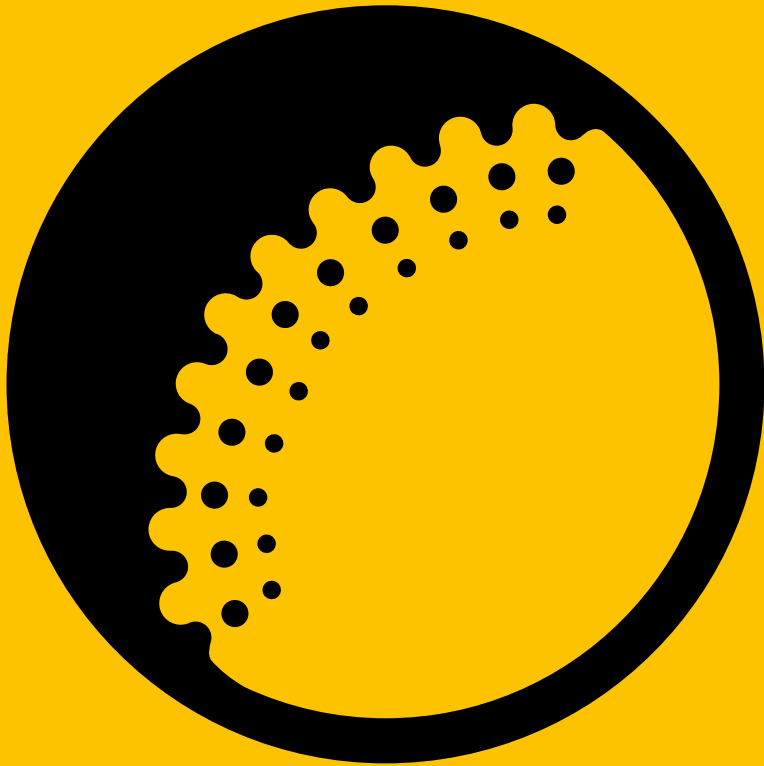


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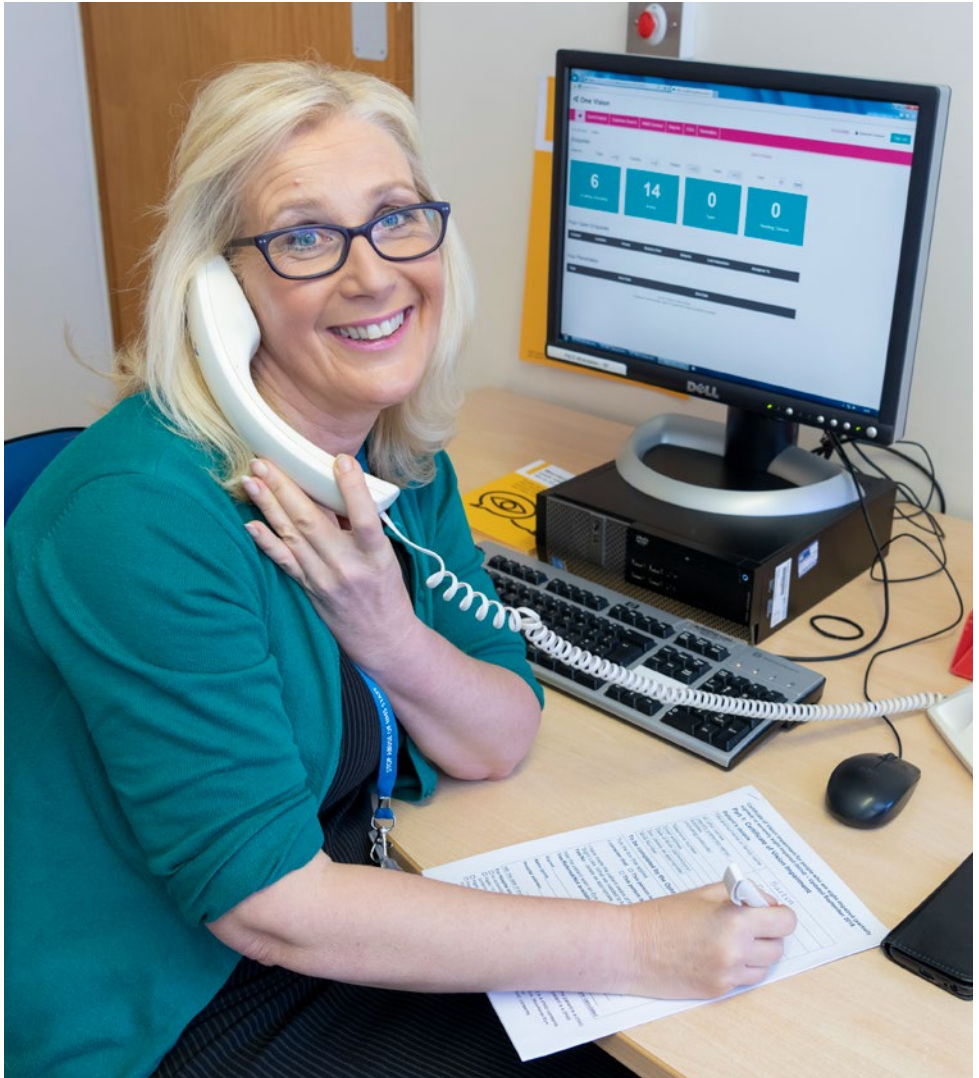
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Sight Advice FAQs

