



Survey of UKISCRS consultant members regarding preferred practice management of persistent Cystoid Macular Oedema

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Received: 3 March 2021 / Revised: 10 March 2021 / Accepted: 11 March 2021 / Published online: 25 March 2021
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To the Editor:

A recent Scottish Ophthalmic Surveillance Unit survey reported a low incidence of persistent Cystoid Macular Oedema (pCMO) at 3 months following uncomplicated cataract surgery in Scotland (2.2 cases per 10,000; 0.02%; based on an average of 42,000 cataract operations/year), with inconsistent and variable management regimes [1]. As there are over 400,000 cataract procedures performed annually across the UK, that could translate to more than 80 pCMO cases nationally. To provide a national view regarding pCMO management, we surveyed the 186 consultant members of UK & Ireland Society of Cataract & Refractive Surgeons

(UKISCRS) to identify their recommendations in November 2020.

41 responses were received within 6 weeks (response rate 22%; 73.2% from England, 14.6% Scotland). 53.7% worked in both public and private practice (34.1% NHS only). Respondents reported high levels of experience (70.7% consultant for >10 years) and regular surgical exposure (46.3% <10 cataract operations/week; 39.0% 10–19; 14.6% 20+).

Standard anti-inflammatory regimes after routine cataract surgery included topical steroids alone (58.5%); topical steroid and topical NSAIDs (36.6%); and topical NSAID alone (4.9%). Notably, 14.6% would alter their standardised NHS protocols in the private sector (adding topical NSAIDs to topical steroids).

Table 1 Recommended first-line treatments and subsequent management strategies by 41 UKISCRS consultant members for persistent Cystoid Macula Oedema (pCMO) following routine cataract surgery.

Treatment Options	Initial management <1 month	3 months post op	6 months post op	9 months post op
Topical steroids alone	1 (2.4%)	–	–	–
Topical NSAIDs alone	1 (2.4%)	2 (4.9%)	–	–
Combination of topical steroids and topical NSAIDs	35 (85.4%)	6 (14.6%)	–	–
Topical steroids, topical NSAIDs and oral Acetazolamide	3 (7.3%)	4 (9.6%)	–	1 (2.4%)
Topical steroid, topical NSAIDs and oral Prednisolone	–	–	1 (2.4%)	1 (2.4%)
Sub-Tenon's triamcinolone injection	–	12 (29.3%)	8 (19.5%)	–
Peribulbar triamcinolone injection	–	3 (7.3%)	1 (2.4%)	–
Intravitreal triamcinolone injection	–	3 (7.3%)	5 (12.2%)	5 (12.2%)
Intravitreal steroid implant	1 (2.4%)	–	4 (9.6%)	10 (24.4%)
Intravitreal anti-VEGF injection	–	2 (4.9%)	2 (4.9%)	2 (4.9%)
Vitreoretinal referral	–	3 (7.3%)	6 (14.6%)	5 (12.2%)
Medical retina referral	–	5 (12.2%)	13 (31.7%)	16 (39.0%)
Other	–	1 (2.4%)	1 (2.4%)	1 (2.4%)

NSAIDs non-steroidal anti-inflammatory drugs.

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For initial management of CMO, 85.4% would use topical steroids with topical NSAIDs. There was a trend towards peri-ocular steroid use by 3 months, which increased by 6 months to include intravitreal steroid. By 9 months, treatment shifted from peri-ocular injections towards intravitreal steroid injection or implants and 51.2% would have referred to vitreo-retinal or medical retina colleagues [Table 1].

Treatment would be stopped by 31.7% if no resolution of CMO after 12 months, in 51.22% if the medical retina team advised no further investigations and 22.0% if vitreo-retinal team advised no surgical intervention. 9.8% would stop if visual acuity was better than 6/12.

This survey reveals the wide-ranging management recommendations of 41 UKISCRS consultant members when faced with pCMO following routine cataract surgery. Our responses confirmed the variable and inconsistent strategies reported by the SOSU study and elsewhere [1–3]. National guidelines would be beneficial to optimise management of pCMO, particularly as routine post-operative cataract patients are increasingly being discharged directly to primary care optometry.

Acknowledgements At time of submission PB was the immediate past-President of UKISCRS and DL was a UKISCRS council member.

Compliance with ethical standards

Conflict of interest The authors declare no competing interests.

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