

# Cataract surgery guidelines for Post COVID-19 pandemic: Recommendations

**This guidance has been developed by the United Kingdom & Ireland Society of Cataract & Refractive Surgeons [UKISCRS] and the RCOphth COVID-19 Review Team in response to the pandemic and may be subject to change.**

**This document provides guidance to assist re-opening of cataract services following the COVID lockdown.**

1. To undergo or to be listed for cataract surgery after April 2020 patients should, as previously, meet *all* requirements in one of the groups of Criteria (A or B) and C; current NICE guidance for cataract surgery should continue to be observed [<https://www.nice.org.uk/guidance/ng77>].
2. In addition, there should be a full discussion about ophthalmological and general medical issues related to COVID-19, in order to assist the patient in deciding whether or not to go ahead with cataract surgery.
3. A process of prioritisation based on need may follow whilst service access remains restricted; this should not be subverted into a restrictive gating system for commissioners or private medical insurance companies.

## Criteria A

- The patient has significant visual symptoms confirmed to be due to cataract
- Visual symptoms due to cataracts are impairing the patient's activities of daily living, and it is anticipated that this will be improved by surgery

## Criteria B

- Cataract surgery is needed to facilitate management of an ocular comorbidity, including but not limited to: screening or treatment of diabetic retinopathy; glaucoma monitoring; treatment of angle-closure glaucoma
- Confirmation of this requirement, including details of the management of the ocular comorbidity, should be clearly documented in the patient's notes

## Criteria C

- The patient indicates willingness to have cataract surgery following a discussion including:
  - How the cataract affects the persons' vision and quality of life
  - Whether one or both eyes are affected
  - What cataract surgery involves, including risks and benefits
  - Consequences of not undergoing surgery for ocular health, quality of life and other reasons such as continuing to meet legal driving standards

A shared decision-making tool (usually a form of questionnaire) can be helpful to guide the discussion and to prioritise patients in greatest need – this should not be used as means of restricting access to care

## COVID-19 discussion for patients already seen and listed for cataract surgery

There should be a waiting list validation and prioritisation process undertaken for patients already listed for cataract surgery, including a new discussion to ascertain whether they still want to undergo surgery in light of the COVID pandemic; this initial contact will usually be by telephone and should consider:

- The option for the discussion to involve family members, to receive written summary information on the discussion and to have some time to make a decision
- If patients withdraw from the waiting list, processes for future relisting
- Assist the patient in making a balanced decision between risks of COVID infection, and the benefits of cataract surgery
- The risk of contracting COVID in hospital is low overall, and all appropriate steps will be taken to minimise this risk, including explanation of local adaptations and practice, e.g. shorter and less crowded attendances, physical distancing measures, follow-up for routine cases by telephone or in the community, PPE and infection-control practices updated regularly based on best practice and the best available evidence
- Risks posed to members of the same household
- Discussion should occur about risks to the patient's health should they contract COVID with reference to risk factors including, but not limited to, age, gender, ethnicity, medication use, immune status, ocular co-morbidity and systemic co-morbidity
- Information about likely COVID testing, and that test positivity may result in rescheduling their operation at a clinically appropriate short interval without loss of priority
- What will happen if they decline COVID testing, i.e. removal from the waiting list or postponement of surgery until guidance changes
- They should be reassured that in the absence of other pathology there are usually no long-term deleterious effects on their eye health due to the delay in undergoing cataract surgery but advised of possible consequences to vision, daily living and driving
- The risk of cataract surgery complications increases slightly as cataracts progress but that the overall chance of a complication is still small, and that if their case becomes more complex as a result of delayed care, a surgeon of appropriate expertise will perform their surgery
- If surgery has been proposed partly or wholly to monitor or treat another eye condition, the consequences of this decision should be discussed, and alternative treatment strategies considered

#### **COVID-19 discussion for new cataract referrals (not yet seen or listed)**

- These patients may undergo an initial consultation by telephone due to COVID-19; this will be greatly assisted by a prior optometric examination in the community or even at home
- Following a discussion to ascertain that they meet criteria (A or B) *plus* C, a clinical needs assessment can be made, which again may be assisted by decision-making tools incorporating objective (visual acuity) and subjective (symptoms and quality of life) measures; these tools are to assess treatment priority and not to restrict access to care
- If after initial discussions and subsequent clinical examination the patient would still like to proceed with surgery, those most affected can be listed sooner (RCOphth priority grading 3a) and those less affected listed more routinely (RCOphth priority grading 3b); the threshold between 3a/3b can be adjusted according to clinical demand and service capacity, and may vary locally according to need
- From the point of listing, local patient pathways will be enacted, requiring regular refinement and streamlined to reduce risk of COVID exposure, to safely optimise clinical throughput and to be responsive to changes in national guidance and evidence

The processes suggested above are likely to result in variable waits for surgery between patients according to need, at least initially, calling into question the utility of the metric 'referral to treatment time' (RTT). Surgical timing should be based on clinical need and priority as the most important factors. Due consideration should be given to strategies maximising efficiency in these challenging times such as one-stop services, appropriate adoption of immediately sequential bilateral cataract surgery, topical anaesthesia and on-table mydriasis.

**All COVID-19 guidance is subject to change. Please visit the [RCOphth COVID-19 web page on restoration of ophthalmology services](#) for regular updates.**

**RCOphth COVID-19 REVIEW TEAM and UKISCRS**