AONA

VISION

NATIONAL NEWSLETTER

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Welcome to the December edition of The Australian Ophthalmic Nurses Association National Newsletter

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AONA NSW

President's Report
Joanna McCulloch

What can you say but "what a year", NSW has experienced fires and like the rest of the country the effects of COVID. However, you have to recognise our Victorian colleagues for doing it tough for so long. We all have lived experiences and have tales to tell, some amusing and others devastating. I have to say personally being President this year of this branch has not been easy. I have to admire Jenny Keller for doing it for so long and doing it so well. I am so proud to be part of the AONA NSW team during this year, supporting each other and together supporting our members.

Over 370 people dialed in for 9 Eye Tele C education sessions, what an achievement for NSW this year. At some point WA, VIC, SA, NT and NSW members (with its 1 QLD member) all joined into the wealth of information shared. I wish to acknowledge those speakers who kindly gave up their free time, as well as the behind the scenes AONA committee members who were pivotal in seeking out speakers and liaising with them to ensure quality education was being delivered. Topics this year have been wide and varied; glaucoma, eye emergency, diabetes from a medical and Diabetic educator perspective, Thyroid Eye and Cornea to name a few. These education sessions will continue in 2021 and we are working hard to bring back clinicals, in light of COVID restrictions.

As members may know AONA VIC, SA & NT have decided to relinquish their association status, and asked AONA NSW if they could merge into our association. Voting occurred in both associations to incorporate AONA VIC, SA and NT into AONA NSW and both associations unanimously agreed to the proposal, as a wider membership base strengthens the networking of ophthalmic nurses from across the country.

To de-register an association is complex and takes time, so the final merge is estimated to occur in early 2021.

On the 8th September a representative from Victoria, South Australia and Northern Territory was welcomed onto the AONA NSW committee. This is the first step towards amalgamation. The Australian Ophthalmic Nurses Association Inc. (AONA) began in NSW, over 37 years ago. Over the years different states began their own associations (QLD, VIC, WA) therefore AONA had to be referred to AONA NSW. The new committee has decided to return to its original name of "AONA "to reflect a membership spread beyond the borders of NSW into VIC, SA, NT and Tasmania in 2021. The website for aonansw.org.au will reflect all the states that will be under the AONA banner. AONA committee planning day will be held on the 16 January 2021 in Sydney, where our interstate colleagues will join us to make AONA's voice bigger and stronger for its members.

Have a wonderful Christmas and New Year, and the word that are now commonplace "Keep Safe'

AONAWA

President's Report
Andrea Montague

Wishing everyone a safe and happy festive season and best wishes for 2021! These greetings have really taken on new depth and gravity after the trauma of 2020 haven't they? They are certainly most heartfelt from me on behalf of WA Ophthalmic Nursing community. It has been a year that we had been looking forward to but will remember so well for all the wrong reasons. We realise that our state has been fortunate so far in the scheme of things in relation to Covid-19 although it has still had an impact on all of our lives and will continue to do so for some time.

In WA we were able to hold a seminar on September 19th.This included our AGM and we had approx. 50 people in attendance adhering to Phase 4 government regulations for Covid Safety. The program included a talk from a leading surgeon on Corneal Grafts, the manager from our Eye Bank and a talk from one of our committee members about the unethical practice of organ harvesting in China. It was great to be able to get together for the purposes of education. Our AGM saw the committee remain largely unchanged which is ok for now although I did put a call out for others to consider stepping up and into some of the executive positions. I think it keeps things fresh if positions turn over after 3 or 4 years, it will also prevent burnout for those putting time and effort into voluntary positions.

Next week we hold our Sundowner that we have titled "See you Later 2020" We have booked a venue that we haven't used before and are looking forward to an afternoon of stimulating content with a view! We have a consultant to talk about Giant Cell Arteritis and a lot of content from nurses who are making an impact in their workplaces and further afield, including Elaina Mullery who hosts "The Happy Nurse" podcast and Lauren Entwistle who has begun a Nurse led Glaucoma Assessment Clinic. We aim to give our members 3 CPD points as well as an opportunity to socialise with colleagues and peers from the Ophthalmic Nursing community.

Sending positivity and cheer to you all, catch you in 2021,

AONAQ

President's Report
Pene Gill

This is the last President's report for 2020 and, like me, I am sure many of you are looking forward to a brighter 2021. This year has certainly been a challenging one. It's been a year of great uncertainty and definitely a challenge for us as an Association.

With limitations on gatherings and the additional burden on healthcare, we have struggled to meet our goal of delivering quality education to members.

COVID restrictions resulted in the cancellation of Clinical Meetings and the postponement of our Annual Conference, scheduled to run concurrently with RANZCO this year in Brisbane. We were fortunate to hold a well-attended Clinical meeting early in the year and some members were able to join us via Zoom to hear Ghislaine Wharton's presentation on Dry Eye in conjunction with our Annual General Meeting (AGM) in August.

A successful AGM was held via Zoom and a new Executive committee for 2020 was elected. My thanks go to returning committee members Amanda Wylie (Vice President), Tia Kemp (Treasurer), Sarah Pervan (Secretary), Carmen Newman, Jiorgia Collingridge, Alison Fielding-Price, Fiona Turner, and Nicole Forzatti. We also welcome Jessica Van Zijl as a new member of the committee this year.

