?
Do you have the correct protocols in place?
How can you examine them more effectively?
Are your records contemporaneous?
Do you stock ancillary products that may help them and earn you revenue?

ANALYSE WHAT YOU DO NOW