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Tips for GP trainees working in ophthalmology

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INTRODUCTION

GP trainees most often enjoy ophthalmology rotations and in turn are a breath of fresh air for the department bringing new skills and perspectives from other specialities. That said, so little is often taught in medical school about ophthalmology that it can appear a daunting endeavour. These tips will help you perhaps avoid some mistakes and may even help you make the most of your time.

1. Plan what you want to get out of the rotation and tell the people who count. Yes, you will have to tell your educational supervisor, but more important practically are the people you work with day to day — other senior house officers (SHOs), registrars, and consultants will help you if they know what you'd like to do.
2. Get a book. *Moorfield's Manual of Ophthalmology* or the *Wills Eye Manual* are invaluable aids to any clinic or casualty session. If you want to do more, Snell's *Clinical Anatomy of the Eye* and Kanski's *Clinical Ophthalmology* are in the library.
3. Look on the web. The internet has a huge number of great sites for the basics. www.ophthobook.com is a fun and simple resource with good introductions to most subjects. If you want to look at some videos of what people are describing through a slit lamp or almost any operation try www.eyetube.com. Most ophthalmology trainees use www.mrcophth.com for basic examination tips and in depth information.
4. Get an audit done. It makes you popular in the department and is relatively easy to do compared to other specialities.
5. Ophthalmology is mainly clinic based and you will have time to hit your ePortfolio. Ophthalmology is also heavily e-portfolio based so people are quite used to filling things in.
6. Plan your leave. Most ophthalmology departments are quite small and you may be part of a small band of ophthalmology SHOs on a rota covering on-call and emergency patients. Sometimes the clinic and on-call coordinator is the same person, sometimes they are not.
7. The other members of your team will expect you to have no prior experience and to ask lots of questions, some units will not give you any on-calls until you are up to speed. Use these early days well, use a notebook to write down your own manual of what to do with what, similar things often come up and soon you will be in the hot seat.
8. Dive in — no toe dipping! In the early days do not sit in clinics medical student style unless you are reviewing signs and really learning. As soon as you feel your first yawn, get your own room and start trying to examine patients and present them to your supervisor.
9. It's a team game. You can feel like an unwanted present when you need support in a clinic. Do as much as you can to assess the patient and try to formulate a plan before going to ask for help, it shows willing and helps you learn.
10. If finding support becomes a big problem, talk to someone. Perhaps you can have a named supervisor with a lighter clinic to allow them the required extra time.
11. Know colleagues' sub-specialisms as they are always more likely to be happy to advise you if they have a sub-specialist interest in the area you are asking about.
12. Most consultants will be happy to be involved in anything involving surgery or if something is going wrong.

13. Ask before dilating a patient if you are unsure. The pupil has lots of useful signs, and colour vision and visual fields are more difficult to assess in a dilated patient.
14. Clean your slit lamp in front of your patient, you can start to take a history while you do so. It sets an evident atmosphere of concern for the patient's welfare that can facilitate rapport.
15. You may be asked to give intravenous fluorescein as part of a fluorescein angiogram. Take extra care to check everything, especially if you are asked to complete only a part of this process. Patients don't always volunteer information, some have unfailing faith and will sit and happily report, at their second angiogram, that their tongue is swelling up AGAIN!
16. It is helpful to advise people on what local services are available to them, there are low visual aid clinics, multiple local patient groups, associations, and charities that can be a real lifeline and make you feel better about poor prognoses. It will also help the registrar who may be unaware of the local resources.
17. If you are being pushed to admit someone, involve the registrar early. Few hospitals have 24-hour on-site ophthalmology; find out what the arrangements are, as at night.
18. Traumatic eye injuries are notorious for distracting from other more urgent medical problems. The ophthalmology registrar will be upset to find a patient with chest pain and a positive troponin sitting in the outpatients waiting room. It is much better to get the relevant team to admit and then review the patient when medically stable.
19. Try not to be a slave to the ophthalmology casualty clinic but see some other clinics and theatre sessions. Ophthalmology is sub-specialised for good reasons and although you may not need to see it all it will give you a better overview.
20. Do some minor operations (for example, incision and curettage of chalazions).
21. Learn the lingo. The best help you can be on call is explaining clearly to your registrar what you can see. Be confident in what you can examine and what you cannot. It is important as they will rely on your eyes when they are at home supervising you on call.
22. Paediatric cases are fairly rare in casualty but when they crop up it is always wise to discuss them with a senior, no matter how insignificant they may be.
23. Know the paediatric emergencies well but also revise your nursery songs. Children can be wriggly at best and kick you at worst, a song can relieve their anxiety and allow you to get near enough to examine.
24. Although we often work in separate rooms, ophthalmologists are experts in assessing how much work people are really doing. You will get to know the hard workers and you will be well regarded if you are able to stay in that circle. This will pay its own rewards when you come to ask for ePortfolio assessments and teaching.
25. Ophthalmology has a high throughput and people are regularly lost to follow-up. Have a way of recording all the scans and bloods you order and when to check them. We remain responsible for the tests we order.
26. The fun part about ophthalmology is that you can usually physically see the problem. However, when people are teaching you or showing you clinical signs be honest about what you can and cannot see.
27. Always buy the nurses biscuits/cakes on your first day — they know the lie of the land and as in many specialities can make your life as easy or as hard as they wish.
28. Often units do not have enough Volk lenses (the little ones used with a slit-lamp to see the retina). If someone lends you theirs treat them as the £250–350 small object they are. They have special coatings and don't work half as well if they are scratched.
29. Breathe when examining patients.
30. Examination is all about practice until you are familiar with all the kit. If you cannot see anything, don't automatically think that it is your incompetence. Check the room illumination, check the slit lamp is correctly aligned, your lens clean and correctly orientated, check the patient's position on the slit lamp as adults can wriggle too.
31. You will take a long time shining a bright light in peoples eyes, just let them know that it will take a while and to let you know if they need a break.
32. Try not to let a patient with 'new vessels'

(proliferative diabetic retinopathy) walk out the door without treatment, or at least being discussed with a consultant. If they have let their diabetes get out of control they may not come back until little can be done for their vision, arguing that you didn't warn them about the risks!

33. If someone referred for a possible retinal detachment does not have a retinal detachment, always warn them strongly to return if they get worsening or new symptoms. Give them a leaflet and record that you have done so. Some intelligent young patients will watch the dark band slowly encroach across their entire visual because they were told that they did not have a retinal detachment.
34. You will rapidly become familiar with treatment of 'the red eye'. If they give a convincing story of infective conjunctivitis but it is persistent, or if the vision is reduced (when the eye is clean and not obscured by ointments), or if it has any other unusual features then ask a senior. Not only are there other causes of a persistent discharge such as canaliculitis or a resistant microbe but other treatments may be indicated.
35. Sunglasses on a dark day doesn't always mean uveitis; conjunctivitis and even corneal abrasions can cause photophobia.
36. Remember to tell patients with a first attack of uveitis that it may recur and that they must attend promptly if symptoms return. Occasionally they feel the drops are a 'cure' and are dismayed by the recurrence.

Provenance

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