Pulling the Trigger

Cases from the Heartland

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Excellence in Optometric Education

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Summary

- OCT allows unprecedented visualization of posterior structures
- OCT ushered in a far better understanding of the relationship between the retina surface and the vitreous
- OCT is now allowing better understanding of the role of the choroid in retinal disease
- OCT facilitates accurate clinical decision making, often without referral, invasive testing, keeping patients in primary care OD's office
- Elevates level of care provided, increases revenue, makes clinical throughput easy and efficient

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Case 1: The "Routine" Flashes

- CC: "Flashes" HPI: OD/1d/mod/no floater
- 33 F, allergy – HC Meds: OCs, valacyclovir, flonase
- VA = 20/20 OU w SCL IOP: 18OU AC: D&Q
- Retina: multifocal choroidal lesions, myopic macular degeneration
- OCT: Inner choroidal thickening and macular edema
- IVFA: no CNV

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Case 1: The "Routine" Flashes

- CC: "Flashes" HPI: OD/1d/mod/no floater
- IMP – Punctate Inner Choroidopathy OD, myopic macular degeneration OU
- PLAN – Medrol 4mg DOSPAK, Durezol tid OD, Bromday qd OD
- Prognosis - excellent

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Case 1: The “PIC”

- OCT Pearls
  - OCT confirms (if not MAKES) the diagnosis
  - Provides an image of the choroid that we cannot evaluate clinically with any other technique

Case 2: The "Bonsai Floaties"

- CC: "floaties on my trees when I work" HPI: OD/1m/mod/ CABG 11 yrs
- 67 M, Meds: atenolol, maxide, plavix
- MR OD: -3.50DS = 20/100
- MR OS: -2.75DS = 20/25
- IOP: 14OU AC: D&Q NS/CX+2OU
- Retina: tear at equator with PVD OD, small micro-aneurisms temporal to FAZ OS
- OCT: OD 233u, OS 271u

Case 2: The "Bonsai Floaters"

- IMP – Retinal tear OD, Juxta-foveal Telangiectasia OS
- PLAN – Laser photocoagulation for tear OD today, return for IVFA OS 2wks
- IVFA: NO leakage from JFT
- PLAN: Observe JFT, order glucose screening, schedule cataract consult

Case 2: The "JFT"

- OCT Pearls
  - OCT demonstrates abnormal thickness
  - IVFA shows no leakage (SURPISE!)
  - OCT & IVFA do not agree
  - OCT is more sensitive test?
  - Allows us to identify pathology at a subclinical level
    - follow closer for progression
    - avoiding vision loss

Case 3: The "CME" Solution

- CC: "Not as good as 1st week" HPI: OU/1m/Cat-IOL/ Lattice Deg OU / Retinal tears OU treated with laser
- 66 F, VA OD = 20/15, VA OS = 20/40
- PCIOL OU
- IMP – Pseudophakic CME OS?
- OCT: OD 306u, OS 383u
- Plan: Predforte tid & Bromday qd OD
- RTO: 2 wks

Case 3: The "CME" Solved

- CC: "Getting better" HPI: OS/2 wks/ CME /PF & Bromfenac
- 66 F, VA OD = 20/15, VA OS = 20/25+
- PCIOL OU
- IMP – Pseudophakic CME OS Resolved
- OCT: OD 306u, OS 310u
- Plan: Predforte tid & Bromday qd OD until gone, new spec Rx

Case 3: The "CME Solved"

- OCT Pearls
  - OCT demonstrates abnormal thickness
  - OCT allows for conservative treatment trial prior to more invasive procedures
  - OCT demonstrates rapid improvement in condition
  - OCT keeps patient in primary care OD doctor's office, specialist not needed
  - IVFA not needed

Case 4: The “glasses dilemma”

- CC: “Had cataract surgery and cant see” HPI: OS/1m/Cat-IOL/OD gave 2 new glasses, likes one better than other
- 80 F, VA OD = 20/30, VA OS = 20/40+ at one week post ops, admits to one drop per day?
- PCIOL OU
- IMP – Pseudophakic OU
- PLAN – Predforte tid OU, release to optometrist for continued care, emphasis on correct drug dosing

