

D12/S(HSS)/a

**2013/14 NHS STANDARD CONTRACT  
FOR OCULAR ONCOLOGY SERVICE (ADULTS AND ADOLESCENTS)**

**PARTICULARS, SCHEDULE 2 - THE SERVICES, A – SERVICE  
SPECIFICATIONS**

<b>Service Specification No.</b>	D12/S(HSS)/a
<b>Service</b>	Ocular oncology service (Adults and Adolescents)
<b>Commissioner Lead</b>	
<b>Provider Lead</b>	
<b>Period</b>	12 months
<b>Date of Review</b>	

<p><b>1. Population Needs</b></p>
<p><b>1.1 National/local context and evidence base</b></p> <p>Uveal melanomas have an incidence of six per million per year. They affect both sexes in equal numbers. The age at presentation peaks at 60 years. Without timely treatment, these tumours cause loss of vision and eventually an inflamed, painful and unsightly eye. Despite successful ocular treatment, about 50% of patients develop metastatic disease, which almost always involves the liver and which is almost invariably fatal within a year of the onset of symptoms. Metastatic disease is more likely to occur in patients whose tumour shows a mutation known as monosomy 3.</p>
<p><b>2. Scope</b></p>
<p><b>2.1 Aims and objectives of service</b></p> <p>The aims of the Adult Ocular Oncology Service are to provide expert diagnosis and treatment of ocular tumours (and other closely related conditions within the scope of this specification) to conserve the health and well-being of adult patients with an ocular tumour and to prolong life. Ocular tumours are rare and diverse and consequently their presentations can be very complex requiring challenging differential diagnosis between different types of tumours and other similar</p>

presentations. Many are life-threatening or associated with lethal syndromes.

Adult ocular oncology services are targeted at patients having an intraocular or conjunctival tumour or pseudo-tumour unless such patients can adequately be managed elsewhere.

## **2.2 Service description/care pathway**

### **A. malignant tumours**

Ocular treatment is aimed at conserving a useful eye, if possible, while preventing metastatic spread to other parts of the body. In most centres, the first choice of treatment is brachytherapy administered with a radioactive plaque containing ruthenium-106 or iodine-125. When such therapy is unlikely to succeed, patients may be treatable with proton beam radiotherapy. Another possible form of radiotherapy is stereotactic radiotherapy, using a Leksell Gamma Knife or linear particle accelerator (LINAC).

Some tumours are considered unsuitable for radiotherapy, because of their large size or proximity to the optic nerve, and these may be treatable by trans-retinal local resection (endoresection) or trans-scleral resection. Trans-scleral resection requires specialist surgical expertise and facilities for profound hypotensive anaesthesia. Endoresection is controversial because of concerns about iatrogenic tumour dissemination around the eye. Therefore such excision may be reserved for patients who have had prior radiotherapy.

Transpupillary thermotherapy involves heating the tumour by a few degrees for about one minute, by means of an infra-red, diode laser beam. It is used for very small choroidal melanomas and treatment of local edge recurrences.

Enucleation (removal of the eyeball) is performed when the chances of conserving vision and a comfortable eye are unacceptable, for example, if the tumour is very large or involves the optic nerve).

Intraocular metastases arise most commonly from breast and lung cancers. Accurate diagnosis is challenging and many are mis-diagnosed as melanoma prior to the patient being assessed at the specialist ocular oncology centre. In many patients, the diagnosis is confirmed by biopsy, which is usually performed in an operating theatre under local anaesthesia.

Metastases usually respond to a small dose of external beam radiotherapy, which can usually be administered at the patient's local hospital. Asymptomatic metastases may be observed without treatment.

Intraocular lymphomas are rare. They comprise vitreo-retinal lymphomas and uveal lymphomas. Vitreo-retinal lymphomas are highly-malignant and usually involve the

brain with a fatal outcome within a few years of diagnosis. Most uveal melanomas are indolent, with a good prognosis for survival. Treatment is with low-dose radiotherapy, with intraocular methotrexate injections for recurrent vitreoretinal lymphoma. With vitreoretinal lymphoma, there is a trend towards administration of systemic chemotherapy instead of radiotherapy, in the hope of delaying or preventing brain disease. Many patients with vitreo-retinal lymphoma tend to be treated by retinal specialists without referral to an ocular oncology centre, this service is not included in the nationally designated service.

