



## 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](http://www.aao.org))