Ask the Sight Advice FAQ website your questions about sight loss, and get helpful answers: sightadvicefaq.org.uk



Contents

- 4** Contact us
- 5** What is a retinal detachment?
- 6** What is the retina?
- 8** Types of retinal detachment
- 11** Who is at risk?
- 13** What are the symptoms of a retinal detachment?
- 18** Treatment for retinal tears
- 23** Treatment for retinal detachment
- 37** How will I manage with any changes in my sight?
- 39** Coping
- 40** Further information
- 42** RNIB booklet series
- 45** Information sources

Contact us

We're here to answer any questions you have about your eye condition or treatment. If you need further information about retinal detachment or on coping with changes in your vision, then our Helpline is there for you.

RNIB's Understanding series

The Understanding series is designed to help you, your friends and family understand a little bit more about your eye condition.

The series covers a range of eye conditions, and is available in audio, print and braille formats.

RNIB Helpline

0303 123 9999

helpline@rnib.org.uk

Or say, **"Alexa, call RNIB Helpline"** to an Alexa-enabled device.

What is a retinal detachment?

A retinal detachment is when your retina separates from the inside of your eye. Your retina needs to be attached inside your eye to stay healthy and work properly. If it remains detached, it will stop working and affect your sight.

A retinal detachment can be repaired with surgery, but it needs to be detected and treated quickly, or it can cause sight loss in the affected eye.

A retinal detachment is an emergency. It needs to be assessed as soon as possible so that your ophthalmologist (hospital eye doctor) can make decisions about your treatment.

How well your sight recovers can depend on how much and what areas of your retina have detached. Most people can have a good level of vision following surgery to reattach the retina if it is carried out quickly.

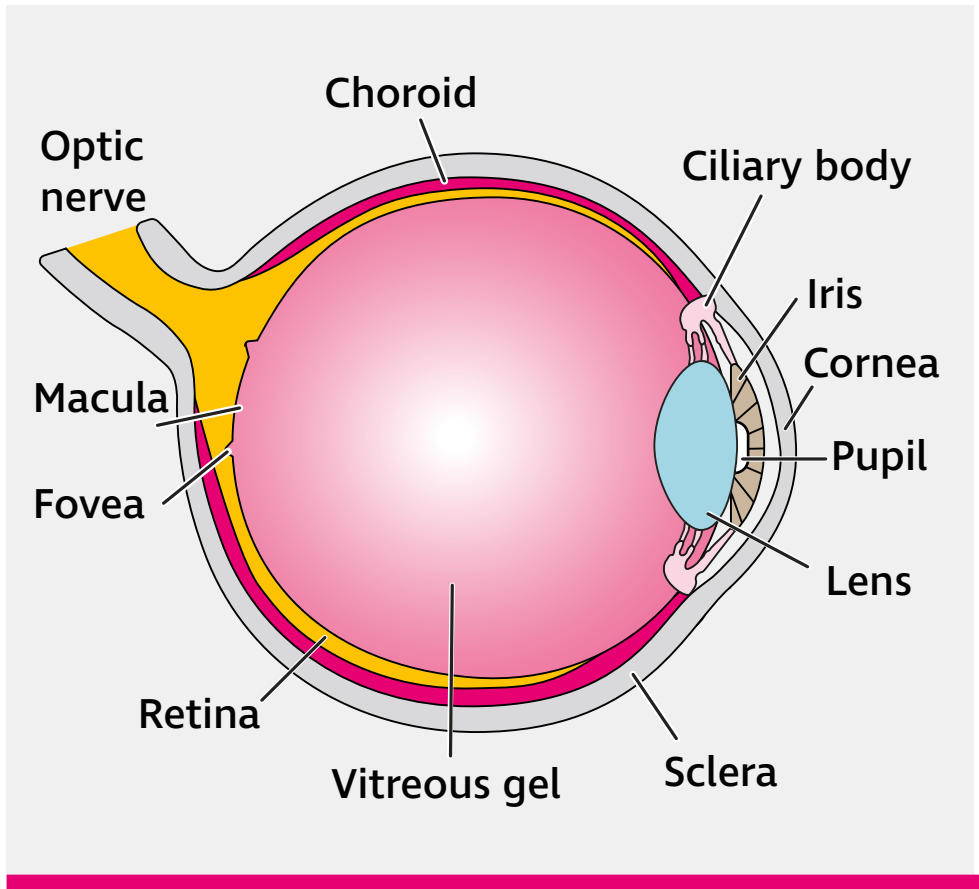
What is the retina?

