# ADULT OCULAR ONCOLOGY REFERRAL FORM

Please e-mail this form, with letter and image(s) of lesion, to:

- Liverpool Ocular Oncology Centre: Jenny.pendlebury@nhs.net T: 0151 7063973
- Moorfields Adult Ocular Oncology Service: meh-tr.ocularoncology@nhs.net T: 020 7521 4639 Option 3
- Scottish Ocular Oncology Service: susan.ewan@ggc.scot.nhs.uk T: 0141 211 3223
- Sheffield Ocular Oncology Service: sht-tr.cancer-ocularoncology@nhs.net T: 0114 271 2179

Referral Date:

Click on down-arrow (black/grey inverted triangle), wherever one appears.

## Patient Details

Title: Name: Surname:

Gender: Date of Birth: NHS Number:

House/Street:

Town/City: Post code:

Mobile phone: Landline: E-mail

## Referring ophthalmologist

(GPs are advised to direct patients to a local optometrist who should refer (directly) to the patient's local hospital eye service, informing GP.)

Consultant: Person referring: Dept:

Address: Post code:

Town/City: Phone: E-mail:

(Supra-regional ocular oncology centres should receive only tertiary referrals from senior ophthalmologists, not GPs and optometrists)

## Clinical Info

History?
Cancer?
Findings?

Tumour location (e.g., iris, conj, etc) Eye:

Retinal findings: Haemorrhage: ☐ Exudates: ☐ Detachment: ☐ Other:

(Image(s) of lesion required for triage and, in selected cases, remote consultation (i.e., virtual- / phone- / video-consultation)

## Images sent:

Fundus photo: ☐ Slit-lamp photo: ☐ OCT: ☐ Autofluorescence: ☐ Ultrasound: ☐ Other:

## MOLES score

**Please complete MOLES form if choroidal melanocytic tumour**

| (Hover over labels for tips) | | (Please click arrow for value) |
|---|---|---|
| Mushroom shape: | Nil = 0 | 0 |
| Orange pigment: | Absent = 0 | 0 |
| Large size: | Diameter <3 DD and thickness < 1 mm = 0 | 0 |
| Enlargement*: | Nil = 0 | 0 |
| Subretinal fluid: | Nil = 0 | 0 |

Drusen, intra-retinal cysts, and tumour proximity to disc are **NOT** signs of malignancy.
*Assume enlargement if tumour is large (i.e., diameter >5 DD or thickness > 3 mm)

MOLES score: 0

Diagnosis : Common naevus

**Suggested management:**

Self-care in community

with monitoring by optometrist

MOLES does not apply to melanocytoma and congenital ocular melanosis, which require monitoring because of the risk of malignant transformation to melanoma.

**NB.** Attach image(s) of tumour and a referral letter to allow triage, remote assessment, and / or video-/ phone-consultation. Failure to submit adequate images and information will prompt a request for these, delaying referral.

# SUGGESTED MANAGEMENT OF PATIENTS WITH MORE-COMMON TUMOURS

## External eye

- **Congenital ocular melanosis:** Full ocular exam with mydriasis (& IOP), by ophthalmologist every 12 months.
- **Naevus:** Self-monitoring if small and visible in mirror, with photograph. Otherwise, monitoring by ophthalmologist after 6-12 months. Urgent assessment by ocular oncologist if documented growth or if tumour is non-bulbar.
- **Papilloma:** Treatment with interferon or excision by ophthalmologist or ocular oncologist.
- **Primary acquired melanosis:** Review by ophthalmologist after 6 months then annually. Referral to ocular oncologist if extensive or if growth is documented photographically.
- **Complexion-associated melanosis:** Reassurance and discharge.
- **Conjunctival squamous/sebaceous intra-epithelial neoplasia:** Urgent referral to ocular oncologist.
- **Nodular melanoma / carcinoma:** Urgent referral to ocular oncologist. (Biopsy at local hospital is not advised because of high risk of seeding.)

## Anterior segment

- **Melanocytic tumour:** Monitoring by optometrist if <3 mm wide and flat or by ophthalmologist if 3-5 mm wide and or elevated. Urgent assessment by ocular oncologist if tumour (a) involves angle, (b) is diffuse or (c) >5 mm wide.
- **Iridociliary cyst:** Monitoring for glaucoma if known diagnosis. UBM by ocular oncologist if uncertain diagnosis.
- **Metastasis:** Urgent assessment by ophthalmologist with urgent onward referral to ocular oncologist or, if certain diagnosis, referral to local medical oncologist/radiotherapist.

## Posterior segment

- **Congenital ocular melanosis:** Full eye exam with mydriasis (& IOP) by ophthalmologist every 12 months.
- **Congenital hypertrophy of RPE:** Self-care (review by optometrist every 2 years or when seen for other reasons).
- **Melanocytoma:** Examination by ophthalmologist after 4-6 months and eventually every 12 months.
- **Common naevus:** Review by optometrist every 2 years or when seen for other reasons.
- **Low-risk naevus:** Non-urgent assessment by ophthalmologist then long-term surveillance by optometrist.
- **High-risk naevus:** Non-urgent assessment by ophthalmologist, then monitoring according to risk of malignancy.
- **Melanoma:** Urgent assessment by ophthalmologist with urgent onward referral to ocular oncologist if confirmed.
- **Choroidal haemangioma:** Assessment by ophthalmologist for confirmation of diagnosis and referral to ocular oncologist if subretinal fluid is present.
- **Suspected vitreoretinal lymphoma:** Urgent multimodal imaging by ophthalmologist with urgent onward referral to ocular oncology centre for vitreous biopsy and multidisciplinary management.
- **Metastasis:** Urgent assessment by ophthalmologist with urgent onward referral to ocular oncologist or, if certain diagnosis, referral to to local medical oncologist/radiotherapist for treatment.

## HOW TO REFER

1. If suspected cancer, refer urgently, following NHS 2-week-wait protocol for suspected cancer (see references).
2. Inform patient of differential diagnosis, need to keep appointment, and what to do if no appointment letter is received by specified date.
3. Optometrists and GP's should refer only to the patient's local hospital eye service (not a supraregional ocular oncology service, which should receive only tertiary referrals from senior ophthalmologists).
4. Refer electronically and securely using NHS e-Referral Service (eRS) or 1st-class post,
5. Include in referral the following:
    a. Patient's name, date of birth, NHS number, address, phone number(s), and e-mail address,
    b. Names, addresses and phone numbers of referrer, GP and optometrist.
    c. Clinical history, ophthalmic findings, and any relevant diagnostic reports
    d. **Recent images of lesion** (e.g., colour photograph(s), optical coherence tomography, autofluorescence imaging, ultrasound) and, if tumour growth is suspected, oldest available images, . Patients presenting to a GP should therefore be directed to their local optometrist for imaging and tentative diagnosis.
    e. Special needs and preferences of patient (e.g., interpreter)
6. Within 24 hours:
    a. Send GP and patient confirmation of referral (e.g., copy of referral letter)
    b. Give patient a number to phone if appointment letter is not received in 2 weeks
    c. Ensure that referral has been received by hospital

**Guidelines:** Royal College of Ophthalmologists College of Optometrists NHS England London & W. Essex