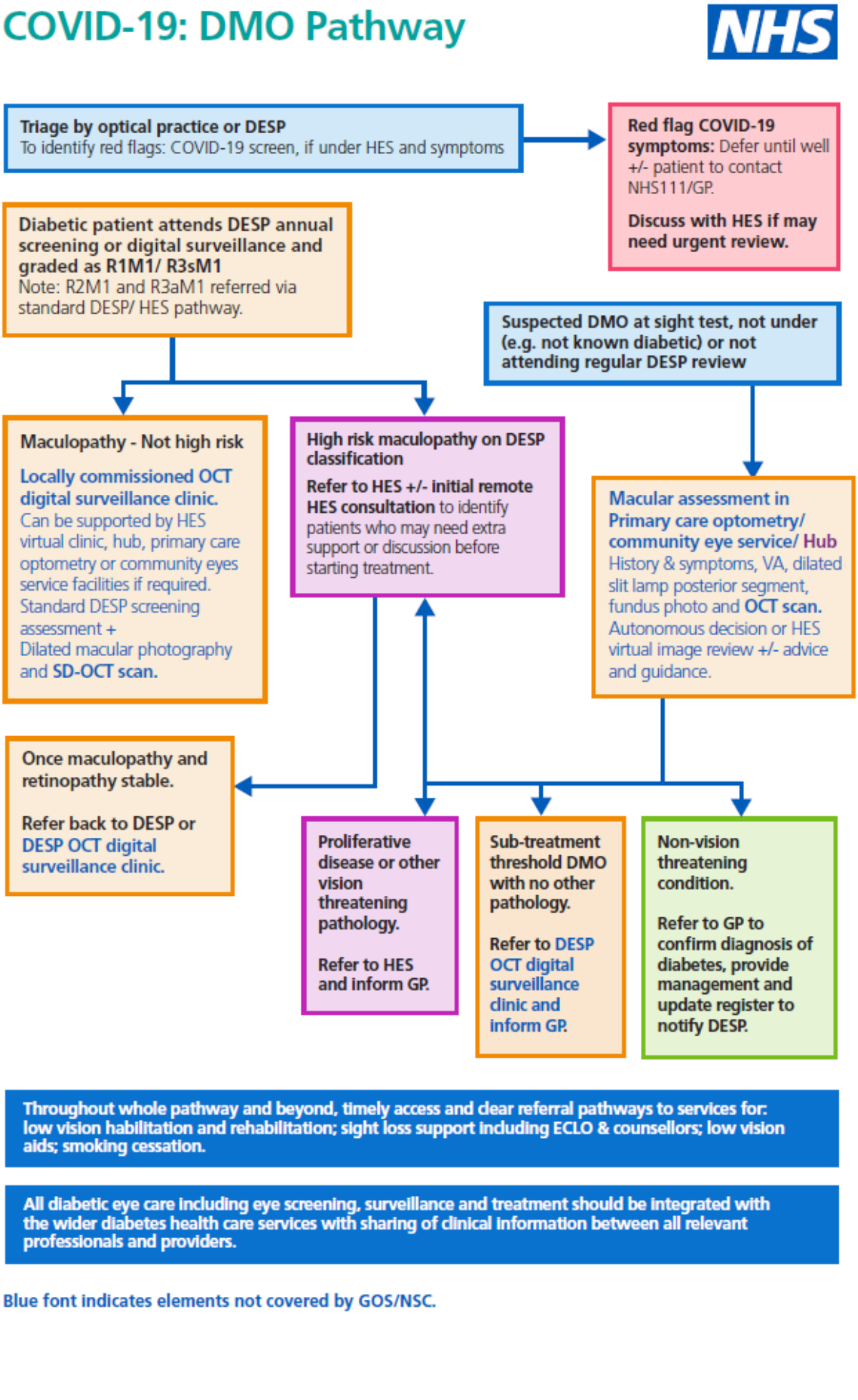
COVID-19 Diabetic Macular Oedema (DMO) Pathway

Sample Protocol



Protocol

This service allows for patients with suspected diabetic maculopathy who may not need treatment to undergo assessment in the community by suitably qualified and experienced professionals before referral using imaging assessment. This will allow those not needing treatment to be cared for in the community and avoid unnecessary hospital eye service (HES) referrals.

