Triage and Ocular History
These presentations have been prepared by:

• Jillian Grasso, Clinical Nurse Consultant, Ophthalmology

• Janet Long, Clinical Nurse Consultant Community Liaison, Ophthalmology

• Joanna McCulloch, Transitional Nurse Practitioner, Ophthalmology

• Cheryl Moore, Nurse Educator, Ophthalmology

Further information contact us at Sydney Hospital & Sydney Eye Hospital: 02 9382 7111

Modules originally designed for emergency nurses as a component of the Eye Emergency Manual Project.

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Aim:
To provide an overview of ocular triage and ocular history taking

Objectives:
On completion of this session you will be able to:
• define the appropriate triage categories for ocular conditions
• ensure that patients are treated according to their clinical urgency
• document an effective ophthalmic history

This presentation is only focused on ocular emergency presentations
“the majority of (eye injuries) are superficial in nature and transient in their effects, but place considerable demands on A & E services”
(MacEwan 1989)
Ophthalmic History
Examples of
Specific questions

Vision
- Working
- Reading
- TV

Medication history

Medical History
- Diabetes – Vitreous haemorrhages

Special questions
- Mechanism of injury - Foreign body
- Discharge – infection

Ocular History
- myopic – retinal detachment

Family History
- Glaucoma
- Squint/strabismus

Vision
- Working
- Reading
- TV
On Presentation to Emergency

There are two important procedures for triage to perform at the same time:

1. **Eye Examination** – refer to Education Session Two & Three for the process of Eye Examination and Visual Acuity.

2. **History Taking**

   Both of these will enable you to allocate patient’s appropriate triage category, and facilitate timely treatment.
Overview of Patient History

- Identify Presenting Problem
- Patients Previous Ocular History
- Family Ocular History
- General Health

If patient is a poor historian, culturally and linguistically diverse (CALD), or has difficulty comprehending the questions - base triage category on eye examination and visual acuity.
Overview of Patient History

Plus EYE EXAMINATION:

- Provides more clues to fit provisional diagnosis
- Provides evidence to refute it

If the patient has one ‘good’ eye only and presents with symptoms in the good eye, referral to an ophthalmologist for review is required.
Presenting Problem

• Record primary reason for visit – what is the presenting problem? What prompted the visit?
• Has something new happened, or have symptoms been ongoing for sometime? Why is patient now worried?

Caution: some patients may include new symptoms to legitimise the presentation.
Presenting Problem (cont)

• First series of questions:
  – Visual acuity – was the change sudden or gradual, partial or total loss
  – Affecting one or both eyes
  – Current form of correction – is presenting problem contact lens related?
  – Blurry or double vision
  – Red/sore/itchy eye
  – Flashes and floaters/ headaches
  – Recent eye surgery or trauma
Patient’s Ocular History

- **Pre injury vision** – has the eye always had reduced vision? i.e. ‘lazy eye’
- **Ocular surgery** - predispose to infection, wound dehiscence, Intraocular lens (IOL) displacement – sudden drop in visual acuity
- **Previous ocular trauma** – Airbag related (may get flashes/floaters months later)
- **Use of eye drops** – how often, when last used, how long has the bottle been open
Patient’s Ocular History (cont)

– Conditions affecting the other eye.

– **Previous use of contact lenses** – check for overwear (using daily wear contact lens for 2 - 3 days instead of 1), using correct contact lens solution (not saliva to clean)

– **Ask if they have had corrective/refractive eye surgery** (when was their last follow up and when is their next follow up), be aware of people having eye surgery overseas, may not have arranged ocular follow up
General Health

- **Systemic conditions** – especially vascular, inflammatory
- **Medications** - (anticoagulants), include all herbal supplements, vitamins, anti malarial
- **Allergies** – can have bearing on allergic eye conditions i.e. lanolin can be used as a base in eye ointments
- **Tetanus immunization status** - (if eye trauma)
- **If c/o headaches** – is there a history of migraine, visual aura’s?
- **Recent overseas trips** – purulent discharge = ? sexually transmitted infections (STIs)
Thinking Points
-when taking an ocular history

