



Monitoring cataract surgical outcome

The manual tally sheet system

(October 2004)

Introduction

The purpose is to assist cataract surgeons and programme managers to monitor the quality and the results of their cataract surgery. Such monitoring is the key to improvement. It is quick, simple and user friendly.

The manual system is developed for eye units without computers or units without data entry staff. Once a system of manual monitoring is being used successfully, you may consider trying the more detailed computerised system. The tally sheet is given in Annex 1.

The process

At discharge

- Before the patient is discharged, the Snellen (or “E”) visual acuity in the operated eye is assessed and recorded in the case notes. If you do not use standard case notes you might use the Cataract Surgical Record (CSR) as shown in Annex 2 as your standard format.
- If the Visual Acuity (VA) is less than (<) 6/60, it is re-checked, both with and without a pinhole.
- If the VA is <6/60 without a pinhole, the eye is carefully examined to determine the cause of the poor vision.
- The details for each patient are recorded on the Cataract Surgery Outcome tally sheet under the heading “Discharge”.

At 4 week follow-up

- At 4 weeks or more follow-up, the Snellen or (“E”) visual acuity, with the spectacles that the patient has or will be wearing (=presenting vision), is assessed and recorded in the case notes or on the CSR.
- If the presenting VA is <6/60, the VA is also tested with best correction or pinhole and the eye is carefully examined to determine the cause of the poor vision.
- The details for each patient are recorded on the Cataract Surgery Outcome tally sheet under the heading “>4 weeks post-op”.

How to complete the tally sheet

Personal & Surgery & Discharge VA (SEE ANNEX 1)

- Section “Personal & Surgery” is completed during admission.
- Section “Discharge” is completed at discharge.
- It should be completed for all cataract operations, except those in patients under the age of 20, those cases of cataract due to trauma and in combined procedures.
- The form is kept on a clipboard either in the ward or in the clinic, depending on where the discharge process happens.
- One row of the form is completed for each eye operated for cataract.
- If a patient is operated on both eyes, two rows will be completed.
- Each form has space for 20 cataract operations.
- Instructions to complete the tally sheet:
 - **Hospital** – Record the name of your hospital.
 - **Period** – The data should only be analysed when a minimum of 100 operations (5 forms) have been recorded. Calculating percentages from less than 100 cases can be misleading. Depending on your surgery volume this may take 1 to 6 months. Then start again for operation 101 up to 200, and so on.
 - **Surgeon** – Depending on your situation and your preference, either one form can be kept for all the surgeons working in your department, or a separate form can be completed for each surgeon.
 - **Serial number** – Record 1 to 100, and then 101 –200 and so on. If you perform more than 1000 operations per year, it may be advisable to start again at no. 1 at the beginning of a new year.
 - **Patient name** – This is optional if accurate patient ID numbers are available.
 - **Patient number** – Record the patient’s number, if your hospital uses a patient number system.
 - **Surgeon** – This is optional. If the form is being used for several surgeons, the surgeon’s ID can be recorded, using either a code or his/her initials.
 - **IOL** – Record “Y” (yes) if an IOL was implanted and “N” (no) if an IOL was not used.
 - **Surgical complications** – Record any surgical complications. The following abbreviations are suggested:
 - CR = capsule rupture without vitreous loss
 - VL = vitreous loss
 - RL = retained lens matter
 - EN = endophthalmitis
 - OT = other complications
 - **Discharge VA** (good, borderline, poor) – Tick one of the three columns, depending on the presenting VA (with the patient’s available correction, if any).
“No IOL” operations should be checked with +10 D spectacles.