Intraocular adenocarcinomas are very rare and tend to be locally invasive and destructive with little metastatic potential.

Conjunctival melanomas are rare, with an incidence of about 1 per ten million per year. They occur in two forms: melanoma in situ (otherwise known as Primary acquired melanosis (PAM) with atypia) and invasive melanoma, which can be nodular, diffuse or mixed. These tumours may invade the orbit and the eye and to metastasize to regional lymph nodes and systemically. Melanoma in situ requires biopsy to be distinguished from benign melanosis (i.e., PAM without atypia). Some centres also advocate sentinel node biopsy in high risk patients. The overall survival is about 70% at ten years, being much worse if the caruncle is involved (i.e., the fleshy lump in the inner corner of the conjunctiva).

Melanomas tend to be treated by local excision of any nodules, with adjunctive radiotherapy in some cases and topical chemotherapy if there is extensive, superficial disease. Many patients with conjunctival melanoma are referred to an oncology centre only after undergoing biopsy or local excision at their local hospital and in these patients the prognosis maybe worse, because of incomplete excision or iatrogenic seeding.

Other malignant conjunctival tumours include squamous cell carcinoma and sebaceous gland carcinoma, both of which are rare in the UK. These are treated in a similar way to conjunctival melanoma.

## **B. benign tumours**

Choroidal naevi are common intraocular tumours, affecting about 10% of the population. Most are easily diagnosed as such and ignored. Patients are referred to an oncology centre only if the naevus is atypical and bulky so that differentiation from melanoma cannot be made with certainty. These patients require life-long surveillance, with examination every 4-6 months initially, then once every year or so.

Melanocytoma is a rare type of naevus, which can (rarely) undergo malignant transformation to melanoma. Congenital ocular melanocytosis is a birth-mark consisting of an over-population of melanocytes (i.e., pigment cells) in and around the eye. This condition predisposes to intraocular melanoma so that patients require life-long surveillance.

Choroidal haemangiomas are rare. They tend to develop near the macula and optic

nerve, causing retinal detachment, with loss of vision and, in some cases, the development of a painful eye. Most are mistaken for melanoma or metastasis.

Treatment is with photodynamic therapy whereby a 'cold' infra-red laser beam is used to activate a drug that is injected into the arm a few minutes before this tumour may also be treated with external beam radiotherapy.

Other benign intraocular tumours include: choroidal osteomas, neurilemmomas and cysts, all of which are rare and non sight-threatening. Some patients require some form of ocular treatment. Retinal haemangioblastoma can occur alone or as part of von Hippel Lindau syndrome, which causes brain tumours as well as cancers of the kidneys and other parts of the body. Apart from ocular treatment, it is necessary to exclude systemic disease by performing scans and other investigations and by genetic tests. Surveillance needs to be life-long.

### **C. pseudo-tumours**

Retinal and subretinal haemorrhages can resemble an intraocular melanoma. These conditions tend to resolve spontaneously.

Vaso-proliferative tumour is a type of granuloma (i.e., a kind of inflammatory mass), which causes exudation and retinal detachment. Most respond to photodynamic therapy, but some large tumours require plaque radiotherapy.

Congenital hypertrophy of the retinal pigment epithelium (CHRPE) is a birthmark consisting of a black spot under the retina. This can very rarely give rise to adenocarcinoma.

### **Initial assessment**

The aims of initial assessment are to:

- diagnose the ocular tumour;
- measure the tumour dimensions and extent, for treatment planning
- identify and secondary effects and concurrent ocular disease
- identify and primary or secondary extraocular malignancy or associated manifestations
- determine the patient's general health and suitability for general anaesthesia.

Ocular:

- visual acuity, measured with a Snellen or LogMar chart, ideally with best optical correction;
- slit-lamp examination and ophthalmoscopy, of both eyes;
- anterior segment and fundus photography of tumour and any other abnormalities;
- fluorescein angiography, in selected cases (e.g., if diagnosis is uncertain);
- Indocyanine green angiography, in selected cases (e.g., if diagnosis is uncertain);

- autofluorescence photography, in selected cases (e.g., to detect lipofuscin pigment);
- optical coherence tomography, in selected (e.g., to detect subretinal fluid);
- ultrasonography, in almost all patients, to detect, diagnose, define and measure any tumour;
- computerised tomography, which is rarely required;
- magnetic resonance imaging, which is rarely required;
- biopsy, to establish diagnosis and, in the case of uveal melanoma, to estimate the prognosis.

