1.**Which type of lens implant would you usually use in an aphakic eye with no capsular support?**

1. Anterior chamber lens

29%

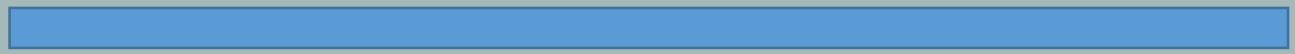
2. Sutured PCIOL

7%

3. Scleral fixated PCIOL – sutureless

18%

4. Lens fixed to anterior/posterior iris



41%

5. Contact lens (no IOL)

4%

2 **Ocriplasmin - who should inject?**

1. VR surgeon only

12%

2. Med Ret specialist only

1%

3. VR and MR

11%

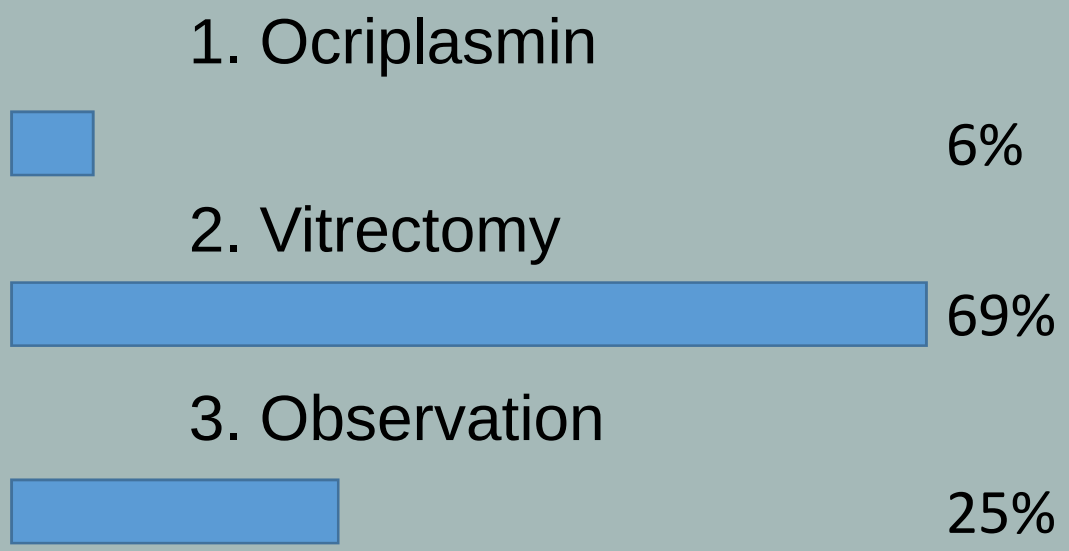
4. Nurse practitioner after consultant decision

5%

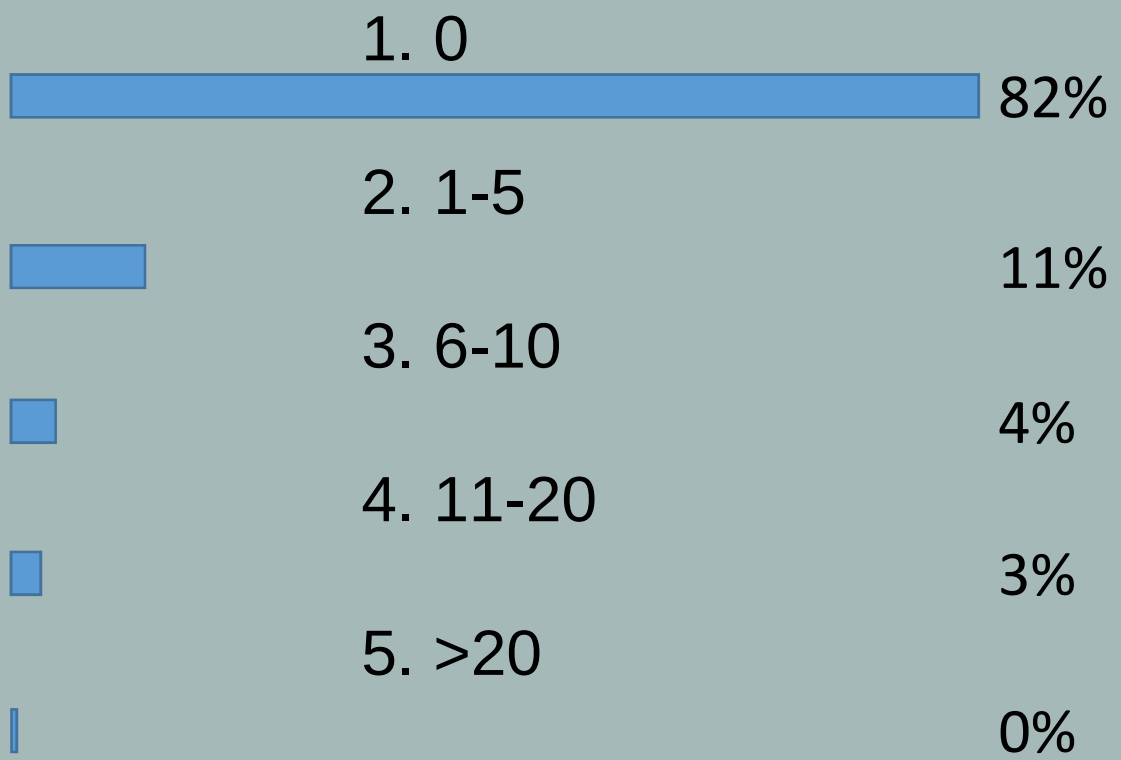
5. Nobody!

71%

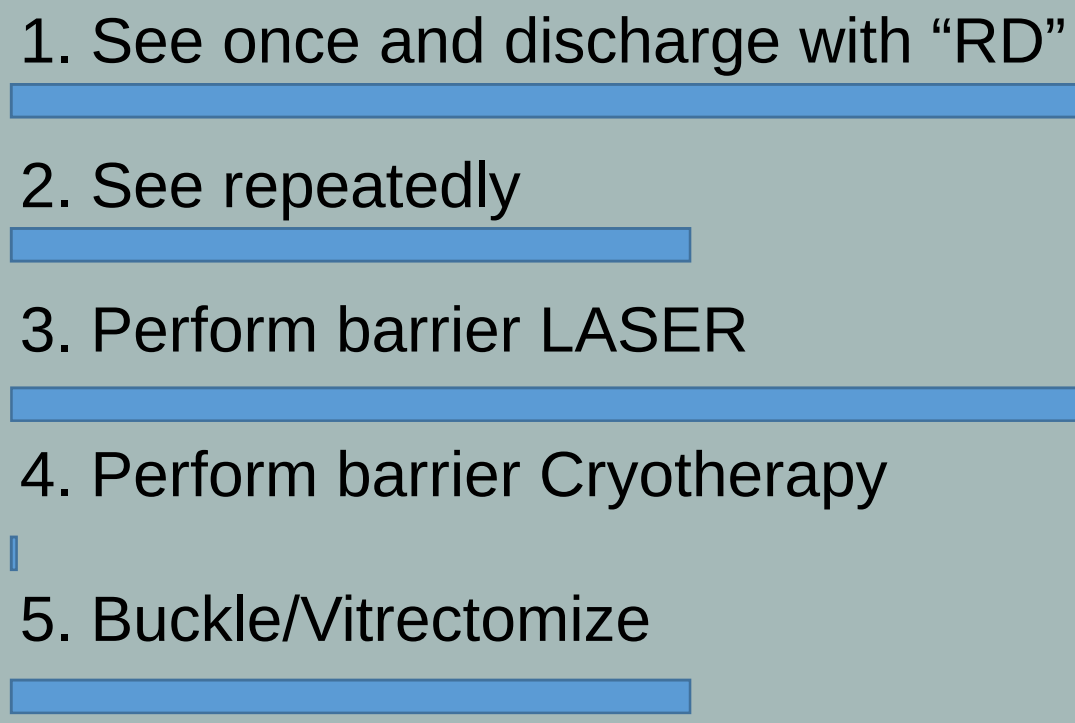
3 **If you had a symptomatic 235 micron macular hole with VMT which treatment would you opt for initially?**



