AONA

VISION

NATIONAL NEWSLETTER

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

DAY CASE CATARACT SURGERY

Looking Back and Looking Forward

This being the 30th anniversary year of AONA in Queensland it is perhaps timely to reflect on the most commonly performed procedure within our specialty, cataract surgery. A search of the literature uncovered an article published in 1988 (30 years ago) in the British Journal of Ophthalmology. The article "Day Case Cataract Surgery" describes a series of 40 cataract extractions with lens implantation performed on day-case patients under local anaesthesia.

This article is from a time when cataract extraction in day surgery was not common in Britain and Australia, although it was popular in the United States of America. The paper describes that with the advent of extracapsular (versus intracapsular) cataract extraction and peribulbar (versus retrobulbar) anaesthesia, day case cataract surgery could be a safe procedure. The author stressed the importance of patient selection, with consideration of physical and mental wellbeing as well as adequate social support.

The paper goes on to describe the episode of care including:

- Once admitted to the day stay unit at the hospital, patients received 10mg of temazepam orally then a peribulbar block was administered half an hour after that.
- Patients who wore hearing aids were encouraged to leave them in place and music was played if so desired (not too different from today!).
- Surgery was undertaken using the standard extracapsular technique (removal of the anterior capsule prior to delivery of the nucleus) or the intercapsular technique (a horizontal cut was made in the anterior capsule, the nucleus expressed and the anterior capsule removed after the insertion of the lens implant!).
- Capsular fixated lenses were inserted (either disc or Y-loop type). In 2 patients no lens was inserted due to posterior capsular rupture.
- The wounds were closed with either 10/0 or 9/0 nylon.
- All patients returned for review the next day and were given Maxitrol eyedrops (neomycin, polymyxin B, dexamethasone) to take 2 hourly until their next visit in 2 – 5 day's time.

The paper concludes that:

> *"day-case cataract surgery is not suitable for all patients, and selection is critical. We do not see the procedure as a replacement for conventional inpatient management but rather as an adjunct to it. Particularly in times of ever increasing demands on Health Service Funds, intraocular day-case surgery helps to make the best of resources".*

Fast forward to 2018, cataract surgery is the most commonly performed surgical procedure in Australia today. The need to make best use of resources continues to be important and as demand increases, controlling variation in supply and demand remains a challenge in healthcare.

The Australian Atlas of Healthcare Variation reported on variation in cataract surgery for adults 40 years and over. The Atlas reported that in 2013-14:

- There were 160,489 MBS-funded services for cataract surgery, representing 1,436 services per 100,000 people aged 40 years and over
- The average number of services varied across states and territories, from 1,132 per 100,000 people aged 40 years and over in the Northern Territory, to 1,685 in Queensland
- Overall, 71% of hospitalisations for cataract surgery were privately funded patients. This proportion varied from 52% in the Northern Territory to 78% in Queensland and 81% in Tasmania.
- The wait time for public patients varied from 37 to 301 days (once placed on the waiting list). This data did not capture waiting times for outpatient appointments.
- The median age of patients at the time of hospitalisation was 74 years for publicly funded patients and 73 years for privately funded patients

It seems that in 30 years many advances in the treatment of patients undergoing cataract surgery have been made. Day case procedures now make up the majority of episodes of care for patients with cataract. Yet the need to make the best of resources in an enduring feature of health service provision. Addressing unwanted variation in the provision of care to these patients is the challenge we face in Australia today and ophthalmic nurses can certainly be part of the solution.

References

Australian Commission on Safety and Quality in Health Care. Australian Atlas of Healthcare Variation. Australia: ACSQHC; 2015.

Watts, M.T. & Pearce, J.L. 1988 "Day Case Cataract Surgery", *British Journal of Ophthalmology*, 72(12): 897-899.