Case 4: The "glasses dilemma"

- CC: "Had cataract surgery and cant see" HPI: OS/1m/Cat-IOL/OD gave 2 new glasses, likes one better than other
- Now after one month VA OD = 20/200 OS
- Hands me the steroid prescription (never filled)
- PCIOL OU
- IMP – Pseudophakic CME OS?
- OCT: OD 311u, OS 510u
- Plan: Retina for IVK (failure with drop compliance)

Case 4: The "*Compliance* dilemma"

- OCT Pearls
  - OCT demonstrates abnormal thickness OS
  - IVFA not needed to confirm diagnosis
  - Pseudophakic CME in this case related to inflammation from non-compliance with steroidal eyedrops
  - Treatment with topicals may be beneficial but with questionable ability to comply, intraocular depot drug is the best choice

Case 5: The "Big Black Spot"

- CC: "Black spot" HPI: OS/2 days/constant/decreased vision Cat-IOL/OU ROS: recent diagnosis Hairy cell leukemia, chemotherapy and spleenectomy, now anemic
- 76 F, VA OD = 20/40, VA OS = 20/400, was 20/25 two months prior
- PCIOL OU IOP: 10 OU
- Fundus: peripheral small retinal hemorrhages OU, thick macular hemorrhage OS, schisis cavity inf OS
- OCT: 286u/333u

Case 5: The "Big Black Spot"

- IMP: Leukemic Retinopathy
- PLAN: Retina consult
  - TPA & gas to displace macular hemorrhage
  - Continue oncologic care
- Follow-up visit one month
  - RE 20/25
  - LE 20/30
  - No retinopathy noted!

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Case 5: The “Leukemic Retina”

- Pearls
  - OCT demonstrates abnormal thickness OS
  - OCT clearly shows pre-retinal and intra-retinal nature of hemorrhages
  - Prognosis often very good

Case 6: The "Black Dot"

- CC: "Black dot" HPI: OS/1 yr/constant/no worse
- Referring doctor: Retinal detachment, partial, old
- 8 M, VA OD = 20/20, VA OS = CF CVF: central scotoma OS, SLE: NL
- Fundus: massive hemorrhage and exudative retinopathy OS
- OCT: massive elevation of macula

Case 6: The “Black Dot”

- IMP: Coat’s Disease
- PLAN: Retina consult
  - R/O toxoplasmosis with serology
  - Consideration of retinoblastoma

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Case 6: The "Coats Disease"

- Pearls
  - OCT demonstrates markedly abnormal thickness OS
  - Serologic testing to R/O toxoplasmosis, toxocariasis
  - Always obtain retina consult (poor prognosis)

Case 7: The "Different Size Images"

- CC: "Different sizes" HPI: OS/2 yr/constant/ worse/failed drivers test
- PMH: colon CA, HTN
- Referring doctor: Cataract surgery requested
- 69 M, VA OD = 20/30, VA OS =20/80 SLE: symmetric NS
- Fundus: Vitreous traction OS
- OCT: 266u/338u
- AL: 24.36/24.45

Ocriplasmin / ThromboGenetics, Inc

- Non surgical treatment for vitreomacular adhesions
  - Increased macular thickness
  - CME Diagnosed 8% at slit lamp 30% with OCT
- Vitrectomy vs Vitreolysis?
  - Invasive
  - Anesthesia
  - Face down
  - Retinal breaks
  - Cataract

Ocriplasmin / ThromboGenetics, Inc

- Truncated form of human plasmin produced by bacteria
- Indications: developed for dissolving blood clots in vascular disease
- Single Intravitreal injection
- Results – resolution 30% at 28 days, closure of hole 40% at 28 days
  - better than all other agents tried
- Spin offs – DME, AMD, adjunct to vitrectomy
- New England JourMed 2013

Case 7 : The “VMT”

- Pearls
  - OCT demonstrates abnormal thickness OS
  - OCT demonstrates vitreo-macular traction clearly
  - IVFA finds no leakage
  - Previous solution limited to vitrectomy surgery
  - Option now includes medical treatment first
  - Ocriplasmin is perfect for this exact clinical presentation
  - If not successful, PPV remains option and will be technically easier

Case 8: The "Lost My Monovision!"