- **Cause of poor outcome** (Selection, Surgery, Spectacles) – If the presenting vision at discharge is less than 6/60, then the reason for this poor outcome should be recorded in the appropriate column. This should only be done if the presenting VA is less than 6/60. Only one cause should be entered. If there is more than one cause for the poor outcome, the clinically most significant cause should be identified.
 - **Selection** (co-existent disease or pathology causing poor vision)
Specify the disease or pathology (for example: corneal scar = CS, Old iritis = OI, Retinal disease = RD, glaucoma = GL, etc.). See legend on form.
 - **Surgery** (peri-operative complication(s))
Specify the complication(s) (Capsule rupture without vitreous loss = CR, vitreous loss = VL, Retained lens matter = RL, Endophthalmitis = EN, etc.)
 - **Spectacles** (uncorrected refractive error)
Tick this column if the VA improves to 6/60 or better with a pinhole, or with spectacles that the patient does not have. “No IOL” operations should be checked with +10.0 spectacles.

How to complete the tally sheet

> 4 weeks post-op. (SEE ANNEX 1)

- Section “>4 weeks post-op” is completed at follow-up at least 4 weeks after surgery.
- It should be completed for all cataract operations except those under the age of 20 years, those cases of cataract due to trauma and combined procedures.
- The form is kept on a clipboard in the clinic.
- One row of the form is completed for each cataract-operated eye, which is seen at 4 weeks or more.
- If a patient is operated on both eyes, two rows will be completed.
- Each form has space for 20 cataract operations.

1. **No of weeks post-op.** – Record the interval in weeks since surgery
2. **Follow up VA** (good, borderline, poor) – Tick one of the 3 columns, depending on the presenting VA (with the patient’s available correction, if any). “No IOL” operations should be checked with +10 D spectacles.
3. **Cause of poor outcome** (Selection, Surgery, Spectacles, Sequelae) – If the presenting vision at 4 weeks or more after the operation is less than 6/60, then the reason for this poor outcome should be recorded in the appropriate column.
 - This should only be done if the presenting VA is less than 6/60.
 - Only one column should be filled.
 - If there is more than one cause for the poor outcome, the clinically most significant cause should be identified.
 - **Selection** (co-existent disease or pathology causing poor vision)
Specify the disease or pathology (see legend on form).
 - **Surgery** (peri-operative complication(s))
Specify the complication(s) (see legend on form).
 - **Spectacles** (uncorrected refractive error)
Tick this column if the VA improves to 6/60 or better with a pinhole, or with spectacles that the patient does not have. “No IOL” operations should be checked with +10.0 spectacles.
 - **Sequelae** (post-operative complication(s))
Specify the complication(s) (see legend on form).

Analysis of the data on the tally sheet

Discharge Visual Acuity

- Note that cases under the age of 20 years, all traumatic cataract cases and all combined procedures are excluded from this analysis.
- The analysis should be done for every 100 cases, and compared with previous results.
- It can be done either for the department as a whole, or for individual surgeons, or both. You need to decide which option is most suitable for your situation.

Add up the entries in each column and calculate the percentages.
It should take about 10 minutes!

Column	Meaning	Results
N	Total number of operations	
Y / N x 100	% with IOL implant	
C / N x 100	% with any surgical complication	
CR / N x 100	% capsule rupture without vitreous loss	
VL / N x 100	% vitreous loss	
RL / N x 100	% retained lens matter	
EN / N x 100	% endophthalmitis	
OT / N x 100	% other surgical complication	
G / N x 100	% with good outcome at discharge	
P / N x 100	% with poor outcome at discharge, due to all causes	
D1 / N x 100	% with poor outcome at discharge, due to other disease or pathology	
D2 / N x 100	% with poor outcome at discharge, due to surgical complication	
D3 / N x 100	% with poor outcome at discharge, due to uncorrected refractive error	

Note: the Borderline outcome column does not need to be reported. If required it can be calculated as 100 – (good + poor outcome).

Follow up Visual Acuity

Add up the entries in each column and calculate the percentages.
It should take about 10 minutes!

Column	Meaning	Result
N	Total number of cases seen at follow up	
Y / N x 100	% with IOL implant	
G1 / N x 100	% with good outcome at 4 week or more follow up	
P1 / N x 100	% with poor outcome at 4 week or more follow up	
F1 / N x 100	% with poor outcome, wk 4+, due to other disease or pathology	
F2 / N x 100	% with poor outcome, wk 4+, due to surgical complication	
F3 / N x 100	% with poor outcome, wk 4+, due to uncorrected refractive error	
F4 / N x 100	% with poor outcome, wk 4+, due to post-op. complication	

Note: the Borderline outcome column does not need to be reported. If required it can be calculated as 100 – (good + poor outcome).

