COVID-19 has resulted in major changes in the way the field of ophthalmology is practiced globally.\(^1\) The novel corona virus not only affects the eyes directly making ophthalmologists the first contact in many cases but also acts as a bystander waiting to spread in other cases where a patient (symptomatic or asymptomatic) seeks an ophthalmic opinion for an unrelated issue.\(^8\)-\(^11\) Various guidelines for practicing ophthalmology have been issued and accepted the world over for a general ophthalmology practice; however these are limited in their purview when it comes to subspecialty practices.\(^12\)-\(^17\) Limited literature is available on specific guidelines for specialty practice.\(^13\)-\(^16\)

As a subspecialty, pediatric ophthalmology needs special attention in the current COVID-19 pandemic, both due to the unique nature of examination or treatment and the increased vulnerability of the age group being treated. Keeping this in mind, there are certain modifications and precautions that ophthalmologists need to employ or take when managing a child with eye problems.

The rationale behind the need for special adaptations emanates from the fact that children are not only a vulnerable group to infection by SARS-CoV-2 but also pose a greater threat to transmit infection to the caregiver or medical professional. The reasons for children being a greater danger to the ophthalmologist than an adult include:

1. Children often wear no masks or ill-fitting masks which are ineffective in preventing spread of aerosols.\(^17\)
2. Children are often scared of doctors in masks, there may be risk of medical professional letting their guard down and removing masks temporarily to get cooperation from a child.
3. Children are unlikely to follow social (physical) distance protocols and OPD etiquettes.

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(4) Children would often have either parents or more than 1 attendant accompanying them and this increases chances of exposure
(5) Children would generate more aerosol by crying, coughing and resisting an ocular exam
(6) Children are more likely to be asymptomatic and may pass the symptom based screening[7,18]
(7) Children are more likely to shed virus for a longer duration as evidenced by prolonged shedding in nasal secretions and stool in asymptomatic children[20,21]
(8) Children require a longer examination time including dilation which increases risk of exposure
(9) Children are most likely to require sedation or general anesthesia for procedures and surgery

For the field of neuro-ophtalmology, many of the conditions go beyond just sight threatening to potentially life threatening, hence early diagnosis and intervention are imperative. Additionally, SARS-CoV2 is known to cause ocular and systemic conditions with neuro-ophtalmic manifestations and this information is essential for all ophthalmo logists. Therefore, there was a need to establish specific set of guidelines for evaluating and managing a neuro-ophtalmology case in the current pandemic.

Methods
An online web-based meeting of experts in the field of ophthalmology (including pediatric ophthalmology and neuro-ophthalmology) and anesthesia was conducted under the Aegis of the All India Ophthalmological Society (AIOS) on 5th of May 2020. A skeleton draft of recommended general practice guidelines, based on a previous publication by the AIOS, was presented to the expert panelists who then commented or recommended specific changes pertaining to pediatric ophthalmology or neuro-ophthalmology practice. After the meeting, a base document was generated by Dr Rohit Saxena and Dr Digvijay Singh and circulated amongst the members who then commented on the same and a final document was created. This final document was then ratified by all the experts.

Consensus Statement
The consensus statement is broadly divided into two sections: one for pediatric ophthalmology and one for neuro-ophthalmology. The sections are further divided into subsections such as list of conditions which entail emergency care, guidelines for outpatient examination/management, guidelines for providing general anesthesia and guidelines for tele-consultation as appropriate.

Pediatric ophthalmology
Emergency care
The expert panel listed a number of ocular conditions which are likely to constitute an emergency and require urgent care. The list is indicative and not comprehensive but broadly covers the common pediatric ophthalmology conditions encountered by an ophthalmologist. Table 1 describes the common ophthalmic emergencies within the realm of pediatric ophthalmology and strabismus along with the rationale for their inclusion in the list.

