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1 **ASSESSMENT OF OPTIC DISC PHOTOGRAPHS FOR GLAUCOMA BY UK**  
2 **OPTOMETRISTS: THE MOORFIELDS OPTIC DISC ASSESSMENT STUDY**  
3 **(MODAS)**

4  
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7  
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13  
14  
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17 **RUNNING TITLE:** Performance of UK optometrists in optic disc assessment  
18

19 **TABLES:** 0

20 **FIGURES:** 5  
21  
22

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1 **ABSTRACT**

2 **Purpose:** To assess the ability of UK optometrists to accurately discriminate between  
3 stereoscopic photographs of healthy and glaucomatous optic discs.

4 **Methods:** An online survey, including questions relating to qualification, practice  
5 environment, and diagnostic methods was completed by 1256 optometrists. Based on their  
6 responses, 208 (17%) were selected to undertake an online disc assessment exercise.  
7 Optometrists evaluated the same disc images previously assessed by European  
8 ophthalmologists as part of the European Optic Disc Assessment Trial (EODAT); the task  
9 was to state if the disc appeared healthy or glaucomatous. There were 110 stereoscopic disc  
10 images, of which 40 were healthy, 48 glaucomatous, and 6 ocular hypertensive, with 16  
11 duplicates images. Sensitivity, specificity and overall accuracy were calculated and compared  
12 between optometrist groups and with the EODAT ophthalmologists using permutation  
13 analysis.

14 **Results:** Median sensitivity was 0.92 (95% CI: 0.70, 1.00) and median specificity was 0.74  
15 (95% CI: 0.62, 0.88). Median overall accuracy was 80% (95% CI: 67%, 88%). Agreement  
16 between optometrists was moderate (Fleiss'  $\kappa$ : 0.57). Optometrists with higher qualifications  
17 did not have overall higher sensitivity than those without ( $p = 0.23$ ), but had higher specificity  
18 ( $p = 0.001$ ) and higher overall accuracy ( $p < 0.001$ ). Optometrists displayed higher sensitivity  
19 but lower specificity than the EODAT ophthalmologists.

20 **Conclusion:** UK optometrists displayed a high sensitivity and moderate specificity when  
21 assessing optic discs for the presence of glaucoma, in the context of this study.

22

1 **INTRODUCTION**

2

3 Subjective assessment of the optic disc is one of the most important examinations when  
4 investigating a patient for glaucoma. Several studies have reported the agreement within and  
5 between practitioners in optic disc assessment<sup>1-9</sup>. Many originate out of a desire to assess the  
6 performance of a particular cohort of practitioners within a particular practice setting, often to  
7 evaluate a training scheme<sup>10</sup>. Typically, the cohorts tend to be relatively small.

8

9 A recent study by Reus *et al*<sup>7</sup>, the European Optic Disc Assessment Trial (EODAT), reported  
10 on the performance of ophthalmologists across Europe in classifying discs in stereoscopic  
11 photographs as either normal or glaucomatous, and found notable differences between  
12 professionals and moderate diagnostic accuracy when compared with imaging devices. In the  
13 UK, more than 95% of glaucoma cases referred to the hospital eye service originate in primary  
14 care optometry practice. While several previous studies have assessed the agreement, or  
15 otherwise, of optometrists' referrals for glaucoma with the ophthalmologist's opinion, there is  
16 a shortage of data on the collective performance of a large sample of UK optometrists when  
17 assessing the disc photographs of a previously well-characterised cohort of glaucoma patients  
18 and healthy subjects. In addition, the influence of various levels of experience and  
19 qualification, and different modes of practice, on optometrists' ability to classify optic discs has  
20 received little attention. This information is especially important given that, over the last 20  
21 years, the role of optometrists in the UK has expanded, particularly in the management of  
22 stable glaucoma. A considerable number of optometrists now assess and manage patients  
23 alongside ophthalmologists in hospital-based glaucoma clinics throughout the UK. In  
24 addition, the number of successful optometry-based shared-care glaucoma schemes<sup>11,12</sup> and  
25 glaucoma referral refinement pathways<sup>13,14</sup> is increasing throughout the country. Optometrists  
26 are increasingly availing of higher qualifications such as the College of Optometrists' Diploma  
27 in Glaucoma, the Independent Prescribing qualification and various MSc modules in glaucoma  
28 that involve advanced training in basic theory, investigative techniques and management of  
29 patients with glaucoma.

30

31 A study of the performance of optometrists, specifically in optic disc assessment, incorporating  
32 large numbers of practitioners, especially those from high-street primary care practices, is long

1 overdue. Particularly important is performance against the confirmed status of a large number  
2 of discs from well-characterised glaucoma patients at different disease stages, rather than  
3 agreement, or otherwise, with an individual ophthalmologist.

## 6 **MATERIALS AND METHODS**

### 8 **Participants**

9 Participants were optometrists registered in the UK. No restrictions were placed on mode of  
10 practice, region of practice, number of additional qualifications, refractive error or binocular  
11 status. The study was divided into two stages.

### 13 **Stage One: Online Survey**

14 An online survey (Appendix 1) allowed preliminary information to be gathered about the way  
15 individual UK optometrists currently practise, to facilitate selection of representative  
16 participants (see below) and analysis by various categories in stage 2.

17 The survey was advertised to optometrists via email through the College of Optometrists,  
18 whose members represent approximately 95% of UK optometrists. A group was produced on  
19 the social networking site, Facebook<sup>®</sup>, advertisements were posted in optometry-related  
20 magazines and short presentations were given to local optometric committees throughout the  
21 UK. On completion of the survey, each optometrist was invited to indicate if they were  
22 willing to take part in stage 2 (optic disc assessment) of the study and advised that if they were  
23 chosen, the investigators would require their contact details. Stratified sampling was conducted  
24 for stage 2, to select optometrists from a wide range of practice environments. This involved  
25 determining the proportion of optometrists who worked for most of their working week in  
26 particular practice environments and sampling the same proportions for a sample size that  
27 approximated that of the EODAT study. The proportions in each group reflected the  
28 proportions in those environments throughout the UK.

