National Institute for Health and Clinical Excellence

789/1 – Laser correction of refractive error following non-refractive ophthalmic surgery

Consultation Comments table

IPAC date: Thursday 13 January 2011

Com. no.	Consultee name and organisation	Sec. no.	Comments	Response Please respond to all comments
1	Consultee 1 NHS/ Private Professional	**1**	Alternatives should also be considered: 1 spectacles 2 contact lenses, including specialist lenses such as scleral contact lenses 3 cataract surgery and intraocular lens implant, including toric implant 4 piggyback implant e.g. Sulcoflex	Thank you for your comment. Section 2.1.2 of the guidance will be changed.
2	Consultee 1 NHS/ Private Professional	**2.1**	There is omission of further surgery, see points 3 and 4 above In the case of corneal graft astigmatism, consider also relieving incisions and tension sutures, and wedge resection	Thank you for your comment. Section 2.1.2 of the guidance will be changed.
3	Consultee 1 NHS/ Private Professional	**2.2**	Lower corrections can be done with surface treatment Higher corrections, especially any hyperopic treatment, or astigmatic treatment best done with LASIK Consider also the danger of dilute alcohol for those eyes with sick ocular surface	Thank you for your comment.

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4	Consultee 1 NHS/ Private Professional	**2.4**	Special consideration should be given to those eyes with poor ocular surface, poor sensation, and pre-existing dryness. Special consideration should be given to altered healing in eyes which have had penetrating keratoplasty as the healing following laser refractive surgery is altered compared with virgin eyes. This is especially the case with surface laser treatment. Special consideration should be given to advisibility of mitomycin treatment in association with surface laser treatment to reduce risk of PRK scarring. Mitomycin C can have longlasting effect years on, including risk of scleral melt.	Thank you for your comment. A section will be added to the guidance at 2.5.1. .
5	Consultee 2 Charity CEO	**2.4**	I am concerned that, while the procedure under consideration is of undouted use and value in the cases described, there appears to be no accunt take of the effect of thinning the cornea in terms of the measurement of intraocular pressure and the possible consequent late diagnosis of glaucoma at a point later in the patients lives. The prevalence of glaucoma is approximately 2% of people over the age of forty years so a significant number of people treated with these procedures have the potential to be affected and the importance and value of central corneal thickness was clearly identified and highlighted in the CG85 guidance. For the purposes of both safety and informed consent, this potentiality should be included in the guidance and patients informed of the importance of mentioning the procedure when attending for subsequent routine eye examinations at both optometric and ophthalmic levels.	Thank you for your comment. There are no safety data available on thinning of the cornea presented in the studies included in Table 2 of the overview. There are no safety data available on consequent late diagnosis of glaucoma presented in the studies included in Table 2 of the overview. A section will be added to the guidance at 2.5.1..

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6	Consultee 2 Charity CEO	**general**	I have served on both the Guideline Development Group for CG85 and the Quality Standards Expert Group for Glaucoma (standard currently under consultation)	Thank you for your comment.