Cataract

**Definition**

Cataract is an opacity of the human crystalline lens sufficient to cause visual impairment.

**Policy**

It is the responsibility of referring and treating clinicians to ensure compliance with this policy. Referral proforma should be attached to the patient notes to aid the clinical audit process and provide evidence of compliance with the policy. For patients not meeting the policy criteria, Optometrists or GPs can apply for funding to the Exceptional Cases Panel by completing the exceptional funding section of the referral proforma: Click policies to access the CCG clinical policies web page: policies – select the Eye Condition Policies drop down option and select Cataracts Policy to access the referral proforma.

This policy covers direct referral for cataract surgery by Optometrists and referral by GPs.

Referrals for cataract surgery will be funded for patients whose visual impairment is attributable to cataract and who, after correction (e.g. with glasses or other adjustments), have:

- visual acuity of 6/12 or worse in the worst eye\(^i, ii\); OR
- the patient has bilateral cataracts, neither of which fulfils the threshold for surgery, but which together reduce binocular vision below the DVLA standard for driving\(^iii\); OR
- a significant optical imbalance (anisometropia or aniseikonia) affecting activities of daily living that can only be corrected with cataract surgery; AND
- who are willing to undergo cataract surgery.

Cataract surgery/lens extraction should not normally be performed solely for the purpose of correcting longstanding pre-existing myopia or hypermetropia.

The reasons why the patient’s vision and lifestyle are adversely affected by cataract and the likely functional benefit from surgery must be documented in the CCG referral proforma and referrals without this information should be returned.

**Smoking**

Patients who smoke should be advised to attempt to stop smoking 8 to 12 weeks before the operation to reduce the risk of surgery and the risk of post-surgery complications. Patients should be routinely offered referral to smoking cessation services to reduce these surgical risks.

**Notes:**

i A cataract with a best corrected visual acuity (BCVA) of 6/12 [Snellen] 0.30 [LogMAR] or worse is defined as a “visually impairing cataract” (North London Eye study, cited in Royal College of Ophthalmologists 2010, 3:2). Patients with monocular vision may be considered for Exceptional Funding even if they do not meet this visual acuity threshold.

ii It is expected that patients who have BCVA better than 6/12 in the worst eye, and who report substantial visual impairment, such as glare, anisometropia or aniseikonia, will be advised, as part of their optometric or GP consultation, on suitable adjustments (for example by an updated prescription and/or by using tinted glasses/lenses, or shading the eyes from strong sunlight).

iii It is accepted that there may be some patients with BCVA better than 6/12 in the worst eye who are drivers and who are unable, despite updated glasses, contact lenses or other adjustments, to meet the DVLA standard.
Pre and Post-operative Assessment

Optical Computerised Tomography (OCT) and Ultrasound scans are not part of routine pre- or post-operative assessment unless clinically indicated due to suspicion of retinal pathology, for example pre-operatively in patients with diabetic retinopathy or AMD and post-operatively when visual acuity is less than was expected. The clinical indication for the test should be documented in the referral proforma.

Rationale

A best corrected visual acuity (BCVA) of better than 6/12 [Snellen], 0.30 [LogMAR] in the worst eye normally allows a patient to function without significant visual difficulties. In population studies using BCVA as an indicator of morbidity, BCVA better than 6/12 is not considered a visually impairing cataract. As DH policy is for CCGs to set a visual acuity threshold, direct referral for cataract surgery will, therefore, not be commissioned for patients with a best corrected visual acuity better than 6/12 in the worst eye. This applies to both first and second eye surgery. The rate at which cataracts progress is unpredictable. Risk factors for progression, in particular smoking, are important to advise the patient about. Control of underlying disease, in particular diabetes, is also important.

An OCT may be indicated in evaluating a macular problem that may coexist with a cataract to help determine the relative contribution of each disease to the visual impairment. Such indications include findings in the history and exam that would point to a new change in the macula, not routine evaluation.17

OPCS Codes

C710 - C759. ICD10 codes H25, H26

References

13. West Essex CCG (June 2013), Coastal West Sussex CCG (Feb 2013), Oxfordshire Priorities Forum (2010) policies on cataract surgery.

   http://www.aao.org/yo/newsletter/200905/article01.cfm

Glossary

Anisometropia:  Difference in lens strength between the two eyes.
Anisekonia:  Differences between the image in one eye and the other.
Hypermetropia:  Long sightedness.
Myopia:  Short sighted or near sighted.