The new committee has already begun planning events and education for 2021. The calendar of events for next year is attached to this email and can be found on our website. We hope to hold our Annual Conference next November in conjunction with the rescheduled RANZCO Annual Scientific Meeting in Brisbane.

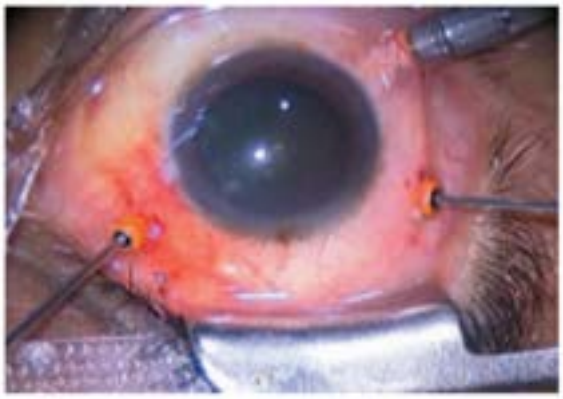
Now, more than ever It is important for the Association to communicate effectively with members through our digital platforms. We understand that some of our members are not receiving our emails. Our email distribution list is drawn from the details you have provided on our website, so please make sure that are up to date. Please also share this information with your colleagues, who may also be missing out. If you have any difficulty updating your details, please contact us via the AONAQ email admin@aona.org.au

I wish all members the very best for the rest of the year and look forward to seeing many of you in the New Year. Merry Christmas to you all, stay safe and may 2021 bring you joy, happiness and hope.

MINIMALLY INVASIVE VITREORETINAL SURGERY

The case scenario presented in the following paper is intended to describe the procedure of Minimally Invasive Vitreoretinal Surgery via a pars plana vitrectomy in the treatment of retinal detachment. The indication for retinal detachment repair with pars plana vitrectomy surgery will be briefly described. The potential patient safety issues during the intra-operative phase during a patient's surgical journey undergoing vitreoretinal surgery will be explored.

The case scenario describes a patient who was seen in the eye clinic in a public tertiary hospital. The patient was a 61year old male presenting with a two week history of right (OD) decreased central vision. A routine eye examination, medical and ophthalmic history was taken. With indirect ophthalmoscopy, the diagnosis was confirmed as rhegmatogenous retinal detachment. As a result, the patient was booked for a planned Minimally Invasive 27gauge pars plana vitrectomy, retinal detachment repair with +/- laser photocoagulation, +/- cryotherapy, +/- insertion of intraocular gas under local anaesthetic - subtenons block with sedation.



The microcannulas are inserted through the conjunctiva into the eye and 23-gauge instruments are in place at the sclerotomy sites.

Retinal detachment is a common ophthalmic condition and refers to the separation of the neural retina from the retinal pigment epithelium. Retinal detachment is usually described in two main ways; rhegmatogenous - with the presence of a retinal break or tear, and non¬rhegmatogenous in the absence of a break or tear (QUT PON, 2018). Rhegmatogenous retinal detachment is a major cause of visual loss in developed countries (Ricker et al. 2011). A Minimally Invasive procedure for surgical repair of rhegmatogenous retinal detachment is described to be either 23, 25 or 27gauge three port system (Buerk et al. 2015). This system permits three port pars plana vitrectomy using microcannulas, trocars and instrumentation without requiring sutures to close the sclerotomies. Henry et al. 2014 reiterate that pars plana vitrectomy surgery has evolved to the degree to where it can be considered Minimally Invasive Surgery. (Leung et al. 2010) suggest endoscopic surgery has therefore been applied to vitreoretinal surgery. The advantages of intraocular endoscopy guided vitreoretinal surgery with the introduction of Microincisional Vitrectomy surgery techniques has led to minimally invasive, faster, safer, and more accurate surgeries (Kawashima & Tsubota 2014).

The safety issues associated with Minimally Invasive Vitreoretinal Surgery will be explored.

Vitreoretinal surgery has undergone remarkable transformations since the first successful pars plana vitrectomy more than 40 years ago. Modern instrumentation and surgical techniques have led to shorter operating times and faster recovery for many patients. As surgical techniques and instrumentation have advanced, Minimally Invasive Vitreoretinal Surgery has emerged as a global standard surgical style of vitrectomy for treating a variety of vitreoretinal pathologies, offering numerous benefits. Minimally Invasive Vitreoretinal Surgery with the advantage of small gauge, sutureless surgery has resulted in minimised damage to tissues and therefore (Natarajan et al. 2016) conclude it is safer for the patient. The introduction of Minimally Invasive Vitreoretinal surgery has resulted in low rates of intraoperative and postoperative complications such as early postoperative hypotony and endophthalmitis (Yoneda et al. 2017). Smaller and more precise wound construction promotes self-sealing and helps to prevent hypotony, therefore eyes may be less prone to vitreous prolapse and developing endophthalmitis. (Franklin et al. 2014) and (Oshima et al. 2015) include in their reviews the benefits are shorter operating time, reduced corneal astigmatism, diminished conjunctival scarring, improved patient comfort and in some cases earlier visual recovery.

