Tips for GP trainees working in ophthalmology

INTRODUCTION

Medical school does little to prepare future GPs for the relatively large number of patients with ophthalmic complaints they will see in everyday practice, so spending a 4-month attachment in ophthalmology is a good way to fill in any gaps in your knowledge.

The beauty of ophthalmology is that it bridges medicine and (micro)surgery, so that even if you know very little about ophthalmology initially, you will be able to integrate a lot of your general medical knowledge when handling ophthalmic presentations (such as, diabetic retinopathy, thyroid eye disease, and retinal vein occlusions).

THE BASICS

1. Read through an ophthalmology textbook before starting your attachment and consider looking through some ophthalmic photographs by referring to an ophthalmic atlas or by searching on an appropriate medical website: (<http://webeye.ophth.uiowa.edu/eyeforum/atlas/index.htm>).
2. Familiarise yourself with the different roles of the staff in the department. There are optometrists, orthoptists, and ophthalmic specialist nurses. All of them have their areas of expertise and knowing who to approach with which query can make your life a lot easier.
3. Ask one of the ophthalmologists to demonstrate how to use the slit lamp to its maximum benefit.
4. Familiarise yourself with the four groups of eye drops (steroids, antibiotics, anti-glaucoma drops, tear substitutes/lubricants) that are commonly used in ophthalmology.
5. Ensure you know how to measure and record a patient's visual acuity at different distances. Familiarise yourself with the 'Snellen' and 'LogMar' charts.

THE PATIENTS

6. A lot of patients are very squeamish when it comes to their eyes, so always be gentle and explain what you are doing as you go along. Tell them beforehand that most eye drops sting for a few seconds. Remember that fluorescein stains contact lenses, so ensure they are removed before instillation.
7. Some patients may have a vagal response to the eye examination. Make sure you know what to do when this happens.
8. Remember that a patient who cannot see well enough to drive but carries on doing so poses a danger to other people. Explain this to the patient and document that you have done so.
9. Never tell a patient with poor vision there is nothing else that can be done. Even if there is no active treatment, patients should be given the opportunity to be seen in a low vision aid (LVA) clinic, where they may at least be given the opportunity to try out different magnifying devices and other reading aids.

OPHTHALMIC EXAM

10. Medically you have no leg to stand on if you have not recorded the patient's visual acuity (VA). It is common practice to measure patients' distance VA, but alternatively, reading vision can be tested with a 'vocational near vision test type'. Using a pinhole will largely correct for refractive errors and allow VA to be tested in other circumstances, for example, when the patient's glasses are not available. A patient's 'corrected VA' refers to their VA with glasses or pinhole.
11. Use the slit lamp to examine the anterior segment of the eye systematically. Start with the lids (and never forget to invert the lids if you suspect a foreign body) and then move on to the cornea, conjunctiva/sclera, lens, and anterior chamber.
12. Corneal defects are visualised with the

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Commonly used ophthalmic abbreviations

VA	—	visual acuity
IOP	—	intraocular pressure
AC	—	anterior chamber
PC	—	posterior chamber
IOL	—	intraocular lens
NPDR	—	non-proliferative diabetic retinopathy
PDR	—	proliferative diabetic retinopathy
PRP	—	panretinal photocoagulation
AMD	—	age-related macular degeneration
POAG	—	primary open angle glaucoma
NTG	—	normal tension glaucoma
OHT	—	ocular hypertension
CNAG	—	chronic narrow angle glaucoma
OCT	—	ocular coherence tomography
HRT	—	Heidelberg Retina Tomograph
CCT	—	central corneal thickness
VF	—	visual field

help of fluorescein. Bear in mind that most fluorescein eyedrops used in clinic contain a local anaesthetic, so if you need to check corneal sensation do so before using any drops.

13. Most dilating drops used in clinic take 15–30 minutes to work and wear off after 3–6 hours. Patients who have had both eyes dilated should not drive until the effect of the drops has worn off and their vision is no longer blurred. Remember that dilating drops can trigger an attack of acute angle closure in patients with narrow anterior chamber angles.
14. Ophthalmologists specify drops by the annotation 'g' as in *gutta*, which is Latin for drop (for example, g chloramphenicol). The abbreviation 'oc' (*oculentum*) refers to eye ointment (for example, oc chloramphenicol).
15. When you start off examining the retina (either with the slit lamp or the ophthalmoscope), always make sure the patient has dilated pupils. Examine the retina systematically, looking at the disc and the macula first, and then at the

vitreous and peripheral retina.

16. When using the slit lamp, you must make sure you are comfortable and that your chair is not too high. Using the slit lamp for several hours in a hunched position can cause severe neck and back pain.

OPHTHALMOLOGY CLINICS AND THEATRE

17. A picture is worth a thousand words and the pathology should be fairly obvious if you know what you are looking for. Draw a large picture of the cornea, optic nerve head, or retina and pencil in what you can see. A good drawing of the optic disc and cup is a lot more useful than simply documenting an arbitrary cup-disc ratio. Use a red pen to indicate injection and blood. Use green to indicate corneal staining and yellow to highlight retinal exudate and drusen.
18. Lots of patients and some doctors do not take compliance with eye medication seriously enough. Bear in mind that certain eye drops (for example, timolol) have systemic side effects. Every year, a few patients with severe asthma end up in resuscitation because of topically applied beta blocker drops.

ON CALLS

19. There are few life- and sight-threatening ophthalmic emergencies. The ones you must not miss are endophthalmitis, giant cell arteritis, acute angle closure, orbital cellulitis (especially in children), corneal ulcers, third-nerve palsies, a painful Horner's syndrome, and retinal tears and detachments. Once a patient has completely lost vision in one eye you probably have missed the boat, but you must bear in mind prophylactic treatment for the remaining eye in cases of giant cell arteritis and acute angle closure glaucoma. An older patient with sudden loss of vision and a headache has giant cell arteritis until proven otherwise.
20. A lot of (neuro)surgical conditions are first diagnosed by the ophthalmologist (for example, optic neuritis in multiple sclerosis, third-nerve palsies, and Horner's syndrome), who will then hand over to the appropriate team (such as neurology or neurosurgery).
21. When assessing patients with posterior vitreous detachments ('flashes and floaters') tell them to return in case of worsening or new symptoms, which may indicate a retinal tear or detachment. Give them a leaflet and record that you have done so.