Guidelines for Cross-referrals

FOR THE COVID-19 SITUATION

Aravind Eye Hospitals

& Postgraduate Institute of Ophthalmology

In view of the current COVID-19 situation, the following guidelines have been set with consensus from the respective Department Chiefs to avoid unnecessary cross-referrals and over-crowding. This is to ensure Social Distancing guidelines throughout.

The following criteria for cross-referral between departments is applicable through the month of May and will get reviewed, revised and updated as the situation progresses.

ARAVIND EYE CARE SYSTEM

CORNEA

Definite referral criteria

- Microbial keratitis
- Open globe injuries
- Neurotrophic ulcer
- Acute corneal graft rejection
- Ocular surface squamous neoplasia
- Steven Johnson syndrome
- Progressive corneal ectasia
- Bullous keratopathy
- Chemical injury
- Marginal keratitis
- Post Lasik patients
- Severe corneal opacity requiring keratoplasty

Conditions to be managed without referral

- Conjunctivitis
- Foreign body removal
- Corneal abrasion
- Mild & moderate dry eyes
- Blepharitis
- Mild corneal dystrophies
- Uncomplicated post pterygium surgeries
- Post C3R without progression
- Old corneal opacity without visual disturbance

Cataract

Definite referral criteria

- Traumatic cataract/ subluxated cataract
- Endophthalmitis
- Post-operative iritis
- Post-operative complications which requires resurgery
  - Wound gape
  - Blood clot in AC
  - Cortex/ epinucleus in AC
  - Subluxated IOL
  - Decentered IOL
- Premium IOL workup (Toric, MFIOL)

  Surgeries to be advised only for - Mature intumescent cataract , Hypermature cataract and Traumatic cataract

RETINA

Definite referral criteria

- Retinal detachments (Rhegmatogenous/Exudative/Tractional)
- Acute history of Flashes or Floaters(not for single floater)
- Sudden loss of vision with suspicion of macular pathology
- CRAO
- CRVO
- BRVO with CME
- Post-opérative CME
- Severe NPDR
- PDR
- Any DR with CSME and vision loss
- Vitreous Hemorrhage
- Vasculitis
- Vitritis
- Suspected Endophthalmitis
- PCV
- CNVM
- Neovascular Glaucoma
- Any VR surgery with silicon oil in situ
- Re Retinal detachments
- Macular hole
- Epiretinal membranes with vision loss or symptoms of metamorphosia
- Choroid detachments
- Open globe injury
- Closed globe injury for indentation and peripheral screening

Conditions to be managed without referral

High Myopia : All high myopias (including pediatric age group) peripheral screening to be done in the respective clinics and only treatable lesions to be referred

Retinal degeneration/Dystrophies: To be seen in the respective clinics, visual prognosis to be explained and asked to review after 6 months.

Macular scar (Patients with vision loss for more than a year): Visual prognosis to be explained and patient asked to review after 6 months.

Heredo macular degeneration : (Stargardt's dystrophy, Best dystrophy) – Visual prognosis explained and patient asked for review after 6 months.

FR Dull : Referrals to be avoided unless vision loss is acute and referring doctor suspects macular pathology

Vision loss not correlating with cataract : Referrals to be avoided if the patient's loss of vision is chronic or amblyopia is suspected.

IJT : If referring doctor is confident that IJT is quiescent, vision is stable as last visit, patient is asymptomatic, and patient can be asked to review after 3 months.

NPDR : All patients with Mild or Moderate NPDR without Central involving macular edema and 6/6 vision can be asked review after 6 months with strict systemic control.

Lasered PDR : All PDR post PRP patients with no complaints and stable vision can be seen in respective clinics and asked to review after 6 months with strict systemic control.

RVO : Any fresh RVO without CME and vision 6/6 can be asked to get systemic blood investigations and review after 1 month in Retina Clinic

Lasered RVO : Any old RVO post sectoral PRP and no CME and stable vision can be asked to review after 6 months with strict systemic control.

