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Sir,  
**Ensuring the quality of cataract referrals**

We read with interest the article by Park *et al*<sup>1</sup> 'evaluating a new cataract referral pathway' and would like to advocate the importance of GP involvement in the direct referral pathway. At 12 months after introducing the direct referral forms to optometrists in the catchment area served by Frimley Park Hospital, we compared the quality of referrals with that obtained through the traditional GP route.

Comparison of 54 age- and date-of-referral-matched referrals showed that direct optometrist referrals documented the symptoms and Snellen visual acuity adequately compared with the traditional GP route (100 *vs* 97.4%). In agreement with Park *et al*, past medical history was more often documented on the traditional referral forms compared with the direct referral forms (66.6 *vs* 22.5%). Traditionally, patients diagnosed by their optometrist with cataracts would be referred to their GP and then onto the hospital eye service (HES). A comparison of the time to HES from diagnosis, showed a significant reduction in time-to-first appointment with direct optometrist referrals (74.9 *vs* 94.9 days),<sup>2</sup> indicating that streamlining the referral pathway does reduce waiting times. Nevertheless, the involvement of the GP in the referral ensures access to the medical and social history of the patient. Although, this information did not seem to affect the outcome of surgery in the Park *et al* study, this is probably because the information is subsequently obtained from the patient by the ophthalmologist before surgery and appropriate action undertaken. General medical and social history is certainly useful for triaging patients and referral to the appropriate ophthalmic sub-specialist. GP involvement is invaluable in ensuring the quality of the referral and should be an integral part of education on cataract referrals from community services. We conclude that direct referral through the optometrist is effective but requires participation and co-ordination between services to ensure and maintain quality.

**Conflict of interest**

The authors declare no conflict of interest.

**References**

- 1 Park JC, Ross AH, Tole DM, Sparrow JM, Penny J, Mundasad MV. Evaluation of a new cataract surgery referral pathway. *Eye* 2009; **23**: 309–313.

- 2 Sim D, Dinah C, Menon G. Streamlining cataract services: a long-lived change? *Br Med J*, accessed 22 January 2007.

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Sir,  
**Response to Dinah *et al***

We would like to thank Dinah *et al* for their helpful discussion in relation to our cataract referral study.<sup>1</sup> We were most interested to find that in Frimley Park Hospital, in agreement with our Bristol study, traditional cataract referrals are more likely to detail the past medical history than direct cataract referrals, emphasising yet again on the importance of collaboration between the patient's general practitioner and hospital eye service (HES).

We agree that at the time of cataract referral review by the HES it is most useful to have the past medical history, drug history and social history, which is used to identify patients that need more urgent surgery or have special needs in relation to their surgery, such as an in-patient stay or need of a senior surgeon because of anticipated surgical hurdles. To ensure this, in Bristol we have devised a combined, direct referral form, which combines the requisite information from both the GP and community optometrist onto a single, unified form. Initially, this will be in paper format, and in due course be managed electronically.

We hope to re-audit our outcomes (and in particular assess the rates of conversion to surgery and reasons for not proceeding to surgery) to see if this combined, direct referral form further improves the standard of care.

**Conflict of interest**

The authors declare no conflict of interest.

**Reference**

- 1 Park JC, Ross AH, Tole DM, Sparrow JM, Penny J, Mundasad MV. Evaluation of a new cataract surgery referral pathway. *Eye* 2009; **23**: 309–313.

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