

National Institute for Health and Clinical Excellence

Glaucoma Stakeholder Comments

1. Please put each new comment in a new row.
2. Please do not paste other tables into this table, as your comments could get lost – type directly into this table.
3. Please fill in the document you are commenting on in the first column, for example, the **Full version**, or the **Appendices to full version**
4. Please insert the **Page number (given at the bottom of the page)** in the 2nd column and the **Line Number** (given at the far left of the document). If your comment relates to the document as a whole, please put '**general**' in this column. **Please refer page numbers not section numbers.**

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Organisation:				Association of British Dispensing Opticians Association of Optometrists College of Optometrists Federation of Ophthalmic & Dispensing Opticians	
<u>Order Number</u>	<u>Document.</u>	Page Number	Line Number	Comments	
Please number your comments if making more than one	Please indicate which version you are referring to: Full/NICE/Appendices.	Indicate Page number or ' general ' if your comment relates to the whole document. Please do not include any non-numerical text (eg the word 'page') in these boxes unless comment is general.	When commenting on the full version Indicate the line number . Please do not include any non-numerical text (eg the word 'line') in these boxes	Please insert each new comment in a new row.	
1	Full	General		Around 10,500 Optometrists working in primary care community practice are responsible for the majority of referrals for suspected open angle glaucoma. They are equipped with intraocular pressure and visual field measuring equipment and trained in the assessment of the optic nerve head. Optometrists currently possess most of the competencies detailed in the guidance as necessary for the diagnosis and all of the competencies required for the monitoring of open angle glaucoma and ocular hypertension (see detailed	

				<p>comments below).</p> <p>Many optometrists are currently participating in a variety of accredited schemes to refine the referral of glaucoma suspects, monitor at risk groups and monitor stable glaucoma patients in collaboration with local secondary care providers.</p>
2	NICE	General		<p>Around 10,500 Optometrists working in primary care community practice are responsible for the majority of referrals for suspected open angle glaucoma. They are equipped with intraocular pressure and visual field measuring equipment and trained in the assessment of the optic nerve head. Optometrists currently possess most of the competencies detailed in the guidance as necessary for the diagnosis and all of the competencies required for the monitoring of open angle glaucoma and ocular hypertension (see detailed comments below).</p> <p>Many optometrists are currently participating in a variety of accredited schemes to refine the referral of glaucoma suspects, monitor at risk groups and monitor stable glaucoma patients in collaboration with local secondary care providers.</p>
3	Full	General		<p>Any care pathway involving community based diagnosis, monitoring and treatment must, be properly resourced either nationally or locally. However this cannot be from the relatively small national General Ophthalmic Services (GOS) budget which is voted exclusively for national sight testing and the provision of optical appliances for those on low incomes.</p>
4	NICE	General		<p>Any care pathway involving community based diagnosis, monitoring and treatment must, be properly resourced either nationally or locally. However this cannot be from the relatively small national General Ophthalmic Services (GOS) budget which is voted exclusively for national sight testing and the provision of optical appliances for those on low incomes.</p>
5	NICE	3		<p>The first paragraph of the Introduction appears to include a confused definition of Primary Open Angle Glaucoma (POAG) in that it suggests that normal tension glaucoma (NTG) is not a form of Primary Glaucoma. We suggest that the paragraph is re-worded for clarity.</p>
6.	Full	General		<p>We welcome the clarity provided by the draft guidelines for all clinicians. We particularly welcome the clear and precise recommendations for the diagnosis, monitoring and treatment of Chronic Open Angle Glaucoma (COAG) and Ocular Hypertension (OHT). This should provide a universal structure for the referral, monitoring and re-referral of glaucoma patients and suspects between primary and secondary care.</p>