1 **Stage 2: Optic Disc Assessment**

2 Optometrists invited to take part in stage 2 of the study received a pair of plano prism  
3 spectacles, with 6Δ base IN each eye, for viewing the stereo images, along with a username and  
4 a unique activation code. The optic disc assessment test was accessed from the same website as  
5 the survey. The stereo-photograph set was identical to that used in the EODAT study <sup>7</sup> and a  
6 study comparing the performance of imaging devices and clinical assessment by  
7 ophthalmologists <sup>6</sup>. Three ‘calibration images’ were presented initially and could be accessed at  
8 any time during the assessment. These images contained healthy optic discs: 1 small (5<sup>th</sup>  
9 percentile), 1 medium (50<sup>th</sup> percentile) and 1 large (95<sup>th</sup> percentile). These were followed by  
10 110 randomised stereoscopic disc images; 40 were healthy, 48 glaucomatous and 6 from ocular  
11 hypertension patients, with 16 duplicates (proportions not revealed to participants). Discs were  
12 classified for the two previous studies<sup>6,7</sup> and the current study by 1 of 4 glaucoma  
13 ophthalmologists at Rotterdam Eye Hospital. Glaucomatous discs were required to have  
14 characteristic glaucomatous changes (e.g. notching, thinning of the neuroretinal rim, possible  
15 haemorrhage) and a corresponding visual field defect with standard automated perimetry.  
16 Patients had established glaucoma clinically and were being followed regularly and treated for  
17 the condition at Rotterdam Eye Hospital. Healthy discs were classified on the basis of a  
18 normal optic disc appearance, the absence of a visual field defect, intraocular pressure  
19 <21mmHg and a negative family history of glaucoma.

20  
21 Optometrists viewed the images and registered their classification by clicking one of two  
22 buttons: ‘glaucoma’ or ‘healthy’. They were also given the opportunity to return to previous  
23 disc images and change their classification, before submission of all responses. Optometrists  
24 who did not have binocular single vision (n = 13) were permitted to undertake the task  
25 without the spectacles. On completion of the assessment, a ‘percentage correct’ score was  
26 presented on the screen.

27  
28 All answers were merged with the participant’s survey responses by their unique activation  
29 code.

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1 **Statistical Analysis**

2 Sensitivity, specificity and overall accuracy (number correctly identified, divided by the total  
3 number) were calculated for each optometrist.

4

5 The significance of differences in performance between groups was determined by  
6 permutation analysis, unless otherwise stated. Firstly, an observed statistic ( $\delta_{obs}$ ) was calculated  
7 as the difference between the mean of Group 1 and Group 2 ( $\mu_1 - \mu_2$ ). Assuming the null  
8 hypothesis, that there is no statistically significant difference between the means of these  
9 groups,  $\delta_{obs}$  would be expected to fall within the 95% confidence region of a distribution of  
10 values of  $\delta$  when optometrists were randomly assigned to each group multiple times. If  $\delta_{obs}$   
11 were to fall outside this region, the difference between groups would be considered significant  
12 at the 95% confidence level. Optometrists were randomly assigned to each group 5,000 times  
13 and a distribution of  $\delta$  values was plotted ( $\delta_p$ ). A p-value was calculated for  $\delta_{obs}$  based on its  
14 position in the permutation distribution.

15

16 Optometrists working in different practice environments were assigned to groups according to  
17 whether they undertake ‘any’ or ‘no’ work within that environment, regardless of their main  
18 mode of practice.

19

20 Optometrists working in a specialist glaucoma clinic setting were asked for the number of  
21 years (<2, 2-5 or >5 years) and hours per week they undertook this work. The number of  
22 hours per year was multiplied by 1, 3.5 or 6, according to the number of years they indicated as  
23 having worked in this setting. A value of 6 was chosen for the ‘>5 years’ category to  
24 approximate the error on the abscissa for the other categories while remaining conservative.

25

26 Each optometrist was asked to indicate, in stage 1, their confidence in optic disc assessment,  
27 on a scale from 1-7 (1: not confident at all; 7: completely confident). Performance in stage 2  
28 was later compared between optometrists reporting different levels of confidence, using a  
29 Kruskal-Wallis test.

30

1 Statistical analysis was carried out using the freely-available open-source statistical  
2 environment, R<sup>15</sup> and associated packages, sp<sup>16</sup> and maptools<sup>17</sup>.

3  
4 We certify that all applicable institutional regulations concerning the ethical use of human  
5 volunteers were followed during this research. The protocol for this study was approved by the  
6 Moorfields Eye Hospital Research Ethics Committee. The research was conducted according  
7 to the tenets of the Declaration of Helsinki.