The retina is the light sensitive tissue which lines the back of the inside of your eye, and it is made up of a number of different layers. A network of blood vessels under the retina supplies it with blood, oxygen, and nutrients to keep it healthy. Your retina is in contact with the vitreous, a clear gel, that fills the inside of your eye.



The retina processes the light that enters your eyes into signals which are interpreted by your brain, allowing you to see.

Your retina is responsible for your full field of vision, which is made up of your peripheral (side) vision, and your central vision (what you see directly in front of you). In the centre of your retina is the macula, which, as well as giving you central vision, allows you to see detail and colour.



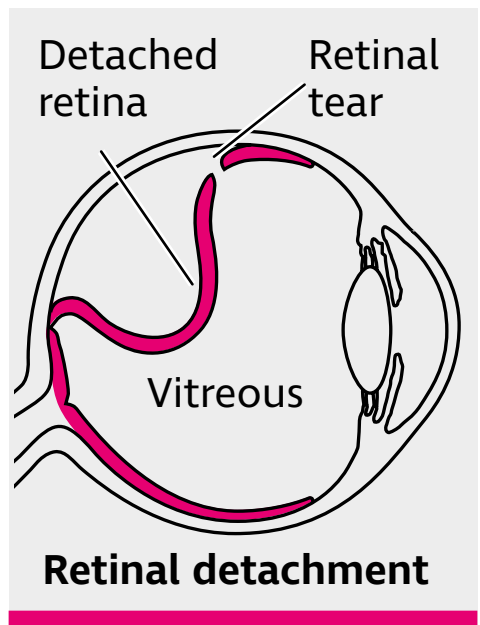
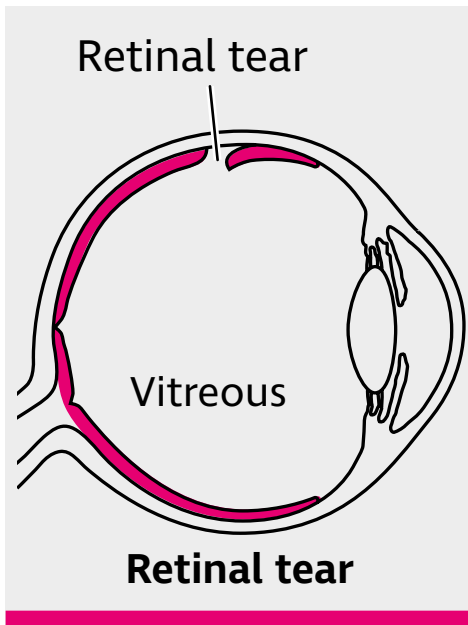
Types of retinal detachment

There are three main types of retinal detachment.

Retinal holes and tears

Most retinal detachments happen because a tear or hole in the retina allows fluid to leak between the retinal layers, lifting the retina away from the back of the eye and causing it to detach. This is known as rhegmatogenous retinal detachment.

Tears happen because the retina has been pulled and torn. The most common cause of a retinal tear is posterior vitreous detachment (PVD) where the vitreous gel naturally comes away from the retina as we get older.



More information about PVD can be found on our website or by calling our Helpline.

In most people with PVD, the vitreous comes away gently from the retina, but in some people, the vitreous may be more firmly attached in certain places to the retina. So as the vitreous moves away from the retina, it can pull on it, causing it to tear.

The symptoms of a PVD and retinal tear or detachment are very similar. Although most people have PVD without developing a retinal tear or detachment, it is always important to have your eye examined if you experience any of the symptoms listed in the section "What are the symptoms of a retinal detachment?".

Scar tissue

Eye conditions such as diabetic retinopathy can cause scar tissue to form on the surface of the retina and inside your vitreous. This scar tissue can then lead to traction (pulling) on the retina, resulting in detachment, so this is also known as tractional retinal detachment.

Fluid

A rare type of retinal detachment happens when fluid from the blood vessels behind the retina leaks between the retinal layers without there being a hole or tear present. This type of detachment happens because of conditions which cause inflammation in the eye or tumours in the eye. This type is known as serous or exudative retinal detachment.



Who is at risk?

Only about 10–15 per 100,000 people have a retinal detachment each year. Retinal detachments are very rare in children and are most likely to occur in people between 40 to 70 years old. Natural ageing changes in the vitreous gel, from PVD, can cause retinal tears, and PVD is more common as you get older.

Anyone can develop a retinal detachment, but certain people are at higher risk.