Guidelines for examining cases of pediatric ophthalmology and strabismus in the OPD
The expert panel referred to guideline published by the AIOS and built upon them with specific recommendations. To reiterate, the general examination guidelines include the need to pre-register patients and see on basis of appointments only with minimum walk-ins, need to screen patients and attendants for symptoms/signs of infection along with history of contact, examine a single patient at any time in the room with staggered timing to avoid crowding in the waiting area, appropriate disinfection of rooms and instruments after each patient encounter and use of appropriate personal protective equipment ideally consisting of disposable gloves, masks (3-ply or N95), overalls/gowns/aprons and protective eyewear or face

| Table 1: List of emergency/urgent conditions in pediatric ophthalmology and strabismus requiring examination/management (medical/surgical) |
|-------------------------------|---------------------------------------------------------------|
| Condition                        | Reason                                                      |
| Pediatric cataract/congenital cataract in amblyopic age group/ traumatic cataract | Sight threatening/permanent visual disability               |
| Buphthalmos/pediatric glaucoma   | Sight threatening/permanent visual disability               |
| Strabismus surgery for torn or lost extra-ocular muscle/post injury/ Complaint of recent onset diplopia or acute onset of squint/nystagmus/ ptosis/head posture | Permanent diplopia/sight threatening/loss of binocularity/ Life threatening |
| Traumatic head & eye injuries    | Sight threatening/permanent visual disability/Life threatening |
| Probing of the nasolacrimal duct obstruction in case of dacryocystocele ROP screening/treatment | Life threatening |
| Retinoblastoma and other ocular tumors | Sight threatening/permanent visual disability/Life threatening |
| Retinal detachment               | Life threatening                                            |
| Breakage/Loss of glasses of child with high/pathological refractive error | Sight threatening/permanent visual disability               |
| Acute Red eye/purulent discharge  | Sight threatening/permanent visual disability               |
| Acute dacrocystitis, preseptal cellulitis/orbital cellulitis | Sight threatening/Life threatening                        |
| Complaint of recent/sudden loss of vision | Sight threatening/permanent visual disability/Life threatening |
| Constant strabismus or severe ptosis in early childhood | Sight threatening/permanent visual disability               |
shields. The appropriate use of PPE’s is already defined by the Government of India and should be followed as per the latest guidelines issued by the respective departments.[22]

The specific suggestions made by the expert panel pertaining to any pediatric ophthalmology and strabismus examination include

1. Instructions to parents/guardians to avoid bringing siblings and grandparents of the child to be examined
2. Delay any routine tests scheduled for children with special needs
3. Closure of any play area for children in the premises
4. Avoidance of handing out candy or sweets to children
5. Hand hygiene of children on entry to premises and examination room
6. Ensure all children (specially above the age of 2) should wear a mask
7. Avoid bringing food stuffs for the child inside the clinic
8. Child friendly and attractive masks may be worn by staff (if available)
9. Children to always be kept in lap or held by the parent/guardian

A guideline regarding the examination and workup of a child in the outpatient clinic is mentioned below and includes certain tenets including possible exclusions that maybe appropriate in the current situation. These include:

1. For children less than 2 years old, a direct consultation maybe done with the consultant without a formal optometry work-up
2. Avoid touching of kids head or face during assessment of visual acuity. Visual acuity assessment may be done either by occluding a child’s eyes with disposable tissue paper or asking parents to close one eye at a time with their hands while preventing peeking
3. Certain tests may be avoided including stereoacuity, worth four dot test, colour vision, use of synoptophore or regurgitation over lacrimal sac
4. Regular follow-up cases and for most patients, squint may be assessed by Hirschberg test rather than a prism bar cover test or use of synoptophore (unless needed for surgical planning)
5. For a child with a visual acuity of 6/6 (with or without glasses), no need to do dry refraction on a routine visit
6. No need for subjective acceptance if the decision is to be taken based on cycloplegic refraction
7. Cycloplegia and dilatation to be avoided in children who have had a detailed checkup within last 6 months
8. If only dilatation is needed to view fundus, 1 to 2 drops of tropicamide may be used
9. If cycloplegia is needed, the parents may be instructed to put eye drops from home and come on next visit or 2 drops of cyclopentolate/homatropine may be instilled with care in a designated area
10. Hand-held spot autorefractors may be ideal for cycloplegic refraction (if available)
11. Routine tonometry to be avoided and, if needed, is best done with applanation or rebound tonometer or tonopen
12. Slit lamp and fundus examination to be done only where necessary
13. Examination under sedation may be preferred to examination under anesthesia (where possible)

