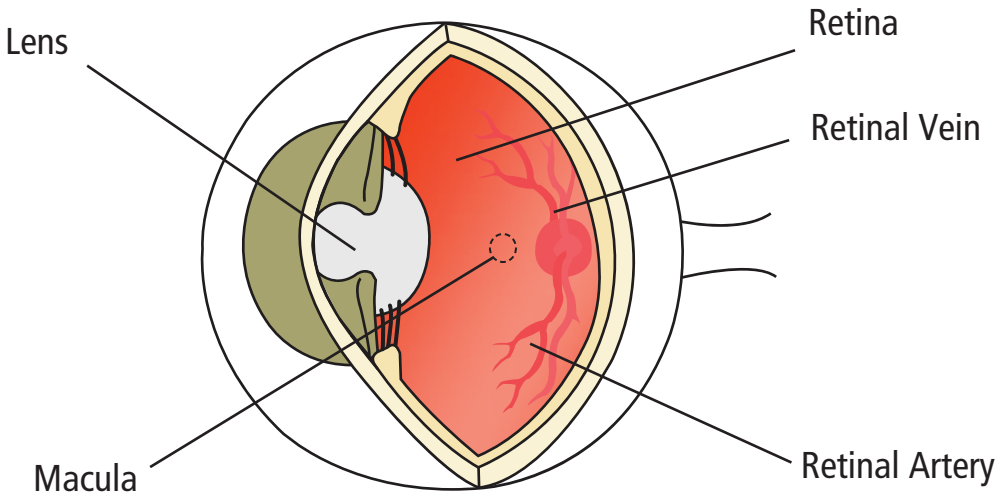
NHS
Royal Cornwall Hospitals
NHS Trust

Panretinal photocoagulation (PRP)

affix patient label

What is this?

Panretinal Photocoagulation (PRP) is a type of laser treatment for the eye. It is used in people who have developed new abnormal blood vessels at the back of the eye in the retina or in the drainage system within the eyeball.



Why do I need this procedure?

In certain conditions, such as diabetic retinal disease (proliferative diabetic retinopathy) or blocked retinal vein (retinal vein occlusion), the PRP laser treatment prevents abnormal new vessels on the retina and in the drainage system of the eyeball from growing and encourages existing ones to shrink and scar up.

If PRP treatment is not done when it is needed, there would be a significant risk of losing sight as a result of bleeding into the eye gel, retinal detachment or painful elevation of eye pressure (neovascular glaucoma).

The aim of the treatment is not always to prevent loss of vision. In situations like retinal vein occlusion or diabetic retinopathy with neovascular glaucoma, the vision is very poor and cannot be improved. The aim in such cases is to prevent the eye from becoming painful through a build-up in fluid in the eye raising the pressure in the eyeball.

How do I prepare for it?

Please read the information leaflet. Share the information it contains with your partner and family (if you wish) so that they can be of help and support. There may be information they need to know, especially if they are taking care of you following this examination.

CHA4502 V2
Reviewed 02/2024 Review due 02/2027

- It is essential that you do not drive to and from your appointment as you will be having dilating drops in the eye undergoing treatment. These drops will blur your vision for up to 6 hours after the treatment.
- You will be called to the hospital 45 minutes before the procedure for pupil dilatation. You can expect to be at the hospital for a minimum of 2 to 4 hours.
- Diabetic patients are advised to ensure they have enough food and medication that they may need during the visit.
- Please take all your normal medications prior to this treatment.
- You may eat and drink normally unless you have been advised not to do so.

What will happen?

This treatment is usually carried out in the Eye clinic. Occasionally, it may be necessary to continue this procedure in the operating theatre under local or general anaesthesia.

1. Your pupils will be dilated using eye drops prior to the procedure.
2. You will be asked to sign a consent form for the treatment. The consent form explains the risks and benefits of this procedure.
3. PRP laser treatment involves applying many laser burns to the peripheral part of the retina, sparing the central part of the retina (the macula), which is responsible for vision. PRP treatment is often given in multiple sessions.
4. At the beginning of the procedure, a local anaesthetic eye drop will be applied (in theatre, this will be replaced by injection to the eye or general anaesthesia).
5. You will be asked to rest your chin and forehead on a head rest attached to a special eye microscope (slitlamp).
6. The eye will be stabilized using a special handheld contact lens to allow clear viewing of the retina during the laser procedure.

The treatment usually takes 15 – 30 minutes depending on how much treatment is required.

What happens afterwards?

Following the treatment you can go home. You may notice discomfort or a dull ache in the eye after the treatment. This can be helped by taking painkillers as you would for a headache (eg paracetamol).

Your vision will be 'dazzled' or may seem darker after the treatment. This effect can last for 2 - 7 days. You should avoid driving for 2 days after the treatment.

A follow up appointment will be arranged for either a further session of PRP laser (if required as part of a course of treatment) or for a follow-up check in a few weeks to check that the eye is responding to the treatment. This varies depending on the reason you are having the laser treatment. It may be necessary for further treatment to be carried out.