7	NICE	General		We welcome the clarity provided by the draft guidelines for all clinicians. We particularly welcome the clear and precise recommendations for the diagnosis, monitoring and treatment of Chronic Open Angle Glaucoma (COAG) and Ocular Hypertension (OHT). This should provide a universal structure for the referral, monitoring and re-referral of glaucoma patients and suspects between primary and secondary care.
8	Full	General		The National Eye Health Epidemiological Model (NEHEM) indicates that the mean estimate of glaucoma prevalence in the UK is 533,623 cases and for ocular hypertension 1,171,446 cases. The model can be interrogated at http://www.eyehealthmodel.org.uk/
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10	Full	General		<p>COAG is an age related, chronic, incurable condition requiring life-long monitoring and care and which already places a considerable burden on secondary care ophthalmology services. With an ageing population this burden will continue to increase. At the Implementation Planning Meeting held by NICE on the 6th November John Sparrow (Chair of the GDG) estimated that, based on the criteria developed by the GDG, an estimated 400,000 – 500,000 additional eye department visits would be required per year. We concur with this estimate and believe that in reality the true figure could be even higher (see specific comments below).</p> <p>Currently a very large number of patients with intraocular pressure greater than 21 mm Hg, but with no other signs of glaucoma, are being successfully monitored by optometrists in the community with no evidence of visual loss occurring as a result. One of the recommendations of the draft guidance is that OHT should be formally diagnosed for intraocular pressure greater than 21 mm Hg; a diagnosis requiring assessment of the anterior chamber angle by gonioscopy. Currently few optometrists are competent to perform gonioscopy (although all could be) and in order to conform with their legal and ethical obligations they will have no option but to refer all of these patients for a formal diagnosis before continuing to monitor them in the community. Unless the introduction of the guidelines is properly managed over a realistic timeframe many thousands of patients will be referred for a diagnosis over a very short period of time, overwhelming hospital eye departments with</p>

				<p>many false positive patients. We fear this sudden influx of very low risk, visually normal, patients will potentially disrupt the care of existing diagnosed patients, with a serious risk of unnecessary disease progression and visual impairment. If implemented we believe this guideline should be phased in, preferably over a 3 to 5 year timescale. We feel it would also be helpful to have guidance on how optometrists should deal with a patient whose IOP (by applanation) is 22mmHg on one visit and 20mmHg on another visit (as can often happen). To expect all these patients to be referred to the hospital eye service will create an enormous burden on both the HES as well as inconveniencing thousands of visually normal patients.</p>
11	NICE	General		<p>COAG is an age related, chronic, incurable condition requiring life-long monitoring and care and which already places a considerable burden on secondary care ophthalmology services. With an ageing population this burden will continue to increase. At the Implementation Planning Meeting held by NICE on the 6th November John Sparrow (Chair of the GDG) estimated that, based on the criteria developed by the GDG, an estimated 400,000 – 500,000 additional eye department visits would be required per year. We concur with this estimate and believe that in reality the true figure could be even higher (see specific comments below).</p> <p>Currently a very large number of patients with intraocular pressure greater than 21 mm Hg, but with no other signs of glaucoma, are being successfully monitored by optometrists in the community with no evidence of visual loss occurring as a result. One of the recommendations of the draft guidance is that OHT should be formally diagnosed for intraocular pressure greater than 21 mm Hg; a diagnosis requiring assessment of the anterior chamber angle by gonioscopy. Currently few optometrists are competent to perform gonioscopy (although all could be) and in order to conform with their legal and ethical obligations they will have no option but to refer all of these patients for a formal diagnosis before continuing to monitor them in the community. Unless the introduction of the guidelines is properly managed over a realistic timeframe many thousands of patients will be referred for a diagnosis over a very short period of time, overwhelming hospital eye departments with many false positive patients. We fear this sudden influx of very low risk, visually normal, patients will potentially disrupt the care of existing diagnosed patients, with a serious risk of unnecessary disease progression and visual impairment. If implemented we believe this guideline should be phased in, preferably over a 3 to 5 year timescale. We feel it would also be helpful to have guidance on how optometrists should</p>