#### Systemic:

- systematic history, to detect disease and establish impact of any disease on health;
- clinical examination, to identify extraocular malignancy and unrelated disease;
- chest radiography, in selected cases, if lung or heart disease is suspected;
- electrocardiography, if general anaesthesia is planned;
- full blood count, if general anaesthesia is planned or if haematological malignancy is suspected;
- serum electrolytes, if general anaesthesia is planned;
- liver function tests, if general anaesthesia is planned or to detect liver metastases from uveal melanoma;
- liver imaging, in some or all patients with uveal melanoma, depending on departmental policy;
- other systemic imaging (e.g., brain scans in patients with retinal angioma and risk of CNS tumours);
- genetic tests (e.g., to identify von Hippel Lindau disease).

#### Treatment

##### Surgery:

- enucleation, if risks of conservative treatment outweigh the possible benefits;
- exoresection (e.g., iridectomy, iridocyclectomy, cyclochoroidectomy, choroidectomy for uveal melanoma);
- endoresection, as primary treatment for uveal melanoma or secondary treatment after radiotherapy;
- conjunctival tumour excision, often with adjunctive Brachytherapy;
- exenteration if a conjunctival or intraocular tumour has spread extensively into the orbit.

##### Radiotherapy:

- plaque radiotherapy (Brachytherapy), using ruthenium, iodine or strontium isotopes;
- proton beam radiotherapy, if brachytherapy is not possible. Via referral to Clatterbridge Centre for Oncology, (this treatment is out with the national service);
- stereotactic radiotherapy, if proton beam radiotherapy is undesirable.

#### Phototherapy:

- photocoagulation, with high-energy burns (e.g., to treat neovascular complications);
- transpupillary thermotherapy, with low-energy burns (e.g., to treat small uveal melanomas);
- photodynamic therapy, using 'cold' infrared laser to activate an intravenously-injected drug.

#### Cryotherapy:

- for treatment of conjunctival malignancy (e.g., diffuse melanoma) and some intraocular vascular tumours.

#### Chemotherapy:

- topical (drops), such as mitomycin C or 5-fluoro-uracil for conjunctival melanoma and carcinoma;
- intraocular (e.g., methotrexate for vitreo-retinal lymphoma);
- systemic (e.g., chemotherapy for metastatic melanoma, usually administered by general oncologist).

#### Other pharmacotherapy:

- topical;
- steroids and antibiotics after surgery;
- tear substitutes, for dry eye.

#### Intraocular:

- anti-angiogenic agents, for retinal exudation or neovascular complications;
- steroids for macular oedema (e.g., after radiotherapy);
- systemic;
- antibiotics after some intraocular procedures (e.g., exoresection);
- steroids after some intraocular procedures (e.g., exoresection).

#### **Follow-up assessment**

Follow-up assessments are performed to assess local tumour control and to detect and treat any side-effects and complications of treatment (e.g., infection, cataract, glaucoma, macular oedema). Such examinations are usually performed about 1 to 4 weeks post-operatively, then every four to six months for one to five years, then once a year indefinitely, depending on the diagnosis and risk of complications. Some or all such follow-up may be delegated to the referring ophthalmologist, at the discretion of the ocular oncologist, on a case-by-case basis.

#### **Ocular investigations**

##### **The following ocular investigations must be available in the national centre:**

- visual acuity, to assess success of treatment;
- tonometry, routinely performed in all eye examinations;

- slit-lamp examination and ophthalmoscopy, of both eyes in all patients is routine;
  - colour photography, to document tumour extent;
  - fluorescein angiography, if radiation-induced exudative or neovascular complications occur;
  - optical coherence tomography, to assess macular oedema (e.g., after radiotherapy) (not available at BLT);
- 
- ultrasonography, to assess tumour dimensions and response to any treatment;
  - biopsy, in selected cases (e.g., to detect persistent conjunctival malignancy after treatment).

### **Systemic investigations**

The following systemic investigations must be available:

- blood tests (e.g., liver function tests in some or all patients with uveal melanoma);
- imaging studies (e.g., liver ultrasonography in some or all patients with uveal melanoma).

