Yorkshire Retina Society COVID-19 Responses - consensus statement

Version 1.7, 30th March, 2020.

The Yorkshire Retina Society recommends the following actions to be considered and action to be taken with immediate effect.

The rapidly expanding COVID-19 infection is putting NHS systems under considerable stress and the UK government has advised people to stay at home, especially those who are at higher risk from COVID-19 infection, and to avoid all but essential travel.

Aims

- To preserve vision from medical retinal disorders when feasible to do so, whilst minimising risk to the general health of patients, staff and members of the public.
- To minimise the burden on intravitreal injection clinics in hospital eye departments, given the reduction in capacity and staffing

Changing landscape

- The application of the response to an individual service requires regular review as resources and demand changes.
- A 'sliding scale' approach as to which patients are seen in clinic or at all is advised.
- Deferred patients will need the decision re assessing after the deferral period, typically 3-4 months.
- Deferred patients should be recorded within a specific database / mechanism and have the decision to defer logged in their patient record as a consequence of a COVID-19 strategy.

Personal protective equipment:

- Minimising the length of the clinic visit and trying to ensure that they are kept 2 metres away from others while waiting
- Regular hand washing and cleaning / disinfection of slit lamps, other instruments, chairs and handles.
- Using slit lamp breath shields and surgical masks for slit lamp and other examinations involving close contact. Masks may also be offered to patients who cough or sneeze during examination.
- Minimum standard: NHSE guidance. FFP2 for symptomatic or known COVID19 patients. Slit lamp shields.
- Ideal standard:FFP3 for all patient contact, PPE3 for known patients.

Guiding principles.

Minimum standard:

- Patients only to attend when they have been risk assessed.
- Consultant team decision making on departmental response.
- All deferred patients should be partially booked

Ideal standard:

- Consultant/ senior clinician risk assessment.
- Tele-consultation rather than face to face.
- Deferred patients should be given a new date.
- Patients involved in decision making about their care.

Risk:

- Every deferment carries potential risk. Aim to minimise and consciously accept this risk against risk of acquiring/transmitting COVID-19 in line with GMC / NHSE guidance.

Staff

- Try to minimise the number of staff coming into contact with patients. Same member of staff may need to perform VA, imaging and consultation.

Clinical services:

Urgent Medical Retina referrals

- Consultant / senior triaged.
- VA, colour photo, OCT based diagnosis if possible.
- Wide field imaging if possible.
- Virtual or tele-consultation-if possible.

Dye based imaging

- Consultant triaged.
- Default is to suspend.
- Only proceed if will lead to major difference in treatment of presumptive diagnosis (very few, if any). Not for AMD, DMO or RVO.
- Consider OCT/ OCTA first.

. **Intravitreal services:**

- Worst case scenario is to close service.
- Tele-consultation (TC) in advance of attendance as a default performed by the usual assessor.
- Follow up TC with letter / documentation.
- Suggested compromise for treatment administration.

Neovascular Age-related Macular Degeneration

- Consider stratifying treatment. Local circumstance and interpretation may guide threshold values. An example would be:
    - best eye >70 ETDRS letters- treat,
    - <40 letters don't treat,
    - 40-70 treat if other eye less than 70 letters.
    - Consider treating both eyes at the same sitting if one eye being treated
- Or consider allowing patients to call if worsening symptoms

On the phone

- Check the patients wish to attend:
- Agree treatment / no treatment strategy
- If wants to attend then:
    - Only to attend if no symptoms and not isolating due to contact, if not defer for 14 days.
    - Check, allergies, recent MI /CVA, symptoms of conjunctivitis / INR
    - Ask patients to attend for their appointment on time to aid social distancing.

On the day.

- Check no new symptoms or no fever before entering the department
- No VA, OCT or Dilation.
- Keep at 2 m at the desk, chairs in waiting room 2 m apart.
- Re organise appointment slots to enable social distancing

New patient initiation:

- Continue to offer treatment to new patients.
- Discuss with patients consideration of the same VA criteria as listed above.

Follow up interval options for existing patients.

- Keep at previous interval.
- Or consider fixed dosing at q8 for those who originally needed 8 weekly dosing or less AND q12 for those who previously managed >8 weekly. Set a finite period for fixed dosing (e.g. 12 weeks based on current government self-isolation period for high risk people). Review the strategy after this period
- Only less than 8 weekly (after the 3xq4 loading phase) with senior MR consultant sign-off and telephone consultation with the patient.
- Go to 8 weekly after 3 initiations doses (3 x q4).

Diabetic Macular Oedema

New patients

- Defer commencement of all new patients unless consultant agreed exceptional reason to do so. E g. ‘only seeing eye’ and severe visual loss / rubeosis management

Follow up patients

- Defer all unless exceptional cases of severe visual loss in only eye without >6 weekly injections.

- Consider R grade requirements – See R3 recommendations below.

See’ on the phone’ and ‘on the day’ above

Macular Oedema secondary to Branch Retinal Vein Occlusion

New patients

- Defer commencement of all new patients unless consultant agreed exceptional reason to do so. E g. ‘only seeing eye’ and severe visual loss.

Follow up patients

- Defer all unless exceptional cases of severe visual loss in only eye without >6 weekly injections.

See’ on the phone’ and ‘on the day’ above

Macular Oedema secondary to Central Retinal Vein Occlusion

New patients

- Defer commencement of all new patients unless consultant agreed exceptional reason to do so. E g. ‘only seeing eye’ and severe visual loss./ part of rubeosis management.

Follow up patients

- Defer all unless:
  - cases of severe visual loss in only eye without >6 weekly injections.
  - ischemic patients.
  - better seeing eye and fellow eye less than 40 letters

- Consider early PRP is ischaemic

See ‘on the phone’ and ‘on the day’ above

Diabetic retinopathy:

Defer all patients for 3 months except R3:

- Non high risk – consider earlier PRP
- High risk- PRP- See PRP

Diabetic Screening:

- Suspend with alternative arrangements made for high risk diabetic patients such as in pregnancy

Retinopathy of Prematurity

- To continue
- Consider regional cover in case of absence

Hydroxychloroquine screening

- Suspend

Retinal laser

- Consultant / senior delivered if possible.

Pan retinal photocoagulation

- FFP2.
- Consider Povidone Iodine conjunctival preparation.
- Aim for 2500 applications in a single sitting.
- If complete 2 month follow up
- Consider indirect – as first line choice where available as treatment at arms length

Macular laser:

- Defer for 12 weeks

Retinopexy:

- Laser to be performed by a member of staff likely to complete it in one sitting
- Consider in clinic cryotherapy for posterior tears