



GUIDELINES FOR THE USE OF CORTICOSTEROIDS BY OPTOMETRISTS IN NEW ZEALAND

Since 2005, New Zealand Optometrists have been prescribing topical corticosteroids. To do this, the optometrist must be registered in the Optometrist (TPA Endorsement) scope of practice.

This guideline offers general guidance for the prescribing of corticosteroids in optometric practice and not for the optometric management of any particular patient. The ultimate decisions on patient care must be made by the prescribing optometrist, having regard to all the circumstances presented by the patient. This guideline should not be deemed inclusive of all proper treatment modalities or exclusive of other reasonable means of care that could be instituted by the optometrist.

The goal of this guideline is to ensure that optometrists prescribe topically administered ocular corticosteroids in appropriate ways for diagnosed conditions of the eye and that public safety is paramount.

BACKGROUND

Inflammation of the eye occurs in response to adverse stimuli. It is a natural response of the body which can serve a useful role in healing, but in some instances the response needs to be controlled, particularly where secondary pathology is a risk.

Corticosteroids are the most potent and most frequently used anti-inflammatory agents. They suppress the manifestations of inflammation that lead to secondary pathology, but they also inhibit the protective aspects of the immune response and slow the process of wound healing.

Topical ocular corticosteroids are used to treat ocular inflammation in instances where there is no other treatment option and the effects of the condition outweigh the side effects of the steroid. Short-term therapies are preferred to the use of corticosteroids long term, and treatment is always tapered. Under no circumstances is steroid treatment to be discontinued without appropriate tapering.

CLINICAL NOTES

- Corticosteroids can provide an effective treatment for ocular inflammation, but because of their potential to produce a number of adverse ocular and systemic events, they must be used judiciously.
- Corticosteroids must not be prescribed for an undiagnosed 'red eye' or for minor ocular irritation.
- Before prescribing ocular corticosteroids, the practitioner is expected to have read and understood the information contained in the Medsafe Datasheet for the medicine being prescribed. These Datasheets are available online by accessing the Medsafe website located at www.medsafe.govt.nz and selecting 'Datasheet access'.
- Corticosteroid-induced cataract and corneal perforation are a risk of prolonged use. Regular monitoring of the anterior segment of patients using ocular steroids with slit-lamp biomicroscopy is necessary. In particular, clinicians are advised to monitor any changes in the cornea and review patient management accordingly.

- Corticosteroid-induced glaucoma is a high risk for susceptible individuals. About one third of the general population are 'steroid responders' who can be expected to have increased IOP of 6 to 15mm Hg after daily corticosteroid treatment for 4 to 6 weeks. Approximately 5% of people will be 'high responders' with elevations of IOP greater than 15mm Hg. Patients must be regularly monitored and if increased IOPs are observed, this should be managed with IOP reducing agents and the steroids tapered if this is appropriate.
- Ocular corticosteroids should not be used where the corneal epithelium is broken. Ocular corticosteroids must not be used where the corneal epithelium is infected. Particular care should be taken to exclude herpes simplex
- Consideration should be given to the possibility of adrenal suppression following an intensive course of topical corticosteroid eye preparations such as Pred Forte, Maxidex, Maxitrol, and Tobradex.
- Caution should be used when prescribing for children, as the safety and effectiveness of these medicines in paediatric patients has not been established.
- Initial metabolism of steroids absorbed via the ocular or nasal mucous membranes differs from that of orally administered corticosteroids and ocular preparations may produce an inherently greater corticosteroid effect than the equivalent dose administered orally.
- Optometrists are advised to use corticosteroids in a conservative manner, where alternative non-steroidal treatments have been unsuccessful. As a general rule, optometrists are advised *to use the lowest concentrations with least propensity for ocular penetration unless otherwise clinically indicated*. However, in order to efficaciously control the immune response in some conditions, a short course of a high dose potent steroid will be the preferred treatment.
- After initiating treatment with topical steroids, the patient must be monitored regularly to assess the response to treatment and to detect any adverse reactions. During this period the optometrist will consider the tapering of steroid treatment. Settings where steroid treatment is stopped suddenly are very rare.
- It is expected that the optometrist will seek a second opinion on any cases where there is a poor response to initial treatment or there are indications of a contributing systemic pathology.

These guidelines are a 2012 update of the document '*Clinical guidelines for the use of topically administered ocular corticosteroids in the treatment of diagnosed conditions of the eye*' developed and approved by the NZAO in February 2004 and adopted by the Board in May 2004.