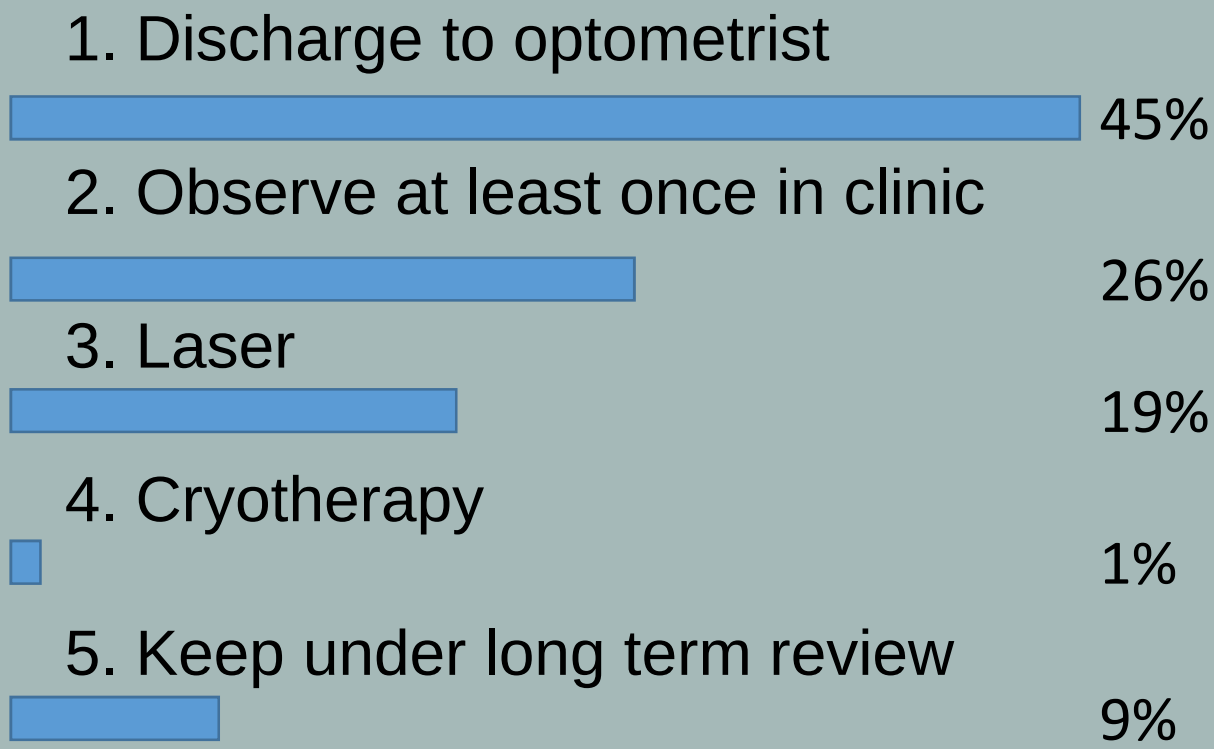
4 How many ocriplasmin injections have you performed (or under your direction) in the last year since BEAVRS 2015?



5 Optician referral - asymptomatic inferior round hole RRD, well beyond the arcades, with little/no demarcation line



6 **What treatment would you advocate for a young myopic patient with multiple areas of lattice degeneration and previous round hole RD in the fellow eye?**



7 **Do you manage stable adult retinoschisis by**

1. Constant review in VR clinic

5%

2. Advise review in a general clinic by a colleague

1%

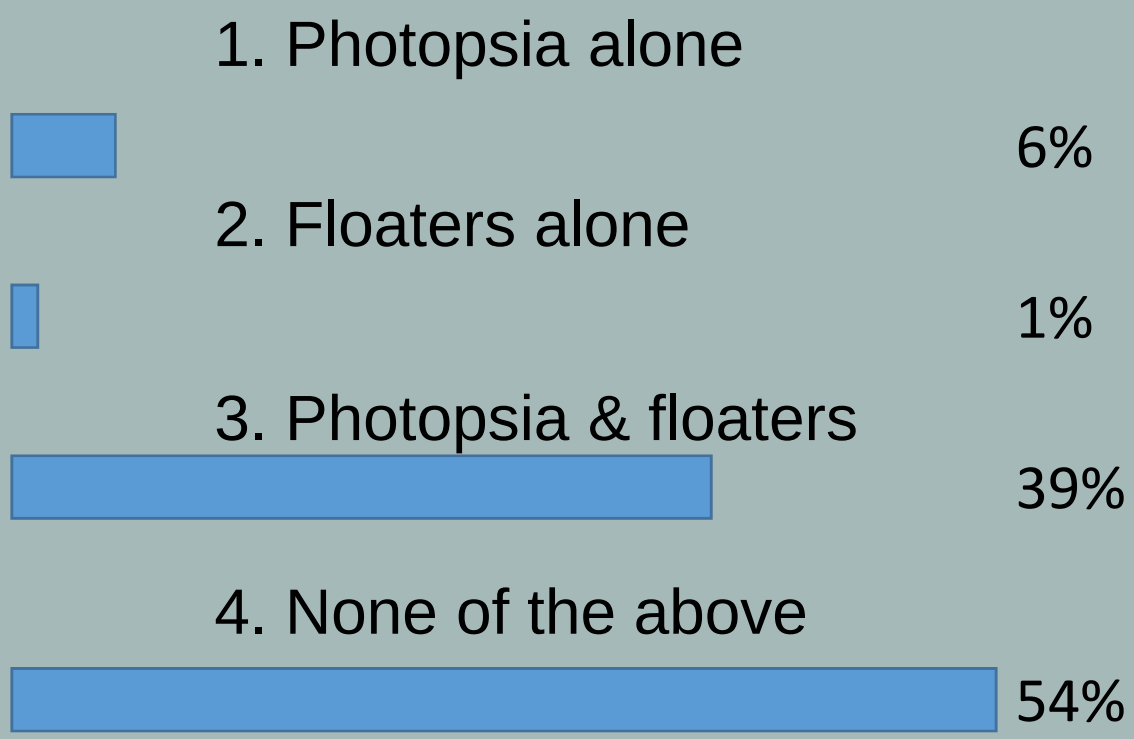
3. Discharge to optometrist for review and RD warning given