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12	Full	32	19	The full guidance indicates that the definition of OHT is: “an untreated IOP repeatedly above 21mmHg” (our bold). As in the paragraph above, we would appreciate guidance on how optometrists should deal with patients whose IOP fluctuates around the low 20s without any signs of visual loss or disc changes.
13	NICE	3		The full guidance (page 32 line 19) indicates that the definition of OHT is: “an untreated IOP repeatedly above 21mmHg” (our bold). This is not reflected in the NICE guideline which simply refers to OHT being “elevated eye pressure in the absence of visual field loss or glaucomatous optic nerve damage”. We believe this may be mis-interpreted as being related to a single episode of raised pressure. We would suggest that the word repeatedly is added to the definition in the NICE guidance, ie. repeatedly raised pressure. As in the paragraph above, we would appreciate guidance on how optometrists should deal with patients whose IOP fluctuates around the low 20s without any signs of visual loss or disc changes.
14	Full	88	2 3 4 5 6 7 8	The competencies required for the diagnosis of COAG, suspected COAG and OHT are, with the exception of gonioscopy, all core competencies possessed by optometrists. Optometrists who have a recognised competence in gonioscopy or who have passed Part A of the College of Optometrists Diploma in Glaucoma possess all of the competencies required for diagnosis.
15	NICE	5		The competencies required for the diagnosis of COAG, suspected COAG and OHT are, with the exception of gonioscopy, all core competencies possessed by optometrists. Optometrists who have a recognised competence in gonioscopy or who have passed Part A of the College of Optometrists Diploma in Glaucoma possess all of the competencies required for diagnosis.
16	Full	109	7 8 10 12 13 15 16 18 19	The range of trained healthcare professionals capable of monitoring COAG, suspected COAG and OHT includes optometrists who have passed the College of Optometrists Diploma in Glaucoma. Although it doesn't appear to be detailed in the guidance text, the view of the GDG is that although such a specialist qualification would be required for the <i>diagnosis</i> of OHT, optometrists without such a specialist qualification have the core competencies to manage patients with non-treated OHT (as implied in the Full Guideline p. 107, line 1). This was clearly stated by

				<p>John Sparrow (Chair of the GDG) at the Implementation Planning Meeting. We would ask that the text is modified to reflect the clear intention of the GDG.</p> <p>Regulations have now been passed granting optometrists Independent Prescribing (IP) rights. Suitably trained and competent IP optometrists would also have the capability of treating these groups as well; this is facilitated by the clear diagnosis and treatment criteria detailed in the guidance.</p>
17	Full	110	1 3 4 6 7 8 10 11	<p>The range of trained healthcare professionals capable of monitoring COAG, suspected COAG and OHT includes optometrists who have passed the College of Optometrists Diploma in Glaucoma. Although it doesn't appear to be detailed in the guidance text, the view of the GDG is that although such a specialist qualification would be required for the <i>diagnosis</i> of OHT, optometrists without such a specialist qualification have the core competencies to manage patients with non-treated OHT (as implied in the Full Guideline p. 107, line 1). This was clearly stated by John Sparrow (Chair of the GDG) at the Implementation Planning Meeting. We would ask that the text is modified to reflect the clear intention of the GDG.</p> <p>Regulations have now been passed granting optometrists Independent Prescribing (IP) rights. Suitably trained and competent IP optometrists would also have the capability of treating these groups as well; this is facilitated by the clear diagnosis and treatment criteria detailed in the guidance.</p>
18	NICE	8		<p>The range of trained healthcare professionals capable of monitoring COAG, suspected COAG and OHT includes optometrists who have passed the College of Optometrists Diploma in Glaucoma. Although it doesn't appear to be detailed in the guidance text, the view of the GDG is that although such a specialist qualification would be required for the <i>diagnosis</i> of OHT, optometrists without such a specialist qualification have the core competencies to manage patients with non-treated OHT (as implied in the Full Guideline p. 107, line 1). This was clearly stated by John Sparrow (Chair of the GDG) at the Implementation Planning Meeting. We would ask that the text is modified to reflect the clear intention of the GDG.</p> <p>Regulations have now been passed granting optometrists Independent Prescribing (IP) rights. Suitably trained and competent IP optometrists would also have the capability of treating these groups as well; this is facilitated by the clear diagnosis and</p>

