BIOS | BRITISH AND IRISH ORTHOPTIC SOCIETY

TOP 10 TIPS

When to give an incorporated prism

1. When you know it will do more good than harm
2. When you have experience with using prisms with similar patients
3. When you have asked advice if unsure – please ring your local orthoptist
4. When the cause and course of the diplopia has been investigated and monitored
5. When the prism correction has been stable for at least 6 months
6. When a trial with a temporary Fresnel prism has been successful – hospital eye services will tell you
7. When the patient does not have a deteriorating condition
8. Very elderly patients with small distance esodeviations often do very well (once medically investigated)
9. Longstanding IVN palsies may do well with a small prism despite a large angle
10. Very few children or young adults need prisms. A new small prism might mean a lifetime of unnecessary prism dependence

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TOP 10 TIPS

What to ask about diplopia

1. When did it start?
2. Vertical / horizontal / torsional?
3. Worst position?
4. Gradual / sudden / intermittent?
5. Definite or vague onset? Are they even bothered about it because it is so longstanding?
6. Has it ever happened before?
7. Do they have an old squint?
8. General health issues – especially vascular risk factors.
9. Can it be controlled by any strategy – head posture/ effort / or only shutting an eye
10. Have you told them they cannot drive with diplopia?

CARD 2 - SIDE A

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TOP 10 TIPS

When orthoptists give orthoptic exercises

1. Not that often!
2. Only when the patient thinks they have a problem – not if you have to tell them! Asymptomatic patients (especially children) will not be motivated, so we often watch and wait until it comes from them.
3. Symptomatic convergence insufficiency that has not responded to simple pencil push-ups / pen convergence
4. Poor fusion range, the patient is actually trying to fuse, and has symptoms
5. Moderate exophorias with symptoms but whose angle is less than approximately 25Δ
6. Small symptomatic esophorias less than approx. 5Δ
7. We would be very careful with suppression. Anti-suppression exercises only if we are sure there is potential for normal fusion once the suppression is eliminated
8. Placebo and encouragement effects are strong – they work, but we all need to be humble about what the effect of the actual exercises has been.
9. Long courses of exercises can be very counter-productive – sometimes diverting attention away from the eyes altogether is the best treatment
10. Occasionally pre- and post-operatively to improve outcomes or build fusion to allow the patient to adapt to residual angles

CARD 2 - SIDE B

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TOP 10 TIPS

What we care about most in a history in a child?

1. Does the child think there is anything wrong
2. The child volunteering symptoms before anyone asked them about their eyes
3. New symptoms
4. Diplopia that is not physiological
5. New shutting of one eye
6. Family history of glasses before age 7.
7. Recent virus / head trauma prior to squint onset
8. When do headaches occur? Sinister / ocular / migrainous
9. Strangers / non-family being concerned
10. Developmental or general health issues

CARD 3 - SIDE A

BIOS | BRITISH AND IRISH ORTHOPTIC SOCIETY

TOP 10 TIPS

What Orthoptic Departments need to know in a referral

You probably think you do this – but you'd be surprised what is often missing!

1. Who was worried – you or the patient?
2. If you ask for an urgent appointment – please say why. Your "urgent" may not be a stretched hospital clinic's top priority.
3. Are you concerned that it is a new problem?
4. In a child, what the full correction is, or would be.
5. In a child – what you have prescribed, ie working distance and why?
6. Did you dilate the child before refraction?
7. Have you given the full or partial correction – and why?
8. How long have they been given to adapt to a full correction?
9. What test you used to test VA?
10. Was a thorough fundus and media check possible and normal?

CARD 3 - SIDE B

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TOP 10 TIPS

When to refer a child over 5 to hospital services

You probably think you do this – but you'd be surprised what is often missing!

1. Any new strabismus
2. Diplopia – but check it is not physiological!
3. Previously undiagnosed fundus or media anomalies
4. *Symptom-producing* heterophoria – not just because the angle is larger than you generally see
5. When you can't test them accurately but are concerned – and tell us why
6. When a full correction of bilateral hypermetropia, astigmatism and anisometropia has not improved VA to 6/9.5 (logMAR 0.2) in each eye or better.
7. Symptom-producing convergence insufficiency that has not responded to simple pencil push-ups.
8. Accommodative or convergence spasm
9. If a known amblyope under 8yrs of age discharged to your care has deteriorated by >2 lines. VA may improve after an hour of occlusion, so try that first.
10. Unexplained reduced VA or very inconsistent results