## 10 RESULTS

11  
12 Stage 1 was completed by 1256 optometrists of working age from all regions of the UK  
13 (Figure 1(A)). At the time of the invitation, the total number of optometrists registered with  
14 the General Optical Council (GOC) in the UK was 12,761. The respondents thus represented  
15 9.9% of GOC-registered optometrists at that time. Of this sample, 208 (17% of those  
16 surveyed, Figure 1(B)) took part in stage two. Ninety-six percent of optometrists participating  
17 in Stage 2 reported using some form of binocular ophthalmoscopy each week. The sensitivity  
18 and specificity of each optometrist are presented as single data points in Figure 2(A) and  
19 compared with European ophthalmologists in the EODAT study<sup>7</sup> (N = 243) in Figure 2(B).  
20 Optometrists were significantly more sensitive than ophthalmologists ( $p < 0.001$ ) but  
21 significantly less specific ( $p < 0.001$ ). Median sensitivity was 0.92 (95% CI: 0.70, 1.00), median  
22 specificity was 0.74 (95% CI: 0.62, 0.88) and median overall accuracy was 80% (95% CI: 67%,  
23 88%). Marginal histograms show that accuracy and specificity values were normally distributed,  
24 but sensitivity values were not. A receiver-operator characteristic curve plotted through the  
25 mean sensitivity and specificity for optometrists and ophthalmologists appears largely  
26 symmetrical. To confirm this, the perpendicular distance from the mean performance of each  
27 group, and a diagonal line visualised from maximum performance (perpendicular) to the  
28 chance line was calculated. The distance from the mean ophthalmologists performance to this  
29 line was 0.1 and that from the mean optometrists performance to the line was 0.09. Inter-  
30 observer agreement was moderate (Fleiss'  $\kappa = 0.57$ ). Agreement between optometrists with  
31 any hospital experience was slightly greater ( $\kappa = 0.60$ ) than between those without ( $\kappa = 0.56$ ).  
32 Similarly, agreement between optometrists with additional qualifications was greater ( $\kappa = 0.63$ )



1 than between those without ( $\kappa = 0.55$ ) and agreement between optometrists working in a  
2 specialist glaucoma clinic was greater ( $\kappa = 0.62$ ) than between those who did not ( $\kappa = 0.56$ ).  
3 Intra-observer agreement was good (median Cohen's  $\kappa = 0.71$ ; range: 0.08 – 1; interquartile  
4 range (IQR): 0.59 – 0.86).

5  
6 Figure 3 shows the difference in mean performance between optometrists who undertake any  
7 ( $n = 53$ ) or no ( $n = 155$ ) work in a hospital setting, using permutation analysis. Optometrists  
8 working in a hospital have a higher specificity ( $p < 0.001$ ) and overall accuracy ( $p < 0.001$ )  
9 when compared with optometrists who do not. Sensitivity was not significantly different ( $p =$   
10  $0.48$ ). Time spent in a specialised glaucoma clinic ( $n = 35$ ) had no significant effect on  
11 sensitivity ( $r^2 = 0.01$ ;  $p = 0.76$ ) but a small, significant, effect on specificity ( $r^2 = 0.22$ ;  $p =$   
12  $0.005$ ) and overall accuracy ( $r^2 = 0.21$ ,  $p = 0.005$ ) (Figure 4(A-C)). There was no significant  
13 association between sensitivity ( $r^2 = 0.01$ ,  $p = 0.88$ ), or overall accuracy ( $r^2 = 0.01$ ,  $p = 0.80$ )  
14 and the number of years since professional qualification (seniority), however the association  
15 was slight, but significant for specificity ( $r^2 = 0.03$ ,  $p = 0.01$ ) (Figure 4(D-F)).

16  
17 Fifty-three optometrists possessed additional qualifications, including successful completion of  
18 the College of Optometrists' Diploma in Glaucoma ( $n = 7$ ), independent prescribing  
19 qualification ( $n = 22$ ) and successful completion of an MSc glaucoma module ( $n = 36$ ).  
20 Thirteen optometrists had more than one of these qualifications. Optometrists with additional  
21 qualifications, compared to those without, had similar sensitivity ( $p = 0.23$ ), but higher  
22 specificity ( $p = 0.001$ ) and accuracy ( $p < 0.001$ ). Results were similar when comparing  
23 optometrists with and without an independent prescribing qualification alone (sensitivity  $p =$   
24  $0.25$ ; specificity  $p < 0.001$ ; accuracy  $p < 0.001$ ).

25  
26 Figure 5(A) shows confidence levels reported by optometrists who took part in each stage of  
27 the study. Figure 5(B-D) shows sensitivity, specificity and overall accuracy for optometrists  
28 who undertook stage 2, as a function of their previously reported confidence level. No  
29 significant difference in any performance characteristic was found between confidence levels  
30 (Kruskal-Wallis; sensitivity:  $p = 0.09$ ; specificity:  $p = 0.53$ ; accuracy:  $p = 0.21$ ).

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**DISCUSSION**

On average, UK optometrists display high sensitivity and moderate specificity when examining optic discs for glaucoma in this study. Those who undertook stage 2 of the study are likely representative of the larger sample that took part in stage 1. Figure 5(A) shows that, overall, the confidence of those optometrists was slightly lower than the average confidence of the entire cohort enrolled in stage 1, thereby avoiding, as far as possible, bias towards optometrists who felt overly confident in their ability to correctly grade an optic disc. Those optometrists with additional qualifications had, overall, more comparable confidence to that of the entire cohort enrolled in stage 1.

The higher sensitivity among optometrists and specificity among ophthalmologists likely reflects a criterion difference, rather than a difference in ability to discriminate glaucomatous discs from healthy discs. This is reflected in the similar overall accuracy between groups and the largely symmetrical receiver-operator curve drawn through the mean performance characteristics for each group in Figure 2(B). This result may not be entirely surprising when one considers the priorities of the optometrist in practice and the ophthalmologist within a hospital setting. It is also worth considering the perceived implications by either group of a ‘false alarm’ and ‘miss’ when assessing discs for glaucoma. For some optometrists, a false alarm (i.e. being over-cautions and making a false referral) may be perceived as having fewer ramifications than missing glaucoma. Conversely, for some ophthalmologists, a false alarm may lead to an inappropriate commencement of treatment, therefore it may be perceived as preferable to exercise restraint in the short-term when deciding on the presence or absence of glaucoma. The nature of the current study may introduce some bias in the results. While no indication was given beforehand about the likely proportion of glaucomatous discs in the set, optometrists are likely to suspect that glaucomatous discs represent a substantially greater proportion of the disc set than the 2% of discs in their practice. This, together with the perception that they are being examined may also have caused them to be over-cautious in their assessments. The agreement among all optometrists was greater than that among all

1 ophthalmologists in the EODAT study (Fleiss'  $\kappa = 0.54$ ), reflected by the reduced spread in  
2 the data for optometrists, compared to that of ophthalmologists in Figure 2(B).

