'Neither the quality nor the quantity, but the mixture...'

From contact lenses to cocktails, **Ranna Rai**, **Ian Dunning** and **Bill Harvey** take a look at the ingredients for this year's Professional Advancement Committee (PAC) conference at the ICC, Birmingham

Entitled 'Helping you find the solutions', the Specsavers' 12th annual PAC Conference yet again delivered the goods, combining quality and quantity with packed programmes and quizzes, worth a total of 15 CET credits.

Testament to this was the attendance of 1,000 delegates – many of whom had already achieved their CET targets – who seemed to appreciate the variety and flexibility of this informative and entertaining programme.

Brian Tompkins mixed a heady cocktail during his lecture on 'What's funky in contact lenses'

CLINICAL PROGRAMME

The clinical track of lectures began with ophthalmologist **Dr Peter Scanlon**, national co-ordinator for the Screening Programme for Sight-threatening Diabetic Retinopathy in England, who reminded delegates that, by April 2006, a minimum of 80 per cent of people with diabetes should have been offered diabetic retinal screening. He added that there were currently 106 potential screening programmes and approximately 60 of these had commenced a systematic screening service using mydriatic two-field digital photography.

Dr Scanlon went on to describe the Certificate in Diabetic Retinopathy Screening and its mandatory and optional components. Optometrists were exempt from three of these components.

Regarding capital funding, the Government had provided £12.4m for cameras and related software in 2005-6. Dr Scanlon also noted that the minimum camera resolution recommended was 20 pixels per degree for a 45-degree image and, once captured, the original image must be stored for a minimum of eight years.

Dr Peter Scanlon discussed retinal screening targets and requirements

One delegate questioned whether digital retinal photography was as good as slit-lamp biomicroscopy at detecting clinically significant macular oedema. Dr Scanlon answered by citing clinical evidence suggesting that a hard exudate within one disc diameter of the macula represented a strong marker for the existence of such oedema.

Optometrist **Dr Anna Kwartz** gave an overview on visual field assessment in optometric practice. She summarised the features of supra threshold and full threshold field-testing. In the majority of optometry practices, she felt that supra-threshold testing within the central 25-30 degrees was appropriate (unless the practice was involved in shared-care). Dr Kwartz went on to discuss the different types of field defects in primary open-angle glaucoma and pointed out that there was often a significant difference in the superior and inferior hemifields because of the anatomical arrangement of retinal nerve fibres. She addressed the problem of how to manage an apparent field defect in an otherwise normal individual by recommending repeat visual field testing to rule out artefacts such as the 'perimetric learning effect'.

Fiona Spencer, a consultant ophthalmologist at the Manchester Royal Eye Hospital, presented on 'Assessing the optic disc in glaucoma'. She demonstrated how the optic disc could be analysed effectively by using five main rules:

- Disc size
- Neuroretinal rim appearance
- Retinal nerve fibre layer
- Optic disc haemorrhage
- Peripapillary atrophy.

Other glaucomatous signs were not forgotten, with comments on tilt, scleral ring shape, cup depth and vascular changes.

After lunch, delegates listened to a well-presented lecture by **Professor John Lawrenson** on 'Ocular therapeutics'. He began by explaining that the list of POMs available needed a major review, since several drugs on the list were no longer commercially available. An updated list was established in April 2005 and now included the antibacterial agent fusidic acid to the POMs available.

The removal of the emergency restriction allowed the direct supply to patients of any P medicine that was used in the course of an optometrist's professional practice. Delegates were referred to the College of Optometrists' website as a useful source of guidance regarding the use and supply of

drugs in optometric practice.

Professor Lawrenson described the information required when issuing a signed order. He also explained that training for supplementary prescribing was similar to that of additional supply but involved a longer period of practical learning.

Dr Stuart Richer, chief of optometry at DVA Medical Center, Chicago, gave a highly entertaining lecture on ageing and nutrition. He argued that optometrists had a responsibility, as healthcare professionals, to educate patients about health, including nutrition and exercise. Dr Richer concluded his fascinating talk by highlighting the benefits of the red wine molecule resveratrol on the ageing process.

Over 1,000 delegates attended this year's conference

Dr Simon Barnard rounded off the clinical track of lectures with an excellent presentation on risk infection in optometric practice. Suggestions for effective hand washing included the wearing of minimal jewellery, removing watches and bracelets, rolling up sleeves, maintaining short, clean nails and covering cuts or abrasions. Soaps with antiseptic properties included 4 per cent chlorhexidine (Hibiscrub) or 10 per cent povidone iodine (Betadine scrub). Dr Barnard continued that Hibiscrub had only bactericidal properties, whereas Betadine had both bactericidal and viricidal properties.