GORE-TEX SUTURED INTRAOCULAR LENS

Jennifer Cartwright RN

The ideal position for placement of the intra ocular lens (IOL) following lens removal is inside the lens capsule (capsular bag). This is not always possible as it is dependent on a stable and complete posterior lens capsule. If the capsule has been compromised or the zonules that support the capsule are broken or weak, the surgeon will assess the best placement and type of IOL in order to achieve a stable IOL and good outcome for the patient. This may be lens placement in the anterior chamber (AC IOL), posterior chamber lens (PC IOL) in the sulcus (between the posterior surface of the iris and the anterior lens capsule) or in capsular bag.

If the capsule is insufficient to support a PC IOL either in the sulcus or in the bag, the only lens the surgeon can place at the time of surgery is an anterior chamber lens. This is not always a good choice for the patient as relative contraindications include:

- Any corneal endothelial disease
- Iridocorneal angle damage such as peripheral synechiae
- Shallow small anterior chamber
- Lack of substantial iris tissue
- Existing glaucoma
- Uveitis

Another option is a secondary procedure to implant a PCIOL that is sutured in place (sutured PC IOL). This lens sits behind the pupil in the position of original lens. In the absence of sufficient capsular support it is held in place by sutures attached to the haptics (arms) of the lens and drawn out of the eye via scleral tunnels.

This procedure has typically been performed using an 11/0 or 10/0 nylon or 10/0 prolene suture. The complication of suture breakage was often encountered and lens instability, such as rotation of lens or tangling of suture around lens also occurred. The use of Gore-Tex suture material has gained popularity in ophthalmology as an alternative suture. It is resilient, less prone to breakage and combined with the Akreos AO60 IOL with four haptic design, enables excellent IOL centration and stabilization through four-point fixation.

For further reading review the following article.

https://www.retinalphysician.com/issues/2016/may-2016/gore-tex-sutured-intraocular-lens

Gortex suture has been passed through one haptic across to the other at one end and repeated on the opposite side, once in place the lens is inserted.

Once in place, fine vitreoretinal forceps are inserted via one of four ports, the suture end is grasped from inside the eye and withdrawn through the corresponding port to the outside. This is repeated for all four sutures. Once all four ends of the suture are outside the eye the ports are removed. The suture ends are tied securely over the sclera, the conjunctiva is replaced over the suture points and secured in place.

References

Hsu, J. & Khan, M. 2016. Gorte-Tex Sutured IOL
https://www.aao.org/clinical-video/gore-tex-sutured-iol

Rahimy, E., Khan, M. et al. 2016. Gore-Tex Sutured Intraocular Lens
https://www.retinalphysician.com/issues/2016/may-2016/gore-tex-sutured-intraocular-lens

XEN STENT

Jennifer Cartwright RN

Glaucoma is a group of diseases that results in damage to the optic nerve and loss of vision. If not treated vision loss is permanent and worsens with time. In a normal eye aqueous humor flows from the ciliary processes (where it is produced) through the posterior chamber, over the lens, through the pupil into the anterior chamber of the eye where 90% of it drains through the trabecular meshwork and returns to the venous circulation. When drainage is impaired, the flow of aqueous is slowed and a rise in intraocular pressure results.

For some time, drainage devices have formed part of the treatment options for patients with glaucoma that is not controlled by other available treatments, such as medications, laser and other surgical procedures. These devices include:

- The Express shunt—creates a new pathway like a trabeculectomy does, via a small tube that passes from the trabecular meshwork and anterior chamber to a flap externally.
- Microsurgical stents and tubes—such as the Istent or Hydrus stent which are placed into the trabecular meshwork
- Glaucoma drainage devices—Molteno or Baerveldt tubes. The procedure resembles trabeculectomy, however a tube is used to pass from the anterior chamber through the trabecular meshwork to a drainage plate that is sutured onto the sclera externally.

While drainage implants (such as Molteno and Baerveldt tubes) have been the traditional treatment for complex glaucoma, minimally invasive glaucoma surgery (MIGS) has gained popularity over the last decade. These procedures include the use of micro stents and share a common theme of intraocular pressure reduction, with minimal tissue destruction, short surgical time, simple instrumentations and fast postoperative recovery.