### **Risk management**

Care delivered by the ocular oncology service providers must be of a nature and quality to meet the care standards, specification and Agreement for the service. It is the trust's responsibility to notify the commissioner on an exceptional basis should there be any breaches of the care standards. Where there are breaches any consequences will be deemed as being the trust's responsibility.

Patients must be managed in line with the specification and care standards. Any deviation from these which has not been approved by NHS England are at the trust's risk both clinically and financially. It is the trust's responsibility to inform the commissioners of any such non-approved deviations on an exceptional basis.

Where a patient's presentation challenges the assumptions that underpin the specification, service standards and contractual arrangements it is the trust's responsibility to inform the commissioners on an exceptional basis, prior to any treatment (except for emergency treatment) so that the implications of the patient's requirements can be considered. This does not affect situations where the Individual Funding Application process applies.

The National Ocular Oncology service recognises that identifying risks and managing these well provides invaluable opportunities to improve patient care and there are formal arrangements in place to support these principles. Risk management is covered in mandatory training programmes for staff and the monthly Directorate Risk and Governance meeting provides the opportunity to review all clinical incidents and to ensure processes are revisited as a part of managing risk. This is also achieved by promoting a policy of openness and accountability and by

effective communication both within the service and with the external community.

The service reports on outcomes annually to the service's commissioners and meets once a year to discuss any issues of clinical governance within the service.

### **Initial assessment**

Ocular assessment is performed to determine the tumour diagnosis, size, location and extent and to identify any secondary effects on the eye (e.g., retinal detachment). In selected cases, systemic screening for extraocular malignancy is undertaken. Patients are counselled on the nature of their condition and on therapeutic options, side-effects, prognosis, etc.

### **Treatment**

Ocular treatment is performed either within a few weeks, as described above.

### **Immediate post-operative care**

Most patients live far from the ocular oncology centre so that arrangements are made for their immediate post-operative care to be undertaken by their local ophthalmologist. This is to detect and treat inflammation and other complications that can occur after any kind of ocular surgery.

### **Long-term follow-up**

Ocular surveillance is required to detect local tumour recurrence and other complications that might require treatment (e.g., cataract, macular oedema, etc). This needs to be life-long after treatment of an ocular malignancy or if a small untreated tumour is of uncertain malignancy. Different centres follow a variety of strategies, some seeing all patients indefinitely with others alternating visits with the referring ophthalmologist. The indications for discharging patients permanently back to the referring ophthalmologist vary between centres. When patients are discharged to their local ophthalmologist, arrangements are made for them to be seen promptly should any problems ever arise.

Systemic screening is undertaken according to the tumour diagnosis. For example, with retinal haemangioblastomas, screening is required for tumours of the brain, kidneys and adrenal glands. Patients with high-risk uveal melanoma tend to be offered screening for hepatic metastases.

### **Discharge criteria & planning including any transition arrangements**

#### **Sheffield Teaching Hospitals NHS Foundation Trust**

Owing to the specialised nature of ocular oncology treatments patients are offered lifelong review.

Patients unable or unwilling to travel to Sheffield are discharged to the referring ophthalmologist or optometrist if that is felt to be more appropriate.

Any discharged patient has open access to the clinic should a problem arise.

Systemic screening for metastases is arranged to coincide with their six monthly reviews at the Sheffield ocular oncology service for high-risk patients. Patients are referred to their General Practitioner (GP) for screening if they have moderate to low risk of metastases; or if they have been discharged from the service.

Patients receive information leaflets prior to treatment and are counselled as to post-operative care and follow-up arrangements prior to discharge.

Referring ophthalmologist, GP and patient receive clinic letters from every attendance.

Personalised advice individualised for each patient is sent to their GP.

Patients needing external beam radiotherapy are referred to a radiotherapist. Patients needing systemic chemotherapy (e.g., for metastases) are referred to their local oncologist.

### **Royal Liverpool and Broadgreen University Hospitals NHS Trusts**

Risk of local tumour recurrence estimated to be less than 1%  
Completed treatment of ocular complications such as macular oedema, if appropriate. (All discharged patients are reviewed without delay if patient or referring ophthalmologist express concerns).

#### *Process of discharge*

Patients discharged from ward are given an information pack. Referring ophthalmologist and GP are sent discharge letters. If appropriate, colour photographs of tumour are sent to referring ophthalmologist.

