Management of Acute Primary Angle-Closure attacks in Casualty (During COVID-19 pandemic)

AAC Diagnosis

Indentation gonioscopy of both eyes

Start Medical Tx immediately

1. **Systemic diamox (PO/IV 500mg)**
2. **Topical Pilocarpine 2% (x4 every 15 minutes)**
3. **Stat. Topical CAI, βBlocker, Iopidine 1%, Latanoprost, steroids (maxidex).**

Attack is broken

Pupil come down and cornea is clear enough

Perform Bilateral LPI

Start with 6 mJ single pulses.

Check IOP after 1h.

D/C home with topical steroids +/- glaucoma drops.

All patients should be handed over properly to a glaucoma fellow to arrange FU

Pupil has not come down / cornea is not clear enough

Keep on MTMT

PI unaffected eye

Phone/text glaucoma fellow to arrange urgent FU

Discharge home

Attack is not broken

A. If the cornea is clear and pupil miosed Consider Early **YAG** laser iridotomy
B. If the cornea is oedematous consider **ALPI**

Alternative options in order of preference :

1. Consider **Paracentesis** only if discussed with glaucoma team, to be done by an experienced doctor, 30 G needle.

2. Trans-scleral **cyclodiode,** consider early, discuss with on call consultant

- Depending on availability of theatre
- Inferior 180, 15 shots x 1500mW x 1.5ms Post-laser S/C steroids, can use subtenon.

3. IV **Mannitol** 20% in 200 mls, after discussing with on-call consultant

All patients should be handed over properly to glaucoma fellow to arrange FU

FOR MANNITOL

1. Recheck IOP after 1h.
2. Ensure systemic observations are stable for **3 hours** following an injection.
3. If IOP is better, then discharge home and review the following day.
4. If IOP is not lower consider diode or admission to a blue (non-COVID) ward

Mannitol contraindications:

1. Heart failure/cardiac disease
2. Renal disease
3. Dehydration
4. Electrolyte imbalance
5. Known Mannitol hypersensitivity