Such stents are designed to increase aqueous outflow via differently designed channels, and they fall into three categories:

- Schlemm canal stents—Istent and Hydrus stent.
- Suprachoroidal stents—CyPass.
- Subconjunctival stents—Xen and InnFocus.

Perth Eye Hospital PEH recently commenced insertion of the XeN Stent. The Xen stent creates a drainage pathway between the anterior chamber and subconjunctival space. It is inserted via a preloaded injector and may or may not involve the use of mitomycin as a subconjunctival injection. Long-term studies have demonstrated stability over several years. It softens within 1-2 minutes allowing it to conform to the surrounding tissue and reduce the risk of erosion.

Contraindications and complications of Xen stent surgery.

The use the XeN Stent is contraindicated in anyone suffering from the following:

- Angle-closure glaucoma where the drainage angle of the eye has not been surgically opened.
- A glaucoma drainage device has been previously implanted or scarring and pathologies of the conjunctiva are present.
- Eye inflammation – eyelids, conjunctiva, cornea or uvea.
- Abnormal formation of new blood vessels on the iris.
- Artificial lens implanted in the anterior chamber of the eye.
- Silicon is in the eye following previous vitrectomy.

Reported complications of the surgery include:

- Reduction of vision
- Eye pressure drops too low (fluid flow too efficient)
- Eye pressure increases

References

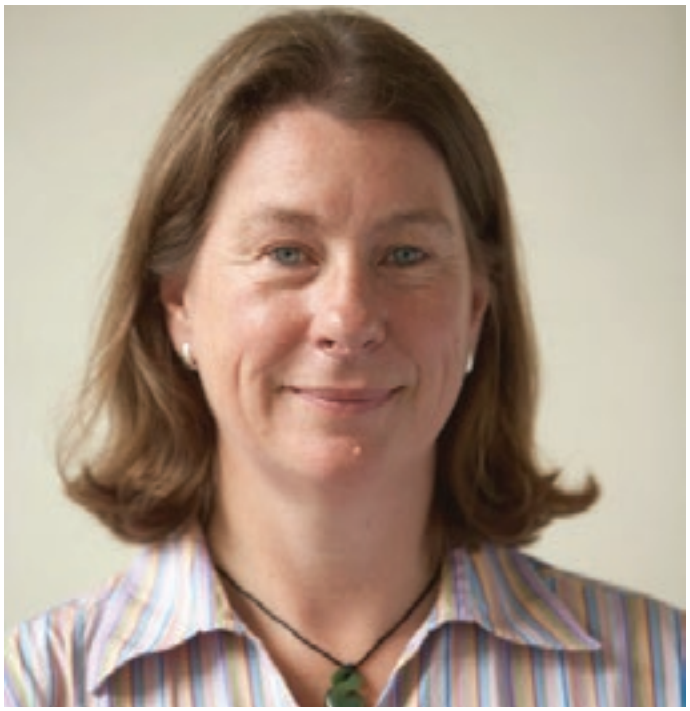
Glaucoma Australia Inc. “Acute Angle Closure Glaucoma Fact Sheet”, https://www.glaucoma.org.au/media/1185/acute-angle-closure-glaucoma-km1701216.pdf, accessed 20.06.18

Manasses, D. & Au, L. 2016. “The New Era of Glaucoma Micro-stent Surgery”, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5125116, accessed: 20.06.18

Medscape.com “Trabeculectomy: Overview, Indications, Contraindications” https://emedicine.medscape.com/article/1844332-overview, accessed: 20.06.18

PROF. JANET MARSDEN

Farewell to our beloved friend and colleague



It is with sadness that the AONANC share with you the passing of our friend and colleague — Professor Janet Marsden.

Janet, from Manchester, visited Australia many times. Her last in 2016 when she provided a workshop to Perth WA members, and headlined the Melbourne VIC conference. Janet brightened up our life, shook us up and propelled us to work together as a national collective in order to advance ophthalmic nursing in our country.

