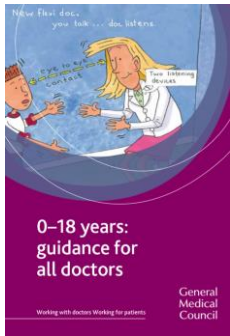




Outline

- Considerations when managing children
- SWBH Pathways
- Specific Conditions



GMC

"Acting in the best interests of the child or young person should be the guiding principle in your decision making. But identifying their best interests can be challenging."

General Principles

- Have child friendly environment
- Develop own style to approaching children
- Exude confidence and friendliness
- Engage child as an individual at their level
- Develop partnership with parents

Examination

- Initial no-touch approach
- Sit at level of child and make it a game
- Examine in parents lap or buggy
- Examine while feeding or sucrose
- Do not have too many people in room



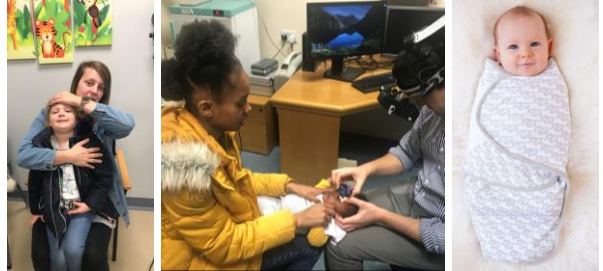
Targeted examination

- Start from far & come closer
- Bruckner test
- Vision assessment
- Indirect + 280 will give you almost all information
- Portable slit lamp then the eye tickler (I care)



Non-cooperative child

Toddlers most difficult to examine
Don't instil drops yourself
Don't make false promises
If it breaks down, take a break
Decision about bringing back or EUA
EUA organised via on-call team



Outcomes from Eye casualty

Discharge to GP
Follow up in Eye A&E
PCFU/UCC
Refer to local eye unit- always ask if children attend another unit
Refer to BMEC paed team
Admit

If you are stuck

Exercise clinical judgement
Obtain a senior review
Contact AJG via email or phone

DO NOT REFER EVERY CHILD TO OPD

Medical admissions

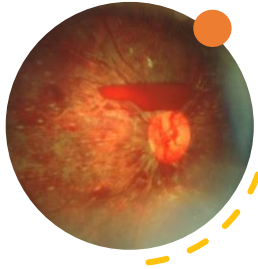
Investigations or treatment
Inform on-call consultant
D/W Paeds reg at SGH
Ensure child has ophthalmology f/u & document

Surgical Admissions

TBC
Supposed to be admitted in CECU (City Hospital) for max 18 hour stay
Children <1 d/w BCH team

Non-accidental injury

- To be seen in Eye Cas or by on-call registrar within 24 hours
- If retinal haemorrhages present
 - Document on RCophth proforma
 - Communicate findings to paed team
 - Inform paediatric ophthalmologist



Suspected Papilloedema

- Do not perform B-scan in visual functions
- History and examination
- No symptoms & normal discs / pseudopapilloedema: Discharge
- Suspected papilloedema: Admit for neuroimaging
- 'Equivocal' discs. OCT + Refer paed ophthal

Orbital Cellulitis

- Treat with 10/7 Co-Amoxiclav unless:
 - Optic nerve dysfunction, Ophthalmoplegia, Proptosis
 - CNS signs or symptoms (e.g. reduced GCS)
 - Child under age 2
 - Septic or systemically unwell
 - Not responding to broad spectrum oral antibiotics
 - Patients in whom it is not possible to examine the eye

External Eye Disease

- Establish correct diagnosis- BKC vs VKC
- Prescribe effective treatment
- Simplify drop regime
- Lubricants do not treat underlying condition
- Discharge to GP unless evidence of sight threatening complications or disabling symptoms
- Refer if >2 flare ups

External Eye Disease Diagnosis

VERNAL KERATOCONJUNCTIVITIS	BLEPHAROKERATOCONJUNCTIVIS
Itchiness	Foreign body sensation
Stringy discharge	Anterior &/or posterior blepharitis
Superior punctate erosions	Inferior punctate erosions
Tarsal/limbal papillae	Diffuse conjunctival hyperaemia
Shield ulcers	Marginal keratitis

Mild: Reassurance + Dietary Omega 3

Moderate: PO Macrolide 6/52

Mupirocin ointment BD 3/7

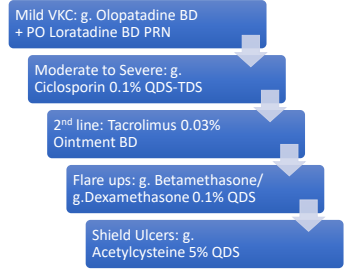
Flare ups: g. Betamethasone/
g.Dexamethasone 0.1% QDS

BKC management

Which antibiotic to use?

- Erythromycin
- 2-7 Years: 125mg BD
- 7-12 years: 250mg BD
- 12+: 500mg BD
- Doxycycline 100mg OD

VKC Management



Acute Onset Squint

Organise Orthoptic review from Eye A&E
 Urgent neuroimaging + neurological assessment under paediatrics if suspicion of cranial nerve palsy or secondary cause (e.g. tumour, trauma, intracranial infection)
 Follow up in orthoptic or paediatric ophthalmology clinic

Medically Unexplained Visual Loss

Check VA at standard distance, 1m and near
 Ishihara, visual fields, pupils including RAPD, dilated fundus exam, refraction, try neutralizing lens and/or tests of stereopsis
 Discuss with orthoptics
 If normal vision demonstrated in ED discharge to GP

Ophthalmia Neonatorum vs CNLDO

Swab & treat neonatal conjunctivitis
 CNLDO- do not swab, no antibiotics, discharge

Chalazion

Reassure and discharge
 All chalazia resolve spontaneously albeit on an unpredictable timescale
 Treat recurrent chalazia for blepharitis





Leukocoria

B-scan if no fundal view
Cataract in infant <1 or suspected retinoblastoma refer to
BCH

Summary



Targeted exam



Learn to manage uncertainty



Treatment should be effective
and not too onerous