

NELSON'S EYE

Bulletin 1. June 2003



WELCOME

This is a new bulletin prepared for General Practitioners, Optometrists and Hospital Staff. We plan about 6 bulletins per year.

We aim to update you on 'new' developments in ophthalmology, remind you of important ophthalmic conditions and keep you informed of 'comings and goings' in the Ophthalmology Department. Please e-mail us with any comments or requests.

All bulletins will be available at eyenz.com - the eye department website. This also has other useful eye information and patient education files.

This first bulletin looks at commonly used systemic medication and their ocular side effects.

CLINICAL NEWS

Drug Induced Ocular Toxicity

Hydroxychloroquine

Used in the treatment of certain rheumatological disorders. The two main potential side effects are maculopathy (irreversible) and corneal deposits. Hydroxychloroquine, however, is much safer than Chloroquine and side effects are unlikely in first ten years of use. **Recommendations:** Baseline ophthalmic assessment on commencing drug, then after five years of treatment, a yearly eye examination.

Quinine

Commonly used for relief of nocturnal muscle cramps. Acute poisoning causes blindness but visual loss can occur on an idiosyncratic basis in patients taking a normal dose.

Amiodarone

Two per cent of patients can develop bilateral swollen discs with reduction in vision. Some improve on cessation, some do not. Advise all patients on Amiodarone about possible visual loss – there is no role for screening. Corneal deposits are universal, asymptomatic and reversible.

Thioridazine (Melleril)

Can cause reduced vision and poor dark adaptation if used in high doses.

Chlorpromazine (Largactil)

Can cause visually insignificant lens changes.

Tamoxifen

Ocular complications (retinal crystals) are uncommon.

Steroids

Both systemic and topical can cause cataract and glaucoma. The exact relationship among total dose, weekly dose and duration of administration of steroids and cataract formation is unclear. Topical or inhaled steroids can cause glaucoma – especially in those with a family history of glaucoma or a worsening of glaucoma in those who already have it. There are no evidence-based recommendations, however, it may be prudent to ask patients on steroids to have a 1-2 yearly eye check.

Vigabatrin (Sabril)

This anticonvulsant can cause asymptomatic and irreversible peripheral visual field defects. It is not clear whether the defect may continue to worsen with increased duration. There is a concentric constriction of the field – worse nasally than temporally. **Recommendation:** visual field test at baseline and 6 monthly thereafter. The risks / benefits of using this drug need to be carefully assessed. Children require special consideration.

EYE DEPT NEWS

We welcome Jo Kennaway, our new orthoptist, who has joined us from Auckland. Originally from Ireland, Jo was trained in Britain, has worked at Moorfields Eye Hospital, London then Saudi Arabia, Auckland and now Nelson! Jo runs the Paediatric Ophthalmology Photo Screening Service, manages children and adults with strabismus and is a great asset to us.

Finally a summary of how we're dealing with the waiting list, as of 1 June, 2003.

The Good News:

Patients seen since July 2002: surgery 432; outpatients – 1454 FSA, 3990 FU. Outpatients remains an area of unmet need despite us seeing 40% more patients than the contract allows.

The Bad News:

Still waiting to be seen: surgical 252; outpatients 727 (155 have appointments, 100 semi-urgents have no appointment, 424 routine have no appointment).

The waiting time for routine referrals is currently estimated to be 3 years!!