



**Useful Information for Patients**

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**Patient**   **Primary Care**   **Secondary Care**

1. All patients presenting with symptoms of flashes and/or floaters should have a full history taken. One would be concerned if the symptoms are of recent onset, increasing and permanent.

All appropriate tests should be carried out to determine if there is any sight threatening disease present. This would include refraction, applanation tonometry, visual field assessment if possible, dilated indirect fundus biomicroscopy using a Volk type condensing lens or preferably a contact lens. An alternative method would be to use the indirect headset technique.

Certain clinical signs would warrant an **urgent referral**:

- Tobacco dust
- Vitreous, retinal or pre-retinal haemorrhage
- Lattice degeneration with retinal break
- Retinal hole or tear
- Operculum – free or attached
- Retinal detachment.

2. The incidence of retinal breaks in patients aged 10 years or more who do not have any history of ocular disease is 6-14%. The incidence of retinal detachment is approximately 12/100,000 of the general population per year. This suggests that less than 0.2% of people with a retinal break eventually have a detachment of the retina. Only a minority of retinal breaks will go on to cause a retinal detachment. Posterior Vitreous Detachment does not have any harmful effect on pre-existing retinal breaks. All patients presenting with posterior vitreous detachment, no vitreous pigment, and no retinal tears or holes at initial examination can be safely discharged with an explanation of the warning symptoms which should prompt the patient to re-attend.

3. All patients presenting with a new onset of flashes and /or floaters should, if possible, undergo a dilated funduscopy ideally by Volk lens. Patients should be questioned about the presence of a subjective visual field defect and if they notice one they should be referred to Eye Casualty or similar. The presence of pigment in the vitreous in patients with new symptoms is an indication for immediate hospital referral to Eye Casualty or similar, as is the presence of a vitreous haemorrhage. All patients should be counselled that if they should develop a visual field defect they should attend Eye Casualty or similar.

4. Where there is no sign of sight threatening retinal disease and the condition appears stable ongoing monitoring should take place in the community by the optometrist. The patient should be well advised of the symptoms of retinal detachment and to return for an examination should there be any concern.

In the absence of symptoms any nominal review period should be based on the time since symptoms last presented:

- Recent onset – recall 2-3 months
- 3 months – recall 6 months
- 1 year – recall annually.

5. When signs and / or symptoms are present that indicate sight threatening disease the patient should be directly and urgently referred to a vitreo-retinal specialist for further investigation with a full, detailed report of the findings.