

Commissioning Guide:

# Adult Cataract Surgery

Revised January 2018



---

18 Stephenson Way, London, NW1 2HD, T. 02037705322  
[contact@rcophth.ac.uk](mailto:contact@rcophth.ac.uk) @rcophth.ac.uk

The Royal College of Ophthalmologists 2018 All rights reserved.  
For permission to reproduce any of the content contained herein please contact  
[contact@rcophth.ac.uk](mailto:contact@rcophth.ac.uk)

## Contents

---

Section	page
1 Plain language summary	3
2 Commissioning for cataract	3
3 Introduction	4
4 Population to which the care pathway applies	4
5 Cataract	4
7 Clinician Information for cataracts	6
8 Cataract surgery	6
9 Benefits of cataract surgery	6
10 Second eye cataract surgery	7
Immediate Sequential Bilateral Cataract Surgery	7
11 Indications for cataract surgery	7
12 Recommended high-quality cataract care pathway	8
13 Training and CPD	9
14 Quality dashboard for cataract surgery	10
14.1 Patient reported outcome measures (PROMs).	11
15 New devices and techniques in cataract surgery	11
15.1 Intraocular lens (IOL) types:	11
15.1.1 <i>Toric intraocular lens</i>	12
15.1.2 <i>Multifocal intraocular lens</i>	12
15.1.3 <i>Blue light filtering intraocular lenses</i>	12
15.2 Laser assisted cataract surgery	12
16 Recommendations for further research and guidance development	12
17 Guideline Development Group	13
17.1 Funding statement:	14
17.2 Conflict of Interest Statement	15
18 References	16
19 Appendix A: Scope of the original Commissioning Guidelines	18
20 Appendix B: Recommended high quality cataract care pathway	19
21 Appendix C: Original Search Questions and Search Strategies	21
22 Appendix D: Original Search record	22
23 Appendix E: Original Evidence Base	23
24 Appendix F: Glossary	24

Date of review: October 2020

## 1 Plain language summary

---

- The presence of cataract causes disability and increases the likelihood that individuals will suffer adverse events such as falls.
- Cataract surgery is the only effective intervention to treat cataracts and is cost effective.
- Access to cataract surgery should not be restricted on the basis of visual acuity. 5
- Further research is required to validate additional measures of visual disability due to cataract and Patient Reported Outcome Measures of cataract surgery.
- A typical cataract surgery care pathway is described in the document but this must be personalised to the patient and adaptable for patients with specific needs.
- The risk of a poor outcome from cataract surgery is generally low but can be increased substantially by a range of systemic and ocular risk factors, many of which can be mitigated by careful preoperative planning and risk stratification by the cataract surgical team.
- Outcome measures of cataract surgery including visual acuity, accuracy of refractive correction, occurrence of significant operative and postoperative complications should be recorded routinely and the data should be available to care providers and commissioners. Information required for the UK minimum cataract dataset should be routinely collected and submitted to the [National Ophthalmology Database Audit](#).
- Commissioning of cataract care should encompass the whole cataract care pathway from initial assessment and treatment planning to final postoperative review.

## 2 Commissioning for cataract

---

In seeking to commission high quality cataract surgery services, it is recommended that commissioners work in partnership with a range of stakeholders, including the Hospital Eye Service, community optometry services, general practice, social care, adjacent clinical commissioning groups, health and wellbeing boards, service users and carers.

Commissioning Guidance aims to improve the health and wellbeing of people and communities, and support local service redesign to ensure the provision of high quality, cost-effective services that meet the needs of the local population and take into account patient experience.

High value care pathways provide patients and the public, health and social care professionals, commissioners and service providers with a clear description of what constitutes a high-quality service. Organisations can use the guidance to assess their current performance against evidence-based measures of best practice, and identify priorities for improvement. Audit and peer review measures support the implementation of the recommendations through commissioning and the contracting process. Commissioning Guidance gives examples of measures that can be used in the service specification and how commissioners can incentivise provider performance by using the indicators in association with incentive payments such as Commissioning for Quality and Innovation (CQUIN).

Implementation of the guidance is the responsibility of local commissioners and/or providers, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of access. Nothing in the guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

We are keen to improve Commissioning Guidance for cataract care in order to better meet the needs of commissioners. Please send us your comments and ideas for future revisions.

Email: [beth.barnes@rcophth.ac.uk](mailto:beth.barnes@rcophth.ac.uk)

The Royal College of Ophthalmologists [www.rcophth.ac.uk](http://www.rcophth.ac.uk)

### 3 Introduction

---

This document was originally written in response to emerging evidence of wide geographical variation in access to cataract surgery in England.<sup>1-3</sup> One report found that half of Commissioners restricted access to cataract surgery by the application of clinical thresholds and one in three made no allowance for second eye surgery.<sup>1</sup> Overall 9 in every 10 cataract surgery commissioning policies contained criteria that followed “neither national guidance nor scientific evidence.” Additionally, there is almost a threefold variation in the number of people having cataract surgery across England, with rates ranging from 285 to 804 per 100,000 population,<sup>4</sup> which cannot be fully explained by variations in known risk factors for the development of cataract.

Acknowledging the variation in commissioning policy for cataract surgery across England, The National Institute of Health and Care Excellence (NICE) has published ‘Cataracts in adults: management’<sup>5</sup>. Following detailed health economic modelling, a key recommendation of this guideline is that arbitrary thresholds of visual acuity should not be used to restrict access to cataract surgery<sup>5</sup>.

The Royal College of Ophthalmologists has also published guidelines on the management of cataract<sup>6</sup>, which include recommendations on the standards that Commissioners should expect from any provider of cataract surgery. This current document aims to provide evidence-based guidance to support the commissioning of high quality cataract services and to promote equity of access to the treatment of visual impairment caused by cataract.

### 4 Population to which the care pathway applies

---

This Commissioning Guidance applies to adults (persons >18 years old) with cataract in England. It does not apply to cataract surgery in children or surgery where the primary aim is correction of refractive error. See Appendix A for further details.

### 5 Cataract

---

Cataract is the presence of visually impairing opacity in the eye’s natural lens, which may occur in one or both eyes. Cataract is the leading cause of blindness in the world.<sup>7</sup> Cataract surgery, whereby the natural lens is replaced by a clear intraocular lens implant, is currently the only effective treatment for cataract. Phacoemulsification (removal of the cataractous

lens using ultrasound) is the standard surgical technique and is used in over 99.7% cataract operations in the NHS.<sup>8</sup>

Symptoms include blurred vision, glare (particularly in bright daylight or night time vision) and refractive change resulting in more frequent updates in spectacle prescription. Risk factors for cataract include increasing age, diabetes mellitus, corticosteroid use, female gender, socio-economic status, ethnicity, smoking and alcohol.<sup>6,9</sup>

Cataracts may be classified into several types based on appearance. These include nuclear, cortical, posterior subcapsular and mixed. Nuclear cataracts result in progressive opacification of the central lens, typically causing impaired distance vision. Cortical and posterior subcapsular cataracts typically cause disabling glare, even before visual acuity is markedly impaired and can progress rapidly.

## 6 Patient Information for cataracts

Patients should be given accessible information in the format they require such as email, large print or audio (compliant with the NHS Accessible Information Standard <https://www.england.nhs.uk/ourwork/accessibleinfo/>).