You have an increased risk of retinal detachment if you:

- are short-sighted. The more short-sighted you are, the greater the risk. The peripheral retina tends to be thinner in people who are very short sighted so may be more likely to tear. There is also an increased risk of developing a PVD at a younger age, with the potential risk of causing a retinal tear to form.
- have had trauma such as an injury or a blow directly to your eye. A bang or blow to the head cannot cause retinal detachment, but a direct blow to the eye may do. Wearing eye protection for DIY, gardening or sport is something you can do to reduce the risk of an eye injury which

could cause a detachment. Retinal detachment does not happen as a result of straining your eyes, bending or heavy lifting.

- have already had a detachment in one eye. About 1 in 8 people with retinal detachment develop a retinal detachment in the other eye.
- have a family history of retinal detachment.
- have had previous eye surgery in that eye, such as cataract surgery.
- have certain other eye conditions such as diabetic retinopathy or inflammation inside the eye.



What are the symptoms of a retinal detachment?

The following symptoms can be the first signs of a retinal detachment:

- floaters
- flashing lights
- a dark shadow in your vision
- blurred vision.

You may have these symptoms but not develop a retinal detachment, but there isn't a way to tell what is causing these symptoms unless your eye is examined.

A retinal detachment can cause a permanent loss of vision so it's best to be cautious and have these symptoms checked, as soon as possible, within 24 hours of noticing any new symptoms. You can do this by having your eyes examined urgently by your optometrist (optician) or by attending Accident and Emergency (A&E) or eye casualty. You can also call 111 for advice about your symptoms and where to go to get your eyes checked.

Floaters

Floaters are caused by floating clumps of cells that form in your vitreous gel which cast a shadow onto your retina. The brain then sees this as something floating around in your vision.

Floaters are very common, and most people develop some as they get older. They can take many shapes, for example, black dots, rings, spiders' legs or cobwebs.

Many people naturally have some floaters in their eyes, which are nothing to worry about, but new floaters or changes to the ones you have already should be checked. People who are short-sighted, or have had eye operations in the past, often have floaters.

If you start to see floaters or notice a change or increase in the floaters you already have, you should have your eyes examined by an optometrist or an ophthalmologist as soon as possible. If you see an optometrist and they find, suspect, or can't rule out a tear in your retina, then they will refer you urgently to an ophthalmologist.

Flashing lights

In most cases flashing lights are caused by a change in your vitreous gel (PVD). This is where the vitreous gel inside the eye moves across and tugs or stimulates the retina. These flashes of light are brief, white and vertical, occurring in the edges or sides of your vision. They may be worse when you move your eye or head and are more noticeable in darker or dimmer environments.

A PVD itself is not harmful, but in some people, it may cause a retinal tear. That's why if you suddenly experience new flashing lights, you should have your eye examined by an optometrist or ophthalmologist as soon as possible.

Dark shadow

If your retina does detach, this means that it cannot work properly anymore, and you will see this as a solid dark shadow moving in from the edge of your vision. You will not be able to see round or through this shadow. If more of your retina detaches, then the shadow will keep moving towards the centre of your vision.

If you experience a dark shadow moving up, down or across your vision, you must attend your local hospital A&E department straight away.

Blurring of vision

Your vision can gradually become blurred for many reasons, and a visit to the optometrist will help you find out why. If your vision suddenly becomes blurred, especially if you also have any of the other symptoms of flashing lights, floaters or a shadow, then this is more serious, and you should have your eyes examined straight away.

Who should check my eyes?

It's important to have someone examine your eye if you start to have any of these symptoms and in most cases, it is best to have your eyes checked within 24 hours.

Sometimes it is easier get an appointment with an optometrist on the high street, but they may refer you straight away to your local A&E or eye casualty department so that you can be seen by an ophthalmologist as soon as possible. A&E departments should have an ophthalmologist on call who can examine your eye and decide what to do next. You can also **call 111** for advice about where to go to get your eyes checked.

If you have been checked for retinal detachment in the past, you should have been given clear instructions on what to do if you have further symptoms. You should follow these if more symptoms develop. This usually involves contacting the hospital eye clinic if you have any concerns.



Treatment for retinal tears

Retinal tears can be treated to prevent them from developing into a retinal detachment.

There is no way to prevent a tear or hole developing in the retina in the first place, but if you do notice any possible symptoms, getting these checked as soon as possible, and (if necessary) treated quickly, can reduce the risk of developing a retinal detachment. The symptoms of a retinal tear are similar to those of a retinal detachment.

Treatment for a retinal tear can be done either using laser, or with cryotherapy (a freezing treatment). These treatments are very successful at preventing a retinal tear from developing into a retinal detachment.

Laser treatment (laser retinopexy)

Laser treatment uses a carefully targeted beam of light to cause very small burns around your retinal hole or tear. These small burns form scar tissue and act to seal your retina more firmly to the back of your eye, preventing a detachment.