				treatment criteria detailed in the guidance.
19	Full	52	1	<p>We notice that the Guideline only refers to applanation tonometry using the slit-lamp mounted (Goldmann) tonometer. The evidence for this is comparative studies of non-contact tonometry with Goldmann tonometry which is considered the gold standard.</p> <p>No evidence is presented as to the use of the Perkins applanation tonometer, which uses the same principle as the Goldmann, but has the advantage of being hand held. Without the evidence that Perkins is inferior to Goldmann we feel that the Guideline should acknowledge that the use of the Perkins tonometer, which is often used in optometric practice, is equivalent to the Goldmann.</p>
20	Full	55	27	<p>We notice that the Guideline only refers to applanation tonometry using the slit-lamp mounted (Goldmann) tonometer. The evidence for this is comparative studies of non-contact tonometry with Goldmann tonometry which is considered the gold standard.</p> <p>No evidence is presented as to the use of the Perkins applanation tonometer, which uses the same principle as the Goldmann, but has the advantage of being hand held. Without the evidence that Perkins is inferior to Goldmann we feel that the Guideline should acknowledge that the use of the Perkins tonometer, which is often used in optometric practice, is equivalent to the Goldmann.</p>
21	Full	56	23	<p>We notice that the Guideline only refers to applanation tonometry using the slit-lamp mounted (Goldmann) tonometer. The evidence for this is comparative studies of non-contact tonometry with Goldmann tonometry which is considered the gold standard.</p> <p>No evidence is presented as to the use of the Perkins applanation tonometer, which uses the same principle as the Goldmann, but has the advantage of being hand held. Without the evidence that Perkins is inferior to Goldmann we feel that the Guideline should acknowledge that the use of the Perkins tonometer, which is often used in optometric practice, is equivalent to the Goldmann.</p>
22	Full	56	13	The Guideline currently states that other methods can be used 'where clinical circumstances preclude the use of standard methods', but we feel that this does not adequately recognise the routine use of the Perkins tonometer as often happens in optometric practice and uses the same principle as the Goldmann (see comments above).
23	Full	57	1	The Guideline gives no advice on what practitioners

				should do if the examining practitioner is monocular and therefore unable to get a stereoscopic view of the patient's optic disc. We would suggest including the statement 'where possible' to qualify this.
24	Full	58	3 7 8 9	The Guideline states that patients "who are ineligible for treatment and deemed stable to remain in regular contact (annual) with their primary care optometrist..." (also full Guideline p. 107 line 1). This is not entirely compatible with the guideline at line 3 (and full Guideline p.106 line 1) where the same category of patient who has not been discharged should be assessed every 12 to 24 months. We would emphasise our earlier comments that any care pathway involving community based monitoring must, be properly resourced either nationally or locally. However this cannot be from the relatively small national General Ophthalmic Services (GOS) budget which is voted exclusively for national sight testing and the provision of optical appliances for those on low incomes.
25	Full	106	1	The Guideline states that patients "who are ineligible for treatment and deemed stable to remain in regular contact (annual) with their primary care optometrist..." (also full Guideline p. 107 line 1). This is not entirely compatible with the guideline at line 3 (and full Guideline p.106 line 1) where the same category of patient who has not been discharged should be assessed every 12 to 24 months. We would emphasise our earlier comments that any care pathway involving community based monitoring must, be properly resourced either nationally or locally. However this cannot be from the relatively small national General Ophthalmic Services (GOS) budget which is voted exclusively for national sight testing and the provision of optical appliances for those on low incomes.
26	Full	107	1	The Guideline states that patients "who are ineligible for treatment and deemed stable to remain in regular contact (annual) with their primary care optometrist..." (also full Guideline p. 107 line 1). This is not entirely compatible with the guideline at line 3 (and full Guideline p.106 line 1) where the same category of patient who has not been discharged should be assessed every 12 to 24 months.
27	NICE	14		The Guideline states that 'At discharge advise patients who are ineligible for treatment and deemed stable to remain in annual contact with their primary care optometrist. This conflicts with the frequency of monitoring in para 1.2.13 which is that patients should be monitored every 12 to 24 months if there is a low risk of optic disc damage.