Table 1 Links to patient information and shared decision-making tools

Name	Publisher	Link
Cataracts in adults: management	NICE	<a href="https://www.nice.org.uk/guidance/ng77/chapter/Recommendations#patient-information">https://www.nice.org.uk/guidance/ng77/chapter/Recommendations#patient-information</a>
Understanding Cataracts	The Royal College of Ophthalmologists and the Royal National Institute of Blind People	<a href="https://www.rcophth.ac.uk/patients/information-booklets/">https://www.rcophth.ac.uk/patients/information-booklets/</a>
Cataract Surgery	NHS Choices	available on NICE Evidence Search <a href="https://www.evidence.nhs.uk/">https://www.evidence.nhs.uk/</a>
Cataracts	College of Optometrists	<a href="http://lookafteryoureyes.org/eye-conditions/cataracts">lookafteryoureyes.org/eye-conditions/cataracts</a>
Shared decision aid for cataracts	NHS RightCare	<a href="http://sdm.rightcare.nhs.uk/pda/cataracts">sdm.rightcare.nhs.uk/pda/cataracts</a>
Guidance for those with learning disability	Seeability	What is a cataract? (Easy Read) <a href="https://www.seeability.org/looking-after-your-eyes">https://www.seeability.org/looking-after-your-eyes</a> Having a cataract operation (Easy Read) <a href="https://www.seeability.org/Handlers/Download.ashx?IDMF=0bf6145d-74fd-4ead-9845-f0bbd32f2692">https://www.seeability.org/Handlers/Download.ashx?IDMF=0bf6145d-74fd-4ead-9845-f0bbd32f2692</a>

## 7 Clinician Information for cataracts

---

Table 2 Links to clinical guidelines, decision support tools

Name	Publisher	Link
Cataract Surgery Guidelines	The Royal College of Ophthalmologists	<a href="https://www.rcophth.ac.uk/standards-publications-research/clinical-guidelines/">https://www.rcophth.ac.uk/standards-publications-research/clinical-guidelines/</a>
Cataract Surgery	The Royal College of Surgeons	<a href="http://www.rcseng.ac.uk/patients/recovering-from-surgery/ataract-surgery">www.rcseng.ac.uk/patients/recovering-from-surgery/ataract-surgery</a>
Shared decision aid for cataracts	NHS RightCare	<a href="http://sdm.rightcare.nhs.uk/pda/ataracts/">sdm.rightcare.nhs.uk/pda/ataracts/</a>
Pre- and Post-Operative Cataract pathway	Local Optical Committee Support Unit	<a href="http://www.locsu.co.uk/enhanced-services-pathways/ataract-referral-and-post-op/">www.locsu.co.uk/enhanced-services-pathways/ataract-referral-and-post-op/</a>
Cataracts In adults: Management	National Institute of Health and Care Excellence	<a href="https://www.nice.org.uk/guidance/ng77">https://www.nice.org.uk/guidance/ng77</a>

## 8 Cataract surgery

---

Cataract surgery is currently the only effective treatment to improve or maintain vision. It is the most commonly performed elective surgical procedure in the UK with around 400,000 cataract operations performed per year in England in recent years.<sup>5</sup> The requirement for cataract surgery is anticipated to increase with increasing life expectancy and associated population numbers.<sup>11</sup>

There are no recent estimates of expected cataract surgery rates based on need. However, The Way Forward Cataract Report<sup>53</sup> provided a crude estimate of demand, average expected rates of adult cataract surgery should be approximately 7.30 per 1,000 population and anticipated ‘...that the number of cataract operations we are expected to deliver to increase by 50% from 2015 to 2023’ (reference)

Historical data from the North London Eye Study in 1998 estimated that 30% of people 65 years or older had visually impairing cataract in one or both eyes.<sup>14</sup> An additional 10% of people in this age group had already had cataract surgery. Some populations have a much higher prevalence of cataract. For instance, 77% of British people originating from the Indian Subcontinent age 42 years old or more have cataract.<sup>8</sup> Diabetes is a risk factor for the development of cataract and cataract is the most common reason for failure to obtain a gradable photographic image for diabetic retinopathy screening.<sup>15</sup>

## 9 Benefits of cataract surgery

---

Cataract surgery improves visual function and the benefits are lifelong unless negated by other eye disease.

---

Cataract surgery is associated with improvements in quality of life, visual acuity, contrast sensitivity, depth perception, activity, anxiety, depression, visual disability, confidence, disability and reduction in falls.<sup>5, 17-19</sup>

Health economic modelling has shown cataract surgery is highly cost effective <sup>5, 20-23</sup>. **It is not cost effective to delay cataract surgery in people with symptomatic cataracts until a visual acuity threshold is met.** <sup>5</sup>

## 10 Second eye cataract surgery

---

Approximately 40% patients undergo cataract surgery on both eyes.<sup>8.10</sup> A recent systematic review<sup>24</sup> funded by the National Institute for Health Research concluded that second eye cataract surgery was associated with a clinically meaningful improvement in stereopsis (depth perception).

A detailed analysis of patients who were unhappy with their vision after their first cataract operation found that anisometropia and cataract in the fellow eye accounted for more than a third of such cases.<sup>25</sup>

NICE has concluded second eye cataract surgery is highly cost effective and should be offered using the same criteria as for first eye surgery.<sup>5</sup>

### Immediate Sequential Bilateral Cataract Surgery

If a patient has cataract in both eyes, surgery on both eyes may be performed at the same admission (immediate sequential bilateral cataract surgery ISBCS) or over two admissions. A RCT comparing both techniques found surgical outcomes and patient satisfaction were similar in both groups and cost analysis suggested significant savings for cases that underwent surgery at the same sitting after accounting for travel and paid home-care costs.<sup>52</sup>

Currently, ISBCS is not commonly performed<sup>5</sup>, but, having reviewed evidence for the Adult Cataracts Guideline, NICE has recommended that ISBCS should be considered for people who are at low risk of operative and postoperative complications.<sup>5</sup> However, it is important that the potential benefits and harms of ISBCS are fully discussed with patients and their carers pre-operatively. These include potential immediate visual improvement in both eyes but that there would not be the option for IOL power selection for the second eye based on the outcome of the first. Albeit extremely rare, there is also the risk of a complication in both eyes associated with the same theatre sitting.

## 11 Indications for cataract surgery

---

Access to cataract surgery should not be restricted on the basis of visual acuity.<sup>5</sup>

Visual acuity is the most common measurement of visual function as it can be quickly and easily measured. However, the use of visual acuity in isolation can underestimate visual disability because it does not take account of symptoms such as glare or reduced contrast sensitivity.

Significant improvements in visual symptoms and visual function may occur following cataract surgery even where the preoperative visual acuity is 6/6 or better. However, the

risk of worse visual acuity after surgery also increases where the preoperative visual acuity is very good<sup>8,19,31</sup>, so surgery should be considered at this level of visual acuity only where the patient is experiencing significant symptoms attributable to cataract.

The Royal College of Ophthalmologists' National Ophthalmology Database (NOD) shows that, for the period 2006-2010, 3%, 5% and 36% of eyes undergoing cataract surgery have preoperative visual acuities of better than or equal to 0.00, 0.18 and 0.30 logMAR respectively (equivalent to 6/6, 6/9 and 6/12 Snellen)<sup>9</sup> indicating that before restrictions on access to cataract surgery based on visual acuity were commonplace, eyes with visual acuities of 6/9 or better accounted for less than 10% of cataract surgery.