- 77yowf CC: "Can't read!"
- HPI: 1 D duration / intermittent loss, altitudinal, preceded episode / painless / OD
- Meds: Amiodarone, ASA, Coumadin, Cartia, Zoloft, Advil, Singulair, Cozaar, Norvasc
- ROS: 190 lbs, recent Spinal surgery (L3-5), planned shoulder (rotator cuff) surgery, Monovision
- BVA: 20/60 OD 20/20 OS PERRL + APD
- EOM: Full EXT: NL
- SLE: ACIOL OD, PCIOL OS Blurred optic disc margin OD, otherwise NL

What is the likely diagnosis?

1. Idiopathic optic neuritis
2. Ischemic optic neuropathy
3. Buried drusen
4. Papilledema
5. Cerebral vascular accident

What eye test would you order now?

- 1. Pachymetry
- 2. Visual fields
- 3. SCODI
- 4. ERG
- 5. IVFA / Photo

What other testing is indicated?

- 1. CBC with differential
- 2. Brain MRI
- 3. C-reactive protein
- 4. ESR
- 5. ESR & CRP

Tests results

- 1. Visual field = Mild central defect OD, normal OS
- 2. ESR = 17mm/Hr
  - Reference 0-20mm/Hr
- 3. C-reactive protein = 0.899mg/L
  - Reference 0.000-3.0mg/L

What should you do now?

- 1. Start Prednisone
- 2. Order biopsy of superficial temporal artery
- 3. Retina consult
- 4. Follow conservatively for NAION

Case 8: “NAION”

- Clinical pearls
  - R/O GCA most important
  - Follow conservatively
  - ASA debatable benefit

Case 9: The "Graduation"

- 83yowf from Memphis, TN CC: "Skim on my eye, then it went black!"
- HPI: 1 D duration / intermittent loss, altitudinal, preceded episode / painless / OD
- Meds: HCTZ, meclizine, centrum, naproxen
- ROS: 115lbs, HA, stiffness
- BVA: NLP OD 20/30 OS PERRL + APD
- EOM: Full EXT: NL
- SLE: PCIOL OD NS 2 OS Fundi: OD Blurred optic disc margin, otherwise NL

What is the likely diagnosis?

1. Idiopathic optic neuritis
2. Ischemic optic neuropathy
3. Buried drusen
4. Papilledema
5. Cerebral vascular accident

What eye test would you order now?

- 1. Pachymetry
- 2. Visual fields
- 3. SCODI
- 4. ERG

What other testing is indicated?

- 1. CBC with differential
- 2. Brain MRI
- 3. C-reactive protein
- 4. ESR
- 5. ESR & CRP

Tests results

- 1. Visual field = absolute defect OD, normal OS
- 2. ESR = 44mm/Hr
  - Reference 0-20mm/Hr
- 3. C-reactive protein = 0.158mg/L
  - Reference 0.000-3.0mg/L

What should you do now?

- 1. Start Prednisone PO stat
- 2. Order biopsy of superficial temporal artery
- 3. Retina consult

Tests results

- 1. C-reactive protein = 27.5mg/L
  - Reference 0.000-3.0mg/L
  - Corrected C-reactive protein test delivered ***by mail*** five days later!

Case 9: “GCA / AION”

- Differential Diagnosis – Anterior ischemic optic neuropathy, Giant cell arteritis, CVA, NAION
- Additional Testing – STAT ESR, CRP, STA Biopsy +/-
- Diagnosis – AION, GCA
- Treatment Plan – Prednisone 80mg PO qd, chronic care with internist or neurologist
- Clinical Pearls – CRP best test, Don’t miss it, Prednisone dose = 1mg/kg/D, tapered with ESR, need to co-manage

Case 10: “I Lost Vision Last Night!”