3  
4 The performance of optometrists with experience working in a hospital, some of which  
5 worked in glaucoma clinics, was compared to that of community optometrists. However,  
6 classifying individuals as 'hospital' or 'independent' optometrists is difficult because  
7 optometrists spend different proportions of time in various settings each week. That specificity  
8 and overall accuracy of optometrists with *any* hospital experience was significantly higher than  
9 that of optometrists without hospital experience may be a consequence of greater  
10 opportunities to compare discs that optometrists typically see when working in community  
11 practice with the discs that they observe in the hospital setting, where there is a much greater  
12 number of patients with glaucomatous discs and where visual field data are available for all  
13 discs examined. This experience may also explain the criterion shift of these individuals  
14 towards that of ophthalmologists. This finding is also supported by the fact that 24 of the 53  
15 optometrists with hospital experience had additional qualifications. The results of this study  
16 support those of previous reports that have documented the effectiveness of professional  
17 training on the performance of optometrists at disc assessment<sup>18,19</sup>. Improvement was greatest  
18 in specificity and overall accuracy, which would result in fewer false positive referrals. It is also  
19 worthy of note that many hospital-based optometrists participate in disease screening as part  
20 of clinical trials and epidemiological studies. Training in this regard may improve their ability to  
21 correctly classify disc images as glaucomatous or healthy.

22  
23 It was expected that participants' level of experience and confidence in disc assessment would  
24 influence their decision-making. However, despite participants having a wide range of reported  
25 confidence levels, there was no effect on performance. Nevertheless, it is interesting to note  
26 the wide range of performance at each level, particularly for those who indicated a confidence  
27 level of 4 or 5. Seniority had little influence on performance, but the degree of variance in the  
28 data shown in Figure 4 (D, E) is noteworthy. Interestingly, overall accuracy was consistent for  
29 all optometrists, therefore the variance is largely accounted for by the diagnostic criterion.

30  
31 In conclusion, the current study provides important information about the performance of UK  
32 optometrists in their ability to classify optic discs and provides evidence for the effectiveness

- 1 of additional qualifications and experience in hospital glaucoma clinics in enhancing
- 2 performance.

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8 authors and not necessarily those of the Department of Health.

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12 Ophthalmology (ARVO) annual meeting, Fort Lauderdale, USA in 2012.

13

14

15 **CONFLICTS OF INTEREST**

16 None

17

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27  
28

1 **FIGURE LEGENDS**

2

3 **Figure 1:** Geographic distribution of optometrists who completed stage 1 (A) and stage 2 (B).

4

5 **Figure 2:** (A) Sensitivity and specificity plots showing the performance characteristics of UK  
6 optometrists in the current study. (B) The same data, plotted together with those of the  
7 EODAT study. The yellow triangle and diamond represent the mean performance of  
8 ophthalmologists and optometrists respectively.

9

10 **Figure 3:** Distributions of permutations of  $\delta$  in the analysis of the effect of hospital experience  
11 on performance. The graphs show the median of the distribution (blue dotted line), the 95%  
12 confidence level (orange line) and the test statistic for the observed difference ( $\delta_{\text{obs}}$ ; red  
13 square).