Other practical methods of infection control included using disposable alcoholic wipes between patients for wiping the slit lamp head/chin rests and using sterile disposable hypodermic needles when removing a corneal foreign body.

Regarding Goldmann tonometry, Dr Barnard intimated that if a conventional cone was used in preference to a disposable cone, the cone should be wiped with a paper towel and placed in a galley pot of Milton (hypochlorite) at 10ppm for a minimum of 10 minutes (30 minutes in the presence of an adenovirus outbreak). The galley pot and solution should be changed daily and the cone soaked in new solution before use.

DISPENSING PROGRAMME

The dispensing strand began with a talk by **Professor Stephen Parrish** about the importance of effective communication which would be relevant to all staff within a practice. He used a variety of mostly entertaining (and some shocking) examples of how inaccurate or jargon-strewn language had led to unnecessary patient concern or failure to comply with instructions.

One memorable example was the patient who had overheard an eye practitioner discussing her fundus with another colleague after having had ophthalmoscopy. She, rather reasonably, assumed this to mean that there was 'fungus' within her eye and had worried unnecessarily thereafter until the misinformation was clarified. Professor Parrish also emphasised that, no matter how clearly a verbal message is given, without adequate, accurate (and legible) record keeping, there is little point anyway.

Dr Colin Fowler, after remarking upon how he had been responsible for teaching most of the audience at some stage in his long lecturing career, gave an excellent talk on driving and vision. He began with some alarming statistics about road accidents. However, road deaths had fallen significantly since the 1950s and, once allowing for the great increase in hours of driving and population in the UK, so had minor injuries. Apparently Portugal is the least safe EU country to drive in.

Dr Fowler then gave a critical review of the current vision standards for driving, reminding all that for type 1 licences, there is no Snellen recommendation. The erratic nature of the number plate test now means that many police forces are reluctant to test drivers as any smart lawyer is able to prove that it might not have been carried out exactly. He also used a number of photos taken in a B&Q car park to show how lighting affects ability significantly. Defocus also has little impact upon the ability to see most of the targets in a driver's vision, so acuity itself is not as major an issue as might be thought. A document all practices should download and print off is the *At a Glance Guide to the Current Medical Standards of Fitness to Drive* from the DVLA website.

Dr Wilkinson: always over-tint then bleach

He also noted how glare from modern headlights was a major factor in impairing the ability of older drivers. He went so far as to say that headlights might not be necessary under adequate street lighting and cause more problems than they solve.

Dr Peter Wilkinson explained clearly the great value of tints in reducing the eye's exposure to potentially harmful radiation. He showed how a tint without UV block was more harmful than a clear lens as the pupil behind it would dilate to allow higher UV levels to enter the eye than through the clear lens.

He also mentioned how it was important for anti-reflection coatings to be used (in his view on all tinted lenses). Reflectance might impact on the actual light transmission or absorbance values which, with adequate control of reflections, should always add up to 100 per cent. He also warned of the dangers of tint fading over time. This could be minimised by over-tinting by at least 10 per cent and then bleaching back to the required amount. This ensures that the tint is mainly the deeper molecules, less likely to fade over time.

Bill Harvey gave a useful review of how to manage some common patient concerns in the low vision clinic. Top tips included reducing the spectacle to hand magnifier distance for a patient wearing multifocals, rather than jumping straight to a stronger hand magnifier. He also explained why near correction is needed for usefully viewing through most modern stand magnifiers and appropriate near correction is often the key for successful stand magnifier usage.

Philip Gilbert gave an interesting insight into the future of dispensing as he described some of the digital dispensing ▶

equipment available or under development. One key advantage would be to reduce some of the dispensing errors commonly at the root of varifocal non-tolerance. Inaccurate pupillary distance measurement is one factor which only needs to be 2mm out for an intermediate corridor to be inappropriately positioned.

CONTACT LENS PROGRAMME

Dr Stuart Richer also delivered a presentation in the contact lens track on nutritional management of dry eye syndrome. He said that the major risk factor for ocular dryness is age, followed by gender, arthritis, diabetes, and smoking, cholesterol level, medications, osteoporosis, and thyroid disease.

In the US, one of the emerging strategies for dry eye is the use of preservative-free artificial tears, which work successfully for at least 50 per cent of mild dry eye sufferers. In more moderate and severe cases of dry eye, Dr Richer advocated a change of diet to help alleviate the problem, with patients increasing their uptake of essential fatty acids such as omega 3, found in oily cold-water fish and flax. The advice given was to increase the amount of omega 3 by up to 2g per day depending on the weight of the individual. He also identified gamma linoleic acid as another essential fatty acid which should be included in the diet and can be found in cooked oats, fatty fish and evening primrose oil.

