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Sir,

Reference: Community refinement of glaucoma referrals

The article by David Henson and colleagues (*Eye* (2003) **17**: 21–26) regarding employment of specially trained optometrists to screen glaucoma referrals from community optometrists attempts to show that this is cheaper than a visit to the hospital eye department.

The cost of an eye department outpatient visit is estimated at £55, which does seem high. I wonder how the group arrived at this figure and whether it could possibly be a hospital wide average outpatient cost. Costings in the NHS are notoriously difficult to pin down, but it is very important to be sure that there is a cost advantage in eye care outside the hospital setting before these schemes are more widely recommended. In our hospital I estimate that the real cost of an outpatient visit to the glaucoma clinic is between £5 and £10 including staffing costs, overheads, and disposables. Interestingly, we have also set up an optometrist-managed secondary screening clinic for glaucoma referrals, but we use hospital-employed optometrists who work in the eye department premises. In this clinic, patients are prioritised and referred to the glaucoma clinic, and are discharged if there are no abnormal findings. Audit data on 200 patients passing through this clinic indicate a discharge rate of approximately 15%, which is considerably less than the 40% nonreferral rate in Henson's study. This variance could indicate a regional variability in the quality of optician's referrals.

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Sir,

Costs of shared care

The glaucoma referral refinement scheme reported from Manchester (*Eye* (2003) **17**: 21–26) has potential benefits for hospital glaucoma clinics that are struggling to keep abreast of the tide of new suspect glaucoma referrals. But the alleged cost savings are doubtful. For example, the savings to the GP of £11 700 are presumably based on an estimate of GP time and expenses in passing the referral on to the hospital: is this a realistic figure?

Hospital-based screening clinics may be a cheaper alternative. For 7 years, I have run a Nurse-led Glaucoma screening clinic to assess the urgency of referrals from optometrists. Patients attend the clinic and records are taken of the history (including details of family history and medications), visual acuity, visual field (Humphrey 24-2 threshold strategy), intraocular pressures by applanation tonometry (Perkins), and nonmydriatic optic disc photographs (Topcon). The records are examined and I write to the patient, general practitioner, and optometrist recommending follow-up by the optometrist or in the glaucoma clinic according to the findings. The clinic is audited annually.

We need to allow more responsibility to optometrists and ensure there is no financial disincentive to the follow-up of glaucoma suspects in the community. In particular, visual field defects are often artefactual rather than real, and improve when the field test is repeated. Visual field tests need careful explanation, supervision, and interpretation. Noncontact tonometry should not be performed by untrained personnel. It is good practice for an optometrist to repeat both tonometry and field tests to help reduce the false positive rate. Optometrists should be able to exercise clinical judgement and not refer nonprogressive field defects in people with anomalies, for example, optic disc drusen, tilted discs, colobomas.

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