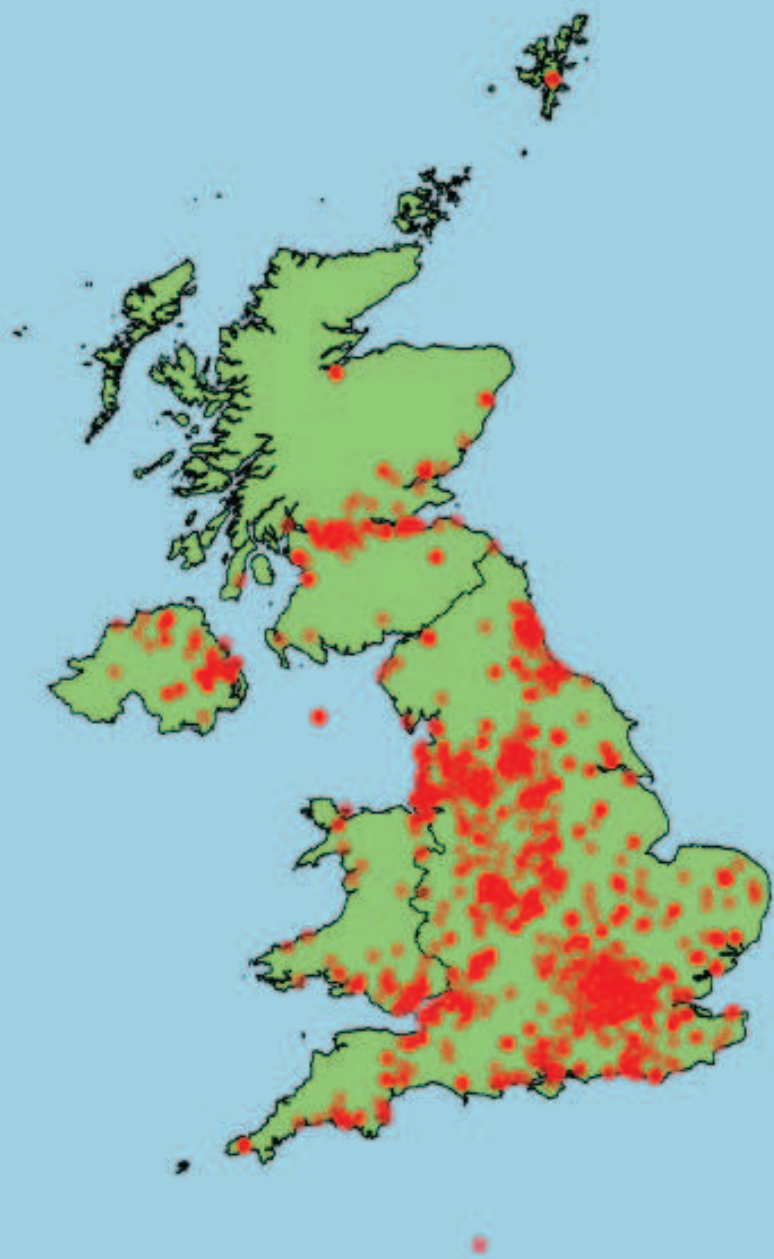
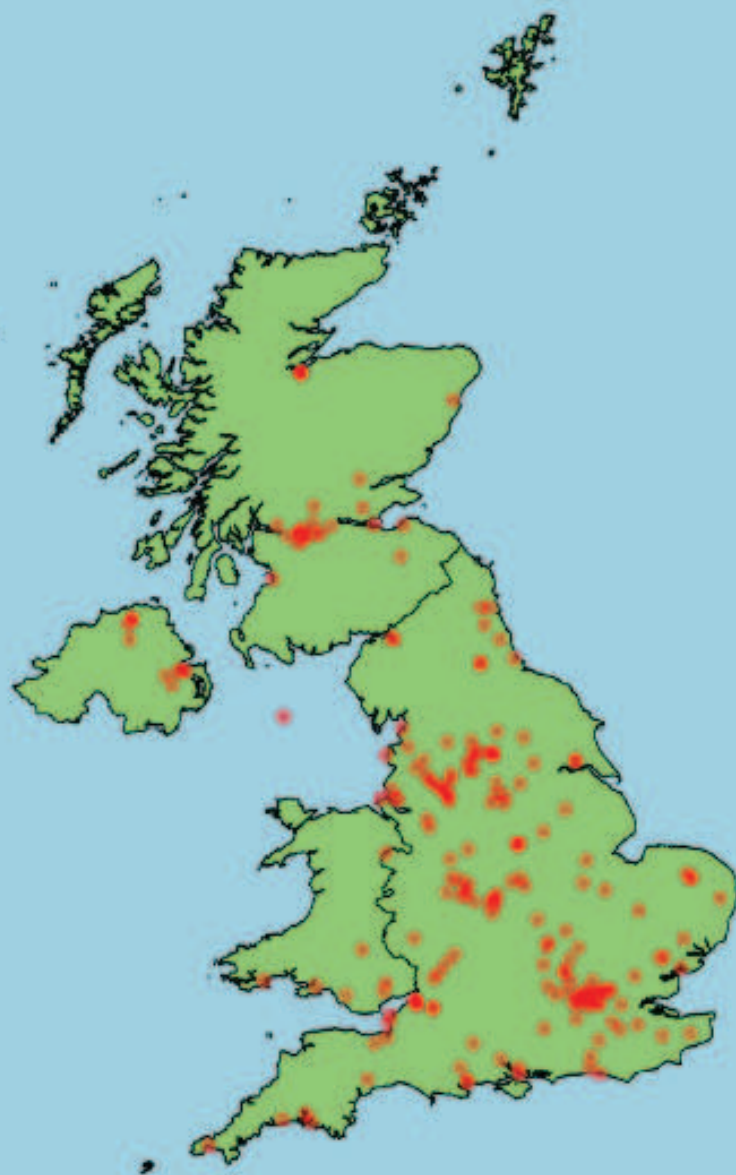
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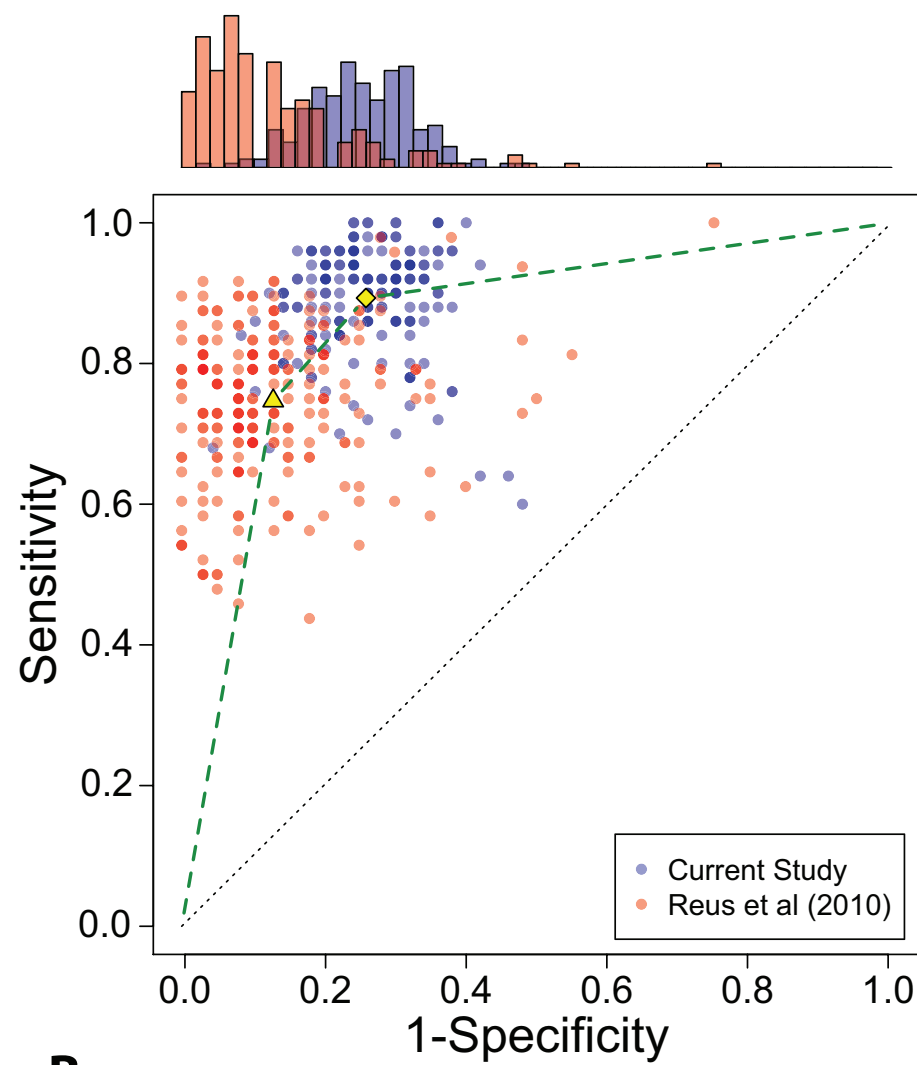
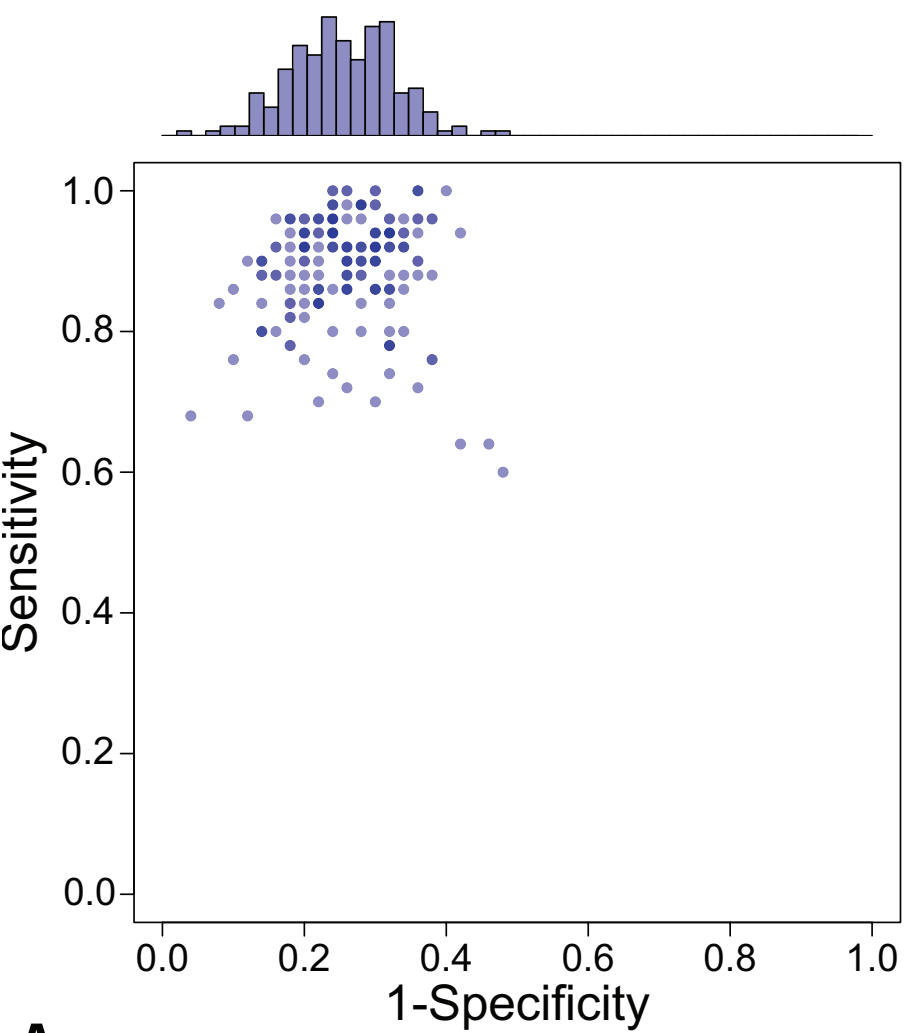
15 **Figure 4:** (A-C) The association between time spent in specialist glaucoma clinics and  
16 performance. (D-F) The association between the time since initial professional qualification  
17 and performance (lower panels).