- 35yowm CC: “Lost vision last night”
- Pupils: PERRLA+MG
- Meds: Glucophage for 3 years
- VA 20/20 OD, HM OS
- IOP: 17/18
- SLE: Nl OU Fundus : As shown

What is the diagnosis?

- 1. Macular twig venous occlusion
- 2. Birdshot retinochoroidopathy
- 3. Hypercholesterolemia (retinal lipidemia)
- 4. CRAO

What is the best test to order?

- 1. IVFA
- 2. Carotid artery ultrasound
- 3. Total cholesterol, LDL, HDL, TG
- 4. Blood pressure
- 5. ANA / ESR & CRP other rheumatologic inflammatory tests
- 6. Cardiac consult/echo

Case 10: CRAO

- Clinical pearls
  - 1. Breathe into a bag, massage globe
  - 2. Anterior chamber paracentesis
  - 3. Topical anti-glaucoma agents
  - 4. Thrombolytic therapy
  - 5. Must have a systemic cause
    - Find it & fix it!

Case 11: The “Pink” Eye

- 17yobm CC: “Pink-eyes”
- HPI: 3 W duration / getting worse / painful
- Meds: Ilotycin from Peds Trauma: None NKDA
- BVA: 20/30 OU PERRL No APD
- EOM: Full EXT: Raised Red Rash-Neck
- SLE: Cell & Flare 3+ OU Fundi:WNL

What is the likely diagnosis?

- 1. Sarcoidosis
- 2. Tuberculosis
- 3. Syphilis
- 4. Idiopathic uveitis

What tests would you order?

- 1. Chest x-ray
- 2. RPR/VDRL
- 3. PPD
- 4. HLA B-27

You Make The Call

- Differential Diagnosis-idiopathic uveitis, sarcoid, TB, syphilis, Lyme, AS/Reiters, HIV
- Additional Testing-ANA, RPR/VDRL, HLAB-27, PPD, CXR, titers, HIV?
- Diagnosis-Syphilis (stage 2), AIDS
- Treatment Plan
  - Ceftriaxone IM, start HAART for HIV,
  - PredForte q2h, Cyclogel option

Case 11: “Uveitis/HIV”

- Clinical Pearls
  - R/O systemic causes in uveitis if bilateral, severe, young, or high index of suspicion
  - Granulomatous presentations more often underlying cause
  - “Everyone lies”….Dr. House

Case 12: “Doc, I See Double”

- 57yobm CC: “Double vision”
- HPI: OU / 3 D duration / Stable / not painful / Horizontal
- Past H: Colon cancer / surgery / radiation / Chemo Meds: Multiple Trauma: None NKDA BVA: 20/30 OU PERRL No APD
- EOM: R Adduction deficit, L Jerky nystagmus
- SLE: NS OU Fundus : NL

What is the diagnosis?

- 1. Internuclear Ophthalmoplegia
- 2. Ocular Myasthenia Gravis
- 3. Duanes Retraction Syndrome
- 4. CN 3 Palsy

What is the best next step?

- 1. ESR
- 2. Neuro-ophthalmology consult
- 3. Neurology consult
- 4. MRI of head

Case 12: INO / Met CA

- Differential Diagnosis - CN 3P, CN 6P, INO, Decompensating heterophoria
- Additional Testing-old photos
- Diagnosis- R INO, metastasis of colon CA
- Lesion- R MLF
- Treatment Plan- MRI, Neurology / Neurosurgery, Oncology, PCP, monocular occlusion
- Pearls-INO often related to MS, stroke
  - Needs imaging to differentially diagnose

Case 13: “Corneal Abrasion”

- Age: 19yowm CC: Floaters
- HPI: OD / 3wks / constant / worsening since corneal abrasion with patching therapy
- Meds: none
- BVA: 20/20 OU Pupils: PERRL EOM:NL EXT: NL
- SLE: small corneal defect / haze at limbus
- IOP: 18/16
- Fundi: As shown
- PFSH & ROS: NL

What is the likely diagnosis?

- 1. Old CA with residual edema
- 2. Intraocular foreign body
- 3. Toxocara canis
- 4. Vitreous condensation

What tests would you order?

