

## LOW PRIORITY PROCEDURE - Policy T11 Cataract Surgery

**Policy author: NHS Suffolk Public Health Team**  
**Policy start date: December 2006 (previously Policy T16)**  
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**Review date: May 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<sup>1</sup>.

### **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  $\geq 3$  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.

### ***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), 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 conjunctivitis)
- 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<sup>1</sup>.

### **Rationale behind the decision**

Cataract is a common and important cause of visual impairment<sup>1</sup>. 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 UK<sup>1</sup>. 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<sup>2</sup> 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<sup>1</sup>. 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<sup>1,3-4</sup>.

\*6/10 equates to 6/9<sup>-2</sup> on Snellen chart

### **References**

1. Department of Health. National Eye Care Plan (2004)
2. 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
3. The Royal Collage of Ophthalmologists: Cataract Surgery guidelines (2010)
4. NHS Executive. Action on Cataracts; Good Practice Guidance (2000).

## **Appendix 1 Cataract Assessment Form**

This form assesses how cataract is affecting daily activity.

### **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 alone  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