For this procedure, you will be given drops to dilate (widen) your pupil and an anaesthetic eye drop to numb the front of your eye.

The laser can be performed:

- While you are sitting upright at the laser machine. A contact lens will be placed on the surface of your eye which helps to keep your eye open and helps focus the laser.
- While lying on your back. The laser is delivered through a device worn on the ophthalmologist's head. The ophthalmologist may need to press on your eyelid with a small instrument to be able to see the tear if it is located at the edge of the retina. This may cause some redness of the tissues that cover the eyeball, but this settles on its own within a few days.
- When the laser is applied you may see several bright flashes of light. The procedure can take 10 to 15 minutes. The laser can cause sharp or stabbing pain. Some people just feel a dull ache or mild discomfort.

Cryotherapy

Cryotherapy uses very low temperatures to freeze the area of the retina around your retinal tear or hole from the outside of the eye. The freezing treatment causes a scar to form around the retinal tear or hole which seals it and prevents fluid passing through to cause a detachment. Because

cryotherapy treats the tear from the outside of the eye inwards, it may be used in situations where it is difficult for the ophthalmologist to view the tear completely from inside the eye; for example, if the tear is positioned at the extreme edges of the retina.

Before the procedure, anaesthetic eye drops will be given to numb the eye. The ophthalmologist will place a probe on the outside of your eye over the area of the tear. When the probe is turned on, that small area is frozen in a few seconds. Several areas will usually need to be frozen to seal the tear. You may notice a cold feeling while this happens. It usually takes about 10 minutes to complete the procedure.

Some people get a cold feeling during or after the treatment or experience a 'freezing' headache. You can usually use mild painkillers if needed. You are likely to have a patch on the eye after this treatment.

Recovering from laser treatment and cryotherapy

These treatments are quick and use a local anaesthetic, so you won't need to stay in hospital overnight.

Immediately after the procedure, it's common for your vision to be blurred and to be light sensitive. Your vision should improve by the next day. Only a small area of your retina is treated so your vision isn't usually affected in the long term.

Laser treatment or cryotherapy won't improve or reduce your symptoms of floaters, so you may still experience these following the procedure. However, you should seek help from your eye clinic straight away if you notice an onset of new floaters, flashing lights or a shadow or curtain coming across your vision.

Although all treatments come with some risks and side effects, the risks of laser treatment or cryotherapy for retinal tears are generally very low. The risk of developing a retinal detachment if the procedure isn't carried out is usually higher than the possible risks of the procedure itself. Your ophthalmologist will go through the risks of the procedure before it is carried out.

People can usually go back to their normal everyday activities following laser treatment or cryotherapy for a retinal tear. Your ophthalmologist will let you know if there are any specific precautions you need to take following your procedure.

It usually takes about 14 days for the scar tissue to fully develop from the treatment, so you will normally be followed up after about two weeks to check that the treatment has worked to seal the tear.



Treatment for retinal detachment

If your retina has detached, this is treated by surgery to re-attach the retina to the back of the eye. The sooner surgery is carried out the better the results are likely to be. If your retinal detachment isn't treated, then you are likely to lose all the vision in the affected eye.

Once your ophthalmologist has examined your eye, they will decide how quickly surgery needs to be done – this may be within 24 hours or within a few days.

Most retinal detachment surgery is done under local anaesthetic, meaning that you'll be awake but won't feel any of the surgery. The anaesthetic also stops your eye from moving during the surgery. During the surgery, you may notice movement and bright lights in front of your eye, but you will not be able to see any detail of what is happening. As you are awake, you will be able to hear what is happening in the operating theatre. Some people may have a general anaesthetic, which means they are unconscious for the surgery. You and your ophthalmologist will decide which type of anaesthetic will be best for you. It's more than likely you will be able to go home the same day as your surgery if a local anaesthetic has

been used, but you may need to stay in hospital overnight following a general anaesthetic.

There are three main types of surgery used to reattach the retina. They all aim to make your retina lie flat against the inside of your eye again. In each case, your ophthalmologist will also repair any tears or holes using cryotherapy or laser treatment during the surgery.

Surgery for retinal detachment is complicated and individual to each person's eye. The type of surgery you may need depends on the type and cause of the detachment, and any complicating factors, such as any other eye conditions you may already have. Your ophthalmologist will decide on what type of surgery is most appropriate for your individual circumstances, and they may combine different options depending on the extent of your detachment.

Vitreotomy

The most common surgery used for a retinal detachment in the UK is a vitrectomy. During surgery your ophthalmologist removes some of the vitreous gel in your eye and replaces it with a gas bubble. Removing some of the vitreous gel helps to remove the traction of the gel on the retina. The gas bubble holds your retina in

place against the inside of your eye while it heals. The gas slowly disappears over time; it may take between two to 12 weeks depending on the type and concentration of gas used.