Although visual acuity remains a useful component of the assessment of visual disability from cataract, cataract surgery should be considered in the first eye or second eye of a patient who has disabling visual symptoms attributable to cataract. For instance, a patient who experiences disabling glare due to cataract when driving may still achieve a visual acuity of better than 6/9 under ideal conditions of illumination. This recommendation is consistent with advice from The Royal College of Ophthalmologists,<sup>32</sup> and where implemented in local commissioning guidance has been found to be practical and equitable.<sup>33</sup>

In patients with learning disability or cognitive impairment for other reasons, it may not be possible to measure visual acuity accurately and in these cases, clinicians will need to base the clinical decision to offer cataract surgery on clinical examination findings and information provided by carers.

- On occasions, cataract surgery may be performed primarily to aid the management of other eye conditions, for instance to facilitate surveillance or treatment of diabetic retinopathy<sup>5</sup> or angle closure glaucoma<sup>6</sup> or occupational legal requirements e.g. group 1 and/or group 2 driving licence holders <https://www.gov.uk/driving-eyesight-rules>. Commissioners should ensure commissioning policies are equitable and do not promote health inequalities. Commissioners have a legal duty to seek to reduce inequalities between patients in access to health services and the outcomes achieved<sup>59</sup>.

There has been considerable interest in the measurement of visual disability as a basis for a decision to offer cataract surgery. Estimates of visual disability include the effects of cataract on lifestyle and activities of daily living, history of falls, caring responsibilities and need to continue driving or working. A number of tools for estimating visual disability caused by cataract have been published, <sup>34-39</sup> however, none have yet been validated for use in UK populations. Further research is needed before they can be recommended for routine use, including cost effectiveness; particularly in community optometric practice prior to referral, where the majority of such assessments will take place.

## 12 Recommended high-quality cataract care pathway

---

A high-quality cataract care pathway should provide equity of access based on individual need, and it is therefore important that commissioning of cataract care embraces the whole care pathway. An exemplar care pathway for cataract surgery published by the NHS Institute for Innovation and Improvement is summarised in Appendix B.<sup>40</sup>

The cataract pathway starts with an assessment where a patient with disabling visual symptoms is confirmed to have a cataract, which accounts for those symptoms and where

---



the patient indicates their willingness to have cataract surgery following an explanation of the risks and benefits. Most referrals for consideration for cataract surgery are made following assessment by a community optometrist, although a significant minority of patients listed for cataract surgery are already under the care of the hospital eye service for other conditions such as glaucoma, and are listed directly. The postoperative phase of the cataract pathway includes a clinical examination to check for, or treat, any postoperative complications, assess visual outcome and refractive status and ascertain the patient's satisfaction. In many cataract services, community optometrists are commissioned to deliver much of the preoperative and postoperative phases of the cataract pathway, though commissioning arrangements may vary depending on geographical factors and the needs of the local population.

The cataract pathway should also cater for the needs of a small percentage of patients whose care needs to be individualised to secure the best achievable outcome of surgery, to reduce the risk of complications, or to make the experience of surgery tolerable. This includes accounting for the needs of those without social support at home, those with disabilities or reduced mental capacity, including any that may also impair optimal post-operative care, and those whose first language is not English. Eye Clinic Liaison Officers (ECLOs) can also offer valuable advice and support to patients in these groups.

Up to 10% of patients require general anaesthesia or intravenous sedation to undergo cataract surgery, administered by a trained ophthalmic anaesthetist [5](#), [8](#), [10](#), [54](#). Some may require formal preoperative assessment because of the existence of systemic co-morbidities.

The risk of operative complications and a poor visual outcome can vary by 10-fold or more depending on the presence of a range of common ocular and systemic risk factors.<sup>41</sup> Although many aspects of preoperative assessment for cataract surgery can be delegated, it is very important that the final decision to operate and individualised planning of care is undertaken in advance of the patient's admission by an appropriately qualified and skilled member of the cataract surgical team responsible for the patient's operative care<sup>6</sup>.

Although cataract care pathways are often delivered in units that offer a wider range of ophthalmology services, including out-of-hours emergency cover, this is not always the case. Emergency situations fortunately rarely arise during the cataract pathway, but a high-quality cataract pathway must have clear, documented and agreed contingency arrangements for such situations<sup>55</sup>. Good communication and clear hand-over of care is essential where the cataract pathway is shared between secondary care and primary care providers.

## 13 Training and CPD

---

Staff delivering care across the whole pathway should be able to provide evidence of appropriate training, competencies and Continuing Professional Development/Continuing Education and Training relevant to their roles.

A crucial component of a sustainable high-quality cataract care pathway is its ability to support high-quality training and continuing professional development for cataract surgeons and all allied professionals who contribute to the cataract pathway.

## 14 Quality dashboard for cataract surgery

---

Providers of cataract care and surgeons should be familiar with their performance and be able to supply commissioners with accurate, complete and up-to-date outcome data.

Participation in the [National Cataract Audit](#) is a mandatory component of the National Standard Contract and for all providers of NHS funded cataract surgery there should be processes in place to ensure that the postoperative section of the UK Minimum Cataract Dataset is collected and submitted to the [National Ophthalmology Database Audit](#) (NOD).

In addition, where most or all the cataract pathway takes place in a primary care setting, there should be a mechanism for feedback of visual and refractive outcome data and patient satisfaction to the surgical team. The benchmark data in Table 3 are derived from large case series and summarise the mean and distribution of significant complications of cataract surgery, visual and refractive outcomes.

These outcomes are influenced by case-mix, and a service that operates on a high proportion of patients with multiple ocular or systemic co-morbidities is likely to have a higher incidence of complications such as posterior capsular rupture than a unit that operates selectively on uncomplicated patients.

Providers and surgeons should use audit tools to continuously monitor quality, tracking outcomes and adverse events in real time. Early detection of a rising adverse event rate can be identified, analysed and appropriate remedial action instituted, potentially reducing the risk of patients to harm through avoidable complications.

*Table 3 Mean Complication rates and outcomes from large UK data series.*

Parameter	National mean or value from large case series; Add 95% CI
Overall mean rate of posterior capsule tear and/or vitreous loss.	1.9 to 2.0%(8,10)
Rate of endophthalmitis.	Less than 1 in 1000 - where intra-cameral cefuroxime is used routinely (42)
Proportion achieving 6/12 or better best measured (no pre-existing ocular co-pathology).	95%(8,10)
Proportion achieving 6/12 or better best measured (with pre-existing ocular co-pathology).	80%(8,10)
Proportion achieving 6/6 best measured (no pre-existing ocular co-pathology).	51%(8,10)
Proportion achieving 6/6 best measured (with pre-existing ocular co-pathology).	30 to 33%(8,10)

*Posterior capsule tear rates will vary with the proportion of patients with ocular co-morbidity. Best measured was defined as the better visual acuity of uncorrected distance visual acuity (UDVA, without glasses or contact lens) or corrected distance visual acuity (CDVA, with glasses or contact lens, with pinhole visual acuity considered if CDVA not available), measured in clinic at between 3 weeks and 3 months after surgery.*

Posterior capsule tear and/ or vitreous loss is a serious intraoperative complication due to its association with delayed visual recovery, need for further surgery, long-term visual dissatisfaction and elevated risk of additional complications such as retinal detachment.