• Ask what the eye symptoms are, when first noticed, and what were they doing immediately beforehand (particularly if the onset was sudden)
• If eye scratched- what, when and force used
• If possible, test visual acuity at this stage
  – only excluded if serious life threatening condition or
  – chemical injury
• If chemical injury ask what chemical, time and previous first aid

Start irrigation NOW! DON’T WAIT

(Thinking points are adapted from Field & Tillotson 2008)
Thinking Points
-when taking an ocular history (cont)

- Record if patient has history of doing any dangerous work. Occupation may give clue to eye problem – jack hammering, use of power tools (anything high velocity), ask about use of eye protection
  - Think of corneal foreign body, intraocular foreign body and corneal abrasion.

- Have they been playing sport.
  - golf, squash & tennis balls fit perfectly in orbit – potential ruptured globe or fractured orbit
Thinking Points
-when taking an ocular history (cont)

• Document pain level and type – try to be accurate, use pain scale, ask detailed questions about exact type, location
  If analgesia has been taken, was it effective? Try to discriminate between soreness, irritation and stinging—look out for photophobia (sensitivity to light), deep pain in and around eye, severe pain, nausea and vomiting – consider acute glaucoma

• Ask about family history of eye problems. Some eye conditions can are inherited – Cataracts, Glaucoma, Retinal / Corneal Dystrophies and Retinal Detachment
Thinking Points
-when taking an ocular history (cont)

• Ask about any previous eye problems. Especially if history of poor vision in one eye since birth/childhood, or possible reoccurrence of previous eye disease – inflammatory (uveitis), recent corrective eye laser (refractive surgery), high myopes (short sighted), retinal holes/detachment

• Has there been any recent illness? An upper respiratory tract infection may indicate viral eye conditions
Thinking Points
-when taking an ocular history (cont)

• Age may be factor, some eye problems affect particular age groups:- circulatory problems may affect macular and cause degeneration; age related cataracts (gradual reduction of vision, glare); glaucoma (halos around lights, loss of peripheral vision)

• Check medications – these can further clarify presenting eye problem i.e. hypertension, diabetes and cardiac conditions may be associated with some vascular eye conditions:- central retinal artery occlusion; diabetic retinopathy
Suggested Triage Category

Based on Australian Triage Scale

Triage 1
• Immediate Life Threatening Condition

A patient should be allocated a higher triage category if discriminator in that category cannot be ruled out.

Triage Category 2

Assessment and treatment within 10 mins potential threat to eye function or deteriorating visual conditions.

- **Chemical Burns** (acid or alkali) needs immediate action by nurse- Start irrigation NOW! DON’T WAIT.
- **Penetrating eye injury** (PEI) – if self evident don’t touch except apply shield if appropriate
- **Sudden vision loss** – central retinal artery occlusion, (<6/60)
- **Severe eye pain** – possible acute glaucoma
Triage Category 2

Acute Glaucoma – semi dilated pupil
Red eye, cloudy cornea, painful

Penetrating Eye Injury –
With iris prolapse
Triage Category 2

- Lid punctures - 3 days after being poked with fork - endophthalmitis
Triage Category 2 & 3

- Triage category 2
  - Alkali Burn

- Triage category 3
  - Hypopyon, central corneal scar

EYE EDUCATION FOR EMERGENCY CLINICIANS
Triage Category 3

Assessment and treatment within 30 minutes.
Potential for adverse outcome, or relief of severe discomfort/distress.

- Painless loss of vision – central retinal vein occlusion
- History which indicates penetrating eye injury (PEI)
- Hypopyon – pus in front chamber of eye
- Hyphaema (total) – blood in front chamber of eye
Triage Category 3 & 4

Triage category 4
Foreign body – metal

Triage category 3
Hyphaema
Triage Category 4

Assessment and treatment start within 60 minutes
There is a potential for an adverse outcome, or
severe discomfort and distress.