28	Full	60	33	The Guideline states that professionals with a specialist qualification can diagnose (and manage) patients with OHT or COAG suspect status. The College of Optometrists liaised closely with glaucoma specialists from the RCOphth when developing its glaucoma diploma. We feel that any other professional body wishing to accredit its members for OHT/suspect glaucoma or glaucoma diagnosis and care should similarly liaise with the RCOphth and the College of Optometrists in view of the unique experiences that the Colleges have of working together on the diplomas.
29	Full	61	22	The Guideline states that professionals with a specialist qualification can diagnose (and manage) patients with OHT or COAG suspect status. The College of Optometrists liaised closely with glaucoma specialists from the RCOphth when developing its glaucoma diploma. We feel that any other professional body wishing to accredit its members for OHT/suspect glaucoma or glaucoma diagnosis and care should similarly liaise with the RCOphth and the College of Optometrists in view of the unique experiences that the Colleges have of working together on the diplomas.
30	NICE	16		The Guideline states that diagnosis of OHT and COAG suspect status should be made by a trained healthcare professional with a specialist qualification (should one be available) recognised by their professional body and relevant experience. The College of Optometrists liaised closely with glaucoma specialists from the RCOphth when developing its glaucoma diploma. We feel that any other professional body wishing to accredit its members for OHT/suspect glaucoma or glaucoma diagnosis and care should similarly liaise with the RCOphth and the College of Optometrists in view of the unique experiences that the Colleges have of working together on the diplomas.
31	Full	61	1	The Guideline states that only a consultant ophthalmologist can give a definitive diagnosis of COAG and formulate a management plan. Although we recognise that in the vast majority of cases such diagnosis will and should be made by a consultant ophthalmologist we feel that with optometrists gaining independent prescribing status there may be instances in which an expert optometrist (with the College's full diploma in Glaucoma as well as independent prescribing rights) may be in a position to diagnose COAG and formulate a management plan for the patient. Whilst we understand the necessity of excluding other diagnoses some optometrists work in the secondary sector, or have access to such facilities, and as such could have access to the same diagnostic tests as consultant ophthalmologists. We would like to

				see the Guideline qualified to reflect this possibility.
32	Full	61	22	<p>At the implementation meeting on 6th November John Sparrow (Chair of the GDG) assured the audience that patients with diagnosed OHT could be <i>monitored</i> by optometrists in the community who did not have a specialist qualification, providing the diagnosis had been made by a specialist practitioner. This is not reflected in this paragraph in the Guideline. As stated before, with the exception of gonioscopy, all optometrists possess the competencies required to monitor patients with COAG, suspected COAG or OHT. As gonioscopy is only required when clinically indicated all of these patients could be monitored by optometrists, in the community, referring patients to a gonioscopy competent practitioner when necessary.</p> <p>The number of practitioners with such specialist qualifications is currently not sufficient to monitor these visually normal patients. In addition there is also no evidence that such patients are currently suffering any harm from being monitored by optometrists in their practices. We would welcome clarification of this point.</p>
33	NICE	8		<p>At the implementation meeting on 6th November John Sparrow (Chair of the GDG) assured the audience that patients with diagnosed OHT could be <i>monitored</i> by optometrists in the community who did not have a specialist qualification, providing the diagnosis had been made by a specialist practitioner. This is not reflected in this paragraph in the Guideline. As stated before, with the exception of gonioscopy, all optometrists possess the competencies required to monitor patients with COAG, suspected COAG or OHT. As gonioscopy is only required when clinically indicated all of these patients could be monitored by optometrists, in the community, referring patients to a gonioscopy competent practitioner when necessary.</p> <p>The bullet also states that healthcare professionals can monitor and treat patients with OHT, COAG suspects and COAG patients if their professional body develops a suitable specialist qualification. The College of Optometrists liaised closely with glaucoma specialists from the Royal College of Ophthalmologists when developing its glaucoma diploma. We feel that any other professional body wishing to accredit its members for glaucoma diagnosis and care should similarly liaise with the RCOphth and the College of Optometrists in view of the unique experiences that the Colleges have of working together on the diplomas.</p>
34	Full	71	15	We consider that Perkins applanation tonometry should be included as an alternative to Goldmann

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Please email this form to: glaucoma@nice.org.uk

Closing date: 24 November 2008

PLEASE NOTE: The Institute reserves the right to summarise and edit comments received during consultations, or not to publish them at all, where in the reasonable opinion of the Institute, the comments are voluminous, publication would be unlawful or publication would be otherwise inappropriate.