62%

4. Discharge to GP with RD warning

32%

8 Round holes with no SRF - Do you consider the following are significant indicators for potential retinopexy



9 **White with or without pressure - do you**

1. Observe

5%

2. Discharge as it is not significant

47%

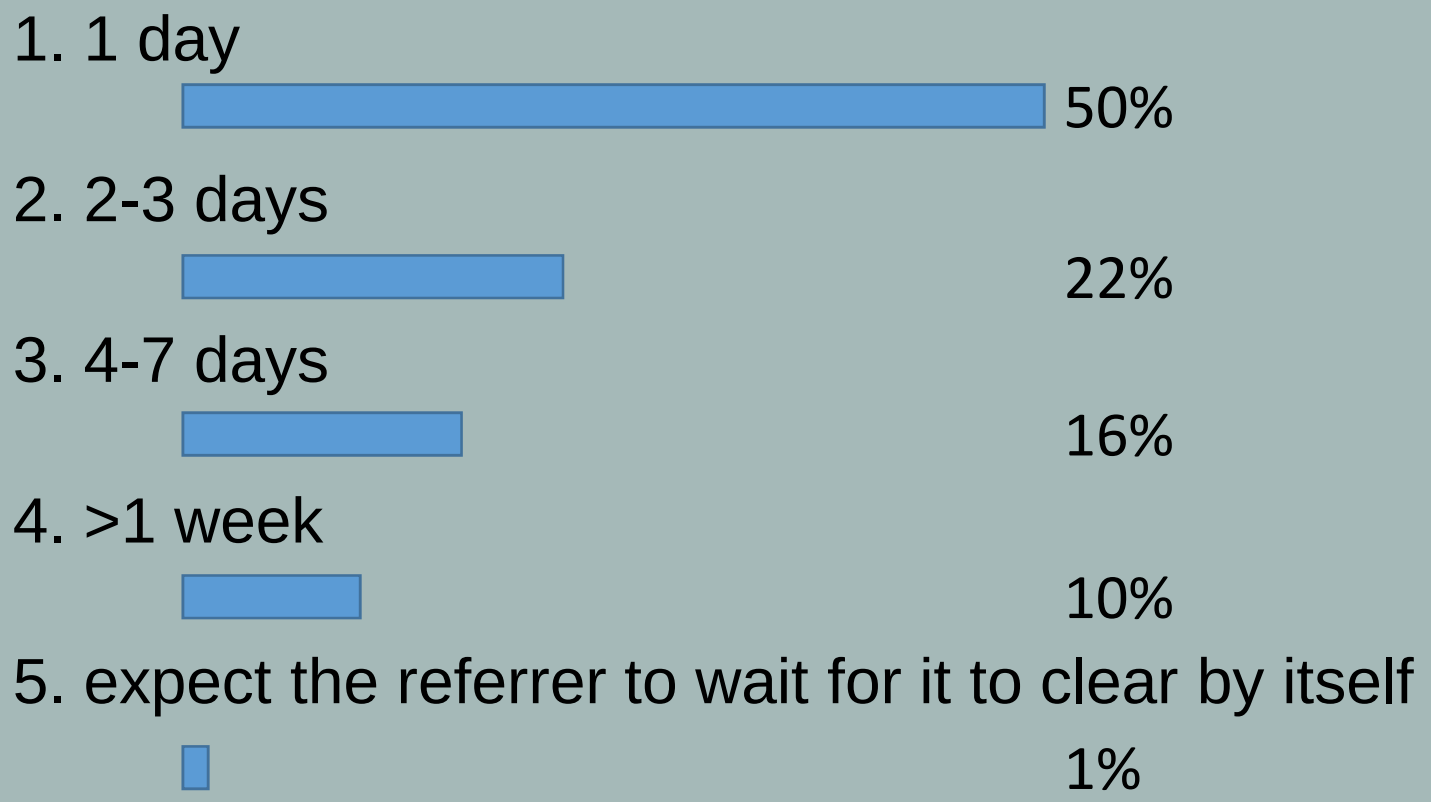
3. Discharge with RD warning

46%

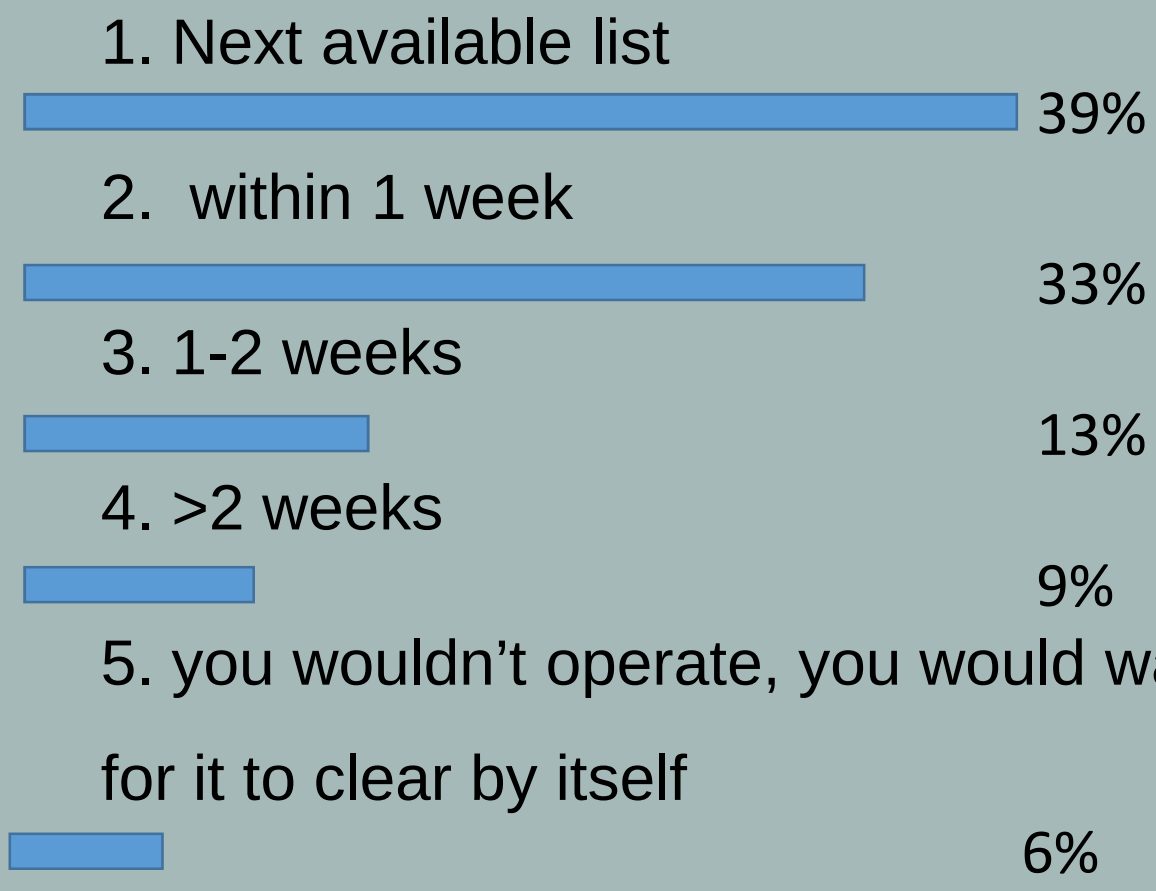
4. Treat prophylactically with either laser, cryo, buckling