Your ophthalmologist may choose to use clear silicone oil instead of a gas bubble. The silicone oil is heavier than gas and is effective for longer at keeping your retina in the right place while it heals. However, unlike the gas bubble, you will need further surgery to remove the oil at some point in the future. Silicone oil is generally used for more complex retinal detachments.

Sclearal buckle

Your ophthalmologist may use a scleral buckle to treat your detachment. The sclera is the white outer layer of your eye.

A scleral buckle involves attaching a tiny piece of silicone sponge or harder plastic to the outside white of your eye. This presses on the outside of the eye, causing the inside of your eye to slightly move inwards. This pushes the inside of the eye against the detached retina and into a position which helps the retina to reattach. Cryotherapy or laser treatment is then used to seal the area around the detachment. The buckle is usually left in place permanently and can't be seen once surgery is finished.

Pneumatic retinopexy

If your retinal detachment is small and uncomplicated, a gas bubble can be injected into the vitreous of the eye, without removing any of the vitreous. This bubble then presses the retina back in place. Like with vitrectomy, the gas is reabsorbed over a period of weeks. This type of surgery has been found to be less successful than other types and is not often done in the UK but may be carried out for a small number of straightforward and small retinal detachments.

Posturing before or after your operation

Posturing (or positioning) is lying or sitting with your head in a certain position. You may be asked to do this:

- before surgery to stop a retinal detachment affecting more of your retina, or
- after your operation to help keep a gas bubble in the correct position. This is so that the gas bubble floats up and continues to put pressure on the part of the retina being reattached while it is healing.

Your ophthalmologist will explain what position you need to lie or sit in, and for how long. You may need to posture for up to 10 days after your

surgery, and you may be advised to maintain the posture for 45-50 minutes of every hour. This gives you 10-15 minutes every hour for things like eating, using the bathroom and putting in any eye drops you've been advised to use after your surgery.

As surgery for retinal detachment is often carried out very quickly once you are diagnosed, it often leaves you with little time to prepare for posturing. You may find it useful to have someone to help you at home while you are posturing. But if that is not possible, and you are worried about coping, let your ophthalmologist or GP know, as they may be able to arrange for some help. It may also be possible to get some tips on how to manage your posturing from a nurse at the eye clinic.

What will my sight be like with the gas bubble in my eye?

If you have had a gas bubble put into your eye, your vision will be very blurry for a while, but this is temporary. With poor vision in one eye, you may find your balance is affected and that you have less depth perception, so you misjudge steps and kerbs. You may have difficulty picking things up accurately or pouring out liquids safely.

Over the weeks that follow your surgery, the gas bubble slowly gets smaller and eventually disappears. As this happens, you may see a horizontal wavy line across your vision, which is the divide between the gas and liquid content of your eye. This line will wobble as you move, like a spirit level. Above the line you may be able to see, but below the line your sight will remain blurred. As the gas disappears, the line across your vision will gradually move downwards, until it becomes a small round dot, before disappearing altogether.

This process can take from two to 12 weeks depending on the type of gas used for your surgery. Your ophthalmologist will let you know which gas has been used in your surgery and how long the gas will be in your eye. While the gas is in your eye and your eye is recovering from the operation, your sight may not be good.

If you have had silicone oil put into your eye, then your vision will be blurred until this is removed by another operation at a later date. Silicone oil does not disappear like a gas bubble does. How long you may have silicone oil left in your eye will depend on your individual circumstances, but your ophthalmologist will monitor when your retina is stable enough to have the oil removed.

How quickly will my eye recover?

After surgery, your eye may feel uncomfortable for a few weeks. There may be some bruising and your eyelids may be sticky. You will be given eye drops to help prevent infection and to control any swelling. Taking a painkiller like paracetamol should help with any discomfort.

Your vision may be blurry for days, possibly weeks, following the surgery, even if a gas bubble wasn't used for your operation. It usually takes about six to 12 weeks for your eye to recover from surgery and for you and your ophthalmologist to get the final idea of the visual outcome.



What are the possible complications of retinal detachment surgery?

If you have had a gas bubble or oil put in your eye, then it is usual to develop a cataract in the eye within about a year following your retinal detachment surgery. A cataract is a clouding of the lens in your eye and can be treated when needed by surgery to remove the cloudy lens and replace it with a clear artificial lens.

You can find more information about cataracts on our website or by calling our Helpline.

Following all types of eye surgery, there is a risk of raised pressure inside the eye. Eye pressure may go up in the short-term following surgery but usually comes back down to normal for most people during their recovery. For a few people, eye pressure may remain too high in the long-term which can damage the optic nerve at the back of the eye and damage sight. If necessary, you will be given treatment to control your eye pressure and protect your optic nerve and sight.

