

RANZCO Triage Guidelines for Fellows and other health professionals

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Ver 3/4/2020	Time Sensitive (see < 3 months of initial or planned appointment)		Defer Appointment (by 4-12 months)
Speciality	High Urgency (Will usually require clinic visit)	Medium Urgency (Where appropriate, consult via telehealth)	Low-Urgency (Where appropriate, consult via telehealth)
General Ophthalmology			
New/Follow-up	ANY ACUTE SEVERE VISUAL LOSS		Blepharitis Mild/moderate dry eye Watery eye Most conjunctivitis (triage via telehealth)
Surgery			ELECTIVE CATARACT SURGERY, YAG Capsulotomy Laser refractive surgery
Cataract			
New/Follow-up			Cataract/PCO reviews
Surgery	Cataract surgery for intractable high IOP (phacomorphic, phacolytic glaucoma, angle closure) (E)	Cataract surgery for cataract blindness when the patient is legally blind (i.e. combined effect of BCVA <6/60 in both eyes or field of vision constricted to 10 degrees or less of arc around central fixation in the better eye)	ELECTIVE CATARACT SURGERY, YAG capsulotomy
Cornea/Refractive			
New/Follow-up	Microbial keratitis Corneal trauma Acute Peripheral Ulcerative Keratitis Neurotrophic cornea with ulceration Therapeutic (bandage) contact lens patients Corneal graft rejection	Minor trauma (eg abrasions, foreign bodies, recurrent erosion syndrome) Corneal ectasia with moderate risk of progression (age <21 or documented progression >1D in 6 months) OSSN Marginal Keratitis (follow-up with telehealth if appropriate) Severe sight-threatening ocular surface disease Routine post-operative patients	Blepharitis Mild/moderate dry eye.other ocular surface condition Corneal ectasia with low risk of progression Drug induced keratopathies Metabolic keratopathies
Surgery	Urgent tectonic keratoplasty (perforations) (E)	Keratoplasty for bullous keratopathy with high risk of infection or pain Keratoplasty in patient <6/60 in both eyes with expected short term improvement Cross linking for progressive ectasia (either rapid progression or borderline thickness)	Laser refractive surgery Routine corneal transplantation Pterygium surgery Collagen cross-linking for slowly progressive ectasia
Glaucoma			
New/Follow-up	IOP>40mmHg Acute angle closure Acute neovascular glaucoma Acute uveitic glaucoma Acute lens related glaucoma New referral that refers and ophthalmologist consider urgent	After change of glaucoma therapy where IOP is anticipated to change Routine post-operative care for glaucoma filtration surgery/tubes New referral optometrist diagnosed glaucoma early/moderate/advanced according to RANZCO referral pathway for glaucoma management Optometrist referred glaucoma suspect with high suspicion of disease (as per RANZCO Referral Pathway) where optometrist and ophthalmologist consider urgency is medium Anyone with IOP>30 and glaucomatous visual field defect Uncontrolled glaucoma	Stable glaucoma monitoring with no documented progression for 2 years Ocular hypertension with no evidence of glaucoma and at low risk of developing glaucoma in the next 6 months Optometrist referred glaucoma suspect with low suspicion of disease (as per RANZCO Referral Pathway) Optometrist referred glaucoma suspect with high suspicion of disease (as per RANZCO Referral Pathway) not considered medium urgency by the
Surgery	Lens extraction surgery to ameliorate angle closure disease not controlled with laser or medical therapies (E) Glaucoma surgery for IOP lowering of any type in advanced glaucoma, rapid progression or very high IOP where clinically important progression is likely in the next 1 month, where conservative therapies have failed, are likely to fail, or are contraindicated Any surgery to manage acute sight treating complication of glaucoma surgery (e.g. bleb or tube infection) (E)	Lens extraction surgery to ameliorate angle closure disease when risk of progression of angle closure or glaucoma over the next 6 months is unacceptably high. This includes the at-risk fellow eye of eyes blinded by angle closure disease Glaucoma surgery for IOP lowering of any type in glaucoma here clinically important progression is likely in the next 9 months, where conservative therapies have failed, are likely to fail, or are contraindicated.	Elective cataract surgery in glaucoma patient not blinded by cataract Any lens extraction procedure combined with microbypass glaucoma surgery where the lens extraction itself does not fall into high or medium urgency