2%

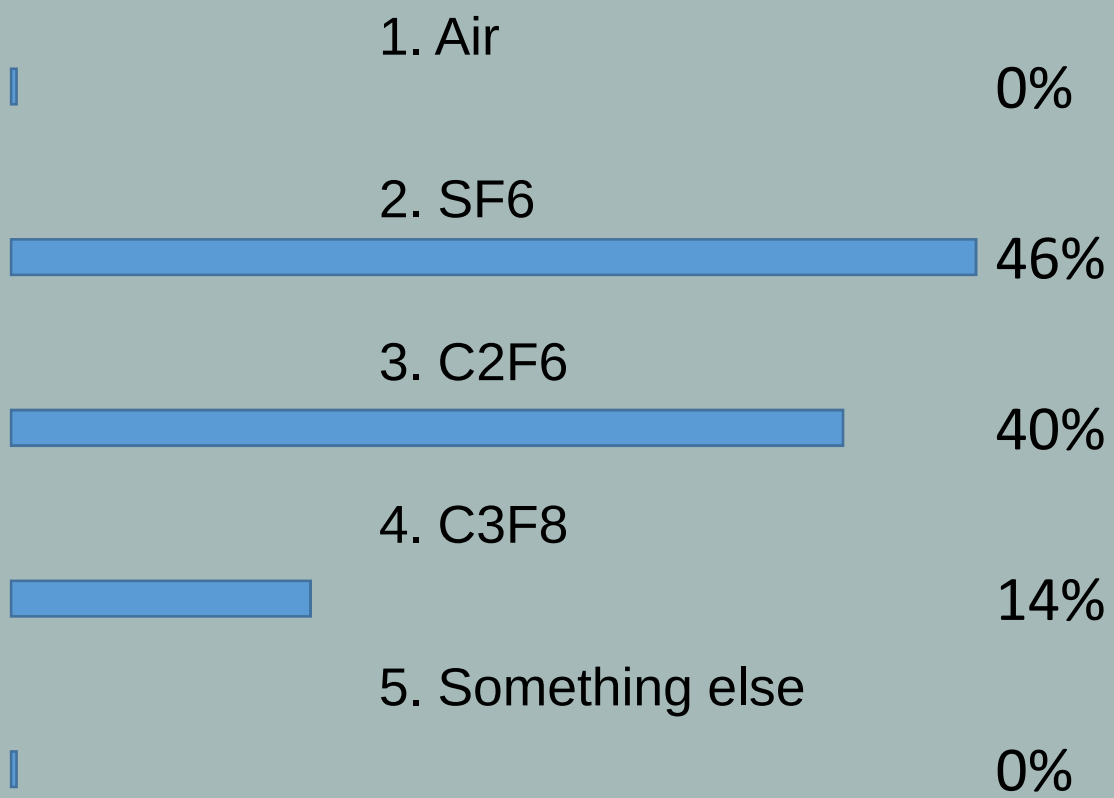
10 **Non-diabetic, non-traumatic vitreous haemorrhage, when would you want referral to VR (B scan - No RD)**



11 Non-diabetic, non-traumatic vitreous haemorrhage, when would you operate (B scan - No RD)



12 With regards to the intraocular gas in primary macular hole (stage II) surgery, do you mostly use



13 With regards to posturing following macular hole (stage II) surgery, do you

1. Posture patient for 1 week or more

9%

2. Posture patient for 5-6 days

26%

3. Posture patient for 2-4 days

27%

4. Posture patient for 1 day only (includes 1st night only)

15%

5. Not posture at all anymore

22%

14 For those surgeons who do NOT posture their primary macular hole (stage 2) patients, which gas do you mostly use

15 **Failed macular hole surgery (assuming gas tamponade and a complete ILM peel took place in first operation). Options for second attempt**

1. Re-do with gas again

56%

2. Re-do with light oil

10%

3. Re-do with heavy oil

7%

4. ILM macular flap or ILM graft from non-macular retina

21%

5. Give up after one attempt

5%

16 **In a patient with macular on retinal detachment due to a GRT extending from 1 o'clock to 6 o'clock (clockwise) what treatment would you advocate?**

1. Vitrectomy with laser and silicone oil 61%
2. Vitrectomy with laser and heavy oil/PFCL 7%
3. Vitrectomy, scleral buckle, laser and silicone oil 3%
4. Vitrectomy, laser and combination of heavy and normal oil 2%
5. Vitrectomy, laser and long acting gas 27%

17 **In a patient with retinal detachment due to a spontaneous (non-trauma related) GRT, do you**

1. Discharge at your usual time

39%

2. Observe the fellow eye only

15%

3. Treat the fellow eye if pathology seen

37%

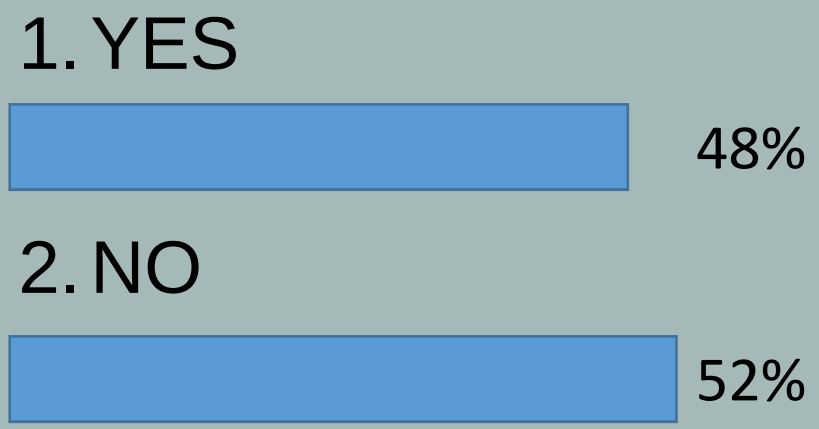
4. Always treat the fellow eye with prophylactic LASER/Cryo, whether any pathology seen or not