All surgery carries some risk of complications such as infection or bleeding, but the risk is low in retinal detachment surgery. Most people will lose all useful vision if their retina has detached and no surgery is carried out, so for most people, the

benefits of having the surgery to save your sight generally outweighs the possible risks associated with the surgery.

What activities can I do after surgery?

During your recovery from surgery you don't have to limit how much you use your eyes, so watching TV, reading or using screens will not cause any problems. Your ophthalmologist will tell you which activities you should avoid after your operation. The advice may be different depending on the type of surgery you have had. Most people will have some restrictions for the first few weeks after the operation.

Most of these restrictions will be to prevent infection to your eye while it is healing, such as avoiding swimming, wearing eye make-up or rubbing your eye. You may be given an eye shield to wear when you are sleeping, and you may be advised to take extra care when it's windy or when washing your hair and face to make sure nothing gets into the eye.

You may be advised to avoid vigorous or strenuous exercises, sports and heavy lifting while your eye is healing from surgery, but light or gentle exercise such as walking is usually fine.

You may also need to take time off work to recover and your ophthalmologist will let you know how long this should be. Most people are advised they may need to take around 2 weeks off work, but this could be longer depending on the type of work you do and on how your eye recovers.

It's unlikely that your vision will be good enough for you to safely drive while you have a gas bubble in your eye. Whilst you are legally entitled to drive if the vision in your other eye is good enough to meet the DVLA driving standard, many ophthalmologists feel that it is unwise to do so whilst the bubble remains in your eye. This is because the vision will be poor and the ability to judge distance will be affected. Ask your ophthalmologist for advice about driving following surgery.

While a gas bubble remains in your eye, it can react with another gas, nitrous oxide, which is used in some general anaesthetics and as pain relief in A&E. Nitrous oxide can make the gas bubble in your eye expand, raising your eye pressure, which can damage your sight. You should tell any medical staff treating you while you are recovering that you have gas in your eye and that you shouldn't be given nitrous oxide.

Similarly, if you need a general anaesthetic while you still have gas in your eye, it's important to tell your anaesthetist.

You should also not take a flight in an aeroplane while the gas bubble is still in your eye, because the change in cabin pressure can cause the gas to expand. This is only a problem while the gas is still present in your eye. Your ophthalmologist will be able to tell you how long it will take for the gas to disappear. They should also let you know when there is no longer gas in your eye so you can safely fly again.

Once your eye has healed from the operation, you can usually continue the sports or activities you enjoy. You can ask your ophthalmologist about returning to any of your usual activities during your follow up appointments. They will be able to advise you depending on how your eye is recovering.

Your ophthalmologist is the best person to let you know if any of your regular activities should be avoided in the long term. Full contact sports which may result in a blow to the eye, such as boxing, kick-boxing and martial arts aren't recommended for someone who has had retinal reattachment surgery.

How successful is surgery?

Surgery is usually very successful at reattaching the retina, but how well your vision recovers depends on:

- how much of your retina detached
- if your macula (the central part of your retina, used for seeing detail and reading) was detached
- how long your retina was detached
- if you have another eye condition, such as diabetic retinopathy.

If your macula, which allows you to see fine detail, remained attached, then results are often very good, and your central vision may not be affected at all.

If you had a shadow in your peripheral vision, this should disappear after surgery. You may be left with some changes in your peripheral vision, which can be picked up by an eye examination, although you may not notice these on a day-to-day basis.

If your macula detached, but surgery was carried out quickly, then your central vision can return, but it may be distorted.



You will probably adapt to this distortion with time, especially if you have good vision in your other eye.

Unfortunately, for some people, surgery may be successful at reattaching the retina, but it may not bring back detailed central vision or areas of peripheral vision. This can happen in any circumstance, but the risk is higher the longer the retina has been detached without any surgery.

What happens if the surgery is not successful, or the retina comes away again after surgery?

Around one in 10 people may need more than one operation to treat a retinal detachment. The reasons for this are new tears forming in the retina, or the formation of scar tissue which contracts and pulls the retina off again.

In these cases, it is possible to have more surgery to reattach the retina. At each stage, your ophthalmologist will discuss with you the likelihood of success and the need to have more surgery or treatments.

How will I manage with any changes in my sight?

If your retinal detachment is detected early and treated successfully, you may not be left with any long-term problems with your vision once your eye has recovered from surgery.

If your retinal detachment has left you with sight loss in one eye, you may still have good vision in your other eye. It can take a few months to get used to seeing with only your good eye, because sometimes the eye with poor vision will interfere with the clear vision of the other eye. With time, the brain learns to ignore the eye with poorer vision in most situations.

What if both my eyes are affected by sight loss?

