Central Mersey Diabetic Retinopathy Screening Programme

Referring patients for Diabetic Retinopathy Screening

Information for GPs in Halton & St Helens, Knowsley and Warrington PCT

Version: June 2008
Review date: June 2009

Index

Introduction

All people with diabetes of 12yrs and over should be sent an annual invitation for diabetic retinopathy screening.

In a small number of circumstances, it may be appropriate to decide not to send a patient an invitation for diabetic retinopathy screening. This should only be done after a careful assessment of the person and their circumstances and this document aims to provide guidance on:

- How to identify those people with diabetes who should not be routinely invited for screening for diabetic retinopathy
- How their status should be recorded
- The person who should be responsible for making this decision.

1. Summary

1.1 People with diabetes who require annual screening for diabetic retinopathy should be placed on the **Active List**.

1.2 People who should not be referred for screening for diabetic retinopathy should be placed on the **Archive List**

1.3 The Archive List may contain people with diabetes in the following categories:

- A person with diabetes who has made his / her own informed choice that he / she no longer wishes to be invited for screening.
- A person with diabetes who is terminally ill.
- A person with diabetes who has a physical disability preventing either screening or treatment.
- A person with diabetes who has a mental disability preventing either screening or treatment.
- A person with diabetes who has no perception of light (NPL) in **both** eyes.
- A person with diabetes who is currently under the care of an ophthalmologist for the treatment and follow-up management of diabetic retinopathy, and then only for that period.

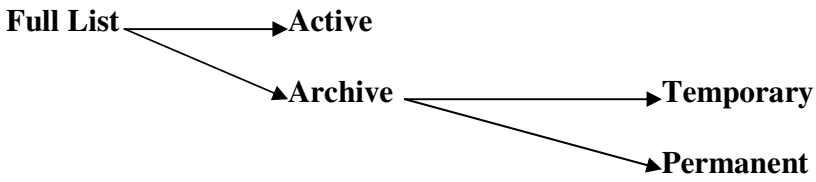
2. List Management

2.1 Screening programme providers need to hold a complete and regularly updated list of people with diabetes in the population who are 12 years old and over, so that they can be offered screening for diabetic retinopathy. This list is termed the **Full List.**

2.2 All people with diabetes who will be called to screening annually are termed **Active**.

2.3 A small minority of people with diabetes on the **Full list** will not automatically be called to screening annually: these are termed **Inactive**.

2.4 A person with diabetes on the **Archive** list may have either **Temporary** or **Permanent** status.



2.5 Placing a person with diabetes on the **Permanent Archive List** will have the effect of stopping all invitations for diabetic retinopathy screening indefinitely.

2.6 Placing a person with diabetes on the **Temporary Archive List** will have the effect of stopping all invitations for diabetic retinopathy screening for a period of time determined by either by that person or by the healthcare professional.

2.7 Where a person with diabetes is given **Archive status**, they should always be encouraged to consider **Temporary Archive** status rather than **Permanent Archive** status.

3. Roles and Responsibilities

3.1 It is the responsibility of the screening programme to hold and update the **Full List**.

3.2 It is the responsibility of the Central Mersey Diabetic Retinopathy Screening Programme to invite all patients on the **Active** list for screening.

3.3 It is the responsibility of the individual GP practice to provide the screening programme with regularly updated Full List identifying patients who are should be invited for screening (**Active**) and patients who should be placed on the **Archive List**, giving the reason and stating whether this should be **Temporary** or **Permanent**.

3.4 Central Mersey PCTs (Halton & St Helens, Knowsley and Warrington) should audit the call/recall status of all people with diabetes aged 12 years and over who are on the Inactive List at least annually to verify that they have been correctly classified..

4. Who should be on the Archive List?

4.1 **A person with diabetes who has made his / her own informed choice that he / she no longer wishes to be invited for screening.** In these circumstances the appropriate health professional (normally GP or senior practice or diabetes specialist nurse) to whom the person with diabetes has made his/her wishes known should ensure that the person has received sufficient information to enable him or her to make an informed choice. **That person should confirm his or her decision in writing. A copy of this document should be retained by the GP and a copy sent to the screening programme.**

4.2 **A person with diabetes who is terminally ill**. It is the decision of the person with diabetes whether to attend or not, and the guidance for Informed Choice 4.1 applies in these circumstances. In special circumstances the GP may decide that invitations might be postponed or stopped depending on the individual person's situation if, in his or her judgement, an invitation to eye screening would cause unnecessary distress. As is usual in these circumstances, the GP would normally discuss this decision with the person's next of kin.

4.3 A person with diabetes who has a physical disability preventing either screening or treatment. If the patient has mobility problems (e.g. wheelchair bound) or other physical disabilities it may still be possible for an ophthalmologist to examine their eyes and treat the patient. The GP or Health Professional should discuss with the **patient** whether referral to an ophthalmologist would cause undue discomfort or distress to the patient. If an examination by an ophthalmologist is thought to be appropriate the Screening Programme should be informed and they will arrange a suitable appointment. If the patient does not wish to attend **4.1** above applies. The patient should **NOT** be put on the **Active** list for screening.

4.4 A person with diabetes who has a mental disability preventing either screening or treatment. In a small number of cases it may still be possible for an ophthalmologist to examine their eyes and in some circumstances to treat the patient (e.g. under General Anaesthetic). The GP or Health Professional should discuss with a **relative or carer** whether referral to an ophthalmologist would cause undue distress to the patient. If an examination by an ophthalmologist is thought to be appropriate the Screening Programme should be informed and they will arrange an appropriate appointment. They should **NOT** be put on the **Active** list for screening.

