

SUMMARY BENCHMARKS FOR PREFERRED PRACTICE PATTERN® GUIDELINES

Introduction:

These are summary benchmarks for the Academy's Preferred Practice Pattern® (PPP) guidelines. The Preferred Practice Pattern series of guidelines has been written on the basis of three principles.

- Each Preferred Practice Pattern should be clinically relevant and specific enough to provide useful information to practitioners.
- Each recommendation that is made should be given an explicit rating that shows its importance to the care process.
- Each recommendation should also be given an explicit rating that shows the strength of evidence that supports the recommendation and reflects the best evidence available.

Preferred Practice Patterns provide guidance for the pattern of practice, not for the care of a particular individual. While they should generally meet the needs of most patients, they cannot possibly best meet the needs of all patients. Adherence to these Preferred Practice Patterns will not ensure a successful outcome in every situation. These practice patterns should not be deemed inclusive of all proper methods of care or exclusive of other methods of care reasonably directed at obtaining the best results. It may be necessary to approach different patients' needs in different ways. The physician must make the ultimate judgment about the propriety of the care of a particular patient in light of all of the circumstances presented by that patient. The American Academy of Ophthalmology is available to assist members in resolving ethical dilemmas that arise in the course of ophthalmic practice.

The Preferred Practice Pattern® guidelines are not medical standards to be adhered to in all individual situations. The Academy specifically disclaims any and all liability for injury or other damages of any kind, from negligence or otherwise, for any and all claims that may arise out of the use of any recommendations or other information contained herein.

For each major disease condition, recommendations for the process of care, including the history, physical exam and ancillary tests, are summarized, along with major recommendations for the care management, follow-up, and education of the patient. For each PPP, a detailed

literature search of PubMed and the Cochrane Library for articles in the English language is conducted. The results are reviewed by an expert panel and used to prepare the recommendations, which they rated in two ways.

The panel first rated each recommendation according to its importance to the care process. This "importance to the care process" rating represents care that the panel thought would improve the quality of the patient's care in a meaningful way. The ratings of importance are divided into three levels.

- Level A, defined as most important
- Level B, defined as moderately important
- Level C, defined as relevant but not critical

The panel also rated each recommendation on the strength of evidence in the available literature to support the recommendation made. The "ratings of strength of evidence" also are divided into three levels.

- Level I includes evidence obtained from at least one properly conducted, well-designed randomized controlled trial. It could include meta-analyses of randomized controlled trials.
- Level II includes evidence obtained from the following:
 - Well-designed controlled trials without randomization
 - Well-designed cohort or case-control analytic studies, preferably from more than one center
 - Multiple-time series with or without the intervention
- Level III includes evidence obtained from one of the following:
 - Descriptive studies
 - Case reports
 - Reports of expert committees/organizations (e.g., PPP panel consensus with external peer review)

PPPs are intended to serve as guides in patient care, with greatest emphasis on technical aspects. In applying this knowledge, it is essential to recognize that true medical excellence is achieved only when skills are applied in a such a manner that the patients' needs are the foremost consideration. The AAO is available to assist members in resolving ethical dilemmas that arise in the course of practice. (AAO Code of Ethics)

Primary Angle Closure (Initial Evaluation and Therapy)

Initial Exam History (Key elements)

- Systemic history (e.g., use of topical or systemic medications) ^[A:III]
- Ocular history (symptoms suggestive of intermittent angle-closure attacks) ^[A:III]
- Family history of acute angle-closure glaucoma ^[B:II]

Initial Physical Exam (Key elements)

- Visual acuity ^[A:III]
- Refractive status ^[A:III]
- Pupils ^[A:III]
- External examination ^[A:III]
- Slit-lamp biomicroscopy ^[A:III]
 - Anterior chamber inflammation suggestive of a recent or current attack
 - Corneal edema
 - Central and peripheral anterior-chamber depth
 - Iris atrophy, particularly sector types, posterior synechiae or mid-dilated pupil.
 - Signs of previous angle closure attacks
- Measurement of IOP ^[A:III]
- Gonioscopy of both eyes ^[A:III]
- Evaluation of fundus and optic nerve head using direct ophthalmoscope or biomicroscope ^[A:III]

Diagnosis

- Establish a diagnosis of primary angle closure, excluding secondary forms. ^[A:III]

Management Plan for Patients in Whom Iridotomy is Indicated

- Treat acute PAC by laser iridotomy or incisional iridectomy if a laser iridotomy cannot be successfully performed. ^[A:III]
- In acute angle-closure attacks, usually use medical therapy first to lower the IOP, to reduce pain and clear corneal edema in preparation for iridotomy. ^[A:III]
- Perform prophylactic iridotomy in fellow eye if chamber angle is anatomically narrow. ^[A:III]
- Perform surgery on one eye at a time for patients requiring bilateral incisional iridectomy (several days apart) whenever feasible to avoid simultaneous bilateral complications. ^[A:III]

Surgery and Postoperative Care for Iridotomy Patients

- Ensure the patient receives adequate postoperative care. ^[A:III] Plan prior to and after surgery includes:
 - Informed consent ^[A:III]
 - At least one preoperative evaluation by the surgeon. ^[A:III]
 - At least one IOP check within 30 to 120 minutes following laser surgery. ^[A:III]
 - Use of topical anti-inflammatory agents in the postoperative period, unless contraindicated. ^[A:III]
- Follow-up evaluations include:
 - Evaluation of patency of iridotomy ^[A:III]
 - Measurement of IOP ^[A:III]
 - Gonioscopy, if not performed immediately after iridotomy ^[A:III]
 - Pupil dilation to reduce risk of posterior synechiae formation ^[A:III]
 - Fundus examination as clinically indicated ^[A:III]
- Use medications perioperatively to avert sudden IOP elevation, particularly in patients with severe disease. ^[A:III]
- Refer for and encourage patients with significant visual impairment or blindness to use vision rehabilitation and social services. ^[A:III]

Evaluation and Follow-Up of Patients with Iridotomy:

- After iridotomy, follow patients with glaucomatous optic neuropathy as specified in the Primary Open-Angle Glaucoma PPP. ^[A:III]
- Follow all other patients as specified in the Primary Open-Angle Glaucoma Suspect PPP. ^[A:III]

Education For Patients if Iridotomy is Not Performed:

- Inform patients at risk for acute angle closure about symptoms of acute angle-closure attacks and instruct them to notify immediately if symptoms occur. ^[A:III]
- Warn patients of danger of taking medicines that could cause pupil dilation and induce an angle-closure attack. ^[A:III]