- 1. Ultrasound
- 2. Orbital CT
- 3. VF

Case 12 : IOFB

- Differential Diagnosis – Old CA, retinal IOFB, primary retinal pathology
- Additional Testing – US, Photography, VF
- Diagnosis - IOFB
- Treatment Plan – pars plana vitrectomy, FB removal, intravitreal antibiotics

Case 14: “Woke Up Blind!”

- Age: 19yobf CC: decrease VA
- HPI: OU / rapid / severe / worsening
- Meds: plaquenil 400mg, lopressor
- BVA: CF OU Pupils:PERRL-APD EOM:NL
  EXT: NL
- SLE: NL
- IOP:16/16
- Fundi: as shown
- PFSH & ROS: SLE x 3yrs, ischemic necrosis of hip secondary to corticosteroids at initial flare

What is the likely diagnosis?

- 1. Diabetic retinopathy
- 2. Hypertensive retinopathy
- 3. Retinal vaculitis
- 4. Bilateral CRVO

What tests would you order?

- 1. BP
- 2. ESR
- 3. ANA
- 4. VF
- 5. Photo

Case 14: Lupus Retinal Vasculitis

- Differential Diagnosis – SLE with retinal vasculitits, HTN and retinopathy, DM and retinopathy, hyperviscosity states
- Additional Testing – IVFA, photos, ESR, ANA, C-reactive protein, VF
- Diagnosis – SLE and retinal vasculitis
- Treatment Plan – IV corticosteroids, rheumatology consult, retina consult
- Pearl – ANA is elevated in acute Lupus

Case 15: The "Blue Freckle"

- Age: 34yobm CC: blurred vision
- HPI: OS / 1 yr / stable / constant
- Meds: none
- BVA: 20/20 OU Pupils: PERRL-APD EOM: full EXT: pigmented lesions of face
- SLE: pigmented lesions of the sclera
- Gonio: pigment puddling
- IOP: 19/29
- Fundi: deeper retinal/choroidal pigmented, asymmetry of CDR
- PFSH & ROS: NL

What is the likely diagnosis?

- 1. Nevus flammeus
- 2. Nevus of Ota
- 3. Sturge-Weber
- 4. POAG

What tests would you order?

- 1. Old photos
- 2. VF
- 3. Scanning lasers
- 4. Gonioscopy

You Make The Call

- Differential Diagnosis – Sturge-Weber, Nevus Ota, Nevus flammeus, OAG
- Additional Testing – VF, GDx/HRT, Gonio
- Diagnosis – Nevus of Ota, OAG OD
- Treatment Plan – Photodocument, blue tint spectacles, latanoprost 0.005% qhs OS

Case 15: The “Nevus Ota”

- Clinical Pearls
  - Follow for malignant transformation of skin lesions
  - Follow for pigment glaucoma
  - Affects other systems
  - Familial tendency
  - More difficult in darker skin to diagnose

Case 16: “Headache” Lady

- 45yowf CC: “HA, Blurred vision”
- HPI: Sudden / Explosive / Constant HA / photophobic
  - Lower Extremity Amputee / Tracheotomy
- Meds: None Trauma: None NKDA
- BVA: 20/40 OD 20/20 OS PERRL No APD
  EOM: Full EXT: WNL
- SLE: WNL Fundi: Globular Sub-Hyaloid Hemorrhage OD

What is the likely diagnosis?

- 1. Valsalva retinopathy
- 2. Terson's syndrome
- 3. Diabetic retinopathy
- 4. Vitreous hemorrhage

What tests would you order?

