

## 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)

# Idiopathic Macular Hole (Initial Evaluation and Therapy)

## Initial Exam History (Key elements)

- Duration of symptoms <sup>[A:III]</sup>
- Ocular history: glaucoma or other prior eye diseases, injuries, surgery, or other treatments; prolonged gazing at the sun <sup>[A:III]</sup>
- Medications that may be related to macular cysts <sup>[A:III]</sup>

## Initial Physical Exam (Key elements)

- Visual acuity <sup>[A:III]</sup>
- Slit-lamp biomicroscopic examination of the macula and the vitreoretinal interface <sup>[A:III]</sup>

## Management Recommendations for Macular Hole

Stage	Management	Follow-up <sup>[A:III]</sup>
1-A	Observation <sup>[A:III]</sup>	Prompt return if new symptoms Every 4 to 6 months in the absence of symptoms
1-B	Observation <sup>[A:III]</sup>	Prompt return if new symptoms Every 4 to 6 months in the absence of symptoms
2	Surgery <sup>[A:II]</sup> *	1 to 2 days postoperatively, then 1 to 2 weeks Frequency and timing of subsequent visits varies depending on the outcome of surgery and the patient's symptoms If no surgery, every 4 to 8 months
3	Surgery <sup>[A:I]</sup>	1 to 2 days postoperatively, then 1 to 2 weeks Frequency and timing of subsequent visits varies depending on the outcome of surgery and the patient's symptoms
4	Surgery <sup>[A:I]</sup>	1 to 2 days postoperatively, then 1 to 2 weeks Frequency and timing of subsequent visits varies depending on the outcome of surgery and the patient's symptoms

\*Although surgery is usually performed, observation is also appropriate.

## Surgical and Postoperative Care if Patient Receives Treatment

- Inform the patient about relative risks, benefits, and alternatives to surgery, and the need for use of expansile intraocular gas or special patient positioning postoperatively <sup>[A:III]</sup>
- Formulate a postoperative care plan and inform the patient of these arrangements <sup>[A:III]</sup>
- Inform patients with glaucoma of possible perioperative increase in IOP <sup>[A:III]</sup>
- Examine postoperatively within 1 or 2 days and again 1 to 2 weeks after surgery <sup>[A:III]</sup>

## Patient Education

- Inform patients to notify their ophthalmologist promptly if they have symptoms such as an increase in floaters, a loss of visual field, or a decrease in visual acuity <sup>[A:II]</sup>
- Inform patients that air travel, high altitudes, or general anesthesia with nitrous oxide should be avoided until the gas tamponade is nearly completely gone <sup>[A:III]</sup>
- Inform patients who have had a macular hole in one eye that they have a 10% to 20% chance of macular hole formation in the fellow eye, especially if the hyaloid remains attached <sup>[A:III]</sup>
- Refer patients with functionally limiting postoperative visual impairment for vision rehabilitation (see [www.aao.org/smartsight](http://www.aao.org/smartsight)) and social services <sup>[A:III]</sup>