The Value of Orthoptic lead for paediatric oncology ophthalmology clinics

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Purpose

To highlight the utilisation of Senior Orthoptists within Paediatric oncology clinics to provide ophthalmological support and triage of relevant cases to the Ophthalmologist. Reducing demand on the paediatric ophthalmology clinics as well as improving patient experience.

To present the range of cases managed by the orthoptist within these clinics.

Introduction

The following work describes a way in which allied health professionals (AHP’s), in the form of Advanced Orthoptists, can be utilised to provide ophthalmology support to paediatric oncology clinics yet still maintain high service provision level, accurate visual and ocular motility monitoring and safe patient care.

Visual problems frequently occur for children suffering with brain tumours\(^1\&2\), and it is often subtle changes in vision which may indicate the need for further scanning or therapy change. As such visual function needs to be assessed systematically and reliably and the results discussed contemporaneously with the oncologist so that any treatment changes can be discussed with the parents and promptly initiated.

With the advent of the Leeds children’s hospital there was a need for patients to attend cross site outpatient clinics to facilitate examination by both ophthalmology and oncology on the same day. To make best use of clinic time and reduce travel and time spent at hospital, AHP support was utilised to bridge the physical gap between the two services.

Method

An experienced orthoptist is placed within the weekly brain tumour clinic to perform a variety of visual assessments (see below) as well as appropriately triage other ophthalmology problems to the relevant and timely clinics. With an Orthoptist within the oncology clinic patient visits to hospital as well as waits within outpatient clinics, for a particularly vulnerable patient group, can be reduced. The eye examination can be performed as the patient waits to see the oncologist. Should any immediate concerns be raised by the orthoptist on the day, an ophthalmologist could be consulted by telephone and appropriate recommendations made. All patients are initially diagnosed by the ophthalmologist/oncologist but monitored by the orthoptist.

Orthoptic Role within Oncology brain tumour clinic:
- Triage of all patients needing ophthalmological opinion.
- Visual field assessment, as baseline & for monitoring of condition progression
- Examination and monitoring of visual acuity
- Diagnosis of ocular movement defects and double vision relief
- Therapeutic and rehabilitative use of occlusion and prisms
- Advice regarding other ophthalmic problems such as “sticky eye”, migraine, access to support services etc.
- Continuity of care/patient relationship development through same clinician examination.

Results

The use of an orthoptic lead for ophthalmology within paediatric oncology released approximately 150 paediatric ophthalmology appointments to be utilised with other patients. In the last 12 months 175 patient incidences were triaged by the orthoptist, with 25 patients requiring additional referral to the ophthalmologist for medical examination, prescription of ophthalmic medicine, registration as sight impaired or listing for squint surgery.

Approximately a third of the work was in an advisory capacity; referring to social/educational supports, triaging symptoms that may not be associated with the cancer such as a need for glasses or migraine.

(Images; craniopharyngioma & optic nerve glioma)

Conclusion

The utilisation of orthoptists within certain oncology clinics can provide not only an effective use of resources but be a convenient combination of services for the patient, seeing two specialities at the same time. Reducing inter site travel and outpatient waits. Parents have commented on the benefit of attending one familiar clinic with less waiting times and travel/parking issues.

There was an additional benefit within this clinic of having the same tester each time, so subtleties of loss/behaviour changes could be observed. Patients were able to build a relationship with the examiner aiding in eliciting coop in a vulnerable young patient group.

Contemporaneous discussion of results between the orthoptist and oncologist allows for treatment decisions to be made while the patient is in face-to-face consultation with the Oncologist.

Previously any visual complaint would automatically be booked for Ophthalmological opinion yet with the orthoptist on hand a large proportion of these queries could be answered on the day or triaged to the MOST appropriate staff such as Optometrist or support teacher over the ophthalmologist.

Orthoptic-led support to paediatric Oncology has been deemed a success from the parents, patients and the medical staff’s point of view. The service is well received in its convenience to service users but is also making financial sense in the better utilisation of paediatric ophthalmology resources. As such we would recommend other departments consider utilising their AHP support in this way to maximise service provision.

References