Data from the Cataract National Dataset in the UK of 55,567 cases showed older age, small eyes, ocular co-morbidity, poor pupil dilation and posterior capsule rupture (PCR) to be independent predictors of loss of vision following cataract surgery (defined as doubling of the pre- to post-operative visual angle).<sup>41</sup> The rate of PCR was the only modifiable risk factor for vision loss<sup>41</sup> and higher PCR rates are associated with increasing age, male sex, diabetic retinopathy, glaucoma, longer axial length, advanced cataract and trainee surgeons.

A small proportion of patients develop visually-impairing opacification of the posterior capsule of the lens following cataract surgery requiring YAG laser capsulotomy (OPCS code C7340) to restore the quality of vision. Typically, this occurs from a few months to a few years following surgery.

#### **14.1 Patient reported outcome measures (PROMs).**

Numerous cataract PROMs, with varying performance,<sup>45</sup> have been proposed. There currently exists no single instrument which has been widely adopted internationally. Until recently the most promising candidate instrument has been the Swedish 9 item Catquest-9SF<sup>43,44</sup>, the English translation of which having been validated in an Australian population. Recent NIHR funded UK based research<sup>46</sup> has produced a brief, validated, highly responsive 5 item questionnaire, Cat-PROM5, with psychometric performance as good or better than Catquest-9S<sup>58</sup>. Cat-PROM5 has been selected as the cataract PROM of choice to be piloted for implementation in the NHS as part of the HQIP commissioned NOD Cataract Audit. Inclusion of a PROM increases the patient focus in cataract services and has the potential to align cataract surgery with other surgical disciplines in which PROMs compliment clinical outcomes (e.g. hip and knee surgery).

## **15 New devices and techniques in cataract surgery**

---

The standard cataract surgical procedure commissioned by the NHS is phacoemulsification with implantation of a monofocal intraocular lens. The cataract pathway and outcome measures described in this document relate to the use of monofocal intraocular lenses. Some providers may offer variants to the standard procedure although this does not attract additional funding unless agreed on an individual patient basis with the commissioning organisation.

#### **15.1 Intraocular lens (IOL) types:**

Monofocal IOLs are the current standard IOL design used for cataract surgery in the NHS. These have a single focal point and, where the intended refractive outcome is one of good

unaided distance visual acuity, patients usually require glasses for reading. Alternative types of IOLs are available at additional cost (so called “premium lens”), and include toric (to correct astigmatism) and multifocal (which aim to give good distance and near vision without glasses).

#### **15.1.1 Toric intraocular lens**

Toric intraocular lenses are effective at reducing postoperative astigmatism and can result in increased unaided distance visual acuity.<sup>46</sup> However, evidence of their cost effectiveness is less conclusive and other interventions such as limbal relaxing incisions are available.<sup>5</sup>

#### **15.1.2 Multifocal intraocular lens**

Multifocal intraocular lenses are designed to provide good near and distance vision and to minimise the need for reading glasses. They can be associated with adverse symptoms, have a significant cost premium and are not recommended by NICE.<sup>5</sup>

#### **15.1.3 Blue light filtering intraocular lenses**

Blue light filtering intraocular lenses have been hypothesised to reduce the incidence or progression of AMD in people after cataract surgery. To date, NICE review has concluded that there is a lack of evidence of their efficacy. <sup>5</sup>

### **15.2 Laser assisted cataract surgery**

Lasers can automate some of the steps of cataract surgery with potentially greater precision and consistency than can be achieved by a surgeon. NICE recommends ‘Only use femtosecond laser-assisted cataract surgery as part of a randomised controlled trial that includes collection of resource-use data, comparing femtosecond laser-assisted cataract surgery with ultrasound phacoemulsification’ <sup>5</sup>

## **16 Recommendations for further research and guidance development**

---

- Further research on the prevalence of visually disabling cataract and the causes of variation in rates of cataract surgery.
- The guidance development group support NICE research recommendations, specifically 1-3 in relation to commissioning<sup>5</sup>

## 17 Guideline Development Group

A commissioning guidance development group was established to develop the content of the commissioning guide. This group met three times, with additional interaction taking place via email.

Name	Designation
Mr Richard Smith - <i>Chair</i>	Consultant Ophthalmologist, Buckinghamshire Healthcare NHS Trust
Dr Kamal Bishai	GP and Primary Care Ophthalmologist
Ms Sophie Coronini-Cronberg	Department of Primary Care and Public Health, Faculty of Medicine, Imperial College, London, Locum Consultant in Public Health with Chelsea & Westminster Foundation Trust Hospital
Dr Nicholas Cook	GP, Central Surgery Eye Clinic, Rugby
Dr Alex Day	NIHR Academic Clinical Lecturer and Ophthalmologist, UCL Institute of Ophthalmology and Moorfields Eye Hospital
Ms Deborah Dow	Chief Executive, Bucks Vision
Ms Clara Eaglen	Royal National Institute for Blind People
Ms Veronica Fergusson	Consultant Ophthalmologist, Imperial College Healthcare NHS Trust
Ms Anne Gilvarry	Consultant Ophthalmologist, Royal Surrey County Hospital NHS Foundation Trust
Mr Mohit Gupta	Consultant Ophthalmologist, United Lincolnshire Hospitals NHS Trust
Ms Rea Mattocks	Lay Representative
Dr Gillian Rudduck	College of Optometrists
Ms Mary Shaw	Senior Lecturer, The University of Manchester and Chair of the Royal College of Nursing Ophthalmic Nursing Forum
Professor John Sparrow	Consultant Ophthalmologist, University Hospitals Bristol NHS Foundation Trust
Mr Nicholas Wilson-Holt	Consultant Ophthalmologist, Royal Cornwall Hospital NHS Trust
Mr Richard Wormald	Consultant Ophthalmologist, Coordinating Editor of the Cochrane Eyes and Vision Group
Ms Katrina Venerus	Local Optical Committee Support Unit

The guidance has been reviewed in October 2017 following publication of the NICE cataract surgery guidelines, by the guidance development group chaired by Mr Nicholas Wilson-Holt.

Name	Designation
Mr Nicholas Wilson-Holt	Consultant Ophthalmologist, Royal Cornwall Hospital NHS Trust
Dr Kamal Bishai	GP and Primary Care Ophthalmologist
Ms Sophie Coronini-Cronberg	Consultant in Public Health; Hon. Research Fellow, Department of Primary Care and Public Health, Faculty of Medicine, Imperial College, London
Dr Nicholas Cook	GP, Central Surgery Eye Clinic, Rugby
Dr Alex Day	NIHR Academic Clinical Lecturer and Ophthalmologist, UCL Institute of Ophthalmology and Moorfields Eye Hospital
Mrs Melanie Hingorani	Consultant Ophthalmologist, Moorfields Eye Hospital NHS Foundation Trust and Chair of the Royal College of Ophthalmologists' Professional Standards Committee
Ms Helen Lee	Royal National Institute for Blind People
Ms Veronica Fergusson	Consultant Ophthalmologist, Imperial College Healthcare NHS Trust
Ms Anne Gilvarry	Consultant Ophthalmologist, Royal Surrey County Hospital NHS Foundation Trust
Mr Mohit Gupta	Consultant Ophthalmologist, United Lincolnshire Hospitals NHS Trust
Ms Rea Mattocks	Lay Representative
Dr Gillian Rudduck	College of Optometrists
Ms Mary Shaw	Senior Lecturer, The University of Manchester and Chair of the Royal College of Nursing Ophthalmic Nursing Forum
Professor John Sparrow	Consultant Ophthalmologist, University Hospitals Bristol NHS Foundation Trust
Mr Richard Wormald	Consultant Ophthalmologist, Coordinating Editor of the Cochrane Eyes and Vision Group
Ms Katrina Venerus	Local Optical Committee Support Unit

### 17.1 Funding statement:

The review of this commissioning guidance has been funded by the following sources:

- The Royal College of Ophthalmologists

## 17.2 Conflict of Interest Statement

Individuals involved in the development and formal peer review of commissioning guidance are asked to complete a conflict of interest declaration. It is noted that declaring a conflict of interest does not imply that the individual has been influenced by his or her interest. It is intended to ensure interests (financial or otherwise) are transparent and to allow others to have knowledge of the interest.

