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)
- 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)
- Frequency and timing of subsequent visits depend on refraction, visual function, and medical condition of the eye.
- More frequent follow-up usually necessary for high risk patients.
- 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 2010 (www.aao.org)