In conclusion he stated that we should consider accepting dry eye as a fatty acid and nutrient deficient disease, with environmental factors such as lack of humidity, allergies and blepharitis influencing the condition.

Dr Philip Morgan delivered an extremely informative discussion of the management of corneal infiltrates. He began by discussing prescribing trends and how one might expect that the introduction of daily wear and silicone hydrogel contact lenses would reduce the number of ocular complications as well as give greater levels of comfort and convenience for wearers.

Despite significant advances in materials, there are still some reports of severe keratitis with wearers of these newer materials. Keratitis was briefly defined and Dr Morgan explained the clinical features, including a combination of pain, photophobia, mucopurulent discharge, corneal infiltrates, epithelial staining, limbal and conjunctival redness, anterior chamber flare, and hypopyon.

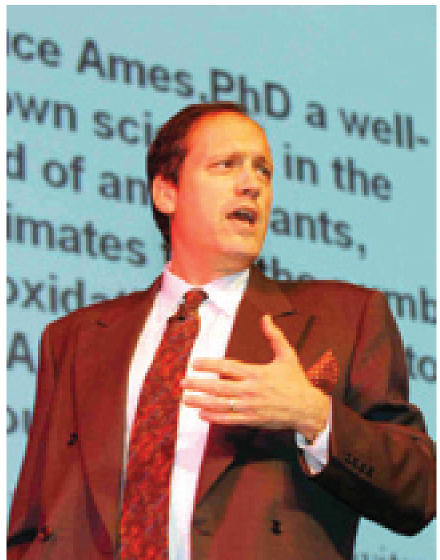
He went on to detail the Manchester Keratitis Study, in which every patient reporting to the Manchester Royal Eye Hospital with any form of corneal infiltrate or ulcer was surveyed. The study recorded the lens type and severity of the keratitis along with their distribution by lens modality providing some very interesting results.

Dr Colin Fowler gave some alarming statistics on road accidents – avoid Portugal!

Other risks factors of developing keratitis were highlighted, resulting in the conclusion that male smokers are more at risk. The study also reported that the risk is greater between January and March compared to mid-summer. Understanding the signs and symptoms is critical when managing patients who report with corneal infiltrates/keratitis, ranging from medical intervention through to the majority of cases where ceasing wear and monitoring for a number of days will be sufficient.

In the afternoon, **Brian Tompkins** gave a hugely energetic performance entitled 'What's funky in contact lenses', which included plenty of audience participation, as well as humorous slides and stunts. This was a highly motivational presentation which had a 'funky' theme throughout, taking the audience through a history of contact lenses, from the 1960s through to the present day, complete with lively soundtrack.

Tompkins emphasised that it is the practitioner's role to 'impress your patients'. The simple way to do this, he said, is to talk to them, educate them every time they step through the consulting room door and teach them one new fact on each visit.



Dr Stuart Richer: managing dry eye

Fiona Spencer: assessing the optic disc in glaucoma

The 'funky' theme continued throughout the presentation which moved on to share the presenter's experiences with orthokeratology. The show concluded with Tompkins bringing all the funky elements of modern contact lenses together to make a unique 'PAC cocktail'.

'Law and the contact lens fitter and supplier' was presented by **Judith Chrystie**, a specialist in public and regulatory law. This presentation took the audience through an understanding of primary and secondary legislation, the Opticians Act and the legislative provisions in relation to optics, which changed on the June 30, 2005.

Chrystie explained what has been defined as a fitting, who can fit, what has to happen before fitting and after fitting. She also reiterated that a contact lens specification must be issued on completion of the fitting and exactly what that document should contain.

In the final presentation in the contact lens track, **Ken Pullum** covered keratoconus. He described the variety of keratoconus end points in the fitting process for rigid gas-permeable lenses, the impact of parameter alterations, and when to go beyond corneals with other lens options. Delegates were presented with a range of images of keratoconic corneas with details of the specifications of the lenses fitted, how they fitted, and the effect of changing different parameters. There was then a more detailed explanation of the lens designs and how changing one parameter can have a very big impact on how the lens fits.

Altogether a truly potent cocktail of education.

Please don't read this...

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- ..if you have maximised **VAT repayments** from Customs & Excise and are completely satisfied with your practices **VAT & tax position**
- ..if you've seen A+E+L at Optrafair 2005 and already received a **free VAT Review** on your practice
- ..if you're one of over 200 Independent Opticians we've already acted for over the past 15 years, providing specialist VAT, tax and accounting advice

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