The following interests have been declared by the Group:

- The Royal National Institute of Blind People receives money from pharmaceutical companies in the form of educational grants. In recent years we have been supported by Novartis, Allergan, Alcon and Bayer for initiatives such as the provision of Eye Clinic Liaison Officers in eye clinics. The funding is declared in RNIB's annual report and each year the support given by pharmaceutical companies represents less than 0.14% of our overall funding.
- Professor John Sparrow has a research interest in Cat-PROM5

## 18 References

---

1. Coronini-Cronberg S, Lee H, Darzi A, Smith P. Evaluation of clinical threshold policies for cataract surgery among English commissioners. *J Health Serv Res Policy*. 2012 Oct;17(4):241–7.
2. Royal National Institute of Blind People. Surgery deferred. Sight denied. Variation in cataract surgery provision across England. 2013 Jul;
3. Coronini-Cronberg S., Bixby H, Lavery AA, Watcher RM, Millett C. English National Health Service's Savings Plan May Help Reduce The Use of Three "Low-Value" Procedures. *Health Aff Proj Hope*. 2015 Mar 1;34(3):381-9.
4. The NHS Atlas of Variation 2010. Map 12. [Internet]. 2011 [cited 2013 Jun 1]. Available from: [http://www.rightcare.nhs.uk/atlas/qipp\\_nhsAtlas-LOW\\_261110c.pdf](http://www.rightcare.nhs.uk/atlas/qipp_nhsAtlas-LOW_261110c.pdf)
5. National Institute for Health and Care Excellence, Cataracts in adults: management NICE Guideline [NG77], October 2017 <https://www.nice.org.uk/guidance/ng77>
6. The Royal College of Ophthalmologists. Cataract Surgery Guidelines 2010 [Internet]. 2010 [cited 2013 Oct 17]. Available from: <https://www.rcophth.ac.uk/standards-publications-research/clinical-guidelines/>
7. Bourne RRA, Stevens GA, White RA, Smith JL, Flaxman SR, Price H, et al. Causes of vision loss worldwide, 1990–2010: a systematic analysis. *Lancet Glob Health*. 2013 Dec;1(6):e339–e349.
8. Jaycock P, Johnston RL, Taylor H, Adams M, Tole DM, Galloway P, et al. The Cataract National Dataset electronic multi-centre audit of 55 567 operations: updating benchmark standards of care in the United Kingdom and internationally. *Eye*. 2007;23(1):38–49.
9. Rauf A, Malik R, Bunce C, Wormald R. The British Asian community eye study: outline of results on the prevalence of eye disease in British Asians with origins from the Indian subcontinent. *Indian J Ophthalmol*. 2013 Feb;61(2):53–8.
10. Day A, Donachie PHJ, Sparrow JM, Johnston RL. The Royal College of Ophthalmologists' National Ophthalmology Database Study of Cataract Surgery: Report 1, Visual Outcomes and Complications. *Eye*. Accepted, pending publication.
11. Minassian DC, Reidy A. Future Sight Loss UK (2): An epidemiologic and economic model for sight loss in the decade 2010-20. [Internet]. [cited 2014 Jan 6]. Available from: [http://www.rnib.org.uk/sites/default/files/FSUK\\_2.pdf](http://www.rnib.org.uk/sites/default/files/FSUK_2.pdf)
12. Health & Social Care Information Centre. Hospital Episode Statistics [Internet]. [cited 2014 Feb 22]. Available from: <http://www.hscic.gov.uk/hes>
13. Office for National Statistics. 2011 Census, Population and Household Estimates for the United Kingdom [Internet]. 2010 [cited 2013 Nov 20]. Available from: <http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-270247>
14. Reidy A, Minassian DC, Vafidis G, Joseph J, Farrow S, Wu J, et al. Prevalence of serious eye disease and visual impairment in a north London population: population based, cross sectional study. *BMJ*. 1998 May 30;316(7145):1643–6.
15. Scanlon PH, Foy C, Malhotra R, Aldington SJ. The Influence of Age, Duration of Diabetes, Cataract, and Pupil Size on Image Quality in Digital Photographic Retinal Screening. *Diabetes Care*. 2005 Oct 1;28(10):2448–53.
16. Cohen S. NHS Diabetic Eye Screening Programme Quality Assurance Standards [Internet]. 2012 [cited 2014 Jan 6]. Available from: <http://diabeticseye.screening.nhs.uk/standards>
17. Gillespie LD, Robertson MC, Gillespie WJ, Sherrington C, Gates S, Clemson LM, et al. Interventions for preventing falls in older people living in the community. *Cochrane Database Syst Rev*. 2012;9:CD007146.
18. Sach TH, Foss AJE, Gregson RM, Zaman A, Osborn F, Masud T, et al. Falls and health status in elderly women following first eye cataract surgery: an economic evaluation conducted alongside a randomised controlled trial. *Br J Ophthalmol*. 2007 Dec;91(12):1675–9.
19. Hodge W, Horsley T, Albiani D, Baryla J, Belliveau M, Buhmann R, et al. The consequences of waiting for cataract surgery: a systematic review. *CMAJ Can Med Assoc J J Assoc Medicale Can*. 2007 Apr 24;176(9):1285–90.
20. Busbee BG, Brown MM, Brown GC, Sharma S. Cost-utility analysis of cataract surgery in the second eye. *Ophthalmology*. 2003 Dec;110(12):2310–7.
21. Hiratsuka Y, Yamada M, Murakami A, Okada AA, Yamashita H, Ohashi Y, et al. Cost-effectiveness of cataract surgery in Japan. *Jpn J Ophthalmol*. 2011 Jul;55(4):333–42.
22. Lansingh VC, Carter MJ, Martens M. Global cost-effectiveness of cataract surgery. *Ophthalmology*. 2007 Sep;114(9):1670–8.
23. Lansingh VC, Carter MJ. Use of Global Visual Acuity Data in a time trade-off approach to calculate the cost utility of cataract surgery. *Arch Ophthalmol*. 2009 Sep;127(9):1183–93.
24. Frampton G, Harris P, Cooper K, Lotery A, Shepherd J. The clinical effectiveness and cost-effectiveness of second-eye cataract surgery: a systematic review and economic evaluation. *Health Technol Assess [Internet]*. 2014 Nov 18;18(68). Available from: <http://journalslibrary.nihr.ac.uk/hta/hta18680>
25. Healthcare Improvement Scotland. Is it clinically and cost effective to perform second-eye cataract surgery in the absence of other ocular co-morbidities in patients who have already had the first-eye surgery? [Internet]. 2012 [cited