If a retinal detachment has caused sight loss in your good eye and you have reduced sight in your unaffected eye, then you may be left with sight problems. There are lots of things that you can do to make the most of your remaining vision. This may mean making things bigger, using brighter lighting or using colour to make things easier to see. We have a series of leaflets with helpful information on living with sight loss, including

how to make the most of your sight. You can find out more about our range of titles by calling our Helpline.

You should also ask your ophthalmologist, optometrist or GP about low vision aids and having a low vision assessment. During this assessment with a low vision practitioner, you'll be able to discuss the use of magnifiers and aids to see things more clearly.

You should also ask your ophthalmologist whether you're eligible to be registered as sight impaired (partially sighted) or severely sight impaired (blind). Registration can act as your passport to expert help and sometimes to financial concessions. Even if you aren't registered, a lot of this support is still available to you.

Local social services should also be able to offer you information on being safe in your home and getting out and about safely. They should also be able to offer you some practical mobility training to give you more confidence when you are out.

Coping

It's completely natural to be upset when you've been diagnosed with a retinal detachment. Often there can be a lot of changes, including surgery, in a short space of time. You may find that you are worried about the future and how you will manage with a change in your vision. All these feelings are natural.

Some people may want to talk over some of these feelings with someone outside their circle of friends or family. At RNIB, we can help you with our telephone Helpline and our Counselling and Wellbeing team. Your GP or social worker may also be able to help you find a counsellor if you feel this may help.

Your eye clinic may also have a sight loss adviser (also known as an Eye Care Liaison Officer or ECLO), who can be on hand to provide practical and emotional support about your eye condition.

Further information

RNIB Helpline

If you need someone who understands sight loss, call our Helpline on **0303 123 9999**, say “**Alexa, call RNIB Helpline**” to an Alexa-enabled device, or email **helpline@rnib.org.uk**. Our opening hours are weekdays from 8am – 8pm and Saturdays from 9am – 1pm

You can also get in touch by post or by visiting our website:

RNIB

The Grimaldi Building
154A Pentonville Road
London N1 9JE
rnib.org.uk

Sightline directory

Find services and organisations near you that support blind or partially sighted people:
sightlinedirectory.org.uk

Connect with others

Meet or connect with others who are blind or partially sighted online, by phone or in your community to share interests, experiences and support for each other. From book clubs and social groups to sport and volunteering, our friendly, helpful and knowledgeable team can link you up with opportunities to suit you. Visit **rnib.org.uk/connect** or call **0303 123 9999**.

Other useful contacts

Driver and Vehicle Licensing Authority (DVLA)
Drivers' Medical Enquiries
Swansea SA99 1TU
0300 790 6806
gov.uk/contact-the-dvla

RNIB booklet series

About the Starting Out series

Essential information about living with sight loss.

Titles include:

- Benefits, Concessions and Registration
- Emotional Support
- Help from Social Services
- Making the Most of Your Sight

About the Confident Living Series

Information to build confidence and independence.

Titles include:

- Reading
- Shopping
- Technology
- Travel

About the Understanding Series

More about your eye condition. Titles include:

- Age Related Macular Degeneration
- Cataracts
- Visual Hallucinations: Charles Bonnet Syndrome
- Dry Eye
- Diabetes Related Eye Conditions including Diabetic Retinopathy
- Glaucoma
- Nystagmus
- Retinal Detachment
- Inherited Retinal Dystrophies including Retinitis Pigmentosa
- Posterior Vitreous Detachment

For audio, print or braille versions of these booklets please contact our Helpline or visit **shop.rnib.org.uk**.

For a list of information sources used in these titles and to provide feedback on the Starting Out and Confident Living Series, email **ckit@rnib.org.uk**.

We value your feedback

You can help us improve our information by letting us know what you think about it. Is this booklet useful, easy to read and understand? Is it detailed enough or is there anything missing?

How could we improve it? We would also like your views on the pictures and diagrams, are they appropriate, helpful and are there places where a diagram might have helped?

Send your comments to us by emailing us at eyehealth@rnib.org.uk or by writing to:

Eye Health Information Service

RNIB

The Grimaldi Building

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Information sources

RNIB and The Royal College of Ophthalmologists do all we can to ensure that the information we supply is accurate, up to date and in line with the latest research and expertise.

This publication uses information from:

- The Royal College of Ophthalmologists' guidelines for treatment
- clinical research and studies obtained through literature reviews
- specific support groups for individual conditions
- medical textbooks
- RNIB publications and research.

For a full list of references and information sources used in the compilation of this publication, email **eyehealth@rnib.org.uk**.

About The Royal College of Ophthalmologists

The Royal College of Ophthalmologists champions excellence in the practice of ophthalmology and is the only professional membership body for medically qualified ophthalmologists.


The College is unable to offer direct advice to patients. If you're concerned about the health of your eyes, you should seek medical advice from your GP or ophthalmologist.

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R N O V S
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