9%

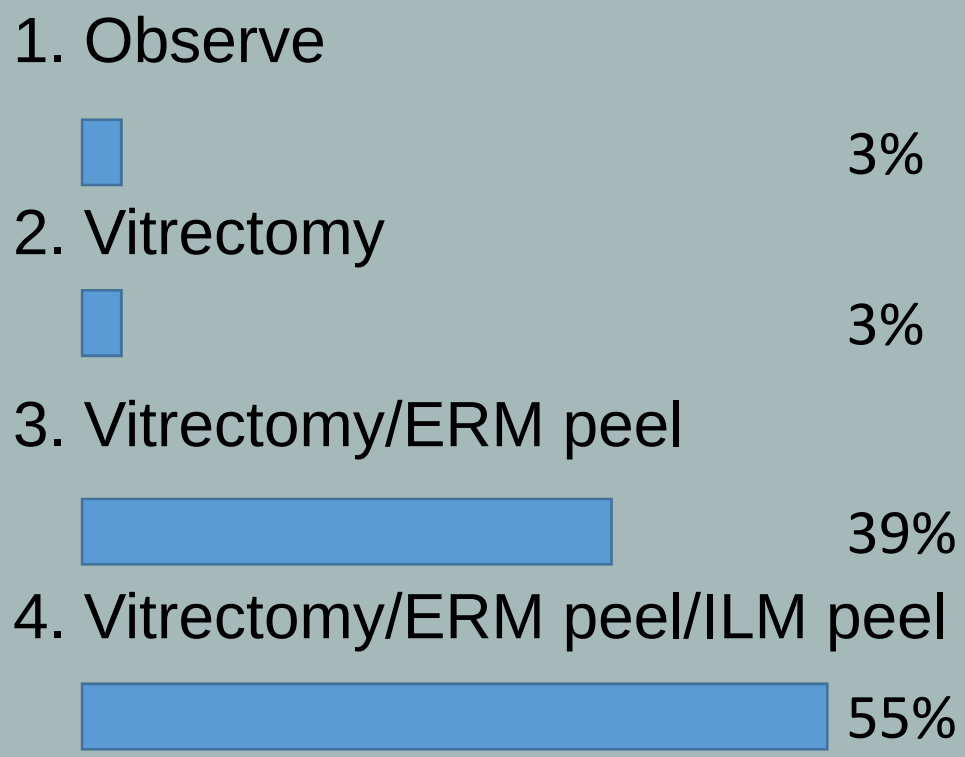
18 **With regards to the management of patients with Sticklers (assume teenage or older)**

1. Discharge to optometrist with RD warning . 11%
2. Observation in VR clinic 39%
3. Treat peripheral retina with 360 cryo as per Cambridge recommendations 11%
4. Treat with other form of prophylaxis eg laser, buckle 9%
5. Refer to Cambridge for management 30%

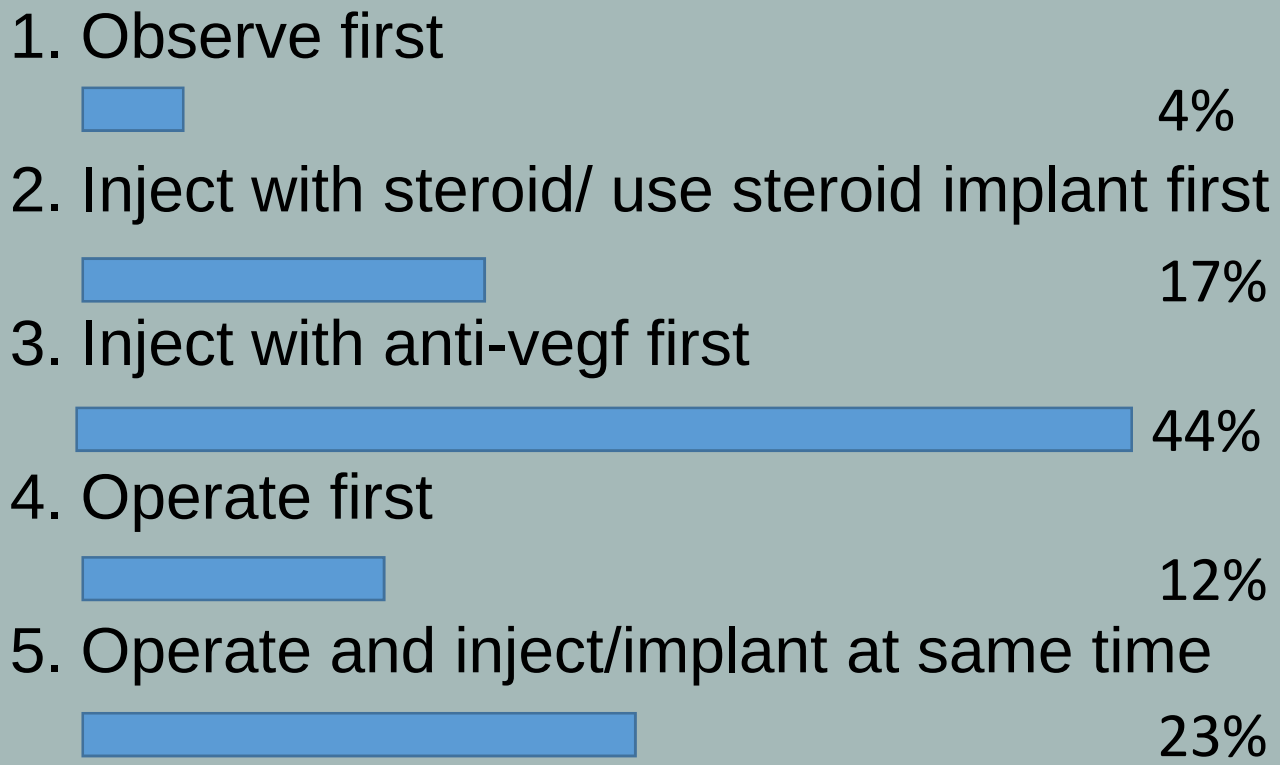
19 **With regards to RD patients who require short term oil (light/heavy) tamponade, do you perform 360 retinopexy in most cases as your “routine” (say yes if performing laser at primary oil surgery, pre-removal oil, at time of oil removal)**



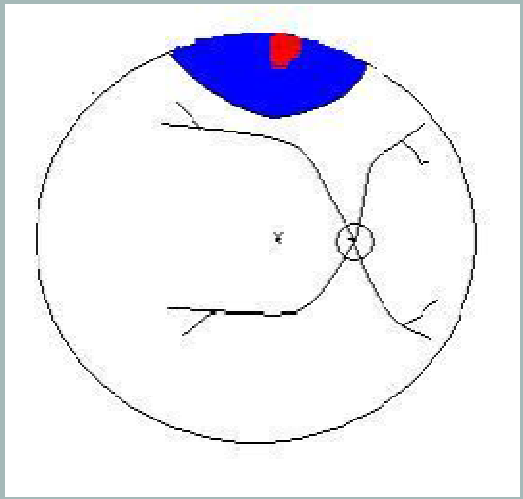
20 **Symptomatic ERM with VA 6/18. Would you**