Using the results to monitor performance and improve

The analysis is a tool to help improve the quality of surgery. It is used to compare past results with present results of an individual eye surgeon or a group of eye surgeons. It is NOT to be used to compare one surgeon with another or one hospital with another.

The results of every 100 cases can be summarised in this table.

The aim is to:

- Reduce surgical complications
- Increase the proportion of operations with good outcome
- Decrease the proportion of operations with poor outcome due to surgery or inadequate optical correction

Guidelines on the various proportions are given on the bottom line of each table. These are only indications and may vary from situation to situation.

REPORTING DISCHARGE RESULTS IN 100 CASES

Operation numbers	% with IOL	% Surgical Complications					% Good Outcome 6/6-6/18	% Poor Outcome <6/60			
		CR	VL	RL	EN	OT		Select.	Surg.	Specs	Total
1 –100											
101-200											
201-300											
301-400											
401-500											
etc.											
Guideline Discharge	90+	<5	<5	<2	<3	<2	50+	varies	<5	varies	<10

REPORTING 4-WEEK FOLLOW-UP RESULTS IN 100 CASES

Operation numbers	% with IOL	% Good Outcome 6/6-6/18	% Poor Outcome <6/60				Total
			Selection	Surgery	Spectacles	Sequelae	
1 –100							
101-200							
201-300							
301-400							
401-500							
etc.							
Guideline Follow-up	90+	85+	Varies	<2	<1	<1	<5

Please note that in most countries not all operated patients will return for review. Therefore the number of operated cases may be much higher than 100 in order to get 100 cases in the '>4 weeks post-op.' column.

WHAT IF THE RESULTS ARE BELOW THE GUIDELINE?

Action to improve results is advisable if:

IOLS

- The percentage of cases receiving an Intra-Ocular Lens (IOL) is less than 90%.
- **Take action to improve the availability and affordability of IOL's.**
- **Ensure that all surgeons are adequately trained in IOL surgery and have the necessary equipment.**

SURGICAL COMPLICATIONS

- The posterior capsule rupture rate is more than 5%.
- The vitreous loss rate is more than 5%.
- The presenting VA at discharge is less than 6/60 in more than 10% of cases.
- **Take action to improve the surgical technique by asking advice from a good and experienced cataract surgeon.**
- **Ensure that all surgeons are adequately trained in IOL surgery and have the necessary equipment.**

VISUAL OUTCOME

- More than 5% of the operated eyes have a presenting visual acuity less than 6/60 at 4 weeks or more post-operation (poor outcome).
- Less than 85% of the operated eyes have a presenting visual acuity of 6/18 or better at 4 weeks or more post-operation (good outcome).
- **Analyse whether the major cause of poor vision is selection, surgical problems or correction of refractive errors.**
- **Improve pre-operative examination to reduce the number of patients with other causes of blindness who will not benefit from cataract extraction.**
- **Take action to improve the surgery as above.**
- **Take action to provide at least best spherical correction spectacles at an affordable price.**
-

TRENDS OVER TIME

- The trend over time is static outside the recommended limits.
- The trend over time is worsening.
- **Carefully analyse the reasons for lack of improvement and take action to deal with the identified problems.**

Annex 1.

CATARACT SURGERY OUTCOME TALLY SHEET

Hospital:

Period:

Personal & Surgery					Discharge						> 4 weeks post-op.							
Serial number	Patient Number or Patient name	Surgeon	IOL Y/N	Surgical Compl.	Good 6/6-6/18	Borderline 6/24-6/60	Poor <6/60	Cause of poor outcome (<6/60)			No of wks post-op.	Good 6/6-6/18	Borderline 6/24-6/60	Poor <6/60	Cause of poor outcome (<6/60)			
								Selection	Surgery	Spec's					Selection	Surgery	Spec's	Sequelae
1																		
2																		
3																		
4																		
5																		
6																		
7																		
8																		
9																		
10																		
11																		
12																		
13																		
14																		
15																		
16																		
17																		
18																		
19																		
20																		
N=total			Y	C	G		P	D1	D2	D3	G1			P1	F1	F2	F3	F4

