Eye (2021) 35:1270–1271
https://doi.org/10.1038/s41433-020-1033-7

The ROYAL COLLEGE of OPHTHALMOLOGISTS

CORRESPONDENCE

Response to: 'Comment on: 'Seeking a practical definition of stable glaucoma: a Delphi consensus survey of UK glaucoma consultants"

B. K. Lakhani[1] · K. Giannouladis[1] · P. Leighton[2] · A. J. King[1]

Received: 21 May 2020 / Revised: 2 June 2020 / Accepted: 9 June 2020 / Published online: 3 July 2020

To the Editor:

We are very grateful to Berrett and colleagues for their interest in our paper and we appreciate the application of the Delphi consensus definition of 'stable glaucoma' to their cohort of secondary care patients which highlights a very important and relevant point.

In our study, we aimed to identify a consensus agreement for "stable glaucoma" amongst UK glaucoma consultants as this term is often used to identify patients suitable for management in community schemes. Prior to our paper, despite the move to commission a greater number of community services for monitoring OHT and suspect glaucoma [1], we were unable to find an established clinical definition of 'Stable Glaucoma' in the literature. This definition was left to the discretion of local service providers, which we believe led to inconsistency in how patients are monitored in these community-based clinics.

Berrett and colleague's application of the definition of "stable glaucoma" demonstrates that only a small number of patients within their secondary care services achieve the definition of stable glaucoma. In essence, this reflects the complexity of their secondary care service cohort and additionally the likely efforts over the years to divert low risk patients such as OHT and glaucoma suspects to alterative care pathways. We believe this is not an uncommon situation within secondary care in England: essentially, Berrett and colleagues have highlighted that few glaucoma patients in secondary care reach the threshold required to be labelled "stable". The suggestion that loosening the criteria to allow more people to be followed up in stable glaucoma community schemes is likely to result in high referral rates back to secondary care services and potential delays in treatment.

As Berrett et al. point out, very little glaucoma is stable and therefore management of these patients needs to be undertaken by well qualified and experienced glaucoma clinicians. Clinical decision making is the key and ensures that decisions are made in a timely manner and unnecessary reviews are not undertaken. This level of decision making may not be available in community clinics, which would inevitably result in referrals back to secondary care as suggested.

We believe that the solution to this problem lies with alternate ways of working within secondary care itself. Many of these "non-stable" glaucoma patients intermittently require treatment change decisions and therefore an alternative may be to review a large number of these patients who do not meet the criteria for discharge to community schemes in "glaucoma virtual clinics" [2, 3]. Virtual clinics facilitate higher volumes of patients to be reviewed by glaucoma consultants, ensuring that all decisions are made by experienced decision makers enabling effective, efficient patient management. Of course, this requires the facilities to support virtual clinics for these patients and sufficient high-level decision makers to review the virtual clinic data with time allocated to this activity in their weekly schedule. Many of the decisions can be made on the basis of virtual data and enacted virtually, only those patients where it is absolutely necessary, such as those requiring surgery would need to be reviewed in a face to face consultation. The ratio of glaucoma virtual clinic reviews to face to face reviews per session would greatly help to manage the large volume of patients that need to be followed in secondary care while ensuring high quality decisions are still made on all patients.

Compliance with ethical standards

Conflict of interest The authors have no conflict of interests to declare.

✉ B. K. Lakhani
bansrilakhani11@gmail.com

[1] Department of Ophthalmology, Nottingham University Hospitals, Derby road, Nottingham NG7 2UH, UK

[2] School of Medicine, University of Nottingham, Kings Meadow Campus, Nottingham NG7 2NR, UK

References

1. The College of Optometrists and The Royal College of Ophthalmologists. Commissioning better health care: Glaucoma; 2013. http://www.locsu.co.uk/uploads/enhanced_pathways_2013/joint_colleges_glaucoma_guidance.pdf.
2. Kotecha A, Baldwin A, Brookes J, Foster P. Experiences with developing and implementing a virtual clinic for glaucoma care in an NHS setting. Clinical Ophthalmol. 2015;9:1915–23.
3. Gunn PJG, Marks JR, Au L, Waterman H, Spry PGD, Harper RA. Acceptability and use of glaucoma virtual clinics in the UK: a national survey of clinical leads. BMJ Open Ophthalmol. 2018;3:e000127. https://doi.org/10.1136/bmjophth-2017-000127.