21 **Symptomatic ERM with BRVO and 6/36 VA. Would you**

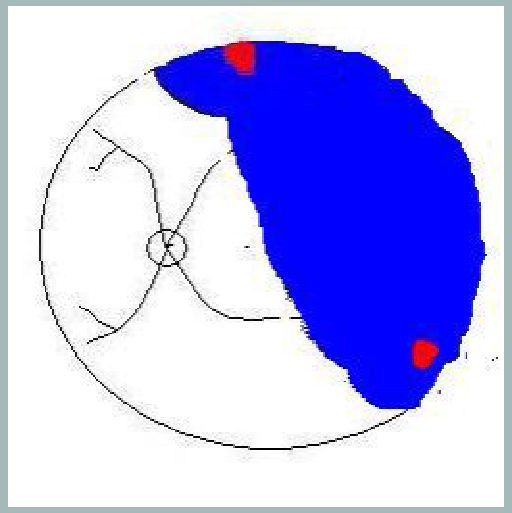


22 **What operation would you use to treat the following case**



1. Vitrectomy — 72%
2. Buckle — 13%
3. Vity + buckle — 1%
4. Pneumoretinopexy — 13%

23 **What operation would you use to treat the following cases**



1. Vitrectomy

94%

2. Buckle

2%

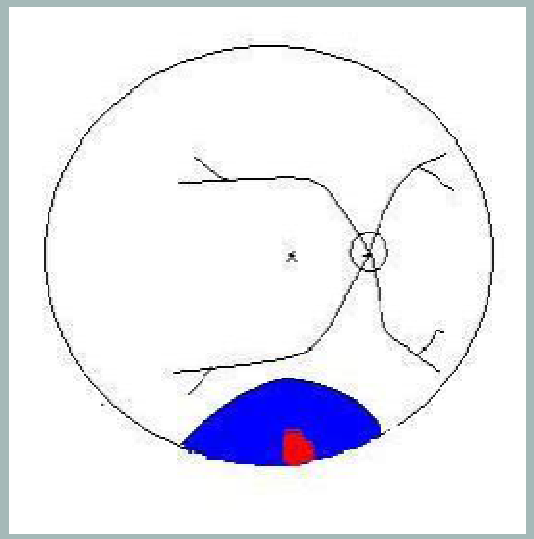
3. Vity + buckle

4%

4. Pneumoretinopexy

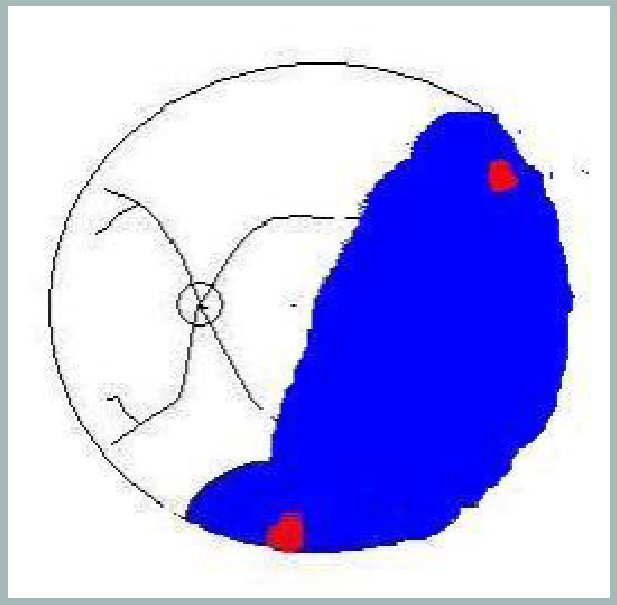
0%

24 **What operation would you use to treat the following cases**



1. Vitrectomy — 60%
2. Buckle — 34%
3. Vity + buckle — 6%
4. Pneumoretinopexy — 0%

25 What operation would you use to treat the following cases



1. Vitrectomy

79%

2. Buckle

5%

3. Vity + buckle

13%

4. Pneumoretinopexy

3%

26 **Management of metallic IOFB which appears to be impacted in the retina-do you**

1. Remove at same time of primary entry site repair

72%

2. Repair entry site & wait 24-72 hours before removal with intravitreal antibiotic cover

28%

3. Wait for a PVD to occur

0%

27 **With regards to post-op drops, do you normally use**

1. Topical steroid/ant-inflammatory & antibiotic

43%

2. Topical steroid/anti-inflammatory, antibiotic & cyclopegic

51%

3. Topical steroid/anti-inflammatory only

4%

4. Topical antibiotic only

2%

5. Other eg only cycloplegic

0%

28 **With regards to post-op follow-up, what is your normal routine**

1. See the majority of your patients 1st day post-op  69%
2. Mostly NOT see your patients 1st day (ie see only certain patients 1st day when " expecting a problem" eg high IOP)

 31%

29 **If you don’t normally see the majority of your patients on day 1, do you**

1. Give your normal post-op drops

76%

2. Give your normal post-op drops plus ocular anti-hypertensives routinely

24%

30 **With regards to posturing the patient with a macular on RD - do you**

1. Always/nearly always posture patient whilst awaiting surgery

64%

2. Sometimes posture if RD is very bullous

17%

3. Not think that posturing is useful

19%

31 **Patient with acute bullous STQ macular on RD presents at 5pm Friday evening - do you**

1. Operate as soon as is feasible that evening/over the weekend  68%

2. Operate on next available weekday list  13%

3. Refer to nearest large eye unit with a VR on-call service for review next day  20%

32 **Patient with acute bullous STQ macular off 1/7 RD presents at 5pm Friday evening - do you**

1. Operate as soon as is feasible that evening/over the weekend

32%

2. Operate on next available weekday list

58%

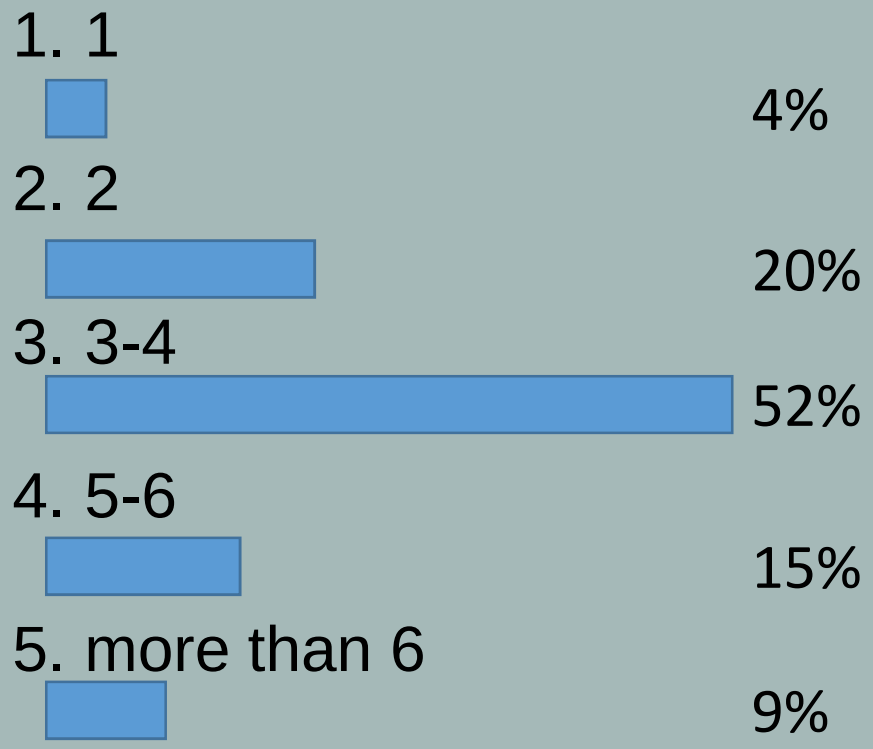
3. Refer to nearest large Ophthalmology unit with VR on-call for review next day

