



## CLINICAL GUIDELINES

# Traumatic Hyphaema Iridocyclitis

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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<b>Lead Author:</b>	Alan Cox
<b>Approval Group:</b>	Medicines Utilisation Subcommittee of ADTC

### Important Note:

The Intranet version of this document is the only version that is maintained. Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

# Traumatic Hyphaema / Iridocyclitis Management Guidelines

In addition to bilateral ocular injury, blunt or lacerating trauma can cause a wide range of intracranial or periocular injuries that may need prompt assessment and treatment.

## History

- Mechanism of injury
- Details of object causing trauma
- Change in VA since injury
- Ocular symptoms following injury
- Complete medical and ophthalmic history
- Associated ocular, neurological and systemic symptoms

## Examination

Complete ocular examination is necessary in all cases and should include:

- Visual acuity
- Pupil reaction / RAPD - Use consensual response if necessary
- IOP
- RBCs in AC and hyphaema height if present
- Exclude globe rupture – see separate guidelines for clinical features. Includes:
  - Shallow anterior chamber
  - Difference in IOP between eyes
- Corneal blood staining

## Investigations to be Performed as Appropriate

**BP**

**Bloods** FBC / Coag / INR - if blood dyscrasia suspected or on warfarin / antiplatelet therapy  
LFT if liver disease suspected  
U&E if systemic treatment to lower IOP or surgical intervention anticipated

**B-scan** Exclude posterior segment injury or intraocular foreign body if no fundal view

***!Caution – do not compress globe when performing B-scan or perform gonioscopy or scleral indentation in the acute setting!***

## Management

There is no evidence that any drug or non-drug intervention currently reported in the literature alters final VA outcome.

See next page for treatment options that can be considered on an individual basis.  
Check contraindications for all medications.

Take clinical photographs if possible and if time permits

# Traumatic Hyphaema / Iridocyclitis Management Guidelines

## Management of Hyphaema Without Other Ocular Injury

### Non-drug Interventions

Minimal Activity - at least 2 week duration. No lifting / straining  
Avoid lying flat for prolonged periods - sleep with head elevated 30-45%  
Clear eye shield - when asleep at night and when traveling outside

### Drug Interventions

In the presence of uveitis or photophobia consider: Prednisolone acetate 1% up to x6 daily  
Cyclopentolate 1% x3 daily  
There is no evidence to support the use of an antifibrinolytic agent  
Analgesia Simple analgesia as required – Paracetamol / Co-Codamol  
Avoid NSAIDs or analgesia that may induce nausea or vomiting

### Management of Raised IOP

20-30mmHg Timolol maleate 0.5% x2 daily  
30-35mmHg Brinzolamide-timolol (Azarga) x2 daily (stop timolol if previously on this)  
>35mmHg Brinzolamide-timolol (Azarga) x2 daily  
Acetazolamide SR 250mmHg  
Theoretical risk of prostaglandin analogues inducing further inflammation  
IOP can be difficult if sickle cell or poor clotting tendency – discuss with senior

### Consider Admission:

- >75% hyphaema
- Significantly ↑ IOP on presentation >50mmHg or uncontrolled on treatment >35mmHg
- Known bleeding disorder
- Unable to attend for daily review / concern over failure to reattend
- Concern over compliance with treatment and limited activity

### When to Consider Surgical Intervention - Discuss with Senior

- Corneal blood staining or uncontrolled IOP over 50mmHg
- Hyphaema: 100% hyphaema or unresolving and >75% by 4 days  
Failure to reduce to <50% by 1 week
- Lower threshold of the above in patients with sickle cell

## Follow Up

Hyphaema Present: Review in ARC on daily basis until resolved. Discuss with senior if still present after 3 days. If resolves refer to microhyphaema  
Microhyphaema: Review in ARC within 4 days if IOP normal then 1 week later if IOP remains normal. Routine clinic review thereafter until resolution  
Elevated IOP: Discuss with senior if uncontrolled on above treatment  
Routine clinic follow up will be necessary for all patients for gonioscopy and fundal examination once hyphaema has resolved

Patient should be advised to return to ARC urgently if there is a sudden reduction in VA, increase in pain, or development of new symptoms suggestive of secondary haemorrhage