Flashes & Floaters

Key information

This document summarises some key points from Docet's 'Flashes & Floaters' course for your reference. It does not constitute formal guidance and does not supersede College of Optometrists or other formal guidance.

Remember: you are strongly advised to familiarise yourself with any local protocols that may be in operation where you practice, and to follow them.

Chapter 2: Symptoms	
Risk Factors	More than -3.00D Over 50 years Previous detachment Family history of retinal detachment History of retinal disease Systemic disease, eg. Marfan's Recent head trauma Peripheral retinal degenerative changes, eg. Lattice.
Key questions	Duration of symptoms? How long since they first appeared? How long do they last? One eye or both? Any headaches to follow? Visual field loss such as a curtain or shadow?
Summary	Establish if the patient is in a higher risk group Ask about their history in a structured way Ask about their symptoms in a structured way.
Chapter 3: Anatomy	
	Understand the difference between innocuous floaters and PVD Understand the relationship between PVD and retinal tears Recognise the risk factors for retinal detachment, such as lattice degeneration On average you're likely to see a patient with a retinal detachment once every sixteen months.

Chapter 4: Pre-dilation checks	
Pre-dilation checks include:	• Letter chart • Pressure test • van Herick If the patient's symptoms are highly suggestive of a retinal detachment, you might take a quick look with the slit lamp before dilation.
Chapter 5: Landmarks and Signs	
Know the landmarks	Vortex veins Long posterior ciliary nerves and arteries Short posterior ciliary nerves Use the SOAP framework Is the evidence clear?
Chapter 6: Slit lamp examination	
Obvious detachment	Look for obvious retinal detachment such as: • Operculated tears • Horseshoe tears.
Risk factors	Some of the risk factors you might see in the peripheral retina: • Lattice degeneration • Snail track degeneration • Atrophic holes • Pavingstone.
Summary	Look for Shafer's sign, or "tobacco dust" Look for evidence of PVD Look for the characteristic annular shape of Weiss' ring Use the landmarks to orient yourself during the examination Remember you still haven't reached the far periphery of the retina.
Chapter 7: Headset BIO	
Setting up the headset BIO	Centralising the dots Reclining the chair Choosing a lens Positioning the lens And seeing the retina.
Summary	A headset BIO will give a wider view than a slit lamp You will still not see the entire retina Still examine the patient fully dilated with a slit lamp.

Chapter 8: Referrals and Record keeping

Remember: you are strongly advised to familiarise yourself with any local protocols in operation where you practice, and to follow them. If there is no protocol in place in your area then consider the following as a guide:

Refer Immediately if:	Retinal detachment An operculum, either free or attached A retinal tear, if there are symptoms Retinal or pre-retinal haemorrhage Vitreous haemorrhage Lattice degeneration, if there are symptoms Shafer's sign, or "tobacco dust".
Manage within the practice if:	Vision is good, and without field loss The symptoms are stable New floaters have been around for more than six weeks Floaters appeared gradually The floaters are not progressing The retina is attached with no breaks The patient is well informed of what to expect if the retina tears – and has been told to go to A&E or eye casualty.
Consider referral or contact local eye unit if:	Persistent symptoms of PVD No retinal breaks seen Possibly Weiss' ring Possibly crinkly membrane At risk of a retinal break. If a patient presents with flashes and/or floaters symptoms that are persistent or of concern to you, or where you may be conscious of your own limitations regarding peripheral assessment, the recommended management option would be for the patient to be seen by a vitreo-retinal specialist as soon as possible.
Summary	Analyse the information you've gathered and make a plan Follow any local protocols in place where you practice Decide if you need to refer within 24 hours Consider if you can manage the patient within the practice Remember it's not a clear-cut decision.