Excluded: age < 20, trauma, combined procedures

Abbreviations: Surgery:

- CR** Capsule rupture, no vitreous loss
- VL** Vitreous Loss
- RL** Retained lens matter
- EN** Endophthalmitis
- OT** Others

Selection:

- CS** Corneal scar
- OI** Old Iritis
- RD** Retinal Disease
- GL** Glaucoma
- OT** Others

Spec's:

Tick if VA improves to 6/18 or better with pinhole or spectacles

Sequelae:

- UV** Uveitis
- RD** Retinal Detachment
- CME** Cystoid Macular Edema
- PCO** Posterior Capsule Opacification
- OT** Others

The Cataract Surgical Record form

To collect the necessary personal and clinical data on all patients operated for cataract you can use your own medical record system, or the standardised Cataract Surgical Record (CSR) form, shown in Annex 2. The CSR form is designed to collect data, for the monitoring of cataract outcome, using computers. For eye surgeons who may consider a change from the manual tally sheet system to the computerised packages at a later stage, it may be useful to use the CSR form from the start.

All calculations programmed in the package are based on the fields, options and keys for Visual Acuity as printed in Annex 2, so do not change any of these on the form. Any change in the fields is likely to make the analysis reports invalid. However, it is possible to translate the CSR form into local language. Take care to preserve the layout of the CSR format.

It is important to realise that the CSR form is not completed at one time. Patient details, pre-operative examination, surgery and post-operative visual acuity at discharge, may all be completed while the patient is admitted. First, second and third follow-up visits can only be completed after several weeks or months. This means that the form has to be stored in a certain place to be retrieved whenever the patient returns for a follow-up visit.

Data entry will be done after discharge and after each follow-up visit, as it is not known if and when the patient will return for follow-up. This means that the form has to move repeatedly from one place to the other.

Each hospital may have its own procedure for patient's records and it may not be possible to standardise such procedures. The following option should therefore be regarded as an example only.

The CSR form stays with the patient during admission, pre-operative examination, surgery and discharge. After discharge the CSR form goes to a data entry clerk.

These CSR forms can be collected two times a week.

At the OPD divide a folder into two sections: 'Seen' and 'To Be Seen'.

After the data has been entered onto the computer take the forms to the OPD and put them in the folder under the 'To Be Seen' section.

Sort the CSR forms by name, serial number or Hospital Registration Number, whatever is common practice.

When the patient returns for follow up, trace their CSR form, complete your findings for that visit and put the form back in the folder, under the section 'Seen'.

Once a week the data entry clerk should collect all the CSR forms from the 'Seen' section, enter the data into the computer and return the forms to the 'To Be Seen' section for the patient's next visit.

It is very helpful if the data entry clerk places a mark behind each follow-up visit that was entered into the computer.

Divide the workload in such a way that the CSR forms remain only a short period at the data entry section.

The amount of work and the accuracy required for correct entry of all records should not be under-estimated. If designated and experienced data entry staff is not available, it may be better to use the manual tallying system to monitor cataract outcome.

The Cataract Surgical Record form is shown in Annex 2 and can be printed and copied from there. Please do not change the original layout of the form.

Annex 2.

CATARACT SURGERY RECORD

A. PATIENT name: _____

Address (optional): _____

Sex: (1) Male
 (2) Female

Hosp. Reg.