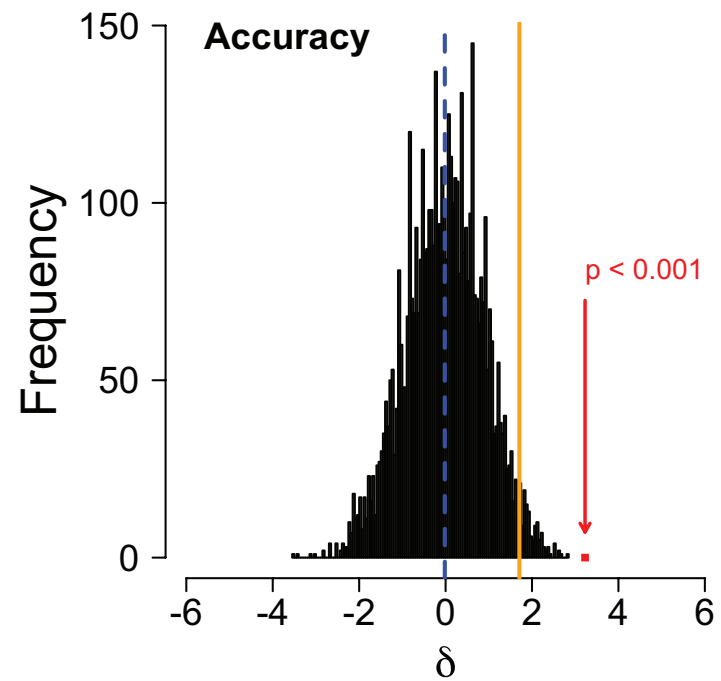
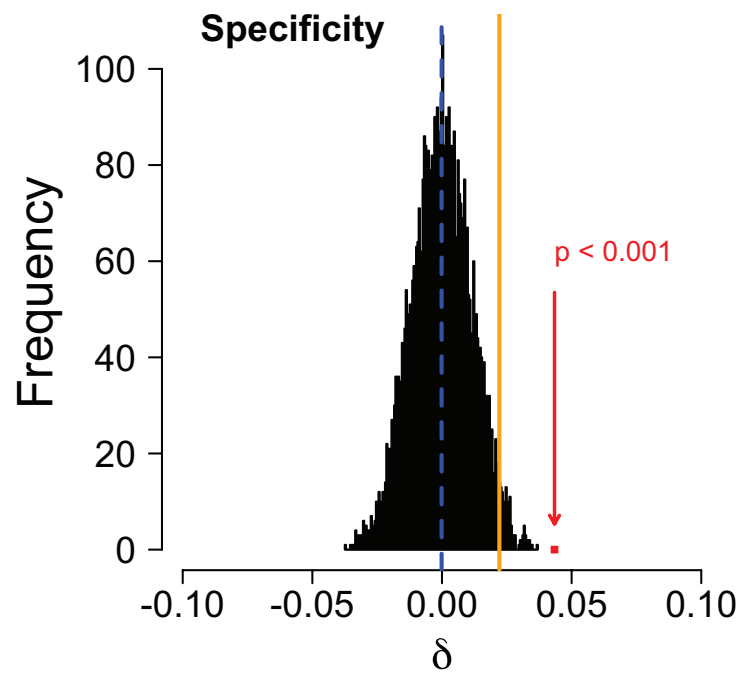
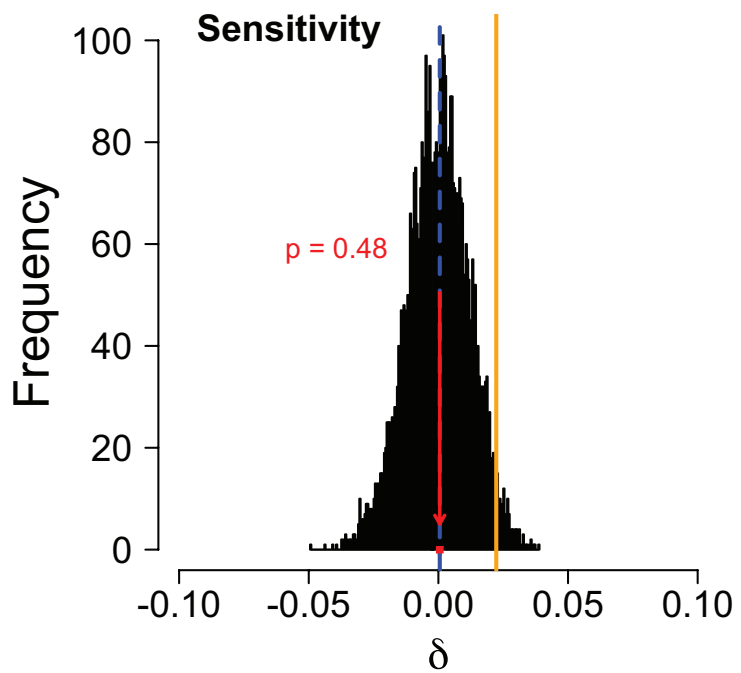
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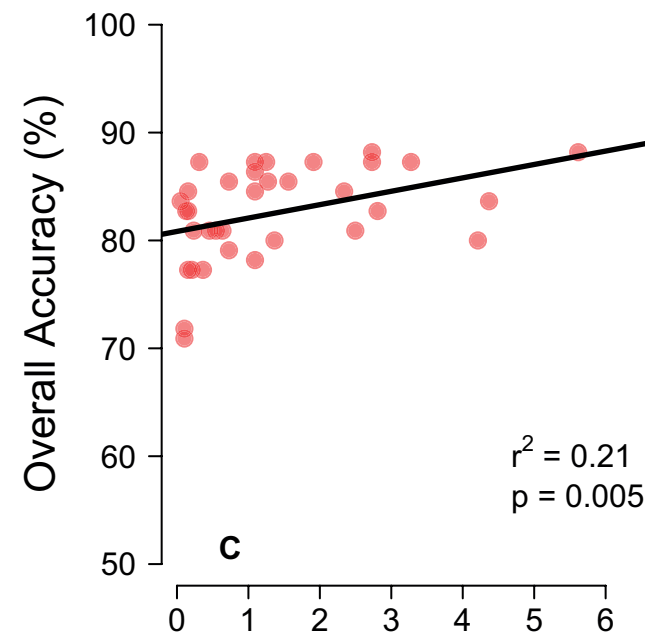
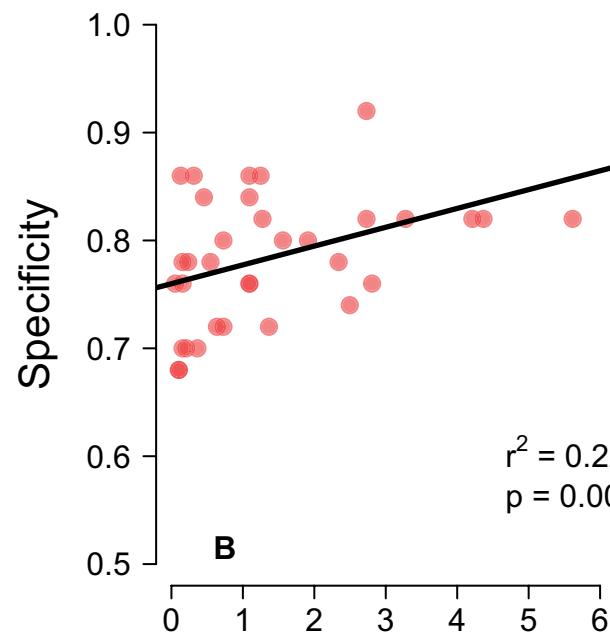
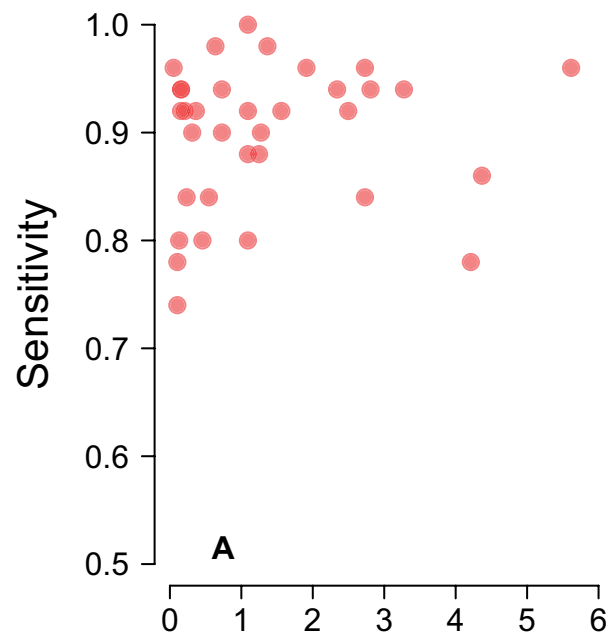
19 **Figure 5:** (A) Confidence levels of optometrists, in their assessment of optic discs. Numbers  
20 in red indicate the reports of all participants in stage 1. Numbers in light grey indicate those  
21 optometrists undertaking stage 2. Numbers in dark grey indicate those with higher  
22 qualifications. (B - D) The distribution of performance levels of optometrists reporting each  
23 confidence level.