2014 Feb 22]. Available from:

[http://www.healthcareimprovementscotland.org/our\\_work/technologies\\_and\\_medicines/earlier\\_advice\\_statements/advice\\_statement\\_008-12.aspx](http://www.healthcareimprovementscotland.org/our_work/technologies_and_medicines/earlier_advice_statements/advice_statement_008-12.aspx)

26. Lundström M, Bregé KG, Florén I, Stenevi U, Thorburn W. Impaired visual function after cataract surgery assessed using the Catquest questionnaire. *J Cataract Refract Surg*. 2000 Jan;26(1):101–8.
27. Drasdo N, Haggerty CM. A comparison of the British number plate and Snellen vision tests for car drivers. *Ophthalmic Physiol Opt J Br Coll Ophthalmic Opt Optom*. 1981;1(1):39–54.
28. GOV.UK. Driving eyesight rules [Internet]. [cited 2014 Feb 14]. Available from: <https://www.gov.uk/driving-eyesight-rules>
29. Minassian D, Reidy A, Desai P, Farrow S, Vafidis G, Minassian A. The deficit in cataract surgery in England and Wales and the escalating problem of visual impairment: epidemiological modelling of the population dynamics of cataract. *Br J Ophthalmol*. 2000 Jan;84(1):4–8.
30. Desai P. Cataract surgery: one or both eyes? *Br J Ophthalmol*. 2012 Jun 13;bjophthalmol–2012–301733.
31. Lundström M, Barry P, Henry Y, Rosen P, Stenevi U. Visual outcome of cataract surgery; study from the European Registry of Quality Outcomes for Cataract and Refractive Surgery. *J Cataract Refract Surg*. 2013 May;39(5):673–9.
32. Royal College of Ophthalmologists. College Statement on Access to Cataract Surgery [Internet]. 2012. Available from: <http://www.rcophth.ac.uk/news.asp?section=24&itemid=491>
33. The London Cataract Criteria [Internet]. [cited 2014 Jan 6].
34. Hadorn DC, Holmes AC. The New Zealand priority criteria project. Part 1: Overview. *BMJ*. 1997 Jan 11;314(7074):131–4.
35. Romanchuk KG, Sanmugasunderam S, Hadorn DC, Steering Committee of the Western Canada Waiting List Project. Developing cataract surgery priority criteria: results from the Western Canada Waiting List Project. *Can J Ophthalmol J Can Ophthalmol*. 2002 Apr;37(3):145–54.
36. Allepez A, Espallargues M, Moharra M, Comas M, Pons JMV, Research Group on Support Instruments - IRYSS Network. Prioritisation of patients on waiting lists for hip and knee arthroplasties and cataract surgery: Instruments validation. *BMC Health Serv Res*. 2008;8:76.
37. Quintana JM, Espallargues M, Las Hayas C, Allepez A, Vrotsou K, Moharra M, et al. Comparison of 3 systems for assigning priority to patients on waiting lists for cataract extraction. *Can J Ophthalmol J Can Ophthalmol*. 2010;45(2):125–31.
38. Ng JQ, Lundström M. Impact of a National system for waitlist prioritization: the experience with NIKE and cataract surgery in Sweden. *Acta Ophthalmol (Copenh)*. 2013 Jun 13;
39. Lundström M, Albrecht S, Håkansson I, Lorefors R, Ohlsson S, Polland W, et al. NIKE: a new clinical tool for establishing levels of indications for cataract surgery. *Acta Ophthalmol Scand*. 2006;84(4):495–501.
40. NHS Institution for Innovation and Improvement. Focus on: Cataracts. Delivering Quality and Value [Internet]. 2008 [cited 2014 Feb 14]. Available from: [www.institute.nhs.uk](http://www.institute.nhs.uk)
41. Sparrow JM, Taylor H, Qureshi K, Smith R, Birnie K, Johnston RL, et al. The Cataract National Dataset electronic multi-centre audit of 55,567 operations: risk indicators for monocular visual acuity outcomes. *Eye Lond Engl*. 2012;26(6):821–6.
42. Endophthalmitis Study Group, European Society of Cataract & Refractive Surgeons. Prophylaxis of postoperative endophthalmitis following cataract surgery: results of the ESCRS multicenter study and identification of risk factors. *J Cataract Refract Surg*. 2007 Jun;33(6):978–88.
43. Lundström M, Pesudovs K. Questionnaires for measuring cataract surgery outcomes. *J Cataract Refract Surg*. 2011 May;37(5):945–59.
44. McAlinden C, Gothwal VK, Khadka J, Wright TA, Lamoureux EL, Pesudovs K. A head-to-head comparison of 16 cataract surgery outcome questionnaires. *Ophthalmology*. 2011 Dec;118(12):2374–81.
45. Sparrow JM. Measuring Visual Disability due to Cataract: Development of a cataract patient reported outcome measure (Cat-PROM) - V2 [Internet]. [cited 2014 Feb 22]. Available from: <http://public.ukcrn.org.uk/search/StudyDetail.aspx?StudyID=15931>
46. Calladine D, Evans JR, Shah S, Leyland M. Multifocal versus monofocal intraocular lenses after cataract extraction. *Cochrane Database Syst Rev*. 2012;9:CD003169.
47. NICE. Implantation of multifocal (non-accommodative) intraocular lenses during cataract surgery. *Interventional Procedure Guidance 264* [Internet]. NICE. 2008 [cited 2013 Nov 20]. Available from: <http://www.nice.org.uk/>
48. NICE. Implantation of accommodating intraocular lenses for cataract [Internet]. NICE. 2007 [cited 2014 Apr 1]. Available from: <http://www.nice.org.uk/>
49. NIHR Horizon Scanning Centre. Femtosecond lasers for cataract surgery [Internet]. 2012 [cited 2013 Nov 20]. Available from: <http://www.hsc.nihr.ac.uk/topics/femtosecond-lasers-for-cataract-surgery/>
50. The Royal College of Ophthalmologists. Commissioning Cataract Surgery – an Outline of Good Practice [Internet]. 2004 [cited 2014 Mar 3]. Available from: [www.rcophth.ac.uk/core/core\\_picker/download.asp?id=343](http://www.rcophth.ac.uk/core/core_picker/download.asp?id=343)

51. Leivo T, Sariikkola A-U, Uusitalo RJ, Hellstedt T, Ess S-L, Kivelä T. Simultaneous bilateral cataract surgery: economic analysis; Helsinki Simultaneous Bilateral Cataract Surgery Study Report 2. J Cataract Refract Surg. 2011 Jun;37(6):1003–8.
52. National Patient Safety Agency. WHO Surgical Safety Checklist: for cataract surgery only [Internet]. 2010 [cited 2013 Nov 20]. Available from: <http://www.nrls.npsa.nhs.uk/resources/?entryid45=74132>
53. The Royal College of Ophthalmologists. The Way Forward: Cataract, January 2017 available from <https://www.rcophth.ac.uk/standards-publications-research/the-way-forward/>
54. Lee RM, Thompson JR, Eke T Severe adverse events associated with local anaesthesia in cataract surgery: 1 year national survey of practice and complications in the UK Br J Ophthalmol. 2016 Jun;100(6):772-6. doi: 10.1136/bjophthalmol-2015-307060. Epub 2015 Sep 24.
55. The Royal College of Ophthalmologists, [Emergency eye care in hospital eye units and secondary care](https://www.rcophth.ac.uk/standards-publications-research/ophthalmic-services-guidance-2/) 2017, available at <https://www.rcophth.ac.uk/standards-publications-research/ophthalmic-services-guidance-2/>
56. Lundstrom M, Pesudovs K. Catquest-9SF patient outcomes questionnaire: nine-item short-form Rasch-scaled revision of the Catquest questionnaire. J Cataract Refract Surg 2009;35(3):504-13 doi: 10.1016/j.jcrs.2008.11.038.
57. NHS England, Guidance for NHS commissioners on equity and health inequalities legal duties, 2015, available from <https://www.england.nhs.uk/wp-content/uploads/2015/12/hlth-inqual-guid-comms-dec15.pdf>
58. Sparrow JM, Grzeda MT, Frost, NA, Johnston RL, Liu CS, Edwards L, Loose A, Elliott D and Donovan JL. Cataract surgery patient-reported outcome measures: a head-to-head comparison of the psychometric performance and patient acceptability of the Cat-PROM5 and Catquest-9SF self-report questionnaires. Eye advance online publication, 26 January 2018; doi:10.1038/eye.2017.297 <http://www.nature.com/articles/eye2017297>