Janet had published widely, and her numerus texts have become a staple to many of us in the sector. She was also heavily involved with the Royal College of Nursing UK – supporting her fellow nurses, and she co-lead the development of the UK's and the world's first Ophthalmic Nursing Competency – Standards Framework. A document that has stood the test of time and has inspired other countries to develop their own.

A keen humanitarian, Janet worked with many NGOs helping develop eye health systems, and supporting ophthalmic nurses as far as Peru, Lesotho and Vietnam – amongst others.

Janet leaves behind husband Dave, a Global Family, and a legacy that teaches us that the way forward is as one.

NINETEEN EIGHTY-EIGHT

AONAQ Celebrates 30th Anniversary

Nineteen eighty-eight was the year of the Australian bicentenary, Bob Hawke was Prime Minister and the Brisbane Broncos played their first game. The long running soap opera Home and Away was launched by the 7 network and A Current Affair began on the 9 network, hosted by Jana Wendt. Queensland hosted World Expo '88 and Queen Elizabeth II opened the new parliament house in Canberra.

In November that year, St Andrew's War Memorial Hospital in Brisbane presented a one-day seminar entitled "Ophthalmic Nursing – Looking Ahead". This seminar was the first time that a group of Queensland nurses interested in ophthalmic nursing had gathered to listen to presentations and exchange ideas. The day was a huge success and sparked the idea of forming our own Association as Sydney had before us.

The mailing list from this seminar was used to notify interested nurses about a meeting to be held on the 10th of February 1989, with the view of forming their own Association. Sixteen registered nurses attended, and with their votes plus sixteen proxy votes the Australian Ophthalmic Nurses Association of Qld was formed. The Executive Committee at the time included President Jenny Streeter, Vice President Eve Wong, Secretary Jenny Nimmo, Treasurer Janelle King, and Committee Members Freda Doran, Shirley Kubach and Sheree Ritchie.

A great deal was achieved in the first six months. Jenny Nimmo moved to Sydney and Freda Doran accepted the position of Secretary. Professor Hirst happily became the Patron. The Constitution of AONA NSW was adopted and a donation of $500 from their Association was gratefully accepted.

This year marks 30 years since then, and our Association has gone from strength to strength. We continue to provide educational and networking opportunities for Queensland and interstate ophthalmic nurses, as well as working to further the advancement of ophthalmic nursing throughout the country. Although like Trump and Oprah we are all a little older, our enthusiasm for advancing ophthalmic nursing is stronger than ever. This year we will hold our 30th Anniversary Conference and celebrate with a cocktail party that evening. We hope many of you can join us!

For further details please visit the AONA Qld website: www.aona.org.au

AONAVIC CLINICAL MEETING

In conjunction with Cranbourne Day Surgery
12th May 2018

The morning air was crisp and the sky cloudless as Cranbourne welcomed AONA members to the Monash Health Community Centre, for this Clinical Meeting. Twenty members were welcomed by AONAVIC Vice-President Robyn Johnston; International Nurses Day was acknowledged in the welcoming address.

The first session of educational content opened with Amy Cowan RN (Diabetes Nurse Educator) who outlined and explained new advances and technologies available in the management of diabetes.

Dr Szczepan Nowakowski (Ophthalmologist) spoke on the aetiology, complications and management of Diabetic Retinopathy.

The next speaker was Sarah Thomas (Orthoptist) who presented issues pertaining to Age Related Macular Degeneration including its progress, management and the importance of a healthy balanced diet.

The final speaker for the first session was Linda Santamaria (Senior Orthoptist) who spoke about her experiences and outlined cases relating to Vision and Ocular Motor Development.

Networking continued during morning tea break, which was delicious, full of carbs and sugar! It was a special morning tea to celebrate International Nurses Day.

The final educational session began with Patrick Lam and Mai Ta Ngoc (Pharmacists) who jointly presented the topic of Topical Medications for Glaucoma – An Update.

