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International Council of Ophthalmology/
International Federation of Ophthalmological Societies

ICO International Clinical Guidelines

Posterior Vitreous Detachment, Retinal Breaks and Lattice Degeneration (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 (Key elements)

- Symptoms of PVD **(A:I)**
- Family history (e.g., Stickler syndrome) **(A:II)**
- Prior eye trauma, including surgery **(A:II)**
- Myopia **(A:II)**
- History of cataract surgery **(A:II)**

Initial Physical Exam (Key elements)

- Examination of the vitreous for detachment, pigmented cells, hemorrhage, and condensation **(A:III)**
- Examination of the peripheral fundus with scleral depression **(A:III)** The preferred method of evaluating peripheral vitreoretinal pathology is with indirect ophthalmoscopy combined with scleral depression **(A:III)**

Ancillary Tests

- Perform B-scan ultrasonography if peripheral retina cannot be evaluated. **(A:II)**
If no abnormalities are found, frequent follow-up examinations are recommended. **(A:III)**

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Surgical and Postoperative Care if Patient Receives Treatment:

- Inform patient about the relative risks, benefits and alternatives to surgery **(A:III)**
- Formulate a postoperative care plan and inform patient of these arrangements **(A:III)**
- Advise patient to contact ophthalmologist promptly if they have a significant change in symptoms such as new floaters or visual field loss **(A:II)**

Care Management

Management Options

Type of Lesion	Treatment
Acute symptomatic horseshoe tears	Treat promptly (A:II)
Acute symptomatic operculated tears	Treatment may not be necessary (A:III)
Traumatic retinal breaks	Usually treated (A:III)
Asymptomatic horseshoe tears	Usually can be followed without treatment (A:III)
Asymptomatic operculated tears	Treatment is rarely recommended (A:III)
Asymptomatic atrophic round holes	Treatment is rarely recommended (A:III)
Asymptomatic lattice degeneration without holes	Not treated unless PVD causes a horseshoe tear (A:III)
Asymptomatic lattice degeneration with holes	Usually does not require treatment (A:III)
Asymptomatic dialyses	No consensus on treatment and insufficient evidence to guide management
Fellow eyes atrophic holes, lattice degeneration, or asymptomatic horseshoe tears	No consensus on treatment and insufficient evidence to guide management

PVD = Posterior vitreous detachment

Follow-up History

- Visual symptoms **(A:I)**
- Interval history of eye trauma, including intraocular surgery **(A:I)**

Follow-up Physical Exam

- Visual acuity **(A:III)**
- Evaluation of the status of the vitreous, with attention to the presence of pigment or syneresis **(A:II)**
- Examination of the peripheral fundus with scleral depression **(A:II)**
- B-scan ultrasonography if the media is opaque **(A:II)**
- Patients who present with vitreous hemorrhage sufficient to obscure retinal details and a negative B-scan should be followed periodically. For eyes in which a retinal tear is suspected, a repeat B-scan should be performed about 4 weeks later **(A:III)**

Patient Education

- Educate patients at high risk of developing retinal detachment about the symptoms of PVD and retinal detachment and the value of periodic follow-up exams. **(A:II)**
- Instruct all patients at increased risk of retinal detachment to notify their ophthalmologist promptly if they have a significant increase in floaters, loss of visual field, or decrease in visual acuity. **(A:III)**

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

(For more ICO International Clinical Guidelines, see 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.

ICO International Clinical Guidelines: Posterior Vitreous Detachment, Retinal Breaks and Lattice Degeneration (Initial and Follow-up Evaluation)

Page 4

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).

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