POSITION STATEMENT

Eye Care Guidelines for Patients With Diabetes Mellitus

Eye care in the diabetic patient reflects a partnership between the primary physician and the eye doctor. The primary physician plays a fundamental role in the medical management, education, and coordination of care for the person with diabetes mellitus. The primary physician should be familiar with the indications for ophthalmic care in patients with diabetes. Therefore, these guidelines are proposed for the familiarity of all involved health professions, and a suggested timetable for patient examination is included.

GENERAL EXAMINATION

In referring patients for routine eye evaluation, the practitioner should be guided by the expertise and qualifications of the eye doctor to perform the examinations described.

1. All patients should be informed that
   a. sight-threatening eye disease is a common complication of diabetes mellitus and is often present even with good vision,
   b. early detection and appropriate treatment of diabetic eye disease greatly reduces the risk of visual loss.
2. People between 12 and 30 yr of age with a diagnosis of diabetes mellitus of at least 5 yr duration should have a baseline ophthalmic examination including
   a. history of visual symptoms,
   b. measurement of visual acuity and intraocular pressure,
   c. ophthalmoscopic examination through dilated pupils.
3. People >30 yr of age should have baseline ophthalmic examinations, as specified in 2 above, at the time of diagnosis of diabetes.
4. After the initial eye examination, it is suggested that people with diabetes mellitus should receive the above ophthalmic exams annually unless more frequent exams are indicated by the presence of abnormalities.

SPECIAL EXAMINATION

1. Women with insulin-dependent diabetes mellitus who are planning pregnancy within 12 mo should be examined by an ophthalmologist.
2. Women with diabetes who become pregnant should have an examination for retinopathy by an ophthalmologist in the first trimester and thereafter at the discretion of the ophthalmologist.
3. Patients should be under the care of an ophthalmologist for
   a. unexplained visual symptoms,
   b. deterioration in visual acuity,
   c. increased intraocular pressure,
   d. any retinal abnormality,
   e. any other ocular pathology that threatens vision.
4. Patients should be under the care of a retinal specialist or other ophthalmologist experienced in the management of diabetic retinopathy when the following conditions are identified:
   a. preproliferative retinopathy (multiple cotton-

Originally approved June 1988.
Reprinted from *Diabetes Care* 11:745–46, 1988.

wool spots, multiple intraretinal hemorrhages, intraretinal microvascular abnormalities, venous beading)
   b. proliferative retinopathy (retinal neovascularization, preretinal or vitreous hemorrhage, fibrosis, traction retinal detachment)
   c. macular edema (hard lipid exudates and/or retinal thickening inside the temporal vascular arcades)
5. Patients with functionally decreased visual acuity should undergo low-vision evaluation and rehabilitation.
6. Laser photocoagulation therapy reduces the risk of visual loss and is generally effective in preventing blindness in patients with high-risk proliferative retinopathy and/or clinically significant macular edema. Vitrectomy can restore vision in certain patients with recent traction retinal detachment or vitreous hemorrhage. Laser therapy and vitrectomy should be performed by a retinal specialist or other ophthalmologist experienced in these procedures in people with diabetes.