

# Glaucoma Management Plans during COVID-19

**This guidance has been developed by the RCOphth COVID-19 Review Team in response to the pandemic and may be subject to change.**

The Royal College of Ophthalmologists (RCOphth) has produced guidance as a pragmatic approach to maintain care for those patients who need it while deferring care for those patients who can wait. Individual eye departments may institute their own guidelines.

Many units were already managing a backlog of outpatient reviews and further delay will cause anxiety for these patients and increase their risk of irreversible vision loss. Many glaucoma patients will fall into the vulnerable categories for COVID 19 including those over 70 years or older and those with co-morbidities. When deciding how to manage their glaucoma patients at this time, providers need to assess the risk of:

- visual loss for the patient from glaucoma
- population spread of COVID by people attending rather than staying at home
- loss of life of the glaucoma patient from acquiring COVID

During the COVID 'lock-down' period there will be little or no access to optometry practices and patients should not be directed there unless agreed in advance. However, use the wider workforce and your local community optometrists where you can to support the care described below, especially interim assessments and remote counselling.

## Patients listed for surgery

Review clinical details of each case to identify those in need of immediate surgery and those that can wait for urgent or routine surgery, based on factors including:

- Level of vision and extent of visual field loss in the affected eye
- Is the affected eye the dominant or only seeing eye?
- Level of Intraocular pressure (IOP)
- Rate of visual deterioration
- Opportunity to temporise with additional medications

Priority for surgery should be given to those on maximal tolerated medication where IOP remains at a level likely to cause continued significant loss of vision in the short term.

Temporise if possible using additional medication (including oral acetazolamide if not contra-indicated) or diode laser or SLT. Ideally arrange medication provision in community via GP or posting prescription. Treatment effectiveness may need to be assessed – do this whilst minimising attendance and contact.

Postpone for 2 weeks operating on patients whilst symptomatic, with a temperature or in quarantine due to exposure, unless an emergency.

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Chose the surgical procedure to minimise post-operative follow-up visits where safe eg convert from trabeculectomy to glaucoma drainage device or non-penetrating surgery. Procedures requiring intensive postoperative outpatient review and intervention with antimetabolite injections or suture manipulation should be avoided if possible.

Perform all cases possible using local anaesthetic and as day cases.

## For new patients

### OHT and Glaucoma

Assess on information from the referral, the medical and drug history from the GP and from the patient (e.g. subacute angle closure symptoms and family history) by phone.

Use NICE guidance (NG81: <https://www.nice.org.uk/guidance/ng81> ) recommendations to commence treatment empirically eg on a topical prostaglandin via a prescription through the GP or posting it with face to face assessment scheduled some months later. Use a telephone or video consultation to explain to the patient the nature of their condition, check they can instil their drops, get repeat prescriptions and assess side effects. Counsel the patient that their treatment is being issued as a protective measure and, following formal assessment, this may change.

Patients with advanced glaucoma can have a telephone or video consultation and be offered primary surgery or commenced on medical therapy, sometimes more than one medication. Assess the effect of medical treatment by methods designed to minimise contact for the patient by named agreed local optometrists or in hospital.

### Suspected Glaucoma

If no confirmed field loss, manage without treatment with review in several months. If information suggests they are at high risk of glaucoma, use phone consultation as above and treat empirically with a topical prostaglandin and review within several months.

### Angle Closure

Suspected angle closure patients without raised IOP who are asymptomatic may be delayed. Use a telephone consultation to identify whether symptomatic and provide guidance on who to contact if symptoms occur. Raised IOP can be treated empirically, with a prostaglandin whilst awaiting review.

Symptomatic patients can be considered for prophylactic laser iridotomy.

### Tertiary Referrals

No new tertiary referrals should be made without direct consultant to consultant discussion. Advice may be offered to temporise until that normal glaucoma services can be offered. Tertiary referrals should only be seen when absolutely necessary, eg in need of urgent surgery. When possible post-operative review should be undertaken locally to avoid unnecessary travel.

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## Outpatient Follow-up Reviews

Triage patients to identify those requiring essential urgent review eg:

- Patients on a post-operative pathway
- Patients with significantly raised IOP at last visit
- Patients with specific conditions such as acute angle closure glaucoma, uveitic glaucoma, neovascular glaucoma or paediatric cases

Patients should be stratified into high, medium or low risk groups based on disease severity and underlying pathology. Record these on your PAS system.

**Low risk patients** write to inform them of delay in appointments with details of what to do if they feel things have deteriorated such as locally agreed optometrist or via a telephone number.

- Ocular hypertension
- Suspected glaucoma
- Mild glaucoma with controlled IOP

**Medium risk patients** offer a telephone consultation to enquire about any new problems or concerns and that they are still on treatment.

- Moderate to advanced glaucoma with controlled IOP

Arrange medication changes remotely or consider arranging a face to face consultation if concerns.

**High risk patients** offer a telephone/video or face to face consultation depending on severity of glaucoma and co-existing comorbidities.

- Advanced glaucoma or secondary glaucoma with significant risk of avoidable vision loss in the short term
- Uncontrolled Intraocular pressure (IOP >30mmHg or IOP 20-30mmHg with advanced disc changes)
- Paediatric glaucoma

Patients may chose not to attend face to face and these people should be offered telephone/video consultations.

Follow general RCOphth guidance on how to minimise risk before and during face to face outpatients.

For optometrists, advice on minimising risk during face to face assessments in their practice is available at

<https://www.college-optometrists.org/the-college/media-hub/news-listing/coronavirus-2019-advice-for-optometrists.html>