This is extracted from the current NEL EBI policy

Evidence Based Intervention Policy

It is important to be aware that many referrals for interventions have a low priority because evidence indicates that only patients that fit specific criteria should be eligible for the procedure.

Optometrist should be aware of two interventions that have specific criteria before they should be referred for surgery:

Chalazia Removal

One of the following criteria should be met

- Has been present for more than six months and has been managed conservatively with warm compresses, lid cleaning and massage for four weeks
- Interferes significantly with vision
- Interferes with the protection of the eye by the eyelid due to altered lid closure or lid anatomy
- Is a source of infection that has required medical attention twice or more within a six month time frame
- Is a source of infection causing an abscess which requires drainage
- If malignancy (cancer) is suspected e.g. Madarosis/recurrence/other suspicious features in which case the lesion should be removed and sent for histology as for all suspicious lesions

If any of the above are suspected please refer to the SPoA

Cataract Surgery

Patients should be referred when both of the following criteria are met:

1. Patient has a best corrected visual acuity of 6/9 or worse in either the first or second eye

AND

2. Patient has impairment in lifestyle such as substantial effect on activities of daily living, leisure activities, and risk of falls

OR

When the patient has any of the following ocular comorbidities:

- Glaucoma
- Conditions where cataract may hinder disease management or monitoring, including diabetic and other retinopathies including retinal vein occlusion, and age-related macular degeneration; neuro-ophthalmological conditions (e.g. visual field changes); or getting an adequate view of fundus during diabetic retinopathy screening
- Occuloplastics disorders where fellow eye requires closure as part of eyelid reconstruction
- 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)
- Severe anisometropia in patients who wear glasses
- Posterior subcapsular cataracts

However, in the above circumstances you should ideally refer to the provider that is managing their ocular comorbidity rather than an alternative provider due to the complexity of the care that may be required and the opportunity to reduce the number of patients appointments and interventions.

Where patients have a best corrected visual acuity better than 6/9, surgery should still be considered where there is a **clear clinical indication** or **symptoms affecting lifestyle**. For NHS treatment to be provided, there needs to be mutual agreement between the provider and the responsible (i.e. Paying) commissioner about the rationale for cataract surgery prior to undertaking the procedure).

Please read the full policy here – of if you require advice then you should contact the SPoA