



April 2007

International Council of Ophthalmology/  
International Federation of Ophthalmological Societies

## ICO International Clinical Guidelines

### Cataract (Initial and Follow-up Evaluation)

**(Ratings:** A: Most important, B: Moderately important, C: Relevant but not critical  
**Strength of Evidence:** I: Strong, II: Substantial but lacks some of I, III: consensus of expert opinion in absence of evidence for I & II)

#### Initial Exam History

- Symptoms **(A:II)**
- Ocular history **(A:III)**
- Systemic history **(A:III)**
- Assessment of visual functional status **(A:II)**

#### Initial Physical Exam

- Visual acuity, with current correction **(A:III)**
- Measurement of BCVA (with refraction when indicated) **(A:III)**
- Ocular alignment and motility **(A:III)**
- Pupil reactivity and function **(A:III)**
- Measurement of IOP **(A:III)**
- External examination **(A:III)**
- Slit-lamp biomicroscopy **(A:III)**
- Evaluation of the fundus (through a dilated pupil) **(A:III)**
- Assessment of relevant aspects of general and mental health **(B:III)**

#### Care Management

- Treatment is indicated when visual function no longer meets the patient's needs and cataract surgery provides a reasonable likelihood of improvement. **(A:II)**

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- Cataract removal is also indicated when there is evidence of lens-induced diseases or when it is necessary to visualize the fundus in an eye that has the potential for sight. **(A:III)**
- Surgery should not be performed under the following circumstances: **(A:III)** glasses or visual aids provide vision that meets the patient's needs', surgery will not improve visual function; the patient cannot safely undergo surgery because of coexisting medical or ocular conditions; appropriate postoperative care cannot be obtained.
- Indications for second eye surgery are the same as for the first eye. **(A:II)** (with consideration given to the needs for binocular function)

### Preoperative Care

Ophthalmologist who is to perform the surgery has the following responsibilities:

- Examine the patient preoperatively **(A:III)**
- Ensure that the evaluation accurately documents symptoms, findings and indications for treatment **(A:III)**
- Inform the patient about the risks, benefits and expected outcomes of surgery **(A:III)**
- Formulate surgical plan, including selection of an IOL **(A:III)**
- Review results of presurgical and diagnostic evaluations with the patient **(A:III)**
- Formulate postoperative plans and inform patient of arrangements **(A:III)**

### Follow-up Evaluation

- High-risk patients should be seen within 24 hours of surgery. **(A:III)**
- Routine patients should be seen within 48 hours of surgery. **(A:III)**
- Components of each postoperative exam should include:
  - Interval history, including new symptoms and use of postoperative medications **(A:III)**
  - Patient's assessment of visual functional status **(A:III)**
  - Assessment of visual function (visual acuity, pinhole testing) **(A:III)**
  - Measurement of IOP **(A:III)**
  - Slit-lamp biomicroscopy **(A:III)**

### Nd:YAG Laser Capsulotomy

- Treatment is indicated when vision impaired by posterior capsular opacification does not meet the patient's functional needs or when it critically interferes with visualization of the fundus. **(A:III)**
- Educate about the symptoms of posterior vitreous detachment, retinal tears and detachment and need for immediate examination if these symptoms are noticed. **(A:III)**

## Patient Education

- For patients who are functionally monocular, discuss special benefits and risks of surgery, including the risk of blindness. (A:III)

\* Adapted from the [American Academy of Ophthalmology Summary Benchmarks, November 2006 \(www.aaopt.org\)](http://www.aaopt.org)

(For more ICO International Clinical Guidelines, see [www.icoph.org/guide](http://www.icoph.org/guide))

## Preface to the Guidelines:

International Clinical Guidelines are prepared and distributed by the International Council of Ophthalmology on behalf of the International Federation of Ophthalmological Societies.

These Guidelines are to serve a supportive and educational role for ophthalmologists worldwide. These guidelines are intended to improve the quality of eye care for patients. They have been adapted in many cases from similar documents (Benchmarks of Care) created by the American Academy of Ophthalmology based on their Preferred Practice Patterns.

While it is tempting to equate these to Standards, it is impossible and inappropriate to do so. The multiple circumstances of geography, equipment availability, patient variation and practice settings preclude a single standard.

Guidelines on the other hand are a clear statement of expectations. These include comments of the preferred level of performance assuming conditions that allow the use of optimum equipment, pharmaceuticals and/or surgical circumstances.

Thus, a basic expectation is created and if the situation is optimum, the optimum facets of diagnosis, treatment and follow up may be employed. Excellent, appropriate and successful care can also be provided where optimum conditions do not exist.

Simply following the Guidelines does not guarantee a successful outcome. It is understood that, given the uniqueness of a patient and his or her particular circumstance, physician judgment must be employed. This can result in a modification in application of a guideline in individual situations.

Medical experience has been relied upon in the preparation of these guidelines, and they are whenever possible, evidence-based. This means these Guidelines are based on the latest available scientific information. The ICO is committed to provide updates of these guidelines on a regular basis (approximately every two to three years).

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(Also see the Introduction to the ICO International Clinical Guidelines at [www.icoph.org/guide/guideintro.html](http://www.icoph.org/guide/guideintro.html) and the list of other Guidelines at [www.icoph.org/guide/guidelist.html](http://www.icoph.org/guide/guidelist.html).)