- 1. MRI of the brain
- 2. Lumbar puncture
- 3. Fundus photography
- 4. Random blood glucose

You Make The Call

- Differential Diagnosis-Drance hemorrhage, CNVM, migraine, subarachnoid hemorrhage
- Additional Testing-MRI/MRA, lumbar puncture+/-, pupillary testing, physical examination (neurology)
- Diagnosis
  - ICA/SAH Terson's Syndrome

You Make The Call

- Treatment
  - STAT admission/high mortality & morbidity
  - Oxygenation
  - Sedatives
  - Control of blood pressure
  - Monitor cerebral edema
  - Surgery +/-
    - endovascular ballons, “clipping” of aneurisms

Case 16: ICA / SAH

- Clinical pearls
  - Neurological/Neurosurgical emergency
  - Prodromal sentinel signs common
  - Rapid onset of pain/HA, nuchal rigidity, loss of consciousness, loss of sight, obtundation, death
  - Neurosurgery if stable
  - Survivors-mild /severe cognitive impairment

Case 17: “LASIK Nevus”

- 34yowf CC: “Freckle in my eye”
- HPI: OD / 2 wks duration / Lasik OU 1 wk
- LASIK doctors request retinal evaluation
- Meds: Allopurinol NKDA
- BVA: 20/15 OU PERRL No APD
- EOM: Full EXT: W&Q
- SLE: Flaps OU IOP: soft OU
- Fundus: as pictured

What is the likely diagnosis?

- 1. Epiretinal membrane
- 2. Congenital hypertrophy of RPE
- 3. Macular drusen
- 4. Choroidal osteoma
- 5. Benign choroidal nevus
- 6. Malignant melanoma

What eye test would you order now?

- 1. IVFA
- 2. Visual fields
- 3. SCODI
- 4. B scan ultrasound

What is the best course now?

- 1. Retina consult
- 2. Ocular Oncology
- 3. PCP
- 4. LASIK retreatment
- 5. Retire; I can’t take another day of this

Case 18: “Upper part missing”

- 65yowm referred for AION CC: “wavy things”
- HPI: OD / 5 wks wavy / 2 wks upper part of vision missing / no pain / no flashes
- Meds: MV, OM3, ASA NKDA
- BVA: HM OD, 20/25 OS PERRL No APD
- EOM: Full EXT: W&Q
- SLE: NS 2 OU IOP: 15 OU
- Fundus: as pictured

What is the likely diagnosis?

- 1. Retinal tear
- 2. Lattice degeneration
- 3. Vitreous hemorrhage
- 5. Benign choroidal nevus
- 6. Malignant melanoma

What is the best course now?

- 1. Retina consult
- 2. Ocular Oncology
- 3. PCP

Case 19: “Fell & Hit head”

- 89yowm MD referred for RD CC: “retina problem”
- HPI: OS / 1 wk / no pain / no flashes / no vision loss
- Meds: levothyroxine, OM3, garlic NKDA
- BVA: 20/50, 20/60 OS PERRL No APD
- EOM: Full EXT: W&Q
- SLE: PCIOL OU IOP: 15 OU
- Fundus: as pictured

What is the likely diagnosis?

- 1. Retinal detachment
- 2. Choroidal detachment
- 3. Vitreous hemorrhage
- 5. Macular degeneration
- 6. Malignant melanoma

What is the best course now?

- 1. Retina detachment surgery
- 2. Ocular Oncology
- 3. IVFA and anti- VEGF
- 4. No Rx; observation

Case 20: “10 days of bad vision”

- 49yowm OD referred for VO CC: “Can’t see for 10 days”
- HPI: OD / 10 days / no pain / no flashes
- Meds: amlodipine, OM3, ASA NKDA
- BVA: CF, 20/20 OS PERRL No APD
- EOM: Full EXT: W&Q
- SLE: NL OU IOP: 13 OU
- Fundus: as pictured

What is the best course now?

- 1. Anti-VEGF injections
- 2. Steroid injections
- 3. Ozudex injections
- 4. Vitrectomy

Case 20: “Spot in vision”

- 63yowf MD referred for AMD CC: “Blur spot in center”
- HPI: OD / 1 mos / no pain / constant Meds: synthroid, restasis, lotemax NKDA
- BVA: 20/50 OD, 20/20 OS PERRL No APD
- EOM: Full EXT: W&Q
- SLE: PCIOL OU IOP: 8 OU
- Fundus: as pictured

What is the best course now?