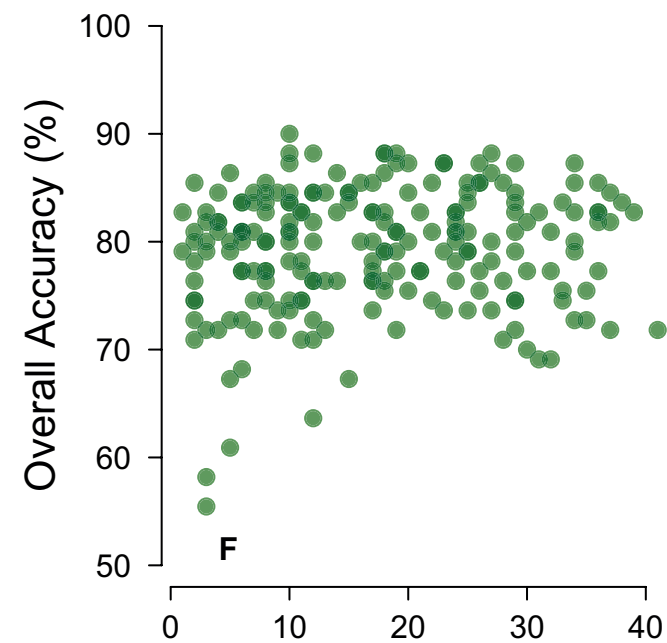
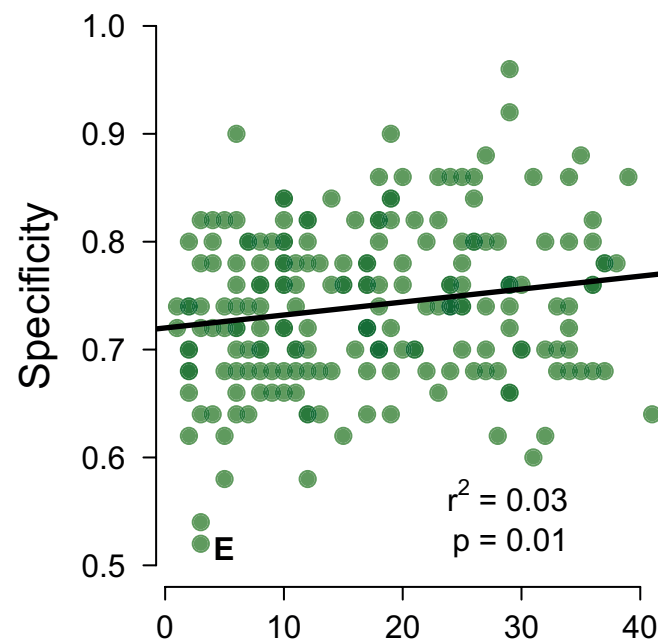
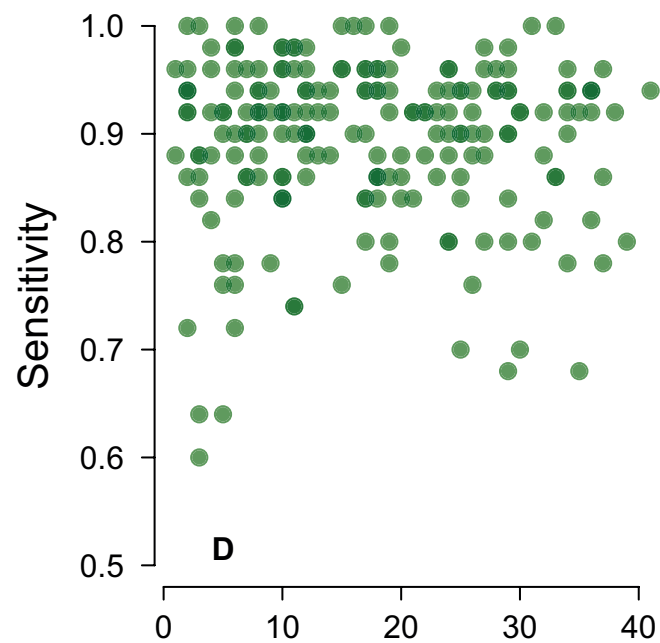
**A****B**







Time in specialist glaucoma clinic (thousands, hours)



Seniority (years)

