American Academy of Ophthalmology
The Eye M.D. Association

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)

Cataract (Initial and Follow-up Evaluation)

Initial Exam History

- Symptoms [A:II]
- Ocular history [A:III]
- Systemic history [A:III]
- Assessment of visual functional status [A:II]

Initial Physical Exam

- Visual acuity with current correction [A:III]
- Measurement of BCVA (with refraction when indicated) [A:III]
- Ocular alignment and motility [A:III]
- Pupil reactivity and function [A:III]
- Measurement of IOP [A:III]
- External examination [A:III]
- Slit-lamp biomicroscopy [A:III]
- Evaluation of the fundus (through a dilated pupil) [A:III]
- Assessment of relevant aspects of general and mental health [B:III]

Care Management

- Treatment is indicated when visual function no longer meets the patient's needs and cataract surgery provides a reasonable likelihood of improvement. [A:II]
- Cataract removal is also indicated when there is evidence of lens-induced disease or when it is necessary to visualize the fundus in an eye that has the potential for sight. [A:III]
- Surgery should not be performed under the following circumstances: [A:III] Glasses or visual aids provide vision that meets the patient's needs; surgery will not improve visual function; the patient cannot safely undergo surgery because of coexisting medical or ocular conditions; appropriate postoperative care cannot be obtained.
- Indications for second eye surgery are the same as for the first eye. [A:II] (with consideration given to needs for binocular function)

Preoperative Care

Ophthalmologist who is to perform the surgery has the following responsibilities:

- Examine the patient preoperatively [A:III]
- Ensure that the evaluation accurately documents symptoms, findings and indications for treatment [A:III]
- Inform the patient about the risks, benefits and expected outcomes of surgery [A:III]
- Formulate surgical plan, including selection of an IOL [A:III]
- Review results of presurgical and diagnostic evaluations with the patient [A:III]
- Formulate postoperative plans and inform patient of arrangements [A:III]

Follow-up Evaluation

- High-risk patients should be seen within 24 hours of surgery. [A:III]
- Routine patients should be seen within 48 hours of surgery. [A:III]
- Frequency and timing of subsequent visits depend on refraction, visual function, and medical condition of the eye.
- More frequent follow-up usually necessary for high risk patients.
- Components of each postoperative exam should include:
  - Interval history, including new symptoms and use of postop medications. [A:III]
  - Patient's assessment of visual functional status. [A:III]
  - Assessment of visual function (visual acuity, pinhole testing). [A:III]
  - Measurement of IOP. [A:III]
  - Slit-lamp biomicroscopy. [A:III]

Nd:YAG Laser Capsulotomy

- Treatment is indicated when vision impaired by posterior capsular opacification does not meet the patient's functional needs or when it critically interferes with visualization of the fundus. [A:III]
- Educate about the symptoms of posterior vitreous detachment, retinal tears and detachment and need for immediate examination if these symptoms are noticed. [A:III]

Patient Education

- For patients who are functionally monocular, discuss special benefits and risks of surgery, including the risk of blindness. [A:III]