Patients will mainly be identified via the diabetic eye screening programme (DESP), but a small number may be identified through sight tests by their optometrist, including new patients not yet known to be diabetic, diabetic patients failing to attend their regular DESP screening and known diabetic patients with new acute symptoms:

- Patients with high risk maculopathy on DESP/NSC (national screening committee) classification will be referred to the HES as normal
- Those with suspect diabetic maculopathy not meeting the DESP / NSC criteria for high risk maculopathy will undergo additional testing to identify those with diabetic maculopathy who need referral for treatment and those who do not need referral
- Those with identified diabetic maculopathy which is below the threshold for treatment and no other pathology identified can then receive ongoing monitoring through the DESP OCT surveillance service
- Those with no diabetic maculopathy or proliferative disease can resume standard DESP screening.
- Other sight-threatening pathology will be referred to the HES following usual referral routes for urgent and non-urgent care, with advice and guidance from the HES as required
- Care should be co-ordinated, and clinical information / outcomes shared, between the patient's GP, optometrist, HES, DESP.

Decisions can be:

- made by the HES based on clinical data and images obtained by DESP, primary care optometrists, community diagnostic hubs or HES high flow diagnostic pathways in a virtual clinic model. The HES will undertake a fast track virtual assessment of the images and data collected by the technician or optometrist to inform on the need for arranging an urgent macular or injection appointment, other referral, discharge or advice to patient.
- made by autonomous experienced optometrists with support available through fast track virtual assessments and advice and guidance (A&G) from the hospital eye service (HES) or delegated specialist clinicians.

Assessments and practice will be in compliance with NICE guideline NG28 and NG17 and DESP/NSC guidance on OCT digital surveillance with further detail supplied by advice / management plan from the HES F2F or virtual assessment.

HIGH RISK MACULOPATHY is defined as:

- macular exudation (circinate) greater than 1/2 disc area and
- within 1 DD of the fovea and
- where there is a drop in visual acuity in this eye to ≤ 6/12.

ASSESSMENT
Principle Pathway - Patient under DESP

- **DESP diabetic eye screening assessment**
- **Dilated macular imaging including photography and OCT**

Secondary Pathway – Patient not under DESP - Primary care optometry/ Community eye service/ HES Hub assessment

History and symptoms

Visual symptoms

- General blur/reduced vision
- Loss of central part of field of vision
- Distortion of straight lines
- Difficulty with specific tasks especially reading or recognising faces

Previous ophthalmic history

Medical history

- Record all medical conditions, ask patient to bring print out from GP

Medication

- Record all systemic and ocular medication – ask patient to bring prescription or print out from GP

Allergies

Family history (major eye conditions)

Social history

- Occupation especially driver, HGV driver or drives for work
- Lives alone, dependents or carer status.

Visual acuity (VA)

- VA, with pinhole if necessary
- VA best corrected distance.

Ophthalmic assessment

Slit lamp dilated fundus examination

- Macula – signs of pathology e.g. age-related macular degeneration (AMD), diabetic retinopathy, epiretinal membrane
- Fundus – any abnormalities including non-macular diabetic retinopathy.

Dilated macular imaging including photography and OCT with wide field view

Provide both digital fundus photography consistent with national criteria and OCT capture. Referral into and from these clinics will be counted in the DESP pathway standards.

https://www.gov.uk/government/publications/diabetic-eye-screening-optical-coherence-tomography-in-surveillance/optical-coherence-tomography-oct-in-diabetic-dye-screening-des-surveillance-clinics#oct-pathway

Advice and guidance should be available from HES or experienced optometrists as required.

Outcomes:

1. **No abnormalities or no diabetic maculopathy detected**. Patient self-care and information. Continue DESP screening and routine sight testing.
2. Those with **high risk or treatable diabetic maculopathy confirmed** through the assessment will receive direct referral to the HES or HES will make this appointment – a routine referral made directly into the hospital macular clinic to be seen within 13 weeks. The referral should be made within 3 weeks of assessment. Initial HES remote consultation can be performed at this stage to identify patients who may need extra support or discussion before initiating treatment. (see support and discussion)
3. **Subthreshold diabetic maculopathy** identified on assessment: refer to locally commissioned DESP OCT Digital Surveillance clinic
4. Patients with final grading of **proliferative diabetic retinopathy (R3A)** in the worse eye on assessment will receive an urgent direct referral to the HES or HES will make this

appointment - to be seen in medical retina clinic within 6 weeks. The referral to be made within 2 weeks of assessment.

5. If **another pathology requiring referral** has been identified, local referral protocols should be followed, and appropriate advice given to the patient. Decisions supported where required by advance and guidance or virtual assessment of clinical data and images by the HES.