Our final speaker for the Clinical Meeting was Michelle Wagner (EEN) who presented a different way of looking, thinking and dealing with the waste we routinely generate in the OR environment. The title of the presentation was War On Waste: Recycling In Theatre.

Questions were asked of all speakers, showing the topics and presentations were greatly appreciated and thought provoking to our audience. Each speaker was presented with a gift of gratitude.

Heather Machin (AONA Vic President and AONA National Chair) outlined current AONA activities and future events.

Robyn thanked Julie Anstis (RN) and Ann Stobo (RN) for hosting this educational opportunity and for making us feel so welcomed to Cranbourne. Julie and Ann were presented with a gift of appreciation.

Networking resumed over lunch, which was delicious and plentiful.

AONAVIC wishes to thank the following Committee members who worked with Julie and Ann in organising this clinical meeting – Kris Spence, Colleen Flanders, Pat Usher, Heather Machin and Robyn Johnston.

AONA NSW

President's Report
Jenny Keller

The 36th Annual NSW Conference on Saturday 23, June — "Eyes all Over" will be held at the Sofitel Hotel in Sydney. Registration closes on June 15. I hope that you and your colleagues have already registered if so, please encourage others to join us.

The annual general meeting will also be held at the conference and at this time unfortunately Joanna McCulloch will be stepping down as the Treasurer and Membership secretary for NSW. Joanna has been a committee member since the 1990's and has been a very strong advocate for ophthalmic nurses during this time. AONA NSW wishes to express our gratitude for the consistent level of dedication she has given over the years and wishes her the best for the future. Joanna is continuing her involvement with the Notre Dame Ophthalmic Nurse Graduate program.

Please refer to the newsletter calendar for the dates of clinical days and EyeTeleC education events, scheduled for the rest of the year.

Our April teleconference, by Dr Con Petsoglou, was about 'Medical Interruptions'. It was interesting to reflect on the impact of interruptions in our clinical work. Record keeping is increasingly completed electronically and it is important to have your own routine of ensuring documentation is relative to the current patient. What happens in your workspace? How important is your interruption to the VMO? Is it about lunch or a clinical priority? By having awareness how our interruptions can change thought processes, "Near Miss" episodes may be reduced.

We attracted over 20 nurses for this teleconference and would like some feedback about this response. Was it the speaker, the topic, the time slot or a combination, that had you joining us on that morning? The main aim of this education opportunity is to provide topics that are of interest to you. Please make your requests via the webpage using the "contact us" icon or on your feedback sheet at the conference.

Lastly a big thank-you, to all the members of the committee who have been assisting me as the President of NSW AONA. It has been an amazing time of great change including a website, national newsletter, the NEON program leading to the Eye Tele-conference sessions, electronic membership renewals, formation of the National Council and the fun of preparing the many confer-ences and clinical days.

AONAQ

President's Report
Pene Gill

Aloha!

Feeling much relaxed after visiting beautiful Hawaii!

Queensland members had the opportunity to visit yet another wonderful practice last Saturday. The second clinical meeting was held at Infinite Vision Ipswich with Dr Jon Farrah giving a presenta-tion – "Red Eye". It was well received with 24 members attending, followed by a tour of the establishment and refreshments. It is fantastic that we are vising so many different Eye clinics and theatres over South East Queensland. Please nominate your work-place if you would like to host a meeting. You just need to provide the venue and speaker, AONAQ will help organise the rest!

AONAQ continues to strive to provide quality education to our members, offer educational grants and many opportunities to network with fellow colleagues. Please utilise these opportunities. Click on the link in the members' area of our website to apply for an educational grant of up to $1000 (T&C's apply).

It's just under 3 months until our big annual event and this year is even more special, being our 30th Annual AONAQ Conference. This year we are back at the Brisbane Convention and Exhibition Centre. The day will be packed with education and networking. Registration is now open on our website. While you're there why not renew your membership, as this is due the end of June and will allow you member's rates for the conference.

We look forward to seeing you in August at the conference.