Guidelines for follow up and management of specific conditions
COVID-19 is likely to remain amongst the population for an extended period of time. In view of this, the expert panel agreed that there is a need to proceed with the management of non-urgent and elective cases, albeit with full precautions. All emergency and urgent situations mentioned in Table 1 need appropriate management, COVID-19 notwithstanding. Keeping the general guidelines described above in mind, the management of a few specific situations is discussed below.

1. **Strabismus:** While several forms of strabismus may be managed conservatively without the need for surgery, the majority would require surgical intervention. Even in cases which require surgery, the strabismus may be managed conservatively for a short period of time using stop gap measures such as orthoptic exercises, occlusion therapy and prism glasses. In cases which are at a high risk of COVID-19 or where conservative treatment is possible for an extended period of time, it may be preferred to a surgery. However, in due course, surgery needs to be planned with proper precautions for anesthesia as described in the subsection on anesthesia below.

2. **Amblyopia:** In case of recently diagnosed and amblyopia, part-time occlusion maybe started and followed up on a monthly basis. Avoid starting penalization and full-time occlusion in young children. Periodic self-checking of the eye undergoing occlusion should be advised to prevent occlusion amblyopia.

3. **Refraction:** Children who have been previously prescribed glasses or have broken their glasses may be continued on the same power, if the cycloplegic examination was done within the past 6-12 months. For children who have been examined for the first time or have not had an eye exam in the past 1 year, cycloplegic refraction may be done (where possible) or else the closest power based on a subjective refraction may be given in the interim.

4. **Follow-up:** Follow-up of certain conditions such as amblyopia, post-operative squint, post-operative cataract, post-operative adnexal, congenital nasolacrimal duct obstruction, allergic conjunctivitis etc., may be done using telemedicine.

Guidelines for general anesthesia
The major concern in operating children in this era of COVID-19 is the high risk of virus transmission during the process of giving general anesthesia, which is an aerosol generating procedure. Ideally, patients who test positive should not be taken up for surgery, unless an emergency so necessitates. While in a positive patient, any general anesthesia would be given knowing the risks, the real threat is patients who are either in the window period and have tested negative or patients who are carriers, where there is a tendency to lower ones guard. The major concern here is the spread of virus during airway management which is mandatory for children who are to be taken up for these procedures.[23] Where possible, a procedure under sedation should be preferred over one under general anesthesia.

Airway management in the OR in times of COVID-19 pandemic poses unique challenges including a high amount of aerosolization, making all the team members at a high risk of acquiring COVID-19 infection during the procedure.[24,25] During airway management, like intubation and extubation of
the pediatric patient, we need to follow measures to prevent aerosol generation and reduce viral spread.\[25\]

To begin with the care and precaution should be taken at 3 levels:

A. Training the staff and doctors in the operation theatre:
   Training of all the members who would be part of the operation theatre regarding the hand sanitization, donning and doffing of the personal protective equipment (PPE) that are to be used in that particular setup. Importantly, they should be specifically told that donning and doffing should be very carefully done and disposal of these is of utmost importance.\[23,26,27\]

B. Explaining to the attendants and conducting various tests on the patients preoperatively:
   a. Investigations which may be indicated include complete blood count, chest X-ray and viral markers. A COVID-19 test should be done if possible, however it is not mandatory in the current scenario.
   b. Pediatric consultation or reference should be done, where possible to rule out possible pneumonia.