Provide all patients with information on diabetes and diabetic eye disease as appropriate (see diabetic monitoring advice). **It is essential patients identified in the community have care co-ordinated in liaison with GP, HES, DESP and optometrist.**

Patients with probable diabetic eye disease who are not having regular DESP review (e.g. not yet known to be or recently diagnosed diabetic, or diabetic patient repeatedly not attending DESP screening) should be referred to their GP for confirmation of the diagnosis and management of their diabetes and to provide onward referral to DESP. If there is urgent pathology such as proliferative disease they should be referred to the HES and their GP informed. If the patient has low risk maculopathy and no other referrable pathology, the optometrist should refer to the locally commissioned DESP OCT Digital Surveillance clinic and also inform their GP.

Support and discussion:

This can be provided by the testing practitioner. Where being referred, the HES can provide a remote consultation before arrival at the HES appointment to include shared decision-making on starting treatment with laser or intravitreal injections. Whatever the clinical outcome, a discussion regarding diabetic retinopathy/eye disease will be needed. The discussion should be tailored to the person's individual needs and current level of knowledge allowing for enough time to discuss the person's concerns and questions.

Information should also be provided in an accessible format (e.g. written in large print and easy to understand) for the patient to take away. If the patient is being referred, this information should include:

- information about diabetic retinopathy and treatment pathways, including likely timescales
- information as required on COVID-19 infection control processes and any requirements for action by the patient or effect on timescales of non-urgent assessments by the HES
- key contact details – for example, who to contact if appointments need to be altered
- advice about what to do and where to go if vision deteriorates.

Diabetic monitoring advice:

Advise all people with diabetic eye disease to improve diabetic control and see diabetic nurse or equivalent regularly for monitoring. Signpost to key sources of information and support. It is essential patients identified in the community receive care which is co-ordinated between the GP, HES, DESP and their optometrist. They should be encouraged and supported to attend diabetic eye screening programme.

Appendix – sources and standards for patient support and information

RCOphth RNIB Understanding Diabetes Booklet 2017
https://www.moorfields.nhs.uk/sites/default/files/DVLA%20licence%20FAQ%E2%80%99s-vision%20and%20driving.pdf
https://www.macularsociety.org/sites/default/files/downloads/Discover%20Kale%20recipe%20booklet.pdf
https://www.rnib.org.uk/sites/default/files/Sight_loss_what_we_needed_to_know.pdf
https://www.nhs.uk/conditions/vision-loss/
https://www.rnib.org.uk/recently-diagnosed/coming-terms-sight-loss
Someone to talk to (PDF)
Starting Out - Emotional Support (PDF)

RCOphth RNIB Understanding Charles Bonnet Syndrome 2017
https://www.nice.org.uk/guidance/ng28/ifp/chapter/Diet-and-lifestyle
https://www.nice.org.uk/guidance/ng28/ifp/chapter/Sources-of-advice-and-support
https://www.macularsociety.org/sites/default/files/downloads/Macular%20Society%20Protecting%20your%20eyes%20accessible%20pdf%20JUN%2017.pdf
https://www.macularsociety.org/sites/default/files/downloads/Macular%20Society%20Smoking%20and%20sight%20loss%20accessible%20pdf%20JUN17.pdf

Smoking cessation advice

Smoking is the main cause of illness and early death in the UK. People who smoke are at higher risk of serious conditions like heart and lung disease, stroke and cancer. If people quit early enough they can prevent smoking-related health problems or at least stop them getting worse. So it's important that health and social care workers in community and primary settings can identify people who need information and support to help them quit.

We want this guideline to help everyone who smokes, but especially those people who smoke heavily or who find it most difficult to stop, by making sure:

- people are asked about their smoking and encouraged to stop every time they see a health or social care worker
- extra help to quit is targeted at people with the highest risk of harm from smoking, such as people in hospital or with serious health conditions like heart or lung disease, pregnant women, mothers with young children and their families, and people in prisons
- people are given help to decide which stop smoking aids would suit them best and can be offered the option they prefer
- people using, or interested in using, a nicotine-containing e-cigarette to quit smoking are advised about these products
- services with trained staff are available to help people quit, including stop smoking services and telephone quitlines, and these are promoted widely to people who need them.

Whenever they talk to you about stopping smoking, health and social care professionals should give you clear information, talk with you about the different options and listen carefully to your views and concerns. They should also:

- talk to you about your smoking in a way that is sensitive to your needs and circumstances
- ask you about any other smoking aids you have tried before
- encourage you to quit in the future if you are not ready to stop yet, and give you advice about ways to reduce harm from smoking.

If you can't understand the information you are given, tell your health and social care professional.

Read more about making decisions about your care.

https://www.nhs.uk/live-well/quit-smoking/10-self-help-tips-to-stop-smoking/?tabname=advice-and-support