With the continuation of development and innovation of not only Minimally Invasive Vitreoretinal Surgery but also robotics there will be advances in surgery and also in patient outcomes.

The barriers to adaptation of eye surgery robots are the same ones once encountered by proponents of Minimally Invasive Laparoscopic Surgery. However, laparoscopic robotic surgeries have evolved through the years and now laparoscopic surgery is a widely accepted technique. Evidence of the past three decades implies that robotic systems might be useful to improve health care (Molaei et al. 2017). Ongoing developments in eye surgery robotics could make them useful tools for ophthalmic applications. For example, various assistive robotic systems for ophthalmic surgery are under development to overcome human tremor and limitations of perception (Ullrich et al. 2014). Further development and refinement of the functionality of instruments will also undoubtedly lead to the establishment for minimally invasive surgery for the full spectrum of vitreoretinal pathologies (Oh & Oshima 2014).

The following will describe the patient undergoing retinal detachment repair via Minimally Invasive pars plana vitrectomy.

The microcannulas are inserted through the conjunctiva into the eye by means of a trocar. An oblique then perpendicular tunnel is made parallel to the limbus through the conjunctiva and sclera creating a self sealing wound. The microcannula consists of a thin walled tube, 4 mm in length. A collar is present at the extraocular portion, which can be grasped with forceps to manipulate the microcannula. The insertion trocar has a sharp tip that forms a continuous bevel with the microcannula, allowing easy entry through the conjunctiva into the eye. After insertion of the first microcannula, the intraocular portion of the infusion cannula is directly inserted into the external opening of the microcannula (Arevalo et al. 2011). The infusion cannula with either balanced salt solution, air or gas maintains the intraocular pressure of the eye, therefore the rigidity of the eye is maintained. The two remaining ports are used for illumination and instrumentation. Three port pars plana vitrectomy surgery is ideal for retinal detachment repair. At the completion of surgery, the microcannulas are simply removed by grasping the collar and withdrawing, along with assessment of intraocular pressure and wound sites for possible leaks (Aravelo et al. 2011).

The patient undergoing retinal detachment Minimally Invasive pars plana vitrectomy presents intraoperative safety issues that the perioperative team need to prepare for. The treatment of retinal detachment may require laser photocoagulation for example. Ensuring the appropriate laser and radiation guidelines and protocols for the facility are adhered to is vital for patient and staff safety. For the patient undergoing a retinal detachment repair there are many surgical treatment options to repair the detached retina including laser photocoagulation, cryotherapy, diathermy, intraocular gas, silicone oil, endotamponades for example. More than one of the above mentioned treatment options during Minimally Invasive Surgery techniques for patients with retinal detachment are often used (Maier et al. 2011). The availability and anticipating the need for the potential equipment and prosthesis is paramount for the success of vitreoretinal surgery and the treatment of retinal detachment.

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AONAVIC

President's Report
Robyn Johnston

Thank you to each of our members who continued to support AONAVIC this year. While we could not host any face-to-face events, we used the time wisely.

Virtual Events: We held our first Zoom Clinical Meeting in October. It was a great opportunity to test the waters with this platform to see how we could accommodate further virtual events in the future. We invited Lynne Hadley from the UK, and had our resident member Heather Machin and Toby Pontifex share their first-hand experiences of working in non-ophthalmic COVID areas. We were joined by 25 adventurous attendees, including those from New Zealand, Fiji and Peru. It gave us plenty of ideas on how we can share forward our knowledge about ophthalmology beyond our state border.

Grant Recipient: We are thrilled to announce that we have provided our very first research grant to our resident member Heather Machin, at the Centre for Eye Research Australia. Heather will lead a 12-month research project with co-Investigator Australian nurses from a range of backgrounds. The project will undertake Australia's first workforce survey of nurse engagement in eye care. We look forward to supporting this project, which will be outlined further in the new year, and hearing the outcomes of the project. We also hope this champions in a new era of nurse led research in Australia.

2020-2021 Executive: At our Virtual AGM, we voted-in a small team of Executives to administer AONAVIC until it amalgamates with AONA in NSW. We acknowledge these representatives as: President – Robyn Johnston, Media-Secretary – Pat Usher, South Australia Representative – Anne Lentakis, Treasurer – Heather Machin and General Members - Kris Spence and Colleen Flanders. We also thank our outgoing general members from last year: Helenka Rubens, Angelina Shi and Anna Huigen.

Amalgamation: Our team has continued with our planned move to amalgamate AONAVIC in and under AONA located in NSW. The committee will use the first quarter of 2021 to prepare for the move and will inform AONAVIC members of when and how the move will take place and how that impacts their membership. We thank members in advance for their patience as we transition into AONA.

To close, while 2020 was not quite the year we wanted, we have welcomed the space it provided, as it allowed us to put in motion our amalgamation with AONA in NSW. We are excited about the transition and we look forward to the new era and the opportunities it will bring.

Have a wonderful Christmas and New Year.