#### **Discharge planning criteria and information transfer:**

- all pathology reports and genetic reports are sent to referring ophthalmologist and GP, with explanatory letter and, if appropriate, personalised survival curve (Liverpool);
- personalised advice individualised for each patient is sent to referring ophthalmologist and GP;
- reports on new patients are sent to patient's optometrist for educational purposes (Liverpool);
- copies of letters (but not lab reports) are sent to all patients after every visit (Liverpool);
- all new patients with serious disease are given a compact disc (CD) recording of their actual consultation (Liverpool).

## How patients will transition to other services

- patients at high risk of metastatic disease from uveal melanoma are referred to a general oncologist who invites them to his clinic but who refers them on to their local oncologist if they are unable to return to Merseyside;
- patients with a treated malignant tumour or with an untreated tumour of uncertain malignancy are referred to their ophthalmologist for life-long surveillance as soon as their condition is deemed to be stable and when the risk associated with such referral is considered to be very small;
- patients needing external beam radiotherapy are referred to a radiotherapist
- patients needing systemic chemotherapy (e.g., for metastases) are referred to their local oncologist.

## 2.3 Population covered

This service covers patients resident in England and European Union residents eligible for treatment in the NHS under reciprocal arrangements.

Patients from Scotland, Wales and Northern Ireland are not part of this commissioned service and the trusts must have separate commissioning arrangements in place.

## 2.4 Any acceptance and exclusion criteria

Patients are mostly referred by hospital consultant ophthalmologists, usually after the tumour has been detected by an optometrist.

Every effort is maintained to promote equal access to the service regardless of culture, disability, gender sensitive issues or where patients live, although the difficulties of funding the cost of travel to access the service are recognised

The service is accessible to all patients. Within the scope of this specification regardless of sex, race or gender.

Providers are required to provide staff with mandatory training on equality and diversity and the facilities used to deliver the service must offer appropriate disabled access for patients, family and carers. When required the providers will use translators and printed information is available in multiple languages.

The provider has a duty to co-operate with the commissioner in undertaking Equality Impact Assessments as a requirement of race, gender, sexual orientation, religion and disability equality legislation.

## 2.5 Interdependencies with other services

Ocular oncology services relate to:

- patients and their relatives;
- general practitioners;
- optometrists;
- referring ophthalmologists.

Interdependencies exist with:

- pathologists;
- geneticists;
- anaesthetists;
- general oncologists;
- vitreoretinal ophthalmic surgeons;
- medical ophthalmologists;
- ophthalmic photographers, ultrasonographers and other imaging experts;
- specialist nurses;
- psychologists.

Dependence on other services:

- Anaesthesia;
- Oncology;
- Radiotherapy;
- Radiology/ultrasonography
- Haematology.

Other services dependent on ocular oncology services

- optometry;
- general practice;
- general ophthalmology.

### Relevant networks and screening programmes

There are no national ocular oncology patient groups established. There are no formal screening services relevant to ocular oncology.

The services depend on the support of the nationally designated ophthalmic pathology services.

Patients are referred for Proton Beam Therapy (PBT) to the Clatterbridge Centre for oncology. The commissioning of the PBT service is outside of the nationally commissioned ocular oncology service.

Referral guidelines have been agreed for the service, appendix 2

### 3. Applicable Service Standards

#### 3.1 Applicable national standards e.g. NICE, Royal College

The nationally designated ocular Oncology providers must be fully integrated into their trust's corporate and clinical governance arrangements.

NHS England commissioners and the provider will conduct a formal Joint Service Review at each centre at least annually and would expect to meet with the national clinical teams annually.

See also the National Service Standards for Ocular Oncology.

### 4. Key Service Outcomes

#### The objectives of the service –strategic

The objectives of the Adult Ocular Oncology Service in England are to diagnose and treat ocular tumours in the hope of prolonging life and improving quality of life by conserving the eye and useful vision whenever possible, also providing psychological counselling. Another important objective is to collaborate with medical and surgical oncologists so as to optimise any opportunities for preventing and treating metastatic disease.

#### The purposes and goals of the service

Ocular, psychological and systemic outcomes vary greatly according to age, gender, clinical stage, histological grade of malignancy and genetic tumour type. Desired levels of outcomes therefore need to be judged in comparison with audit results reported in articles listed in the previous section.