Serial No:

Age: years

B. PRE-OPERATIVE EXAMINATION:

Visual Acuity:	Presenting	Right	Key	Left	Key
	'Best' or pinhole	VA	<input type="text"/> <input type="text"/>	VA	<input type="text"/> <input type="text"/>
		VA	<input type="text"/> <input type="text"/>	VA	<input type="text"/> <input type="text"/>

Lens Examination:	Clear lens	<input type="radio"/> (1)	<input type="radio"/> (1)
	Opacity, not ready for operation	<input type="radio"/> (2)	<input type="radio"/> (2)
	Operable cataract	<input type="radio"/> (3)	<input type="radio"/> (3)
	Inoperable cataract	<input type="radio"/> (4)	<input type="radio"/> (4)
	Aphakia	<input type="radio"/> (5)	<input type="radio"/> (5)
	Pseudophakia	<input type="radio"/> (6)	<input type="radio"/> (6)
	Cannot examine	<input type="radio"/> (7)	<input type="radio"/> (7)

Other ocular pathology in the eye to be operated, likely to affect outcome:

Corneal scar	<input type="radio"/> (1)
Old iritis	<input type="radio"/> (2)
Retinal disease	<input type="radio"/> (3)
Glaucoma	<input type="radio"/> (4)
Other & specify	<input type="radio"/> (5) _____
None	<input type="radio"/> (6)

KEY for VA:

Category of Visual Acuity

1 6/6	9 1/60
2 6/9	10 PL+
3 6/12	11 NPL
4 6/18	12 Cannot examine, believed <6/60
5 6/24	13 Cannot examine, believed >6/60
6 6/36	
7 6/60	
8 3/60	

CLINICAL DATA:

C. SURGERY:

Date (dd/mm/yy): / /

Place: Base hospital (1)
 Other hospital (2)
 Out of hospital (3)

Training: Qualified / consultant (1)
 Resident / trainee (2)
 Cataract surgeon (3)

Biometry: Yes: (1) No: (2)

Centre ID _____

Eye operated: Right: (1) Left: (2)

Surgeon ID _____

Type of surgery: IOL:
 ICCE (1) **PC IOL** (1)
 ECCE (2) AC IOL (2)
 SICS (3) No IOL (3)
 Phaco (4)

Operative complications in operated eye:

None	<input type="radio"/> (1)	Wound leak	<input type="radio"/> (6)
Capsule rupture w/o vitr. loss	<input type="radio"/> (2)	Striate keratopathy	<input type="radio"/> (7)
Vitreous loss	<input type="radio"/> (3)	Endophthalmitis	<input type="radio"/> (8)
Zonular dehiscence	<input type="radio"/> (4)	Others	<input type="radio"/> (9)
Retained lens matter	<input type="radio"/> (5)		

D. VISUAL ACUITY OF OPERATED EYE POST-OP.

Cause of presenting vision <6/60 (Key 8, 9, 10, 11, 12)

Follow-up visits	Presenting	'Best' VA	Selection	Surgery	Spectacles	Sequelae	Entered on
At discharge, <input type="text"/> days post-op.	VA <input type="text"/> <input type="text"/>	VA <input type="text"/> <input type="text"/>	<input type="radio"/> (1)	<input type="radio"/> (2)	<input type="radio"/> (3)		
1-3 wks po. <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	VA <input type="text"/> <input type="text"/>	VA <input type="text"/> <input type="text"/>	<input type="radio"/> (1)	<input type="radio"/> (2)	<input type="radio"/> (3)	<input type="radio"/> (4)	
4-11 wks po. <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	VA <input type="text"/> <input type="text"/>	VA <input type="text"/> <input type="text"/>	<input type="radio"/> (1)	<input type="radio"/> (2)	<input type="radio"/> (3)	<input type="radio"/> (4)	
12+ wks po. <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/>	VA <input type="text"/> <input type="text"/>	VA <input type="text"/> <input type="text"/>	<input type="radio"/> (1)	<input type="radio"/> (2)	<input type="radio"/> (3)	<input type="radio"/> (4)	

Instructions for completing Cataract Surgery Record (CSR) forms

The Cataract Surgery Record (CSR) form must be completed for each cataract operation. This can be done for all patients or for patients randomly selected for follow-up. If the same patient has a cataract operation on the second eye, a new form should be completed for the second operation. Each operated eye should be treated as a separate event.

Information such as name and address should be written on the lines. In the square boxes a number should be entered. Circles can be filled in or ticked. For each parameter only one circle can be marked. All spaces need an entry, unless they are marked 'optional'.