## 19 Appendix A: Scope of the original Commissioning Guidelines

---

1. Adult cataract:
  - a. Age-related cataract. (ICD code H25.x)
2. Exclusions:
  - i. Other cataract (ICD code H26.x)
  - ii. Other disorders of the lens (ICD code H27.x)
  - iii. Cataract in diseases classified elsewhere (ICD code H28.x)
  - iv. Refractive lensectomy
3. Procedures:
  - a. Phacoemulsification with intraocular lens implantation.
  - b. Extracapsular cataract extraction.
  - c. Intracapsular cataract extraction.
  - d. Other techniques for removal of crystalline lens.
  - e. Anterior vitrectomy (concurrent with cataract extraction).
  - f. OPCS codes: C71.x, C72.x, C74.x, C75.1
4. Reimbursement codes:
  - g. BZ01Z Enhanced cataract surgery.
  - h. BZ02Z Phacoemulsification cataract extraction and lens implantation.
  - i. BZ03Z Non-phacoemulsification cataract surgery.

## 20 Appendix B: Recommended high quality cataract care pathway

---

An overview of an exemplar cataract care pathway is available in the NICE Guideline Cataracts in adult: management<sup>5</sup>

<https://pathways.nice.org.uk/pathways/cataracts>

### Key points

1. Patient visits GP or optometrist for assessment, information provision and shared decision making, and if appropriate, is referred<sup>5</sup> directly to the hospital eye service. Patients may also be listed for cataract surgery from hospital eye clinics.
2. Pre-operative assessment:
  - Measurement of visual function and ocular examination including biometry.
  - Provision of patient information leaflets
  - Verification of suitability for day case surgery including discussion of anaesthesia options (usually subtenons or topical anaesthesia). Peribulbar anaesthesia may also be considered and general anaesthesia may be required in some circumstances.
  - Identification of need for second eye surgery if there is cataract affecting both eyes, postoperative anisometropia or another indication for second eye surgery. (see¥ below)
  - Completion of information provision and shared decision making, cataract consent form and discussion / choice of post-operative refractive target.<sup>6</sup> including information<sup>5</sup> on:
    - The refractive implications of different intraocular lenses
    - types of anaesthesia
    - the person's individual risk of complications during or after surgery
    - what to do and what to expect on the day of cataract surgery
    - what to do and what to expect after cataract surgery
    - what support might be needed after surgery
    - medicines after surgery and medicines that people may already be taking
    - the refractive implications after previous corneal refractive surgery, if appropriate
    - bilateral simultaneous cataract surgery, if appropriate
  - Verification that the case is appropriate to the level of expertise of the operating team and its clinical facilities. Adequate account must be made for any ocular or systemic co- morbidity which might increase the technical difficulty of the procedure, or increase the risk of complications.<sup>6</sup>
3. Day of surgery:
  - Ophthalmologist or appropriately trained nurse marks eye and confirms consent. The operating surgeon should meet patient before the surgery, and examine and assess the patient before the operation and provide information (5) on:
    - their position on the list, what to expect during and after surgery

- what visual changes to expect
- signs and symptoms of potential complications to look out for
- any restrictions on activities e.g. driving
- possible problems and who to contact
- emergency situations and who to contact
- eye drops
- pain management
- their next appointment and who they will see
- Preoperative check using the WHO surgical safety checklist<sup>53</sup> performed prior to surgery.
- Patient reviewed by a trained nurse following surgery- postoperative patient information, postoperative appointment date confirmed, and post-operative drops already dispensed.

4. After-care:

\*In-person first day review should not routinely be offered to patients after uncomplicated, cataract surgery.

- 2-4 week review by nurse, optometrist or ophthalmologist
- 4-6 weeks post-operative refraction by optometrist.

(This may be combined as a single postoperative visit)

\*At the first post-operative review, patients should be provided with information about eye drops and what to do if their vision changes or if they have concerns or queries. They should also be advised when it is appropriate to get new spectacles and how to do so. There should be arrangements in place for healthcare professionals to discuss second-eye cataract surgery in the non-operated eye and for the management of ocular co-morbidities, e.g. glaucoma /diabetic retinopathy.

- Providers of cataract care should be able to demonstrate to commissioners that the service makes appropriate provision for complications of surgery or other unexpected events which may occur during the cataract care pathway, including arrangements for urgent review or handover of care.
- Information required for the UK minimum cataract dataset should be routinely collected and submitted to the [National Ophthalmology Database Audit](#).

There should also be a commitment to the culture and practice of training and continuing professional development of staff.<sup>6</sup>

## 21 Appendix C: Original Search Questions and Search Strategies

Short title	Cataract surgery
Research question	What is the clinical and cost effectiveness of surgical procedures for adults with cataracts?
Population(s)	Adult patients undergoing surgery for the following conditions: Idiopathic (age related) cataract. (ICD code H25.x) Familial (congenital) cataract. (ICD code H26.x) Cataract secondary to conditions known to increase the risk of cataract. (ICD code H28.x) Cataract following ocular trauma. (covered by ICD code H26.1) Lensectomy for non-optical reasons (eg. angle closure, aqueous misdirection) Second-eye cataract
Intervention(s)	Procedures: Phacoemulsification with intraocular lens implantation. Extracapsular cataract extraction. Intracapsular cataract extraction. Other techniques for removal of crystalline lens. Anterior vitrectomy (concurrent with cataract extraction). OPCS codes: C71.x, C72.x, C74.x, C75.x, C77.x, C79.1  Non-operative aspects: Models of care (care pathways)
Comparators	N/A
Outcomes	Visual scores Quality of life Disability scores Risk from cataract associated falls and other accidental injury Cost effective (£ per QALY) Post-operative complications (including endophthalmitis)
Exclusion criteria	Paediatric cataract (ICD code Q12.0) Refractive lensectomy
Level of search	Level 1 and 2 search for: Guidelines Systematic reviews Economic evaluations Commissioning grey literature
Notes	Database limit (where available): English language only Date limits: 2003-present

