NICE National Institute for Health and Care Excellence

Cataracts in adults: management

Consultation on draft guideline – deadline for comments 5.00pm on 23 June 2017
email: Cataracts@nice.org.uk

	Please read the checklist for submitting comments at the end of this form. We cannot accept forms that are not filled in correctly. We would like to hear your views on the draft recommendations presented in the short version and any comments you may have on the evidence presented in the full version. We would also welcome views on the Equality Impact Assessment. We would like to hear your views on these questions: 1. Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. 2. Would implementation of any of the draft recommendations have significant cost implications? 3. What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.) 4. [Insert any specific questions about the recommendations from the Developer, or delete if not needed] See section 3.9 of Developing NICE guidance: how to get involved for suggestions of general points to think about when commenting.
Organisation name – Stakeholder or respondent (if you are responding as an individual rather than a registered stakeholder please leave blank):	The Royal College of Ophthalmologists
Disclosure Please disclose any past or current, direct or indirect links to, or funding from, the tobacco industry.	N/A
Name of commentator person completing form:	Professor Andrew Lotery, Chair of the Scientific Committee

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Type		[office use only]		
Comment number	**Document** (**full** version, **short** version or the **appendices**	**Page number** Or **'general'** for comments on the whole document	**Line number** Or **'general'** for comments on the whole document	**Comments** Insert each comment in a new row. Do not paste other tables into this table, because your comments could get lost – type directly into this table.
Example 1 Example 2 Example 3	Full Full Full	16 16 16	45 45 45	We are concerned that this recommendation may imply that …….. Question 1: This recommendation will be a challenging change in practice because …… Question 3: Our trust has had experience of implementing this approach and would be willing to submit its experiences to the NICE shared learning database. Contact……..
1	Full	24	536	This recommendation should refer to the need to the Hill RBF http://rbfcalculator.com/ method as a self-validating method for IOL power selection and what to use if the patient has had previous refractive surgery (eg American Society of Cataract and Refractive Surgery website calculator http://iolcalc.ascrs.org/, 'No-history method of intraocular lens power calculation for cataract surgery after myopic laser in situ keratomileusis etc. H. John Shammas, MD and Maya C. Shammas MD, Journal of Cataract and Refractive Surgery, 2007 Volume 33, Issue 1, Pages 31–36 http://www.jcrsjournal.org/article/S0886-3350(06)01221-1/abstract
2	Full	25	562	This statement should be tied to the risk scoring and appropriate level/experience of surgeon should be ensured to carry out surgery in such cases. Day AC, Donachie PH, Sparrow JM, Johnston RL. The Royal College of Ophthalmologists' National Ophthalmology Database study of cataract surgery: report 1, visual outcomes and complications. Eye

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				(Lond). 2015 Apr;29(4):552-60. doi: 10.1038/eye.2015.3. Epub 2015 Feb 13. http://www.nature.com/eye/journal/v29/n4/full/eye20153a.html
3	Full	25	571	Square edged lenses may be associated with negative dysphotopsia and spherical lens models with spherical aberration. This should be mentioned. Issues with Silicone lenses may be present if the eye has or is likely to be filled with silicone oil.
4	Full	25	574	This is too strong a statement regarding the routine use of blue-light filtering lenses. Many units use them routinely on the basis that there is very strong evidence of blue light damage to the retina and although there is not yet evidence of prevention of AMD with blue-light filtering lenses, clinical choice should help to guide this decision especially in patients with a family or history of macular problems. Some units have contracts in place which save significant money using such lenses and undoing this nationally would **cost very large amounts of money** for no sustainable reason. There is good published evidence that the blue-light filtering lenses do not disturb circadian rhythm cycles or sleep patterns, and they have been in routine use for many years.
5	Full	25	576	This is too strong a statement regarding the use of multifocal lenses. Prepresbyopic adults (and some children) benefit from these lenses if only one eye is affected particularly (current on-going trial in Oxford 'Binocular Vision in Monocular Pseudophakia (BVMP)' https://clinicaltrials.gov/ct2/show/NCT01872000?cond=Cataract&cntry1=EU%3AGB&draw=1&rank=6) and some personal experience over many years of practice) described by cataract surgeons. For patients, the cost benefit analysis of multifocal may show significant savings over years of post-operative life. Some professional groups may also find them more convenient having considered the relative risks and benefits. Tens of thousands have been implanted in the UK (especially in private patients) and advice should have been sought regarding outcomes from involved surgeons and patients. They are