4.4 A person with diabetes who has no perception of light (NPL) in BOTH eyes. Note that blindness registration does NOT necessarily mean NPL and patients with some vision in one or both eyes should be on the **Active List.**

4.5 A person with diabetes who is currently under the care of an ophthalmologist for the treatment and follow-up management of diabetic retinopathy, and then only for that period. If the patient with retinopathy is discharged from ophthalmic care they should be placed on the **Active List.** If the patient is lost to follow up, for whatever reason, they should be referred back to ophthalmology.

NB. A person with diabetes, who is currently under the care of an ophthalmologist for any other eye condition and not specifically being seen for retinopathy, will still be sent an invite for screening.

Screening pregnant ladies with diabetes

To conform to NICE guidance on the screening of pregnant ladies, the Central Mersey Screening Programme has established the following protocol.

Pregnant ladies with diabetes should be offered digital screening a soon as possible after their first antenatal clinic appointment and again at 26 weeks, if the first assessment is normal and doesn't require referral. If any diabetic retinopathy is present, an additional assessment is required at 16 weeks.

The risk of development and the progression of existing diabetic retinopathy during pregnancy are greater than average. Also, treatment may be required early before later stages of pregnancy make treatment more difficult. Therefore, if the pregnant lady is found to have retinopathy of a degree of R2, M1 or above, they will be referred to the HES urgently. Additionally, pregnant ladies with referable retinopathy should be followed up at a hospital eye department for at least 6 months following the birth.

When a lady with diabetes becomes pregnant, please inform the Screening Administration Centre to ensure they send the necessary invite letters.

Tropicamide, used commonly for dilation, is not registered for use with pregnant ladies unless under the direction of a medical practitioner, although there are no known risks. In view of this, the Central Mersey Screening Programme agrees that screeners can still continue to use Tropicamide with pregnant ladies. However, if in doubt, the screener should take the best images possible without dilation and flag this up in the "Comments" section. Alternatively, the lady can be referred to a Hospital Eye Service for examination by a consultant ophthalmologist and can be returned to the screening service once appropriate.

Appendix 1

Standard Grading Protocol

Retinopathy (R)

Level 0 None	
Level 1 Background	Microaneurysm(s) Retinal haemorrhage(s) ± any exudate not within the definition of Maculopathy
Level 2 Pre-proliferative	Venous beading Venous loop or reduplication Intraretinal microvascular abnormality (IRMA) Multiple deep, round or blot haemorrhages (CWS - careful search for above features)
Level 3 Proliferative	New vessels on disc (NVD) New vessels elsewhere (NVE) Pre-retinal or vitreous haemorrhage Pre-retinal fibrosis ± Tractional Retinal Detachment

Maculopathy (M)

Level 0.5	Exudate within 1 disc diameter (DD) of the centre of the fovea
Level 1	Circinate or group of exudates within the macula retinal thickening within 1DD of the centre of the fovea (if stereo available) Any Microaneurysm or haemorrhage within 1DD of the centre of the fovea only if associated with a best VA of ≤ 6/12 (if no stereo)
Photocoagulation (P)	Evidence of focal/grid laser to macula Evidence of peripheral scatter laser
Unassessable (U)	Unobtainable / Upgradeable

Appendix 2

Glossary of terms

Arcades	Superior and inferior branch retinal vessels
Circinate	in a roughly circular pattern
CWS	Cotton Wool Spots; areas of relative ischemia
Blot	Larger and thicker retinal haemorrhage
Dot	Small retinal haemorrhage
Exudate	leakage of plasma in retinal tissue
Flame haemorrhage	superficial retinal haemorrhage
Focal grid laser	finer beam laser treatment to a smaller area, usually within the central arcades
Fovea	Geographic centre of the retina
IRMA	Intra-retinal microvascular anomalies; new vessels within retinal structure
Laser photo-coagulation	focused laser beam to seal off areas of leakage. It would leave an area of scarring
Macula	Central part of the retina
Microaneurysm	focal dilation of retinal capillaries
NVD	New vessels on the optic disc
NVE	New vessels elsewhere, i.e. not at the optic disc
Optic disc	visible part of the Optic nerve on the retina
Peripheral scatter laser	numerous laser burns to the periphery of the retina, i.e. outside the central arcades
Pre-retinal fibrosis	Fibrosis/scar tissue between the retinal surface and vitreous
Tractional Retinal Detachment	Involves displacement of retinal tissue
Vitreous	The clear, semi-jelly structure in front of the retina

Appendix 3

Useful Contacts

Central Mersey DRSS Screening Centre
Retinal Screening Manager: Paula McGarry
Direct Line: 0151 495 5104

Address:
Mill Brow
Widnes
Cheshire
WA8 6RT
Tel: 0151 495 5100
Fax: 0151 420 4157
paula.mcgarry@nhs.net

Clinical Leads

Clinical Director: Prasad Palimar
prasad.palimar@nch.nhs.uk

Programme Optometric Lead: Bob Wilkes
Tel: 0151 426 2214
bob@rdwilkes.co.uk

Warrington Optometric Lead: Finlay Rosenburgh
Tel: 01925 721071
finlay@rosenburghoptoms.co.uk

Commissioning Leads

Halton and St Helens: Deborah Leigh
01928 593717
deborah.leigh@hsthpct.nhs.uk

Knowsley: Liz Gaulton
0151 443 4911
liz.gaulton@knowsley.nhs.uk

Warrington: Helen Pressage
01925 843720
helen.pressage@warrington-pct.nhs.uk