# Wakefield Optometry



## Greetings!

Welcome to the latest edition of Wakefield LOC's Newsletter. As the memory of those snowy drives to work fades with the arrival of the lighter evenings , it's time to get back into optical mode.

**Venue : The Holmfield Eating Inn, Wakefield April 10th**

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| 6.15pm | Refreshments |
| 6.30pm | ***Is Everyone Comfortable?***<br>Peer Discussion – Presented by Alcon |
| 7.30pm | Close |

## April CET Event

Our next CET event will take place at the usual venue of The Holmfield Eating Inn on Tuesday 10th April starting promptly at 6.30pm. It will be a Peer Discussion event entitled *Is Everyone Comfortable?* and will be presented by Alcon. The event code will be C-52977 and it will be worth 3 Peer Review CET points.

There will a total of 20 places available comprising of two tables of ten with an Alcon facilitator on each table. There will clearly be a high demand for these places and so on this occasion, preference will be given to Optometrists working in the Wakefield area on a first come, first served basis. Optometrists from outside the area are very welcome to apply and will be allocated a place should any places be unfilled. Consequently, if you wish to take part, send your name, GOC number and practice name to ***cet@wakefieldoptometry.org.uk*** so that we can prepare the CET paperwork.

## AGM Date

This years Annual General Meeting will be a little later this year on the 5th June. The evening will, as usual, contain a CET event but the exact details of this are still to be confirmed.

## Pre-registration appeal

We have received a request for help from a local optical student who is looking for a pre-registration post starting in summer 2019. Can you help her? Here is her request:

*Hi, my name is Natalie & I am currently in my second year at City, University of London studying Optometry. I am in the process of looking for a placement for my pre-registration year and would ideally prefer to move back to Yorkshire. I live in West Yorkshire but would be happy to travel further afield. (Last summer I commuted to London on a Saturday, returning on the same day to be able to continue working at my Saturday job which is a Trainee Optical Consultant with one of the Boots franchises in London!) I am an extremely hard working, polite, dedicated, conscientious & enthusiast individual. Seeing customers happy is something I strive to achieve at all times.*

*I would be thrilled to hear from you if you would consider me for an interview if you have any pre-Reg positions available commencing summer 2019.*

*My contact details are:- 07508 808 839* *nataliemoore1007@gmail.com*

## Ask an Expert! - a new series where you get to ask the questions….

If you are like me, then there are lots of things that crop up in our work that I don't always know the answer to. Wouldn't it be nice if we could simply ask one of our local Ophthalmologists and get answers which we could all share and benefit from? Now we have the chance. 'Ask An Expert' will be a series that will run in the WLOC Newsletter starting this month with Mrs Nagar (Consultant Ophthalmologist with a speciality in glaucoma) sitting in the experts chair. You can see the questions and answers below.

In the next edition, it will be the turn of Mr Andrew Chung which will answer questions on the anterior eye. If you have a question then please email as soon as possible to *cet@wakefieldoptometry.org.uk*

**Q 1.** ***What extra precautions should we take with patients who have Pigment Dispersion Syndrome?***

PDS - The release of pigment into the anterior chamber and the subsequent deposition on the trabecular meshwork constitutes a major mechanism in IOP elevation and glaucoma in patients with pigment dispersion syndrome. It typically occurs when patients are in their early 20s, but the condition begins to regress with increasing age, enlargement of the lens, and the loss of accommodation due to the onset of presbyopia.
The classic diagnostic triad consists of corneal pigmentation (Krukenberg's spindle); slitlike, radial, mid-peripheral iris transillumination defects; and dense trabecular pigmentation.
Patients with pigment dispersion syndrome or pigmentary glaucoma may experience sudden IOP spikes after pupillary dilation. Exercise may cause the shedding of pigment and a subsequent pressure spike in some patients with pigment dispersion syndrome, the majority of patients do not appear to be affected. Pigmentary shedding is most commonly associated with jogging or bouncing.

**Treatment :**

- Miotics constrict the pupil and increase aqueous outflow, they are, in principle, first-line therapy. In practice, pilocarpine completely stops the exercise-induced release of pigment and elevation of IOP
- Laser iridotomy can eliminate reverse pupillary block, flatten the iris' contour, and reduce the extent of iridolenticular contact. Iridotomy may relieve IOP spikes, it does not lower baseline IOP, because it takes years for pigment to clear from the trabecular meshwork. As a rule of thumb, we restrict iridotomy to young patients with elevated IOP, no glaucomatous damage and experience a release of pigment upon pharmacologic dilation or spontaneously after exercise.

**Referral** : Young patients with risk of pigment dispersion should be referred to HES for assessment and baseline diagnostics along with gonioscopy.

***Q2 Thin corneas give artificially low tonometry readings but do thin corneas increase the risk of developing glaucoma?***

A very interesting question! We do know that eyes with thin corneas have an underestimation of intraocular pressure, and eyes with thick corneas have an overestimation of intraocular pressure. Consequently, studies have shown that some eyes with so-called ocular hypertension—that is, increased intraocular pressure readings in the presence of a normal appearance of the optic nerve head and normal visual fields -have an abnormally thick cornea that artificially induces the elevated applanation tonometric measurement. On the other hand, normal-tension glaucomas have abnormally thin corneas. Patients with chronic open-angle glaucoma have more advanced glaucomatous optic nerve damage if the cornea is relatively thin than if the cornea is relatively thick. The reason may be that patients with thick corneas may be referred earlier because they have falsely higher intraocular pressure measurements than patients with thin corneas.

**Q 3.** ***Some areas are now switching to preservative free glaucoma medications. Could Wakefield follow this trend?***

It is definitely a way forward but we need to find a fine balance. On one hand we are being asked to move to generic drugs and on the other hand we are discussing the benefits of moving towards preservative free glaucoma medications. At the moment the answer is no. Elderly patients and patients with arthritis do however struggle to use preservative free drops.

**Q 4.** ***Do you recommend Benoxinate or Proxymetacaine for Goldmann tonometry?***

I do not have any particular preference, we use Proxymetacaine because of better tolerability.

**Q 5.** ***Should asymptomatic patients with no signs of glaucoma and normal IOP's be referred with narrow angles of VH1?***

If there is a risk of IOP spikes due to narrow angles or development of PAS due to subacute angle closure then yes these patients should be referred for Goniscopy and Laser Peripheral Iridotomy if required. Laser Peripheral Iridotomy may resolve the condition.

## Data Protection changes

Many of you will be aware already that there new data security and protection requirements which practices need to be aware of and act on in the very near future. This applies to anyone who provides eye health services and who contracts via the NHS Standard Contract.

Just to make sure that everyone is aware, a copy of the LOCSU/Optical Confederation guidance has been included with this email.

*If you know of a colleague who would like to receive updates and information directly from Wakefield LOC then please ask them to email us at* ***info@wakefieldoptometry.org.uk*** *Their contact details will only be used for that purpose and will never be passed on to, or made available to, a third party. Finally, if you have been to a particulary useful CET lecture that you feel would benefit all of our members then again get in touch and tell us about it. Perhaps you would like to suggest a topic that you would like to see covered? Your feedback and contributions would be most welcome.*