

Eyes

Disclaimer: The recommendations contained in this guideline do not indicate an exclusive course of action, or serve as a standard of medical care. Variations, taking individual circumstances into account, may be appropriate. The authors of these guidelines have made considerable efforts to ensure the information on which they are based is accurate and up to date. The authors accept no responsibility for any inaccuracies, information perceived as misleading, or the success of any treatment regimen detailed in the guidelines.

Paediatric Ophthalmology Services

We are always keen to maintain a high standard for the services we provide for children with eye problems.

Referrals for which we would take no action:

1. Meibomian cysts or chalazions:

In nearly every case, a meibomian cyst in a child will resolve with conservative management, including topical antibiotics. We now rarely carry out surgical intervention.

2. Watering eyes in young children:

Spontaneous resolution of watering eyes takes place in over 90% of cases within the first year and in approximately 70% of remaining cases during the second year of life. Cases which warrant referral include those with persistent infection despite treatment and those in whom gentle pressure on the lacrimal sac produces a discharge on the eye and therefore indicates the presence of a mucocele. We prefer to carry out probing procedures in children whose watering has not cleared by the age of two.

Children who require urgent referral:

1. *Squint*, in particular convergent squint, is common in children. By far the majority are managed using patching and spectacle correction.

However, about twice a year we see children with squint which is either due to:

1. Blinding pathology in one eye such as *retinoblastoma*
- or**
2. Central nervous system pathology such as a *brain stem tumour*.

It is therefore important that all children with newly presenting squints have an assessment for a red reflex carried out with a direct ophthalmoscope in a darkened room. This will elicit cataract and retinoblastoma. It is also important to check for any evidence of central nervous system pathology. All such patients are given urgent appointments.

The quality of referrals which we now receive is uniformly high but if we can address these issues we hope to obtain further improvements in the services we offer.

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Dear Doctor

We are seeing significant numbers of children and babies referred to us with two conditions that are unlikely to need intervention, but often cause parents to bring their children to a doctor. Reassurance that these conditions resolve naturally in their own time is key in their management. There is little harm in offering simple non invasive treatments but it is important that parents do not have falsely high expectations that these will “cure” the problem. Time is the cure.

CHALAZION IN CHILDREN

This benign self resolving condition can cause a lot of anxiety to parents resulting in repeated visits to general practitioner and referral on to hospital. Treatment with chloramphenicol which prevents or treats secondary infection but does not make the chalazion go away can be seen as a failure by parents who may then push for a referral to hospital for something definitive to be done.

Our current management of chalazion is conservative in all cases and by the time we see them in clinic (usually 12-15 weeks after referral), they have almost all resolved fully or partially. To relieve the pressures on our outpatient clinic and reduce the waiting time for more serious conditions, **we ask that you consider not referring children with obvious chalazia at all, or at least not until they have been present for over 6 months.** Treatment of patients with lid hygiene, hot compresses and chloramphenicol are all employed but, with or without such measures, slow spontaneous resolution (or rupture and discharge) is the invariable natural history.

Active surgical intervention under general anaesthetic for children is hardly ever justified.

NASOLACRIMAL DUCT OBSTRUCTION

Watery and sticky eyes in infancy is a common situation and often due to nasolacrimal duct (NLD) obstruction. The NLD is often non-patent at birth but opens by 12 months of age in 95% of cases. This suggests that probing before 12 months is unnecessary in almost all cases. Waiting till after 18 months ensures even more cases will resolve spontaneously so saving the unnecessary administration of a general anaesthetic. The symptoms can be distressing to parents necessitating much cleaning and wiping, but rarely are there any lasting complications resulting from conservative management for 18 months. Antibiotic drops or ointment rarely give lasting relief as the drainage problem is unchanged. Downward massage over the NLD is sometimes said to help. **We ask that you routinely wait 18 months before referring us babies in whom you diagnose NLDObstruction.**

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