Medical Retina			
New/Follow-up	Suspected or confirmed CNV needing treatment Intravitreal injections for: Neovascular AMD, Diabetic macular oedema, Retinal vein occlusion, other CNV, macular oedema. Treat and extend to maximum interval possible. Active proliferative diabetic retinopathy requiring treatment (PRP laser or intravitreal-antiVEGF) Malignant hypertensive retinopathy	Macular oedema requiring treatment	Non-neovascular (dry) AMD Low-risk diabetic retinopathy screening Non-proliferative diabetic retinopathy without macular oedema Stable treated proliferative diabetic retinopathy Central serous chorioretinopathy Macular telangiectasia without CNV Retinal Dystrophies Screening for macular toxicity (e.g. plaquenil) Angioid streaks Hypertensive retinopathy (non-malignant) Choroidal folds
Vitreoretinal Surgery/Trauma			
New/Follow-up	Acute retinal detachment (E) Suspected retinal tears (E) Open globe injuries: Including PEI, IOFB (E) Acute endophthalmitis (E) Vitreous haemorrhage (dense, requiring vitrectomy) Dropped nucleus requiring vitrectomy/lensectomy (E) Submacular haemorrhage requiring vitrectomy (E) Aqueous misdirection requiring vitrectomy (E) Complex Surgery post-ops (minimise visits) Diagnostic vitrectomy for infectious or oncological causes	Acute full thickness macular holes Severe vitreomacular traction syndrome Myopic traction maculopathy with foveal detachment Heavy liquid, densiron removal Exposed scleral buckles at risk of infection Most routine post ops (minimise visits)	Epiretinal membranes Silicone oil removal (unless developing complications such as emulsification) Intraocular lens procedures Symptomatic vitreous opacities
Surgery	Surgery for the above	Surgery for the above	Surgery for the above

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Uveitis			
New/Follow-up	Panuveitis	New cases of Acute Anterior Uveitis should be given a standard 6-8 week tapering course of drops and review (or telephone consult) at 4-6 weeks. Clinic review in 3 months if indicated by telephone consult at that time point.	Patients with an established history of recurrent, self limiting episodes of AAU without sight threatening complications (e.g. CMO, steroid response) could be considered for telephone consult at the onset of a recurrence and for follow-up at 6-8 weeks, with clinical review if indicated
	Posterior Uveitis	Chronic/persistent anterior uveitis managed with topical therapy only, telehealth recommended where possible	Uveitis cases in remission (=quiescence without ANY treatment)
	Intermediate Uveitis with vision threatening complications	Quiescent/stable forms of uveitis on stable systemic therapy (prednisolone dose <=7.5mg/daily); telehealth recommended where possible	
	Retinal vasculitis	It is highly recommended that patients receiving an intravitreal depot steroid injection for uveitis have at least 1 clinic review/in person IOP check (ophthalmologist or optometrist) 3-6 weeks post-injection	
	Patients with uveitis of any form affecting an only eye (VA in fellow eye <6/60)		
Surgery	Vitreous biopsy and/or AC tap for infectious/inflammatory uveitis		Most uveitic cataracts
Ocular Oncology			
New/Follow-up	Suspected malignant ocular tumours (e.g. ocular melanoma, metastases, intraocular lymphoma)	Fundus tumours causing macular exudation (choroidal haemangioma, Coats, retinal capillary haemangioblastoma)	Stable choroidal naevi, CHRPE, iris cysts
	Confirmed malignant ocular tumours requiring acute treatment	Tumours previously booked for up to 6 months planned follow-up interval	Stable treated tumours
	Tumours previously booked for 3 month planned follow-up interval		Tumours previously booked for over 6 months planned follow-up interval
Surgery	Surgery for malignant tumours (including plaque brachytherapy for choroidal melanoma)	Surgery for the above	
Oculoplastics			
ALERT: DUE TO THE HIGH RISK OF COVID-19 INFECTION FROM THE NASOPHARYNX, AVOID ALL NASAL SYRINGING, LACRIMAL SURGERY AND NASAL ENDOSCOPY. TREAT THYROID EYE DISEASE MEDICALLY FIRST. IF ORBITAL DECOMPRESSION IS STILL REQUIRED, AVOID MEDIAL WALL/FLOOR DECOMPRESSION WHICH CREATES AN ENTRY INTO THE PARANASAL SINUSES.			
