**Mr Colin Waldron**
**Chair, Optometry Board of Australia**
**GPO Box 9958**
**Melbourne VIC 3002**

**4 February 2013**

**By email: optomconsultation@ahpra.gov.au**

**Dear Sir,**
**Submission to the Optometry Board of Australia, Public Consultation Paper on amendments to Guidelines for use of Scheduled Medicines, with particular reference to:**
**Section 6- Collaborative Care Guidelines**
**Section 7- Guidelines for care of patients with, or at risk of developing, chronic glaucoma.**

As the peak glaucoma patient association in Australia for the past 24 years, Glaucoma Australia values the opportunity to comment on the submission by the Optometry Board of Australia (OBA) to vary the Guidelines for use of Scheduled Medicines to allow optometrists the right to diagnose, treat (with anti-glaucoma eye drops) and subsequently manage glaucoma patients independently of medically-qualified ophthalmologists.

The prevalence of glaucoma cited in two Australian population-based studies is 3%[1, 2], which equates to approximately 300,000 people afflicted by this potentially blinding disease. Both studies found the glaucoma detection rate to be approximately 50%, similar to most first-world countries. Varying reasons for this low detection rate are assumed to include:

- Approximately 40% of the adult population do not have regular (at least two yearly) eye checks
- Those who attend either may not be assessed for the presence/absence of glaucoma or their glaucoma may not be detected despite an assessment having taken place.

The suggested OBA guideline changes:

- Will not alter the outcome for those who don't attend,
- Will not alter the detection rate in those who attend but are not checked for glaucoma and,
- Would be unlikely to alter the detection rate in those being checked currently but being missed.

Glaucoma is known as a ‘difficult to diagnose’ disease, with up to 70% of neurons being lost before an individual notices vision loss themselves- hence the term "the sneak thief of sight". A high number of patients remain likely to be missed; an Australian study[3] indicated up to 59% of subjects whose glaucoma was previously undiagnosed had visited an eye-care provider in the previous year.

The public needs to be seen by eye health professionals who can diagnose glaucoma by[4]:

- Undertaking a thorough history, followed by,
- A comprehensive examination and only finally,
- Tests and investigations to confirm and document a diagnosis.

Once diagnosed, a treatment regime and management plan, based on an assessment of likely progression, risk of visual disability and many other medical and social factors is required, followed by rigorous follow-up to ensure treatment strategies are safe, tolerable and effective.

Glaucoma Australia contends it is the ophthalmologist who is able to recommend and initiate all types of glaucoma treatment, whereas the proposed OBA changes to the guidelines recommend optometrists be able to initiate eye drop therapy, only. This is somewhat limiting for the patient, who usually wants to know the risks and benefits of all therapeutic options (drops, laser or even incisional surgery), as they are unlikely to be covered meaningfully by an optometrist who can only prescribe one type of therapy.

Being restricted to only prescribing eye drops has its own limitations as any patient diagnosed with glaucoma may have co-morbid conditions, known or unknown, and that likelihood increases with age (as does the incidence and prevalence of glaucoma). All anti-glaucoma medicines have side effects and should at least initially be prescribed by medically-trained eye-care providers who are well-placed to detect and act upon problems as they occur, especially those related to concerns external to the eye, such as within the cardiovascular and respiratory systems.

The ongoing management of patients with glaucoma is concerned with maintaining a consistent and low intraocular pressure so progressive sight loss is either halted or at least delayed. Anecdotal information related to anti-glaucoma medications dispensed via the Pharmaceutical Benefits Scheme (PBS) indicates up to 12% of all prescriptions are as a result of a switch in therapy. This indicates at least one in eight patients have a significant amount of treatment dissatisfaction, either from:

- An inadequate therapeutic response or,
- Side effects from the used product/s.

The continuing move toward concomitant therapy increases the complexity of treatment, even if prescribed as a combination product. At least one of these products is likely to be a beta blocker, an alpha-2 agonist or a carbonic anhydrase inhibitor, all potentially with a significant range of systemic adverse events.

Independent and ongoing management of a glaucoma patient by an optometrist alone has the potential to increase the likelihood of missing disease progression on the one hand or to over-treat glaucoma suspects on the other. Glaucoma Australia believes the best option from a patient perspective is the current system where optometry is the logical first port of call for the Australian community to be comprehensively assessed for signs and symptoms of glaucoma, with an ophthalmologist confirming that diagnosis and then discussing and initiating treatment. This system currently supports collaboration between an optometrist and an ophthalmologist when the optometrist is seeing an individual in whom the condition is suspected but it is not able to be confirmed definitively. Without this interaction the inappropriate utilization of resources is more likely if an optometrist feels uneasy monitoring rather than treating glaucoma suspects. Over-treatment is as problematic to the health service as missed diagnoses and inadequate treatment for those with damage, especially those in whom damage is progressing.

Glaucoma Australia believes an optometrist is well-placed to review patients on an ongoing basis, seeking the advice of an ophthalmologist in the event of circumstances that may indicate disease progression and/or a change in therapy is required. Glaucoma Australia supports the concept of less collaborative care 'red tape', to increase the likelihood of both groups of eye-care providers being able to focus on the needs of the patient and to organise for initial and ongoing patient care, for the betterment of those patients.

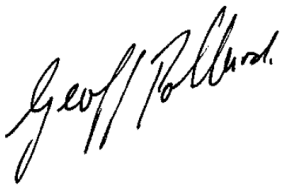
Glaucoma Australia asserts that systems to help ensure:

1. Increased presentations for comprehensive eye checks (including a review of the optic nerves and not just an intraocular pressure test),
2. Wider professional promulgation of, and adherence to, the NHMRC (2010) Guidelines for the Screening, Prognosis, Diagnosis, Management and Prevention of Glaucoma and,
3. Increased treatment persistence,

would result in a higher detection rate and more appropriate use of treatment strategies within the Australian community than those suggested in the proposed guideline changes.

Glaucoma Australia urges organised Optometry and Ophthalmology to work collaboratively to enhance glaucoma care for our community.

Yours sincerely,



Geoff Pollard

National Executive Officer


1- Mitchell P, Smith W, Attebo K, Healey PR. Prevalence of open-angle glaucoma in Australia. The Blue Mountains Eye Study. Ophthalmology 1996; 103: 1661-1669.
2- Wensor MD, McCarthy CA, Stanislavsky YL, Livingston PM, Taylor HR. The prevalence of glaucoma in the Melbourne Visual Impairment Project. Ophthalmology 1998; 105: 733-739.
3- Wong EY, Keefe JE, Rait JL, et al. Detection of undiagnosed glaucoma by eye health professionals. Ophthalmology 2004; 111: 1508-1514.
4- Chua B. The need for a comprehensive test. Optometry Pharma, 2012; June: 20-21.