C. Precautions for ophthalmologist and anesthetist:
   a. Securing the vein: The child can be first put under sevoflurane mask and a vein can be secured since in a child who is alert and crying, the risk of aerosolization is high. This has to be done with full PPE.
   b. Induction: Any method to cover the patient’s face may be used but ideally we can use a transparent box (called COVID-19 GA Box) to induce the child. The COVID-19 box has two open holes for the anesthetist to insert his whole hands.\[28\] It is preferable to do tracheal intubation over the use of laryngeal mask anesthesia or supra-glottic device.\[29\] In addition, a deeper plane of anesthesia can be achieved using intravenous anesthetic drugs.
   c. Maintenance: Heat and moisture exchanging filters (2 in number) should preferably be installed. One is attached between the breathing circuit and the mask and the other one is attached between the expiratory limb of the breathing circuit and anesthesia machine. This effectively prevents the contamination of the breathing circuit. It is best to avoid mask ventilation to prevent any aerosol generation unless O2 saturation goes below 95%.\[23\]
   d. Extubation: There should be a closed suction system. Suction should be done only if it is required as it is also an aerosol generating procedure. This too should be performed under a COVID-19 box. A face mask can be threaded over the endotracheal tube prior to doing the intubation to prevent any further spread of aerosols\[23\]
   e. Postoperative: The patient should be wearing this face mask before transferring to the postoperative area
   f. PPE for the Anesthetist/Surgeon: A full level PPE consisting of Reusable N95 mask, face shield/goggles, gown and double gloves should be used by all personnel present in the operating room. Have a dedicated Doffing and Donning area, if possible.
   g. Protocol for personnel: During intubation only anesthetists, technician and patient should be inside the operating room. After intubation scrub nurse can go in and drape and prepare followed by the surgeon. Any trainees should watch from outside or viewing box.
   h. Operation room (OR) air circulation:
      a. Negative air pressure: A negative pressure OR is preferred as it helps to avoid the spread of corona virus infection by reducing the viral load inside the OR. A normal OR would be a positive pressure area (approx. 5-10 cm H\(_2\)O).\[30\]

b. Role of air Purifiers: The exact role of HEPA based air purifiers is not established. However, it would be good to use air purifiers which reduces the viral load and purifies the air. A typical air purifier which does 6-7 air exchanges would be preferred.

c. Role of air exchanges: Encourage using the air exchanges to dilute the viral load. A system which can generate negative pressure area during intubation and extubation time, as these are the aerosol generating procedures (AGP), would be preferable. During the AGP’s the central air conditioning should be switched off and a negative pressure should be generated. NABH recommends around 20 air exchanges in an hour with at least 4 fresh air exchanges in an hour.\[23,26,27\]

i. Reusable equipment/items: The reusable items should be immersed immediately after their use into a disinfectant solution like sodium hypochlorite 1%.

j. OR disinfection: Clean the OR table and other surfaces thoroughly with isopropyl alcohol or chemical disinfectant once the procedure is over. Try to have time between two procedures to help reduce viral load (it is recommended to have minimum 20 minutes between two surgeries for re-sterilization and air exchanges to take place), if present, in the OR.\[7\] Fogging in between two procedures and surface cleaning can effectively disinfect. UV light can also be used to sterilize the air but has limited role on surface due to the shadow effect. The placement may be above the air conditioning to avoid direct light exposure and its side effects.

Guidelines for special therapeutic situations

A. ROP lasers
   a. Although mask ventilation is to be discouraged during any anesthesia procedure, here the mask would indeed reduce the aerosols that originate due to the crying of the baby
   b. A mask should be put with oxygen and taped around the mouth and nose to reduce the aerosols. A drape can be used to separate the nasal and mouth opening from the ocular area
   c. The mask need to be cleaned or disposed taking utmost precautions for every patient
   d. Take only one child for any procedure on a single day

B. Examination under anesthesia: Preferably avoid and reduce the examination under anesthesia. It may be preferable to examine a child under sedation, where possible. If at all an examination under anesthesia needs to be carried out, it should be done with same precautions as any other surgery.