Please note that the following patients might be excluded from monitoring because the expected visual outcome after cataract surgery could be less than optimal:

- persons, operated for cataract and younger than 20 years
- persons with traumatic cataract
- persons having combined procedures (i.e. cataract surgery with corneal graft, or cataract surgery with trabeculectomy, etc.)

A. Patient name

Write the surname first, followed by the first name and other name(s).

Address

Write the detailed address of the patient.

Hospital Registration No.

Write the hospital registration number. This should be the same as the number used in the hospital to store the patient's file.

Serial No.

Leave this box empty. This number will be generated by the computer and must be entered on the form by the computer operator.

Sex

Tick the sex of the patient – either male or female.

Age

Write the age of the patient in years. Patients younger than 20 should not be included.

B. Pre-operative examination

Presenting Visual Acuity (VA) (right and left eye): How the patient sees, with spectacles if they use any (available correction).

Measure the visual acuity of each eye separately using any available correction (= patient's presenting vision). Use the categories listed in the box on the right (category of visual acuity). Write the acuity next to VA on the appropriate line. You can use any of the systems. These are 6/60, 20/200, francophone, the LogMar or the decimal system. If you want to change the visual acuity measurement system for data entry, close the 'Patients' screen first, then click System \ Options and select the VA system of your choice.

Best corrected Visual Acuity (VA) (right and left eye): How the patient sees, with the best possible correction, using refraction or a pinhole.

Measure the acuity with the best possible correction (= patient's 'best' vision). If refraction can not be done, vision with pinhole can substitute for 'best' correction. Use the categories listed in the box on the right (category of visual acuity). Write the acuity next to VA on the appropriate line. You can use 6/60, 20/200, the Logmar or the decimal system. The 'best' VA cannot be worse than the presenting vision. If this is the case you cannot continue until the correct entries are made.

Lens examination (right and left eye)

The lens of both eyes should be examined. Only one option may be marked for each eye. At least one eye should have operable cataract, otherwise there is no need for cataract surgery. Only mark 'cannot examine' for a case where the lens can not be seen. This could be due to phthisis bulbi, dense corneal scarring, etc.

Other ocular pathology?

If there are other eye diseases in the operable eye which might affect the outcome, mark it on the form. Mark 'corneal scar', 'old iritis', 'retinal disease', 'glaucoma' or 'other' and specify the condition. If there are no additional eye diseases, mark 'None'.

Clinical data (optional)

Under 'Clinical Data', conditions like blood pressure, results of urine and blood examination, etc. can be written. This will not be entered into the computer.

C. Surgery

Date

Write the date of the cataract operation in dd/mm/yy format. You can enter "00" for the year 2000.

Place

Mark the place where the surgery was performed.

Biometry

Mark whether biometry was done or not.

Eye operated

Mark which eye was operated upon – left or right.

Type of surgery

Mark the surgical technique used.

Intra-Ocular Lens (IOL)

Mark which type of IOL was used. ICCE cannot be combined with PC-IOL.

Training

Mark the level of training of the surgeon. The term 'Cataract surgeon' is reserved for those specially trained and qualified to perform cataract surgery but are not doctors.

Hospital/camp ID

If you intend to analyse outcome by hospital(s) or camp(s), you should create a code for each hospital or camp. You can do this under Utilities, option 1.1. in the MS-DOS package or under Files/Other Files/Surgeons in the Windows package. This will make it possible to analyse visual outcome of cataract operations for each of the coded centres or for all centres

together. If you work in one centre only or do not want to analyse outcome by centre, just enter code "1" for 'Base hospital' on all records.

Surgeon ID

If you wish to analyse outcome by surgeon, you should create a list of codes for each surgeon. You can create such a list under Utilities, option 1.2. in the MS-DOS package or under Files/Other Files/Surgeons in the Windows package. It is possible to analyse visual outcome of cataract operations for each coded surgeon or for all surgeons together. If you work with one eye surgeon only, or do not want to analyse outcome by surgeon, just enter code "1" on all records.