Dry ARMD: Dry ARMD with drusens, with 6/6 vision and no active CNVM can be asked to review after 6 months, warning symptoms of CNVM should be explained and oral anti-oxidants can be prescribed.

Post SOR patients: If vision is stable since last visit and retina is attached the patients can be seen in respective clinics and asked to review in Retina clinic after 6 months.

Aphakia patients: Surgical aphakia, periphery to be screened and patient asked to refer in Retina clinic after 1 month to plan for SFIOL

ORBIT

Definite referral criteria

1. **DACRYOLOGY**
   - Matted lashes
   - Lacrimal sac area swelling
   - CNLDO (New and review)
   - All post op patients
   - All cases planned for ocular surgery requiring syringing (NO ROPLAS or syringing to be done anywhere except in Orbit clinic)
   - All patients with symptoms of watering

2. **OCULOPLASTY**
   - Hordeolum Externum (Not responding to conservative management/ associated with preseptal cellulitis)
   - Hordeolum internum (Not responding to conservative management/ associated with preseptal cellulitis)
   - Chalazion (Large/ Not responding to conservative management/ associated with granuloma/burst chalazion/ Recurrent chalazion)
   - Preseptal celluliits
   - Lid abscess
   - MGD – symptomatic, nonresolving
   - Anterior Blepharitis with severe ulceration/ scarring/ nonresolving
   - Ptosis – all cases other than Mild +Aponeurotic ptosis+ Age >50 yrs,+Asymptomatic
   - Ectropion
   - Entropion
   - Lagophthalmos

3. **ORBIT**
   - All cases of Proptosis/ orbital mass/ orbital infections/ orbital inflammations
   - All symptomatic mass lesions/ suspicious mass lesions
   - Paediatric amblyogenic lid/ orbital capillary haemangiomas

4. **ONCOLOGY**
   - All cases of suspicious conjunctival/ Lid/ Orbital mass lesions
   - All known cases of ocular/ orbital malignancy
   - All review/ poostop oncology patients

5. **PROSTHESIS**
   - All patients using an ocular prosthesis
   - All patients with Anophthalmic sockets/ exenterated sockets
   - All patients with microphthalmos/ Phthisis bulbi

6. TRAUMA

- All lid tears/ abrasion/ tissue loss/ Haematomas
- All cases with emphysema
- All globe ruptures
- All orbital wall fractures
- All cases orbital haemmorhage/ acute proptosis

7. Cases Requiring ONSD

Conditions to be managed without referral

- Previous known duct not free/ partially free – asymptomatic i.e. No complaints of watering/ signs of inflammation or active infection.
- Hordeolum Externum
- Hordeolum internum
- Small typical Chalazion
- Acute Herpetic Blepahritis without ocular involvement/ scarring
- Phthiriasis palpebrum
- MGD – asymptomatic
- Anterior Blepharitis

Protocol for management of non-referrals

I. Blepharitis

A. Anterior Seborrhoeic/ Squamous blepharitis
   a) Lid hygiene (baby shampoo/lid scrub)
   b) Moisturization of lids
   c) RA 15 d- 1 m

ii. Staphylococcal blepharitis
   a) gentle lid hygiene
   b) Chloramphenicol+ Polymixin B e/o BD x 2 wks
   c) R/A 10-15 d

B. Posterior blepharitis, Meibomitis
   i. Mild MGD with no Tear film instability
      a) Warm compress
      b) lid massage
      c) R/A 1-3 m

II. Hordeolae

A. Externum
   i. Epilation of offending eyelash
   ii. Warm compress QID x 15 d
   iii. Chloramphenicol+ Polymixin B e/o BD x 2 wks
   iv. R/A 2wks