Are there any risks or complications?

- There is good scientific evidence that laser treatment will significantly reduce the risk of vision deterioration. It also reduces the risk of the eye developing painful high pressure.
- The laser treatment can reduce the peripheral field of vision. You may not notice the effect of this. However, it might mean you will not meet the visual legal requirement for holding a driving license, particularly if both eyes need treatment. Ask the doctor about this if you are a driver.
- Your night vision may be reduced and your colour vision altered in the eye having the treatment.
- Rarely, your vision may be worse after the treatment. This can be caused by a build up of fluid at the back of the eye (macular oedema), bleeding within the eye (vitreous haemorrhage) or by an unintended burn to the centre of the retina. This deterioration of vision may be permanent.

What should I look out for?

If you experience sudden loss of vision or pain after the laser treatment, contact the emergency number **01872 252324**.

Any questions?

This leaflet provides just an overview of panretinal photocoagulation. If you have any questions please do not hesitate to speak to us during your clinic visit.

If you would like this leaflet in large print, Braille, audio version or in another language, please contact the General Office on 01872 252690

CONSENT FORM 1
PROCEDURE SPECIFIC PATIENT AGREEMENT

NHS
Royal Cornwall Hospitals
NHS Trust

Panretinal photocoagulation (PRP)

NHS number: .....
Name of patient: .....
Address: .....
AFFIX PATIENT LABEL
Date of birth: .....
CR number: .....

☐ Right eye

☐ Left eye

STATEMENT OF HEALTH PROFESSIONAL (to be filled in by health professional with appropriate knowledge of proposed procedure, as specified in consent policy)

I have explained the procedure to the patient. In particular, I have explained the intended benefits:

- *Reduce the risk of permanent vision loss*

Significant, unavoidable or frequently occurring risks

- *Eye pain or discomfort during or after the procedure*
- *Redness in the white part of the eye that can be caused by bleeding or inflammation*
- *Transient reduction or darkening of vision for 24 to 48 hours*
- *Headache*
- *Reduction in night vision and / or colour vision*
- *Reduction in the peripheral field of vision: 12% of diabetic patients undergoing bilateral laser treatment may not meet the eligibility criteria for driving after laser treatment.*

Rare but serious risks:

- *Retinal detachment*
- *Bleeding into the jelly of the eye*
- *Accidental burn in macula (the centre of the retina)*

Any extra procedures which may become necessary during the procedure:

- *Other procedure (please specify):*

I have also discussed what the procedure is likely to involve, the benefits and risks of any available alternative treatments (including no treatment) and any particular concerns of this patient.

I have given and discussed the Trust's approved patient information leaflet for this procedure: Panretinal photocoagulation (PRP) CHA4502 which forms part of this document.

I am satisfied that this patient has the capacity to consent to the procedure.

This procedure will involve: ☐ General and/or regional anaesthesia ☐ Local anaesthesia ☐ Sedation

Health Professional signature: ..... Date: .....

Name (PRINT): ..... Job title: .....

STATEMENT OF INTERPRETER (where appropriate)

I have interpreted the information above to the patient to the best of my ability and in a way in which I believe he/she can understand.

Interpreter signature: ..... Name (PRINT): ..... Date: .....

affix patient label

Panretinal photocoagulation consent form

STATEMENT OF PATIENT

Please read this form carefully. If your treatment has been planned in advance, you should already have a copy of the patient information leaflet which describes the benefits and risks of the proposed treatment. If not, you will be given a copy now. If you have any further questions, do ask - we are here to help you. You have the right to change your mind at any time, including after you have signed this form.

I agree to the procedure or course of treatment described on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anaesthesia).

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

I understand that tissue samples will only be taken in relation to the procedure explained to me. No samples will be taken for quality control, clinical education or research purposes.

I have been told about additional procedures which may become necessary during my treatment. I have listed below any procedures **which I do not wish to be carried out** without further discussion.

I have received a copy of the Consent Form and Patient Information leaflet: Panretinal photocoagulation (PRP) CHA4502 which forms part of this document.

Patient signature: ..... Name (PRINT): ..... Date: .....

A **witness** should sign below if this patient is unable to sign but has indicated his or her consent.
Young people / children may also like a parent to sign here (see guidance notes).

Witness signature: ..... Name (PRINT): ..... Date: .....

CONFIRMATION OF CONSENT (to be completed by health professional when the patient is admitted for the procedure, if the patient has signed the form in advance).

On behalf of the team treating the patient, I have confirmed with the patient that they have no further questions and wish the procedure to go ahead.

Health Professional signature: ..... Date: .....

Name (PRINT): ..... Job title: .....

Important notes (tick if applicable):

☐ See advance decision to refuse treatment ☐ Patient has withdrawn consent (ask patient to sign/date here)

Patient signature: ..... Name (PRINT): ..... Date: .....

File copy

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