Peri-Operative complications in operated eye

Mark if there were any operative complications in the operated eye. Only one complication may be marked. In case of more than one complication the principal complication most (likely) responsible for the reduction in post-operative vision, should be marked. In case the complication is not listed, mark "Other" and specify the condition.

D. Visual acuity of operated eye post-operatively

The visual acuity, of the operated eye only, can be assessed at several periods after the operation. First assessment should be done at discharge.

No days between operation and discharge

Write the number of days between the operation and the discharge assessment.

Discharge - presenting VA

Look at 'Key for VA'. Write the code corresponding to the visual acuity of the operated eye, with any available correction, in the box 'presenting VA' at discharge.

Discharge - 'best' VA

Write the code corresponding to the visual acuity, of the operated eye only, with best correction. If refraction cannot be done, pinhole vision can be used. Use the codes as given in 'Key for VA'. 'Best' VA cannot be worse than presenting vision.

Discharge - cause of presenting VA <6/60

If presenting VA at discharge is less than 6/60, mark one of the three causes of poor outcome. If the presenting VA at discharge is 6/60 or better, do **not** mark any of the boxes under 'cause'. Under 'Comments' you can specify any conditions important for follow-up.

First follow-up visit - date

The first follow-up visit should take place 1-3 weeks after the operation. Write the date in dd/mm/yy format.

First follow-up visit - presenting VA

Enter the code for visual acuity of the operated eye only with any available glasses, at first follow-up visit.

First follow-up visit - 'best' VA

Write the code corresponding to the visual acuity of the operated eye only with best correction or with pinhole. 'Best' VA cannot be worse than the presenting VA.

First follow-up visit - cause of presenting VA <6/60

If presenting VA at first follow-up visit is less than 6/60, mark one of the four causes of poor outcome. Post-operative sequelae, like retinal detachment, PCO, etc. can be marked here.

*Only one cause can be marked. If there is more than one cause for poor outcome select the cause that contributes most to the poor outcome. If the presenting VA at discharge is 6/60 or better, do **not** mark any of the boxes under 'cause'. Under 'Comments' you can specify any conditions important for follow-up.*

Second follow-up visit - date

The second follow-up visit should take place 4-11 weeks after the operation. Write the date in dd/mm/yy format.

Second follow-up visit - presenting VA

Write the code corresponding to the visual acuity, of the operated eye only, with any available glasses, at second follow-up visit.

Second follow-up visit - 'best' VA

Write the code corresponding to the visual acuity, of the operated eye only, with best correction or with pinhole. 'Best' VA cannot be worse than the presenting VA.

Second follow-up visit - cause of presenting VA <6/60

*If presenting VA at second follow-up visit is less than 6/60 mark one of the four causes of poor outcome. Post-operative sequelae, like retinal detachment, PCO, etc. can be marked here. Only one cause can be marked. If there is more than one cause for poor outcome select the cause that contributes most to the poor outcome. If the presenting VA at discharge is 6/60 or better, do **not** mark any of the boxes under 'cause'. Under 'Comments' you can specify any conditions important for follow-up.*

Third follow-up visit - date

The third follow-up visit should take place 12 weeks or more after the operation. Write the date in dd/mm/yy format.

Third follow-up visit - presenting VA

Write the code corresponding to the visual acuity, of the operated eye only, with any available glasses, at third follow-up visit.

Third follow-up visit - 'best' VA

Write the code corresponding to the visual acuity, of the operated eye only, with best correction or with pinhole. 'Best' VA cannot be worse than the presenting VA.

Third follow-up visit - cause of presenting VA <6/60

*If presenting VA at third follow-up visit is less than 6/60 mark one of the four causes of poor outcome. Post-operative sequelae, like retinal detachment, PCO, etc. can be marked here. Only one cause can be marked. If there is more than one cause for poor outcome select the cause that contributes most to the poor outcome. If the presenting VA at discharge is 6/60 or better, do **not** mark any of the boxes under 'cause'. Under 'Comments' you can specify any conditions important for follow-up.*



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