# REFERRAL GUIDELINES FOR OCULAR PATHOLOGY IN GREATER MANCHESTER

| May 19 | **Emergency**<br>As soon as possible | **Emergency**<br>Within 24 hours | **Urgent/Priority**<br>May wait overnight/weekend | **Routine**<br>Routine or appropriate direct referral pathway |
|---|---|---|---|---|
| **Conditions** | | | | |
| **Anterior** | **Red eye (non traumatic)**<br>• Acute Angle Closure Glaucoma<br>• Painful recent post-op/hypopyon/blebitis<br>• Corneal graft rejection<br><br>**Red eye (traumatic)**<br>• Chemical burns- irrigate & refer asap<br>• Penetrating injuries | **Red eye (non traumatic)**<br>• Scleritis<br>• Infective keratitis<br>• Herpetic infection: simplex & zoster<br>• Iritis/Uveitis<br>• Severe corneal abrasion<br>• Acute dacryocystitis<br><br>**Red eye (traumatic)**<br>• Hyphaema<br>• Embedded foreign body | • Iris rubeosis<br>• Repeatable IOP >32mmHg<br>• Marginal keratitis | • Symptomatic entropion/ectropion<br>• Chronic Exophthalmos/proptosis<br>• Persistent lid disease/cysts/hordeolum<br>• Longstanding ptosis<br>• Severe dry eye<br>• Pterygium (affecting visual axis)<br>• Persistent epiphora<br>• Keratoconus<br>• Recurrent corneal erosion syndrome<br>• Corneal dystrophy (reduced VA)<br>• Allergic conjunctivitis<br>• Naso-lacrimal duct obstruction<br>• Cataract<br>• IOP >=24mmHg <32mmHg **Follow Local Glaucoma Pathway** |
| **Visual Loss** | • Possible Temporal Arteritis with visual symptoms | • Sudden visual loss unknown cause (<24hrs) | • Amaurosis fugax: refer via GP same day for TIA work-up<br>• Optic neuritis | • Gradual loss of VA >4weeks with no sudden loss |
| **Posterior** | • Retinal artery occlusion <24hours<br>• Retinal detachment: macular on | • Floaters/photopsia <48 hours + tobacco dust<br>• Retinal tears & breaks<br>• Retinal detachment: macular off<br>• Papilloedema<br>• PVD related vitreous haemorrhage | • Vitritis<br>• Vitreous haemorrhage (non-PVD)<br>• Nystagmus with other neurological signs<br>• Wet AMD } **REFER ACCORDING TO**<br>• CRVO } **THE PATHWAY FOR**<br>• Myopic CNV } **THE PATIENT'S AREA**<br>• Diabetic proliferative retinopathy **Refer to Eye Cas if DR appears to be new and Px not recently seen in HES**<br>• | • Retinal haemorrhages<br>• Branch retinal vein occlusion } ***refer within 4wks;***<br>• Central Serous Retinopathy } ***if not electronic***<br>***you must check the referral is processed***<br>• Suspect glaucoma/abnormal discs<br>• Dry AMD requiring registration/LVA<br>• Retinitis Pigmentosa<br>• Macular hole<br>• Epiretinal membrane<br>• Diabetic maculopathy **Refer to Eye Cas if DR appears to be new and Px not recently seen in HES** |
| **Other** | • Orbital cellulitis<br>• Acute proptosis<br>• Acute onset diplopia/ squint/ptosis/nerve palsy | | • Suspected retinal cancers<br>• Suspected compressive lesion<br>• New pupillary defects | • Repeatable suspicious field defects<br>• Long standing squint requiring correction<br>• Children's manifest squint, amblyopia/reduced VA **REFER VIA DIRECT ORTHOPTIC PATHWAY** |
| **Making referrals** | | | | |
| | **You should refer electronically using the Healthi referral module or extended service module where appropriate** | | | |
| | **Referral pathways for all GM areas are at www.gmlocs.co.uk - follow 'Referrals' for the patient's GP areas. The GP search can be used to locate the GP area** | | | |

*This list is not exhaustive & practitioners should always apply their clinical judgement when deciding on the appropriate clinical pathway for a patient.* *GM Version May 19*