## 22 Appendix D: Original Search record

Databases and sites searched	Dates searched	Search terms/strategy	Number of hits
Cochrane Library: Cochrane Database of Systematic Reviews – CDSR	27/09/13	<ol style="list-style-type: none"> <li>1. MeSH descriptor: [Cataract Extraction] explode all trees</li> <li>2. MeSH descriptor: [Cataract] explode all trees</li> <li>3. urg* or implant* or extract* or remov*:ti,ab</li> <li>4. #2 and #3</li> <li>5. ((cataract and (idiopathic or age related or familial or secondary or ocular trauma or second eye)) or (crystalline lens and remov*)):ti,ab</li> <li>6. (surg* or implant* or extract* or remov* or lensectomy):ti,ab</li> <li>7. #5 and #6</li> <li>8. #1 or #4 or #7 from 2003 to 2013, in Cochrane Reviews (Reviews only), Other Reviews, Technology Assessments and Economic Evaluations</li> </ol>	24
Cochrane Library: Database of Abstracts of Reviews of Effects – DARE	27/09/13	As above	29
Cochrane Library: Health Technology Assessments (HTA)	27/09/13	As above	20
Cochrane Library: NHS Economic Evaluation Database (NHSEED)	27/09/13	As above	24
MEDLINE	27/09/13	<ol style="list-style-type: none"> <li>1. Cataract Extraction/</li> <li>2. Cataract/</li> <li>3. (surg* or implant* or extract* or remov*).ti,ab.</li> <li>4. 2 and 3</li> <li>5. ((cataract adj2 (idiopathic or age\$related or familial or secondary or "ocular trauma" or second\$eye)) or ("crystalline lens" adj remov*)):ti,ab.</li> <li>6. (surg* or implant* or extract* or remov* or lensectomy).ti,ab.</li> <li>7. 5 and 6</li> <li>8. 1 or 4 or 7</li> <li>9. exp review/</li> <li>10. (scisearch or psychinfo or psycinfo or medlars or embase or psychlit or psyclit or cinahl or pubmed or medline).ti,ab,sh.</li> <li>11. ((hand adj2 search\$) or (manual\$ adj2 search\$)).ti,ab,sh.</li> <li>12. ((electronic or bibliographic or computeri?ed or online) adj4 database\$).ti,ab.</li> <li>13. (pooling or pooled or mantel haenszel).ti,ab,sh.</li> <li>14. (peto or dersimonian or der simonian or fixed effect).ti,ab,sh.</li> <li>15. or/10-14</li> <li>16. 9 and 15</li> <li>17. Meta Analysis/</li> <li>18. (meta-analys\$ or meta analys\$ or metaanalys\$).ti,ab,sh.</li> <li>19. ((systematic\$ or quantitativ\$ or methodologic\$) adj5 (review\$ or overview\$ or synthesis\$)).ti,ab,sh</li> <li>20. (integrative research review\$ or research integration).ti,ab,sh.</li> <li>21. or/17-20</li> <li>22. 16 or 21</li> <li>23. 8 and 22</li> <li>24. limit 23 to (english language and yr="2003 -Current")</li> </ol>	121

EMBASE	27/09/13	<ol style="list-style-type: none"> <li>1. Cataract Extraction/</li> <li>2. exp Cataract/</li> <li>3. (surg* or implant* or extract* or remov*).ti,ab.</li> <li>4. 2 and 3</li> <li>5. ((cataract adj2 (idiopathic or age\$related or familial or secondary or "ocular trauma" or second\$eye)) or ("crystalline lens" adj remov*).ti,ab.</li> <li>6. (surg* or implant* or extract* or remov* or lensectomy).ti,ab.</li> <li>7. 5 and 6</li> <li>8. 1 or 4 or 7</li> <li>9. exp review/</li> <li>10. (scisearch or psychinfo or psycinfo or medlars or embase or psychlit or psyclit or cinahl or pubmed or medline).ti,ab,sh.</li> <li>11. ((hand adj2 search\$) or (manual\$ adj2 search\$)).ti,ab,sh.</li> <li>12. ((electronic or bibliographic or computeri?ed or online) adj4 database\$).ti,ab.</li> <li>13. (pooling or pooled or mantel haenszel).ti,ab,sh.</li> <li>14. (peto or dersimonian or der simonian or fixed effect).ti,ab,sh.</li> <li>15. or/10-14</li> <li>16. 9 and 15</li> <li>17. Meta Analysis/</li> <li>18. (meta-analys\$ or meta analys\$ or metaanalys\$).ti,ab,sh.</li> <li>19. ((systematic\$ or quantitativ\$ or methodologic\$) adj5 (review\$ or overview\$ or synthesis\$)).ti,ab,sh.</li> <li>20. (integrative research review\$ or research integration).ti,ab,sh.</li> <li>21. or/17-20</li> <li>22. 16 or 21</li> <li>23. 8 and 22</li> <li>24. limit 23 to (english language and exclude medline journals and yr="2003 -Current")</li> </ol>	29
NHS Evidence - guidelines	27/09/13	Cataract surgery	184
NHS Evidence – commissioning	27/09/13	Cataract surgery	147
National Guidelines Clearing House	27/09/13	Cataract surgery	48
Google	27/09/13	“cataract surgery” commissioning (first 50 records scanned for indicative CCG thresholds, commissioning guides)	660,000
<b>Total number after first sift</b>		<b>Tagged with ‘Included’</b>	<b>123</b>

## 23 Appendix E: Original Evidence Base

A systematic search of the literature was undertaken. The Guideline Development Group came to a consensus on the topics and questions for the search, formulated in a PICO structure if appropriate. The systematic search was undertaken by Bazian Ltd on 15th October 2013 and included the Cochrane Libraries, MEDLINE, EMBASE, NHS Evidence – guidelines, NHS Evidence – commissioning, National Guidelines Clearing House, Google and other grey literature including The Royal College of Ophthalmologists and College of Optometrists websites. The following Figure illustrates the search flow. For areas where there was an absence of evidence identified by the Bazian search, separate additional searches were made as required.

For the guidance review no further formal literature review as undertaken and the NICE Guideline Cataracts in adult: management,<sup>5</sup> was used as an updated evidence base. [23](#)

## 24 Appendix F: Glossary

---

- **Anisometropia:** unequal refractive power in the two eyes (for instance where one eye is more short-sighted than the other). This may occur in the time between cataract surgery on the first eye and that on the second eye, and cannot always be corrected satisfactorily with spectacles.
- **Astigmatism:** uneven focussing power of the eye, usually due to uneven curvature of the cornea.
- **Biometry:** measurement of the eye prior to cataract surgery to estimate the power of the intraocular lens implant that will be required to focus the eye at a desired distance.
- **Endophthalmitis:** sight threatening infection inside the eye; a rare, but serious complication of cataract surgery.
- **Phacoemulsification:** the use of ultrasound waves to help soften a cataract, facilitating its removal.
- **Posterior capsule tear and/ or vitreous loss:** An uncommon complication of cataract surgery where there is an unplanned breach in the capsule of the natural lens (which is normally kept intact in order to support the lens implant) that may be accompanied by prolapse of the vitreous gel. This occurrence increases the risk of further complications following surgery and a poorer visual outcome.
- **Snellen chart/ visual acuity:** A Snellen chart is the traditional test used to measure visual acuity (the ability to perceive detail) and consists of letters in lines of decreasing size, usually read at a distance of 6 metres. Snellen scores are expressed as the distance from the chart divided by a letter size value, with typical values in order of improving visual acuity being 6/60, 6/36, 6/24, 6/18, 6/12, 6/9, 6/6, 6/5, 6/4. 6/6 is considered to be good/ normal vision and is equivalent to the “20/20” value used in the United States.