4%

4. Do electively on your own routine list the following week

6%

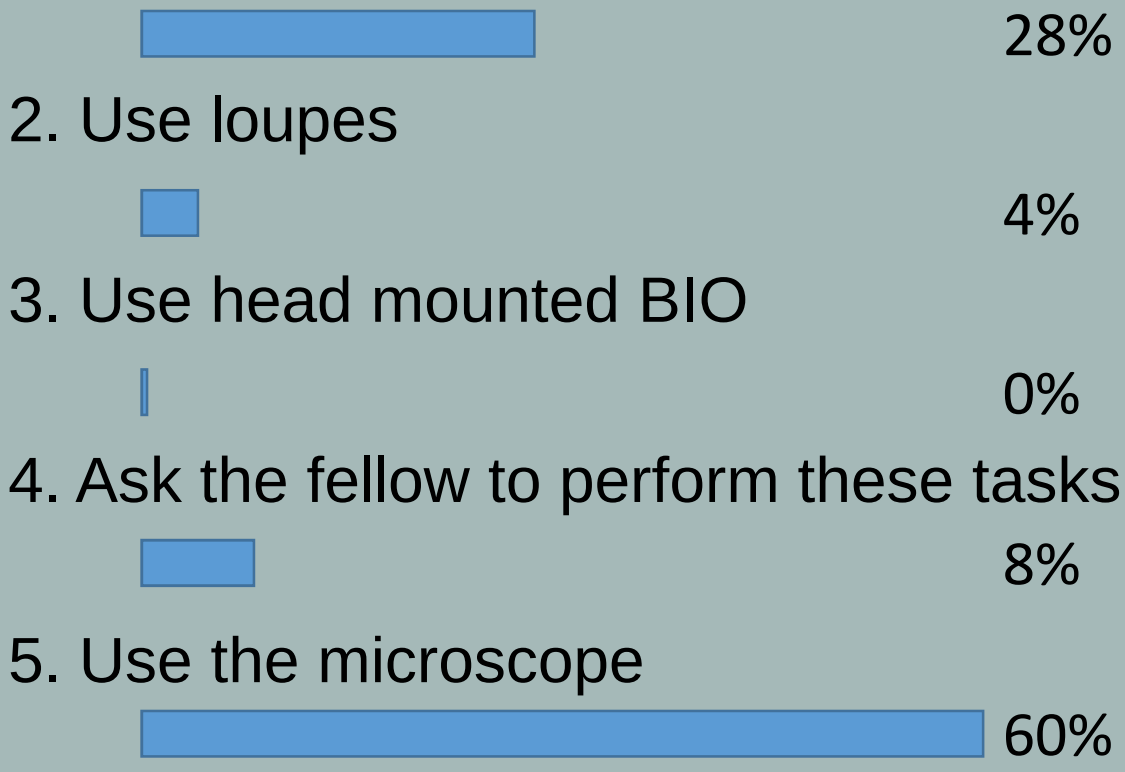
33 **In providing a weekend vitreoretinal on-call service for the hospital in which you mainly work, please choose the option with which you mostly agree regarding the minimum number of VR consultants needed**



34 **In providing a weekend vitreoretinal on-call service for the hospital in which you work, please choose the option with which you mostly agree regarding the following statement**

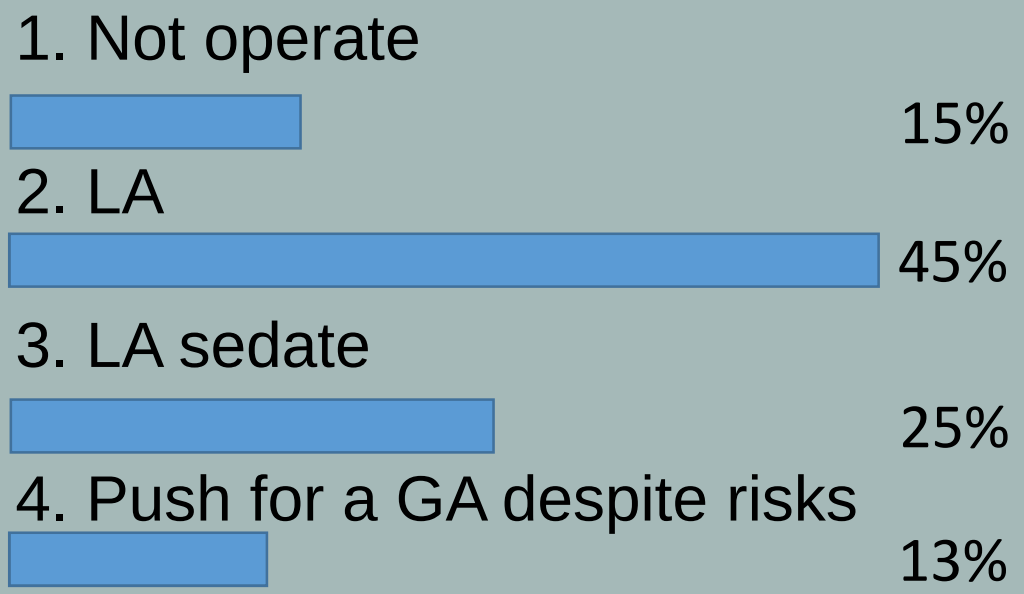
"All consultant VR surgeons should take part either by providing a local service or by joining forces with nearby units (if their own unit falls below a generally accepted minimum number of VR consultants)"

35 **For the over 43 yr old: when performing a cryobuckle surgery what do you use to assist you with close up tasks ie. Suturing the sclera?**

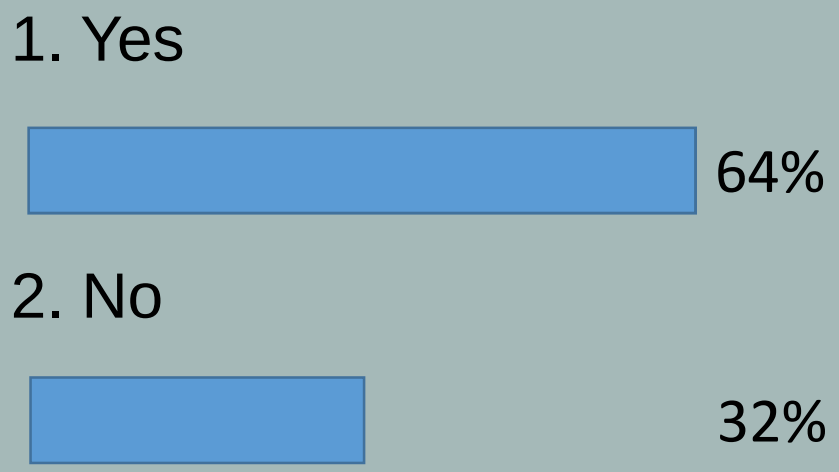


36 **A demented 80yr old presents with a macula on retinal detachment (assume single break @ 1030 STQ). Other eye OK.**

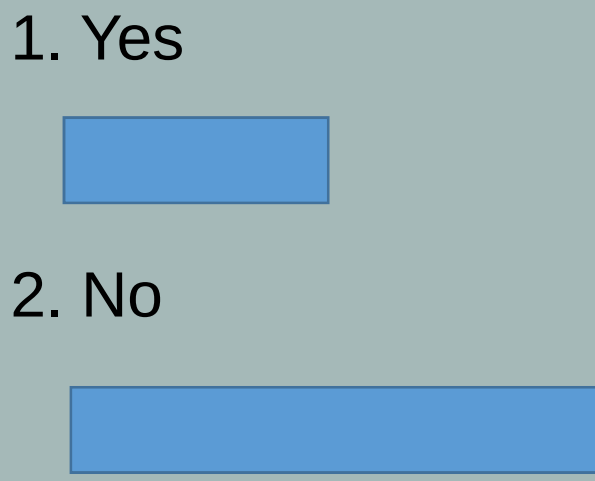
The anaesthetist has informed you that she is not fit for a GA-what do you do?