B. Internum
   i. Warm compress QID x 15 d
   ii. Chloramphenicol+ Polymixin B e/o BD x 2 wks
   iii. R/A 2wks

III. Chalazion

A. Small
   i. Warm compress QID x 15 d
   ii. Gentle lid massage
   iii. R/A 1m

IV. Herpetic blepharitis without ocular involvement

A. Herpes simplex
   i. T.Acyclovir 400 mg 5 times a day x7d (if presented within 72hrs of onset of skin lesions, after physician clearance)
   ii. Topical Acyclovir ointment(5%) 5 times/ day local application
   iii. RA 2 weeks/ SOS in case of ocular symptoms

B. Herpes zoster
   i. T Acyclovir 800 mg 5 times/d x7-10 d (if presented within 72hrs of onset of skin lesions, after physician clearance)
   ii. Topical Acyclovir ointment(5%) 5 times/ day local application
   iii. RA 2 weeks/ SOS in case of ocular symptoms

V. Phthiriasis palpebrum:

A. Manual removalof all mites and nits after application of Fluroscein for 10 minutes
B. Examination of and counselling of family members to look for infestation
C. Consultation with a dermatologist in case of severe /massive infestation

VI. For all asymptomatic cases of lacrimal drainage system obstruction with no signs of inflammation/ active infection kindly advise review after 3 months on appointment basis.

VII. For all asymptomatic cases of mild ptosis kindly advise review after 3 months on appointment basis.

UVEA

Definite referral criteria

- All granulomatous anterior uveitis
- Recurrent non granulomatous anterior uveitis
- All posterior uveitis

Conditions to be managed without referral

- Episcleritis
- Traumatic iritis
- Mild post op iritis
- Acute mild non- granulomatous anterior uveitis

NEURO-OPHTHALMOLOGY

Definite referral criteria

- New onset nerve palsies
- Acute field defects
- Papilloedema
- Acute vision loss

Conditions to be managed without referral

- Old temporal pallors with stable vision
- Resolved / resolving nerve palsies
- Grade 4 hypertensive retinopathies with papilloedema
- Bells palsy .
- Optic atrophies with back ground retinal/ vascular changes.
- Simple hyperemic discs with no recent onset of headache or other symptoms
- Colour blindness
- Old traumatic optic atrophy

PAEDIATRIC AND SQUINT

Definite referral criteria

- Accommodation weakness
- Ocular deviations persisting >6 months for prism trial
- Ptosis interfering with visual acuity
- Orbital blow out fractures planning for surgical management
- ROP babies with strabismus

Conditions to be managed without referral

- Fusion weakness
- Chronic squint
- Patients with squint coming for license renewal
- Chronic TRO cases
- ROP babies if retinoscopy has been done within 6 months

GLAUCOMA

Definite referral criteria

- IOP >30 mm Hg
- Congenital and developmental glaucoma
- Acute angle-closure
- Acute neovascular glaucoma
- Pupillary block and aqueous misdirection
- Secondary glaucomas eg -post traumatic, uveitic glaucoma
- Lens induced glaucoma
- Advanced glaucoma
- Monocular patients with glaucoma
- New Patients with definite glaucomatous ONH changes and or visual field defect
- Uncontrolled glaucoma
- Patients requiring clearance before IV injections

Conditions to be managed without referral

- Disc suspect, PACS, (normal IOP, no risk factors, where disc and macula can be seen in nonmydriatic conditions)-Observe and review after 3- 6 months
- Ocular hypertension (< 30mmhg) with no evidence of glaucoma and at low risk of developing glaucoma in the next 6 months
- Patients with stable glaucoma /glaucoma suspect post routine cataract surgery/VR surgery (Can continue same AGM if IOP is normal).
- IOP elevation in the postoperative period post cataract /VR surgery with no definite evidence of ONH damage - initial IOP spike to be managed by starting AGM depending on IOP(after ruling out contraindications) ,and then if IOP is uncontrolled on follow up visit, can be referee to glaucoma clinic.
- Patients with family history of glaucoma with no definite e/o ONH damage.