Ocular outcomes are assessed in terms of:

- conservation of visual acuity, measured with a Snellen or LogMAR chart;
- preservation of the eye;
- local tumour control/treatment of local tumour recurrence;
- avoidance of ocular complications/treatment of complications (e.g. retinal detachment, cataract, glaucoma, macular oedema, strabismus/squint);
- patient centred outcomes, measured with quality of life instruments.

Systemic outcomes are measured in terms of:

- survival time;
- cause of death;
- iatrogenic complications (e.g., deep vein thrombosis, nosocomial infections, anaesthetic deaths).

Satisfaction:

- patient satisfaction, measured with anonymous questionnaires;
- referring ophthalmologists' satisfaction, measured with anonymous questionnaires.

National clinical outcomes measures for the service have been agreed and these are attached as App 1.

Adopted

## 5. Location of Provider Premises

Royal Liverpool and Broadgreen University Hospitals NHS Trusts

~~Barts Healthcare NHS Trust and~~ Moorfields Eye Hospital NHS Foundation Trust.

Sheffield Teaching Hospitals NHS Foundation Trust

Adopted

**APPENDIX 1**

Intraocular Melanoma 1/01/YR-31/12/YR <b>PATIENT CHARACTERISTICS</b>	Centre	
	No. of patients	%
<b>Total no. of patients</b>		
<b>Sex: Male</b>		
<b>Female</b>		
<b>Mean age (range)</b>		
<b>Largest tumour diameter:</b>		
<10mm		
10-15mm		
>15mm		
Data missing		
<b>Mean largest tumour diameter (mm)</b>		
<b>Tumour thickness:</b>		
<5.5mm		
5.5mm and > 5.5mm		
Data missing		
<b>Mean tumour thickness (mm)</b>		
<b>Optic disc involvement:</b>		
No		
Yes		
<b>Location:</b>		
Iris		
Ciliary body (including pars plana)		
Choroid		
Ciliary/Choroid		
Iris/Ciliary		
<b>PRIMARY PROCEDURES</b>	No. of patients	%
<b>Primary enucleation</b>		
<b>Plaque radiotherapy</b>		
<b>Proton beam</b>		
<b>Other radiotherapy</b>		
<b>Local resection</b>		
<b>Endoresection</b>		
<b>Stereotactic radiosurgery</b>		
<b>Transpupillary thermotherapy</b>		
<b>Cryotherapy</b>		
<b>Photodynamic therapy</b>		

**Other primary treatment (specify)**

**Argon laser**

**Exenteration**

**Ruthenium plaque + cryotherapy**

**Ruthenium plaque + local  
resection**

**....Vitrectomy**

**No specific treatment:**

**Observation**

**.....Biopsy**

**.....Declined treatment**

Adopt

**APPENDIX 2**

## **1. INTRODUCTION**

In 1997 Liverpool, London and Sheffield were designated as Centres of Excellence for adult ocular oncology in England by the National Commissioning Group (formerly the National Specialist Commissioning Advisory Group). The National Services Division in Scotland similarly designate a service for Scotland at North Glasgow University Hospital.

These guidelines are not intended to be prescriptive but to act as an aid to considering referral of patients to the nationally designated ocular oncology centres. Referring ophthalmologists should continue to exercise discretion based on the individual clinical presentations of individual patients.

## **2. WHOM TO REFER TO THE SERVICE**

### **2.1 Patients with intraocular tumours**

- Any primary intraocular tumour other than naevus
- Any intraocular metastatic tumour if specialist ocular oncology is required
- Suspected intraocular lymphoma.

### **2.2 Patients with conjunctival and epibulbar tumours**

### **2.3 Refer patient with conjunctival melanocytic tumour if:**

- Cornea, caruncle, and/or palpebral conjunctiva is/are involved
- Feeder vessels are present
- Nodule is associated with diffuse pigmentation
- Diameter exceeds 3 mm, especially in absence of clear cysts.

### **2.4 Patients with a suspicious melanocytic choroidal tumour having:**

A: One of the following:

- Thickness greater than 2.0 mm
- Collar-stud configuration
- Documented growth

B: Two of the following:

- Thickness > 1.5mm
- Orange pigment
- Serous retinal detachment

- Symptoms.

## 2.5 Refer patient with an iris nodule if:

- Tumour is more than 3.0 mm in diameter
- Tumour is markedly elevated
- Secondary glaucoma or cataract
- Tumour involves angle.