- **Foreign body** – non penetrating
- **Painful red eye**
- **Flash burn** (welder flash) – often the pain is delayed
- **Sudden increase in numbers of floaters**, especially with previous retinal history - Retinal detachment
- **Flashes** - Retinal detachment, especially if previous retinal history
- **Small hyphaema** - blood in front chamber of eye
Triage Category 5

Assessment and treatment within 2 hours
Less urgent – condition is chronic or minor, clinical outcome will not be affected by delay in treatment.

- Conjunctivitis
- Blepharitis
- Chalazion
- Dry eyes
- Long term history of floaters (with no previous retinal history)
- Subtarsal foreign bodies – no eye redness.
Triage Category 5

Subtarsal Foreign Body

Chalazion
Documentation

- **Identification**
  - Name, Address, DOB
  - Date of arrival/time
  - Name of relatives with child

- **Examination**
  - Examination of both eyes

- **Management**
  - Investigations
  - Treatment
  - Follow-up arrangements

- **History**
  - When, where, and how the injury occurred
  - Ocular symptoms caused by the injury
  - First Aid treatment given
  - Previous ocular disorders and their effect on vision
  - Whether glasses, contact lenses or protective eye wear was worn
  - Tetanus status

Summary

• Reiterate a summary of presenting problems to check for misunderstandings
• If possible perform and document a visual acuity and eye examination as soon as possible – this may help in the assessment
• Use clinical judgement based on clinical presentation, the information presented is a guide only
## Differential Diagnosis of the Red Eyes – Appendix 1

<table>
<thead>
<tr>
<th></th>
<th>Conjunctivitis</th>
<th>Iritis</th>
<th>Acute Glaucoma</th>
<th>Keratitis (foreign body abrasion)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Discharge</strong></td>
<td>MARKED</td>
<td>None</td>
<td>None</td>
<td>Slight or none</td>
</tr>
<tr>
<td><strong>Photophobia</strong></td>
<td>None</td>
<td>MARKED</td>
<td>Slight</td>
<td>Slight</td>
</tr>
<tr>
<td><strong>Pain</strong></td>
<td>None</td>
<td>Slight to marked</td>
<td>MARKED</td>
<td>MARKED</td>
</tr>
<tr>
<td><strong>Visual Acuity</strong></td>
<td>Normal</td>
<td>Reduced</td>
<td>Reduced</td>
<td>Varies with site of the lesion</td>
</tr>
<tr>
<td><strong>Pupil</strong></td>
<td>Normal</td>
<td>SMALLER or same</td>
<td>LARGE OVAL and FIXED</td>
<td>Same or SMALLER</td>
</tr>
</tbody>
</table>
# Conjunctivitis – Appendix 2

<table>
<thead>
<tr>
<th></th>
<th><strong>Bacterial</strong></th>
<th><strong>Viral (usually adenoviral)</strong></th>
<th><strong>Allergic</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Symptoms</strong></td>
<td>Redness, FB sensation, Itching is less Irritating Superficially sore</td>
<td>Itching, Burning, FB sensation Can have recent URTI Starts one eye Within 2 days fellow eye affected</td>
<td>Itchy, Watery discharge, History of allergies</td>
</tr>
<tr>
<td><strong>Signs</strong></td>
<td>• Purulent discharge • Chemosis • Caution: Gonococcal Conjunctivitis (sudden onset 12 – 24 hrs)</td>
<td>Conjunctival follicles Palpable preauricular lymph nodes, Watery mucus discharge Red oedematous eyelids,</td>
<td>Chemosis, Red oedematous eyelids</td>
</tr>
<tr>
<td><strong>Treatment</strong></td>
<td>• Antibiotics – cultural sensitivity • Lid hygiene • Highly contagious – stress importance of personal hygiene – to avoid cross infection</td>
<td>• Lubricants • Cold compresses • Antibiotics if required • Highly contagious • Personal hygiene</td>
<td>• Compresses – cold • Lubricants without preservatives • Remove pathogen if known</td>
</tr>
</tbody>
</table>
References


MacEwan. 1989