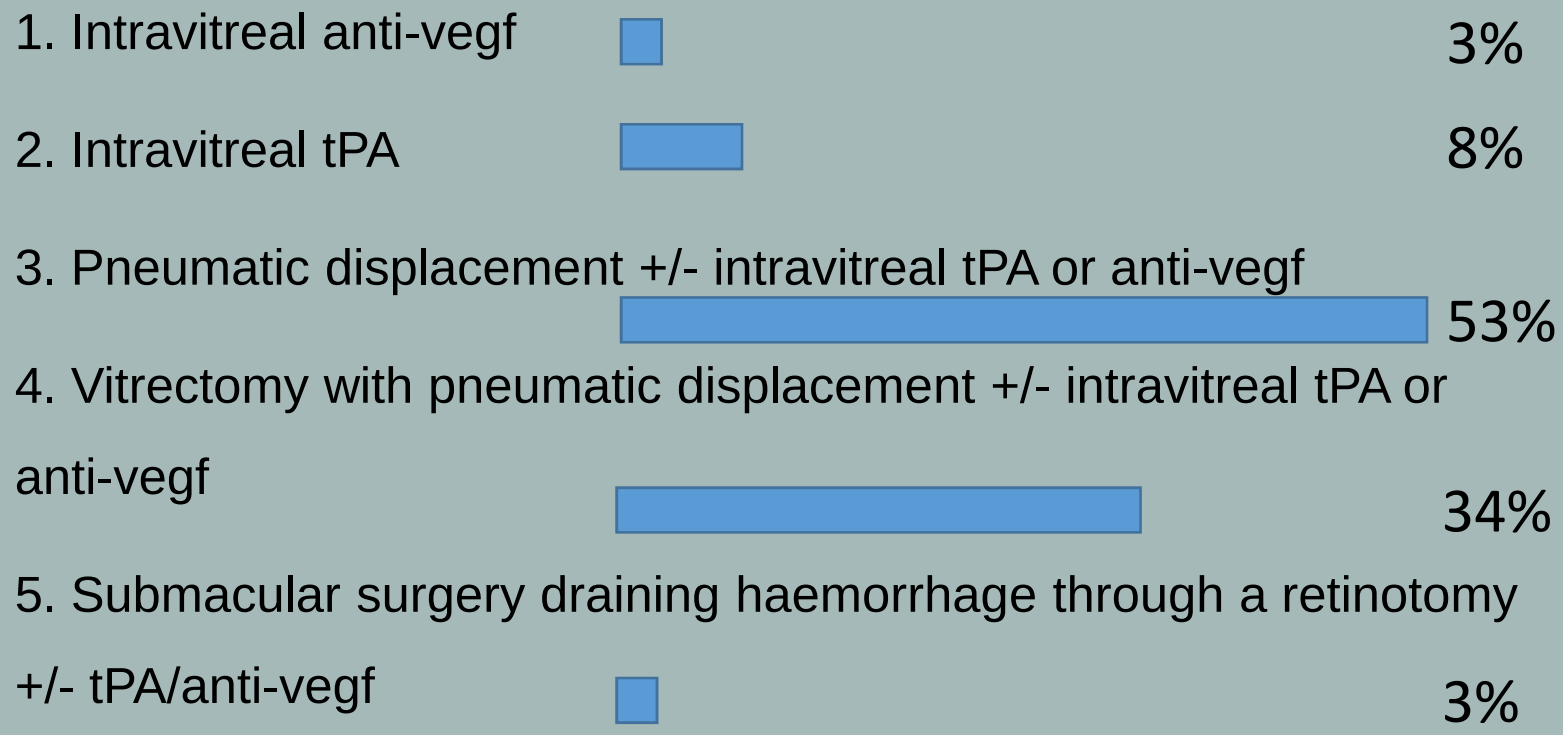
37 **Assuming there are anaesthetists elsewhere in the building but not assigned to your list. Would you be happy to perform complex VR surgery?**



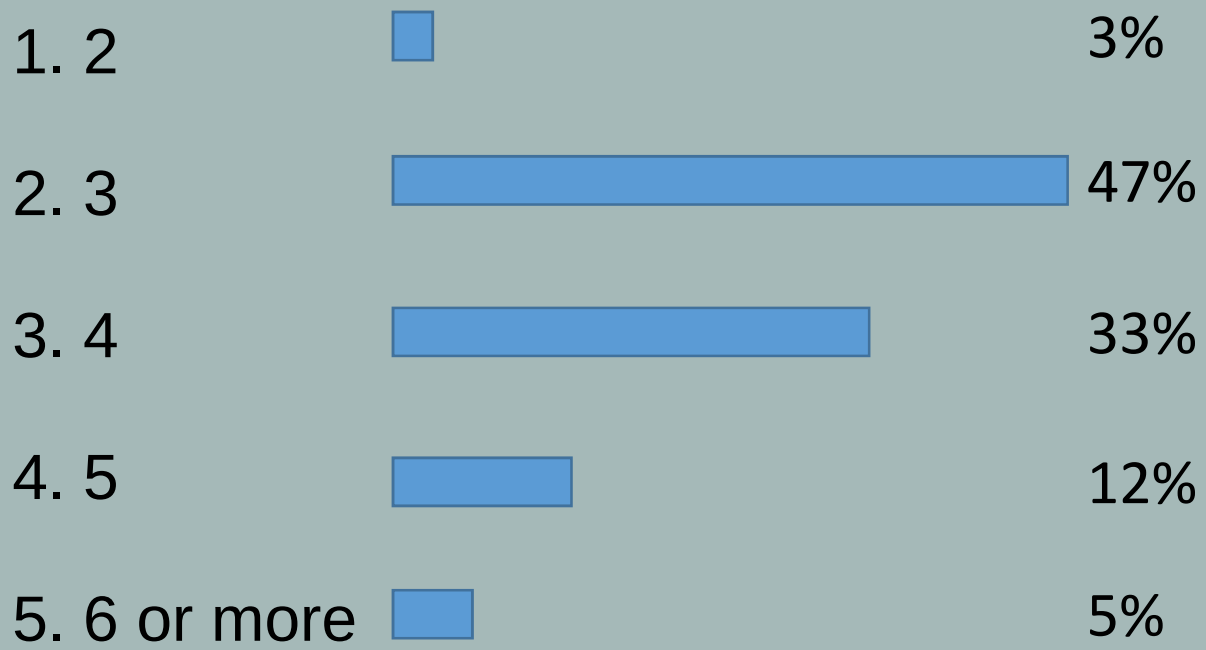
38 Assuming you operate in a stand alone unit would you be happy to perform complex VR surgery without an anaesthetist in the building?



39 **Assuming you would operate and not just observe : In the case of an acute large (whole macular area) submacular haemorrhage secondary to an age-related CNVM with moderate vision before the haemorrhage. Would you consider**



40 **There are many pressures on our VR service. How many patients would you put on your list ie a 3.5-4 hour half day list? Assume straightforward , mostly LA cases, small gauge surgery, consultant +/- experienced fellow**



41 How long would you leave on your list for a complex diabetic vity - delam - PRP patient?