Focusing on A&E

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THINGS TO WORRY ABOUT WITH ANY EYE PROBLEM

- CHANGES IN VISION
- SEVERE PAIN
- HOW LONG HAD PROBLEM?
- HISTORY OF INJURY OR NOT
- ? DISCHARGE
- REDNESS

- Floaters, flashes and bits missing etc
- Sharp or dull
How serious is eye problem?

Look at eye if redness, (injection), away from corneal edge less like to involve cornea, therefore less serious e.g. conjunctivitis
How serious is eye problem?

If the redness, (injection),
Up to edge of cornea look at cornea as it means something going on there!
This likely to be slightly more serious.
e.g iritis, cfb, abrasion
Pain can give clue to problem

• If pain gritty i.e. Foreign body sensation, then eye problem relates to surface area of eye such as FB’s or conjunctivitis.
• Will be relieved by local anaesthetic

• If pain is ache usually inflammatory problem such as viral conjunctivitis or iritis.
• May not be relieved by local anaesthetic.
• Patient may also have photophobia
Conjunctival and Corneal Foreign Bodies

- **Symptoms**
- Foreign body sensation/pain
- Redness
- Epiphoria, (watering of eye)
- ? Light sensitivity, (photophobia)
- ? History of wearing eye protection and
- ? High velocity
Conjunctival & Subtarsal Foreign Bodies

**Sub-tarsal FB**
No anaesthesia unless unable to open eye.
Lid eversion and wipe patient usually feels instantly better.

**Conjunctival FB**
Anaesthetistic
Move conj near to FB with cotton bud.
if moves with conj only superficial and ok to remove
Corneal Problems

Are very painful
The nearer the centre of cornea the more painful it will be.

Pain control is best thing for patient as cornea will regenerate in 24-48 hours.

Is it an ulcer or an abrasion?
History will tell patients: remember specific incident if no trauma more likely to be ulcer.

Ulcer tend to be around edge of cornea, (exception being dendritic)
• Anaesthetise with proxymethacaine. (Sub-tarsal no but corneal yes)

• Corneal... **refer to eye unit within 24 hours** for removal with needle on slit-lamp. (worth trying damp cotton bud wipe first but only once)

• Topical antibiotic 5/7. (also helps to loosen FB so stat dose helpful).
Corneal Abrasions

- **Symptoms**
- History of glancing blow or direct poke to eye. Eg. Fingernail or twig etc.
- Pain and watering
- Redness
- Blurred vision
- Light sensitive
- ? Tetanus state if organic injury
Treatment

- Flourescein dye to show epithelial defect
- Topical antibiotic
- Pupil dilation if eye inflamed,
  - (Usually done by eye unit)
- ? Eye pad
- Warn patient very painful condition
- Analgesia
- **Review within 24 hours if abrasion central and/or large**
Other things to consider

• Lagophthalmos
• Arc eye or welders flash
• Recurrent corneal erosion
• Does the patient wear contact lenses?
• Dry eyes
• Concretions
Subconjunctival Haemorrhage

• Bleeding in the subconjunctival tissue
• May occur with trivial injury straining coughing vomiting etc
• Pool of bright red blood localised to conjunctiva
• No treatment provided no other injured tissue
• Like a bruise resolves spontaneously 10-14 days

• Things to worry about are severe pain, change in sight, headache or trauma but more likely needs referral to medical team or GP
Dry Eye

• Various symptoms – gritty/ache
• sticky/watering
• Minor infections
• Worse at certain times and environments
• lagophthalmos

• Treatment long term and individual
CONJUNCTIVITIS

• SYMPTOMS….red gritty sore eye no history of injury, no severe pain or visual disturbance other than slight blurring **None urgent priority**

• 3 types
Bacterial, as above with sticky discharge treat with topical antibiotics refer to GP or treat locally. Patients now able to self medicate.
Viral no discharge and difficult to diagnose and treat? Refer to eye unit if other problems.
Allergic ... acute swelling of lids and or conjunctiva settles on its own refer to eye unit if not settling after 3-4 days.
Lumps and bumps!

- Usually cyst or stye - None urgent.. 1/52 priority
- Can be treated by GP or eye unit or self medication

- Styes usually general
- Lid swelling and aches no discharge. Inflammatory so anti-inflammatories most use.

Not to be confused with orbital cellulitis as eye usually white if red pain not severe and patient apyrexial.
• Cysts localised lump on eyelid with discharge and ? FB sensation.

• Treat with topical antibiotic, (ointment not drops)
Styes

- tend to ache or feel bruised
- Inflammation rather than infection
- Self limiting
- Possible to remove lash
- Anti inflammmatories
Eyelid inflammation

- Blepharitis --- dandruff of eye lids
- Meibomianitis --- excess grease from lid glands
Lid lacerations

- Refer to eye unit especially if full thickness or lid margin involved as may be other injuries to eye
- Cover but not firm pad if penetrating injury suspected
Iritis

- Inflammation of internal structures of the eye
- Dull ache may be severe
- Blurred vision
- Pink rather than red eye
- Light sensitivity++++
- No discharge
- Can be confused with viral conjunctivitis
- **REFER TO EYE UNIT 24hours**
Ophthalmic Herpes

- Herpes simplex..cold sore
- FB sensation red eye ? Discharge
- Lesions on eye lids
- **Refer to eye unit 24 hours** as may have corneal ulcer
- Herpes Zoster.. Shingles
- Rash over quadrant of face
- Painful
- **Refer to eye unit if eye has severe FB sensation and or flourescien stain 24 hours** other wise GP can treat
Chemical Burns

• Frequently trivial but can be potentially blinding

• IRRIGATE, IRRIGATE, IRRIGATE
Chemical Burns

- Agents include
- Alkali, acids, solvents, detergents, irritants
- Any thing and everything!!
- *Most dangerous are alkalis: have rapid penetration of ocular tissues*
Hyphaema

- Blood in the anterior chamber usually from blunt trauma but may be spontaneous
- Micro hyphaema ie. Suspended RBCs’ in the AC.
Symptoms

• History of trauma or drug to thin blood
• Pain usually a dull pain
• Vision loss or blurred
• Red fluid level visible in eye

**POTENTIALLY SERIOUS**

• REFER TO EYE UNIT / ED ASAP
• Keep patient as still as possible and no eye pad
Visual disturbances

- any visual changes may be referred to eye unit as causes are numerous and treatments varied
- (unless duration weeks/months not A&E more like OPD)
- Mostly painless but not always
- (E.G. ACUTE GLAUCOMA)
- The longer the history the less urgent problem is as less likely to get good prognosis
- Could be neuro/medical problem
- Priority could be ASAP-1/52
Blow Out Fracture

- Fracture of orbit floor.
- Not always obvious.
- Exophthalmos with eye tissue herniating through # causing eye to sink into orbit.
- Double vision especially on up gaze.
- Anaesthetic cheek and lower eyelid.
- Bruising and surgical emphysema due air escape from associated sinus fractures.
Treatment

• **REFER TO EYE UNIT OR MAX FAX OR BOTH within 24 hours**

• Observation if fairly asymptomatic

• Double vision usually resolves as swelling of tissues resolve

• Referral to maxillo facial for surgical intervention of symptoms not settling.
The end!