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				certainly not suitable for all patients but should be able to be discussed and considered for particular patient groups.
6	Full	26	595	There is a tendency for some trusts to insist that the IOL strength is hand-written on the white-board in theatre for each patient as their operation is done. This may lead to transcription errors and should be avoided. Only printed data should be used wherever possible.
7	Full	26	603	Where electronic notes are used it may not be possible to print out biometry results but they are available on screen in theatre. Provision should be made to allow for this rather than insisting that a printed version is available.
8	Full	27	653	If bilateral simultaneous surgery is routinely offered to all eligible patients, there will only be half the number of patients (not eyes) operated on. Each will get more benefit assuming no complications, but only half the number of patients will be able to get an operation. This will have significant effects on waiting times for each individual to get at least one operation. Patient choice should also be offered. It should not be a surgeon's choice to carry out bilateral simultaneous procedures but a combined patient/surgeon choice.
9	Full	27	673	The use of hyaluronidase should not be recommended. There is good evidence that it does not help significantly, is associated with significant allergy/sensitivity and is an unnecessary additional risk/cost. (Reference?) If trying to stop eye movements a GA is the only sure way to do this. Using increased amounts of local anaesthesia and or hyaluronidase are not reliable or repeatable methods of being sure the eye will not move.
10	Full	27	677	There needs to be more complete guidance for the use of triamcinolone to visualize vitreous in the anterior segment after PC rupture/vitreous loss. There is currently no other way of doing this and if it is not used there will be many more complications arising

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				from inadequate removal of vitreous from the anterior segment. Notes should be made of the methods recommended for removing lens fragments from the posterior chamber (not using the phaco probe and being sure to use a vitreous cutter via a 3port approach within 5 days of the initial operation to remove cataract.
11	Full	28	684	Capsule tension rings **should** be used if the capsular bag is particularly large or floppy. This significantly reduced the risk of PC rupture. Their use in pseudoexfoliation is at the very least controversial as if there is a progressive zonulopathy such as in pseudoexfoliation, the presence of a ring and an implant in the capsular bag will add to the risk of the zonules disinserting later and the lens/bag complex dropping into the back of the eye. A better way to stabilize the capsular back during surgery where there is zonular laxity is to use iris hooks as capsule anchors and to place the IOL in the ciliary sulcus rather than in the capsular bag. Capsular tension rings should be used in cases of sectoral zonular dehiscence such as congenital colobomatous lens change or after trauma causing sectoral loss.
12	Full	28	715	It is sensible to offer much of this advice at discharge rather than waiting two weeks to give advice (at the first post-op review) about drops.
13	Full	66	1704	The most recent version of The Royal College of Ophthalmologists' cataract surgery guidelines was published in 2010 not 2001.Plesae amend,
14	Full	66	1720	The acronym for The Royal College of Ophthalmologists is RCOphth not RCO. Please amend.
15	Full	181	4675	This recommendation should be strengthened to give examples of how commissioners can commission services to ensure data required for the national cataract audit can be collected. e.g. Commissioners should ensure all existing or new contracts with NHS funded providers including independent sector treatment centres include quality

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				assurance for the well-being of the population they serve, through participation in the national cataract audit. Commissioners are encouraged to incentivise in quality assurance through participation in the national cataract audit via provider contracts. Commissioners are in a key position to influence visual acuity data returns through appropriate contracting and surgical providers should engage with commissioners and local optometrists to develop such 'enhanced community services'. Commissioners are encouraged to commission services which reward quality assurance regarding visual acuity outcome.

Insert extra rows as needed

Checklist for submitting comments

- Use this comment form and submit it as a Word document (not a PDF).
- Complete the disclosure about links with, or funding from, the tobacco industry.
- Include page and line number (not section number) of the text each comment is about.
- Combine all comments from your organisation into 1 response. We cannot accept more than 1 response from each organisation.
- Do not paste other tables into this table – type directly into the table.
- Underline and highlight any confidential information or other material that you do not wish to be made public.
- Do not include medical information about yourself or another person from which you or the person could be identified.
- Spell out any abbreviations you use
- For copyright reasons, comment forms do not include attachments such as research articles, letters or leaflets (for copyright reasons). We return comments forms that have attachments without reading them. The stakeholder may resubmit the form without attachments, but it must be received by the deadline.

You can see any guidance that we have produced on topics related to this guideline by checking NICE Pathways.

Note: We reserve the right to summarise and edit comments received during consultations, or not to publish them at all, if we consider the comments are too long, or publication would be unlawful or otherwise inappropriate.

Comments received during our consultations are published in the interests of openness and transparency, and to promote understanding of how recommendations are developed. The comments are published as a record of the comments we received, and are not endorsed by NICE, its officers or advisory Committees.

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