LOW PRIORITY PROCEDURE - Policy T11
Cataract Surgery

Policy author: NHS Suffolk Public Health Team
Policy start date: December 2006 (previously Policy T16)
First revision date: March 2009
Second Revision date: April 2011 (minor amendment August 2011)
Review date: April 2013

Policy summary

A cataract is an opacification (clouding) of the eye's natural lens. It usually develops over a period of time, causing a gradual deterioration in eyesight, and may eventually lead to blindness.

Referral criteria

All requests for the surgical removal of cataract(s) will **only** be supported by the PCT when all of the following apply:

• The patient should have sufficient cataract in the eye you are proposing to refer cataract surgery on, to account for the visual symptoms as evidenced in the Cataract Referral Form:

- Blurred or dim vision with a corrected binocular distance acuity of 6/10* (0.20 logMAR) or worse, ***or***
- Blurred or dim vision with a monocular distance acuity of 6/18 (0.40 logMAR) or worse
- The cataract should affect the patient's lifestyle scoring ≥3 as evidenced in the Cataract Assessment Form (appendix 1)
- The patient has waited 7 days to make a decision and wishes to undergo cataract surgery and understands the risks and benefits of this surgery.

*6/10 equates to $6/9^{-2}$ on Snellen chart

For second eye surgery

If vision in the first operated eye is better than 6/10 (0.20 logMAR) corrected postoperatively then the patient will need to have sufficient cataract to cause blurred or dim vision with a monocular distance acuity of 6/18 (0.40 logMAR) or worse in the second eye to qualify for cataract surgery. If vision in the first eye does not correct to better than 6/10 then second eye cataract surgery can be offered only if the binocular corrected vision is 6/10 or worse or the second eye vision is monocularly worse than 6/18 corrected.

Exceptions

The only exceptions to the above referral criteria are as follows:

- Anisometropia (a large refractive difference between the two eyes, on average about 3 dioptres), which would result in poor binocular vision or disabling diplopia which may increase the risk of falls.
- Angle closure glaucoma including creeping angle closure and phacomorphic glaucoma
- Diabetic and other retinopathies including retinal vein occlusion and age related macular degeneration where the cataract is becoming dense enough to potentially hinder management.
- Oculoplastics disorders where fellow eye requires closure as part of eye lid reconstruction or where further surgery on the ipsilateral eye will increase the risks of cataract surgery
- Corneal disease where early cataract removal would reduce the chance of losing corneal clarity (e.g. Fuch's corneal dystrophy or after keratoplasty)
- Corneal or conjunctival disease where delays might increase the risk of complications (e.g. cicatrising conjunctivitides)
- Other glaucoma's, inflammatory eye disease or medical retina disease where allowing a cataract to develop would hamper clinical decision making or investigations such as OCT, visual fields or fundus fluorescein angiography
- Neuro-ophthalmological conditions where cataract hampers monitoring of disease (e.g. visual field changes)

Background to the treatment

Surgical removal of the cataract is the only effective treatment available to restore or maintain vision. This involves the surgical removal of the cloudy lens, using the most appropriate technique. Cataract operations are performed using a local anaesthetic and the patient is allowed home the same day.

Rationale behind the decision

Cataract is a common and important cause of visual impairment. Cataract extraction accounts for a significant proportion of the surgical workload of most ophthalmologists and is the most common elective surgical procedure performed in the UK5. The increasing life expectancy and number of over 65's will result in an increase in the prevalence of cataract and therefore the demand for surgery[4] thus making it imperative to ensure that there is referral process which will promote fairness across Suffolk. The referral criteria will ensure that the most severely affected patients get the opportunity for surgery in a first eye before second-eye surgery is offered to others.

It has been well established that visual impairments in cataract cannot be described in terms of a single visual loss of function[1]. By itself monocular visual acuity (VA) provide an incomplete assessment therefore obtaining self-reported information relevant to the patients every day visual experience in the context of their own environment should be undertaken alongside the visual functioning testing[1-3].

References

1. Department of Health. National Eye Care Plan (2004)

2. The Royal Collage of Ophthalmologists: Cataract Surgery guidelines (2004)

3. NHS Executive. Action on Cataracts; Good Practice Guidance (2000).

4. Evans JR, Fletcher AE, Wormald RP, Ng ES. Stirling S. Prevalence of visual impairment in people aged 75 years and older in Britain: Results from the MRC trial of assessment and management of older people in the community. *Br J Ophthalmol* 2002; 86: 795-800

Appendix 1 Cataract Assessment Form

Patients need to evidence how cataract is affecting daily activity. A patient needs to score ≥3.

1. Visual disability

Affected by glare □ 2
Difficulty with reading □ 1
Difficulty watching television □ 1
Difficulty performing work or hobbies □ 1

2. Social functioning (Tick ONE box only)

Lives independently □ 2
Cares for partner □ 2
Lives in sheltered accommodation □ 1
Lives with carer □ 1
Lives in a residential or nursing home □ 1

3. Other

Drives a car/is in paid employment □ 1
Mild/moderate hearing impairment □ 1
Severe hearing impairment (Deaf) □ 2
Has fallen twice or more in the last 12 months □ 2