The National Institute for Clinical Excellence (NICE) has published guidelines for eye screening and management of retinopathy in people with type 2 diabetes (NICE, February 2002). The Health Technology Board for Scotland (HTBS) has also published advice concerning the organisation of services for diabetic retinopathy screening for both type 1 and type 2 diabetes (HTBS, April 2002). NICE utilises the grading system proposed by Eccles et al. (1998) to indicate the strength of evidence upon which they base their recommendations. The strongest evidence is derived from meta-analysis of randomised controlled trials (grade A). The weakest evidence (grade D) is largely derived from expert committee reports and/or clinical experience of respected authorities. Most of the NICE recommendations are based upon the lowest level of evidence with the exception of preventative strategies to achieve a target blood pressure of less than 140/80 and tight glycaemic control (HbA1c less than 7%) which are derived from the UKPDS and graded A (UKPDS 38 and 33). Screening for retinopathy, even by carefully co-ordinated screening programmes utilising retinal photography and conducted and evaluated by trained personnel, or examination by slit lamp indirect ophthalmoscopy, only achieved grade C levels of evidence.

The guidelines also provide indications for urgent ophthalmology referral. They state that sight-threatening retinopathy should be seen ‘within a day’ whilst less acute but still urgent categories are left to the strategic health authorities and trusts to agree local standards for maximum waiting times. This latter ‘soft’ target is strengthened by the statement that the NICE guidance development group considered a maximum waiting time of one week to be the appropriate non-immediate, but still ‘urgent’, category and four weeks for the ‘soon’ category.

These guidelines, based upon available clinical evidence, are helpful and must be seen as a challenge to those providing diabetes services. The differences between the recommendations from NICE and the specific framework required by the Scottish screening programme is instructive. The latter requires all people with diabetes (not just type 2) to have had their eye status recorded on the local diabetes clinical management system by September 2003. The Scottish diabetes group are also to produce plans to take forward the recommendations of their HTBS report on the organisation of services for diabetic retinopathy screening by summer 2002.

Implementation of clinical guidelines for retinopathy screening will require health communities to produce strategies to identify and provide the necessary resources. The NICE guidelines are ambitious but without specified milestones it is difficult to imagine that they will be uniformly applied across the country. Many health authorities currently have some form of diabetic eye screening programme but to-date their quality has been difficult to assess and published audit data, even of the proportion of patients attending for annual screening, is rarely forthcoming. Those responsible for providing diabetes services, which should involve joint management between primary and secondary care, need to ensure that appropriate
strategies are developed, maintained and resourced. The cost implications are considerable. While the guidelines quote clinical evidence for the effectiveness of screening provided by trained personnel with experience in grading retinopathy from photographic images, there is so far no national programme to provide such training or to accredit those delivering the programme. Again, this requires agreed targets and central direction since, as with any national screening programme, it needs to be delivered equitably.

Most people will be asymptomatic until their retinopathy is very advanced and the risk of visual impairment and blindness is substantially reduced by a comprehensive care programme which combines methods for early detection with effective treatment of diabetic retinopathy. People with diabetes attending for eye screening need to be assured that the quality of service they receive will be of the highest standard provided by trained and accredited personnel and supported by published audit data. Without such organisation, the screening programme will remain patchy and fail to identify many people with potentially sight-threatening retinopathy who would otherwise be treated by preventative measures.

References