New/Follow-up	Severe thyroid eye disease	Progressive benign orbital tumours	Orbit: all other, including TED (stable mild-moderate)
	Orbital tumours (sight-threatening or malignant-suspected/known)	Moderately-severe thyroid eye disease	Other eyelid malpositions: ptosis, brow ptosis, dermatochalasis, ectropion
	Orbit: Vascular (CCF, progressive/sight-threatening vascular anomalies- e.g. extensive haemangioma, progressive vascular malformation e.g. acute bleed)	Entropion (triage with telehealth if appropriate)	Some low-risk BCC that has previously been examined (triage with telehealth if appropriate)
	Orbital inflammatory disease (orbital/periocular cellulitis, orbital abscess; sight-threatening orbital inflammation of any cause; acute dacryocystitis/sac abscess)	BCC (triage with telehealth if appropriate)	Benign periocular tumours (e.g. chalazion/papilloma)
	Periocular malignancy (biopsy proven or suspected) including melanoma (invasive & in situ), sebaceous carcinoma, SCC, other high grade malignancy (Merkel cell, adenexal carcinoma etc.), high risk BCC (medical or lateral canthal, recurrent, high risk subtype, locally advanced i.e. orbital invasion)	Lacrimal: Recurrent/low grade dacryocystitis, canaliculitis. Treat medically first, if requires surgery prefer percutaneous drainage, avoid DCR due to COVID-19 risk	Lacrimal: All other
	Post-operative complex surgery	Post-operative simple surgery	
	Recent trauma including eyelid and canalicular lacerations, orbital fractures and suspected orbital foreign body	Paediatric ptosis with known/high risk of amblyopia (visual deprivation, failed amblyopia therapy)	
	Dacryocystocele (paediatric CNLDO with nasal involvement not resolving/acutely infected). Treat medically first, if requires surgery prefer percutaneous drainage, avoid DCR due to COVID-19 risk		
	Surgery	Surgery for the above	Surgery for the above
	Genetics		
New/Follow-up			Most patients
Paediatrics			
New/Follow-up	Sight or potential life (systemic) threatening conditions	Patients having amblyopia treatment. Where possible, use telehealth	Case by Case triage
	Cataracts causing amblyopia or under 4 months old	Paediatric oculoplastic/adnexal cases	
	ROP screening	Reduced vision in one eye over age 7. Where possible, use telehealth video/photos to triage	
	Children on medication (drops or systemic) for glaucoma, uveitis, corneal disease	Examination under anaesthesia where management is time-sensitive	
		Reduced vision in both eyes	
		Reduced vision in one eye under age 7	
Surgery	Cataract surgery in under 4 month olds or where causing amblyopia		Strabismus surgery
	Retinoblastoma treatment		
	Paediatric glaucoma surgery where conservative therapies have failed		
	ROP treatment		
Strabismus			
New/Follow-up	Triage of referrals on case by case basis (accept suspected neurological strabismus)	Triage of referrals on case by case basis (accept strabismus where amblyopia management is also required). Where possible, use telehealth video/photos	Most other non-acute strabismus cases
Surgery	Acute trauma related requiring surgery		Most strabismus surgery and botulinum muscle injections
Neuro-Ophthalmology			
New/Follow-up	Patient by patient triage needed (accept acute optic neuropathies, suspected SOL or raised intracranial pressure, neurological diplopia, acute pupillary)	Where possible, use telehealth video/photos	Stable patients or patients where management will not change outcomes
Surgery	Optic nerve sheath fenestration for severe visual loss in IIH (E)		

Note regarding surgery:
 "High Urgency" include Emergencies (Marked "(E)") and Category 1 (clinically indicated within 30 days) elective procedures.
 "Medium Urgency" includes Category 2 (clinically indicated within 90 days) elective procedures. "Urgent Category 2" is at the discretion of the ophthalmologist, who must balance the need to operate in a timely period with preservation of healthcare resources during the current COVID-19 crisis.
 "Low Urgency" includes Category 3 (clinically indicated within 365 days) elective procedures.