Neuro-ophthalmology

Emergency care

Neuro-ophthalmology as a subspecialty often deals with conditions that are not just sight threatening but potentially life threatening. The expert panel listed a number of ocular conditions which are likely to constitute an emergency and require urgent care. The list is indicative and not comprehensive but broadly covers the common neuro-ophthalmology conditions encountered by an ophthalmologist. Table 2
describes the common ophthalmic emergencies within the realm of neuro-ophthalmology along with the rationale for their inclusion in the list.

**Guidelines for neuro-ophthalmology cases**

The expert panel referred to guideline published by the AIOS and built upon them with specific recommendations for managing neuro-ophthalmology cases.[7]

These include:

1. Assessment of visual acuity using a Snellen chart or app based vision screeners in a non-contact manner
2. Pupil reflex/RAFD assessment using distance direct ophthalmoscope
3. Use of indirect ophthalmoscopy, fundus photographs and optical coherence tomography to assess pathology rather than direct ophthalmoscope
4. Avoid holding the patients head during testing ductions and movements.
5. Perform diplopia charting without the use of special equipment such as diplopia goggles, if possible
6. Use clinical photographs to assess acquired strabismus
7. Neuro-imaging may be ordered with a lower threshold to avoid a lengthy clinical exam
8. Investigations for systemic disorders (FBS, BP monitoring, Lipid profile) can be advised and evaluated remotely for screening for etiology, if needed
9. If a case of possible optic neuritis or traumatic neuropathy needs IV steroids, rule out high risk features for COVID-19 (through physician consult)
10. Visual fields to be done only if essential; most cases can be evaluated by confrontation fields. If a field is needed, all patients must wear masks during perimetry and chin and forehead rest should be cleaned with alcohol swabs between patients. Have a gap between two patients needing to use the field machine. While the dome may be cleaned with use of light soap-water, specific recommendations of the manufacturer may be followed for this.
11. Teleconsultation plays an important role in neuro-ophthalmology as a detailed history and basic examination can be conducted remotely. Conditions such as mild to moderate headaches, oribucularis myokymia, follow-up of resolving cranial nerve palsies, follow up of old optic neuritis or optic atrophy cases, follow up cases of pituitary adenoma with no new complaints and review of reports may be done through telemedicine.
12. COVID-19 specific neuro-ophthalmic manifestations: There have been reports of optic neuritis, ophthalmoplegia and cerebral vasculitis in COVID-19 patients.[32,33] The general ophthalmologist needs to be aware of this.

(13) Frequent cross-consults from other departments such as neurology, medicine and neurosurgery are received by neuro-ophtalmologists and there is a need to take adequate protection when visiting or examining these patients as they may be carriers of Novel SARS-COV2 (COVID-19) or have manifestations secondary to infection.

**Conclusion**

There is a need to exercise specific precautions and alter practice patterns based on the nuances of practicing pediatric ophthalmology and strabismus and neuro-ophthalmology in the wake of the COVID-19 Pandemic. A decision on possible emergency or urgent care may be done based on the list provided in this statement or if a rationale to treat under urgency exists on an individualized basis. Examination of children needs to be done in accordance to the protocol recommended in this statement and has to ensure safety of both the practitioner and patient. General anesthesia is a critical part of the pediatric ophthalmology practice and also entails amongst the highest risks for transmission of SARS-CoV2 infection. Following some of the tips mentioned in this article would help mitigate this risk substantially. Neuro-ophthalmology needs special precautions due to its association with systemic conditions and recent reports of neuro-ophtalmic manifestations of COVID-19.

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