AONAVIC

President's Report
Heather Machin RN MBA

We have been busy. In the last quarter – AONAVIC participated in reviewing the WHO World Report on Vision (keep an eye out for the final document launch by the WHO around World Site Day – this Report will shape development and our practice); we also pledged to support blindness prevention in Commonwealth Countries – as part of the Queens Jubilee Trust initiative; and I held the International Agency for the Prevention of Blindness's very first nurse led webinar – to support and connect nurses and development agencies globally – and to start to tackle new approaches to Eye Team integration – something that we can expect to see in the WHO Report.

Our move to professionalise our partnerships and relations has resulted in Alcon coming along as our Annual Gold Sponsor and Johnson & Johnson as Bronze. They will both be joining us at our 2018 conference, and you may see both at our clinical meetings across our region.

We are hosting the RANZCO conference this year – in Adelaide. We have confirmed about 90% of our presenters – who join us from the USA, NZ, Fiji, Singapore and from every corner of our country. We also have about 80% nurse led content. The program and the registration pages will be launched in the new financial year – so keep checking the website for details.

We have 6 clinical meeting scheduled this year - with Cranbourne Day Surgery kicking it off on International Nurses Day. This was our first time on the Peninsula, and we were delighted with the outcome. We can certainly see ourselves returning to the region. I make special mention of members Ann Stobo and Julie Anstis for their event hosting (and baking).

As I head of to Barcelona to present at the World Ophthalmology Congress – I would like to remind members that AONAVIC is a volunteer member-based organisation, managed by members for members. If you want to see AONAVIC do more or be more – then please let us know. In the eloquent words of Helen Keller "Alone we can do so little – together we can do so much". Please help - get involved.

AONA WA

President's Report
Gina Storey

This is my final letter as president of AONA WA. I am currently on Long Service Leave and after 12 years on the committee it is time for someone else to develop the association. Our current committee members are doing a great job and we encourage new ideas especially from younger ophthalmic nurses. I have seen changes from snail mail to email and facebook and potentially other social media trends used to connect our members. We are now part of a national group and it has been amazing to see the process of ophthalmic nursing being recognized as a specialty.

We had a fantastic start to the year with our first seminar "IOL Calculations - From Clinic to OR & Beyond" attended by 73 delegates. We had a mix of theory and a practical session. The theory session by Dr Johnathon Lam and Dr Graham Furness discussed the topic of IOL Calculations and the intricacies of achieving best patient outcomes. The practical session gave delegates opportunity to trial equipment used to determine lens selection and to experience this from the patient's perspective. With the support of Company Representatives from Alcon (Bronze sponsors), Zeiss, J&J Vision and Ophthalmic Nurses with experience in diagnostic procedures delegates were free to move between 6 stations to learn about the different techniques used in calculating IOL's.

Our next seminar "A Close Look at Macular Oedema" will be on 16 June. This will be held at a different location, The Boulevard - Floreat Forum, due to unavailability of our usual venue.

Our AGM will also be held on the 16th June 2018 prior to the start of the seminar. I encourage members to consider putting in a nomination for the committee.

By the time you receive this newsletter we expect to have our new website up and running. I hope you will explore the site and be interactive on the Blog to give us feedback.

Bye fr now and hope to see you at our next seminar.

CALENDAR OF EVENTS

4 AUG
Eye Teleconference
Hosted by AONA NSW

25 AUG
AONAQ Conference
Brisbane Convention and Exhibition Centre

1 SEP
Clinical Meeting & AGM
Hosted by AONA VIC

8 SEP
Clinical Day
AMO wetlab, Phaco / IOL loading
Hosted by AONA NSW

13 OCT
Eye Teleconference
Hosted by AONA NSW

18 NOV
AONA VIC Conference
Adelaide Convention Centre

17-21 NOV
RANZCO Adelaide 2018
Adelaide Convention Centre

24 NOV
Clinical Day
Liverpool Surgery Centre
Hosted by AONA NSW

24 NOV
Clinical Meeting
Hosted by AONAQ