## 3. WHOM NOT TO REFER

- Congenital hypertrophy of retinal pigment epithelium
- Simple naevi, if:
  - (A) small and flat, or
  - (B) minimally raised with only drusen on the surface
- Eyelid tumours
- Orbital tumours [Note: Scottish patients with eyelid and orbital tumours can be referred to the Scottish service].

## 4. RETINOBLASTOMA

Children with suspected retinoblastoma should be referred to the nationally designated retinoblastoma services in London or Birmingham.

## 5. HOW TO REFER

Please send a fax and letter with the following:

- Name, date of birth
- Address, telephone number (including mobile number if appropriate)
- GP name, address and fax
- Relevant ocular and systemic details
- Results of any recent blood tests or scans – **please do not carry out conjunctival biopsies and never delay a referral because of any investigations.**
- **An old photograph, if tumour growth suspected and if available**
- Special needs and preferences.

The NHS Cancer Plan (England) specifies that referrals for possible cancer should reach the specialist hospital within 24 hours of the decision to refer.

Please give the patient a number to phone if an appointment letter is not received within two weeks. All ophthalmologists can refer patients to any centre. Referrals of patients from Scotland to centres other than Glasgow will be on the basis of exceptional circumstances only and will require prior approval from National Services Division NHS Scotland.

## 6. CONTACTS

### 6.1 Contacting the Ocular Oncology Team in Liverpool

#### Referrals to:

St Paul's Eye Unit  
Royal Liverpool University Hospital  
Prescot Street  
Liverpool L7 8XP

Alternatively, you can telephone the Ocular Oncology Secretary on 0151 7063973 or send a fax to 0151 706 5436.

### 6.2 Ocular Oncology Team in London

#### Referrals to:

~~Ophthalmology Department~~  
~~Ocular Oncology~~  
~~1st Floor RSQ~~  
~~St. Bartholomew's Hospital (Barts)~~  
~~West Smithfield~~  
~~London~~  
~~EC1A 7BE~~  
~~Moorfields Eye Hospital NHS Trust~~  
~~Moorfields Eye Hospital NHS Trust~~  
~~162 City Road~~  
~~London~~  
~~EC1V 2PD~~

Alternatively, you can telephone 020 7601 7657

### 6.3 Ocular Oncology Team in Sheffield (Royal Hallamshire Hospital)

#### Referrals to:

Fax to 0114 271 2530  
E-mail to generic mail box: [sht-tr.Cancer-OcularOncology@nhs.net](mailto:sht-tr.Cancer-OcularOncology@nhs.net)  
For any referral enquiries please contact:  
Ocular Oncology Co-ordinator on 0114 271 3962

## 6.4 Ocular Oncology Team in Glasgow

### Referrals to:

Service Administrator  
Ocular Oncology Service  
Gartnavel General Hospital  
1053 Great Western Rd  
Glasgow G12 0YN

Email: [susan.campbell2@ggc.scot.nhs.uk](mailto:susan.campbell2@ggc.scot.nhs.uk)

Alternatively, you can telephone the Ocular Oncology Service on 0141 211 2934 or send a Fax to 0141 211 2054.

Adopted



## Change Notice for Published Specifications and Products

### developed by Clinical Reference Groups (CRG)

#### Amendment to the Published Products

**Product Name**

Ocular Oncology Service (Adults and Adolescents)

**Ref No**

D12/S(HSS)/a

**CRG Lead**

Alison Davis (CRG Chair)

#### Description of changes required

Describe what was stated in original document	Describe new text in the document	Section/Paragraph to which changes apply	Describe why document change required	Changes made by	Date change made
Barts Healthcare NHS Trust and Moorfields Eye Hospital NHS Foundation Trust	Remove 'Barts Healthcare NHS Trust and ' <del>Barts Healthcare NHS Trust and Moorfields Eye Hospital NHS Foundation Trust</del>	Section 5 – Location of Provider Premises	Responsibility for providing the service has been transferred solely to Moorfields	Iain Mellis	September 2015
Referrals to: Ophthalmology Department Ocular Oncology 1st Floor RSQ St. Bartholomew's Hospital (Barts)	Referrals to: Moorfields Eye Hospital NHS Trust 162 City Road  London	6. Contacts	As above	Iain Mellis	September 2015

West Smithfield London EC1A 7BE Alternatively, you can telephone 020 7601 7657	EC1V 2PD				