- 1. Anti-VEGF injections
- 2. Steroid injections
- 3. Ozudex injections
- 4. Vitrectomy
- 5 . Photodynamic therapy

Case 21: “Itchy retina”

- 35yowm OD referred for pink eye CC: “Itch, swollen”
- HPI: OD / 1 d / no pain / constant NKDA
- BVA: 20/30 OD, 20/20 OS PERRL No APD
- EOM: Full EXT: conjunctival injection chemosis
- SLE: same IOP: 14 OU
- Fundus: as pictured

What is the best course now?

- 1. Anti-VEGF injections
- 2. PE, CBC, CXR, ANA, ESR, autoimmune, coagulopathies
- 3. Ozudex injections
- 4. Photocoagulation
- 5 . Photodynamic therapy

Case 22: “Lost vision for 15 mins”

- 24yowm OD referred for retinal hemorrhage CC: “episode of lost vision”
- HPI: OD / days / no pain / constant / had CL exam one month ago NKDA
- BVA: 20/40 OD, 20/20 OS PERRL No APD
- EOM: Full Ext: Nl
- SLE: Nl IOP: 14 OU
- Fundus: as pictured

What is the best course now?

- 1. Anti-VEGF injections
- 2. Pneumatic retinopexy
- 3. Vitrectomy +/- buckle
- 4. Photocoagulation to lattice
- 5 . Photodynamic therapy

Case 23: "I Want Chalazion Removed"

- 55yowf CC: "OD dx chalazion"
- Pupils: PERRLA-MG
- Meds: Premarin, Zocor, HCTZ
- VA 20/30 OU
- IOP: 16/17
- SLE: Lid lesion E2 OS Fundus : NL

What is the best option now?

- 1. Remove chalazion with I&D
- 2. Intralesional kenalog injection
- 3. Biopsy
- 4. Oral antiobiosis and hot packs

Case 24: “Exotopia”

- Age: 2yowm CC: R/O strabismus
- HPI: XT OD / 4mos / constant / severe
- Meds: none Ref: Peds
- BVA: No Fix or follow Pupils: PERRL-APD
  EOM: L XT 45 EXT: NL
- SLE: NL
- IOP: Soft
- Fundi: ON abnormal OS
- PFSH & ROS: NL

What is the likely diagnosis?

- 1. Coloboma optic nerve entrance
- 2. Morning glory syndrome
- 3. Retinal detachment
- 4. Cavernous hemangioma

What tests would you order?

- 1. PE
- 2. MRA brain and orbits
- 3. EUA
- 4. IVFA

You Make The Call

- Differential Diagnosis – morning glory, retinal hemangioma, ON coloboma
- Additional Testing – PE family members, eye examination family members
- Diagnosis – cavernous hemangioma retina, strabismus, amblyopia
- Treatment Plan – external plaque radiation, EOM surgery, patching treatment

Case25: “Light Sensitive”

- Age: 15 yowf CC: “Lights hurt”
- HPI: OS / 2D / worsening / severe
- Meds: none OcHx: Accuvue SCL denies sleeping in lens (Dr. House “everybody lies”) Renu
- VAsRx: OD 20/100, OS LP Pupils: PERRL-APD
  EOM: full EXT: injected, ptosis
- SLE: as pictured
- IOP: not done
- Fundi: not viewed
- PFSH & ROS: NL

You Make The Call

- Differential Diagnosis – bacterial keratitis, fungal keratitis, acanthameba keratitis, foreign body, hypopion uveitis
- Additional Testing – culture/sensivity
- Diagnosis – bacterial keratitis
- Treatment Plan – moxifloxacin q1h, close watch
- RTO 24h

Case26: “Glaucoma or Not?”

- Age: 68 yowm CC: “Need new doc for glaucoma”
- HPI: OU / 6 yrs / Trav qhs OU / mild / No SE
- Meds: Metformin, diovan, crestor, zetia, ranitidine
- VAsRx: OD 20/25 OU Pupils: PERRL-APD EOM: full EXT: nl +Fam Hx Glauc mother
- SLE: NS/CX 1 OU
- IOP: 13 OU OCT normal VF normal
- Fundi: Normal CDR .75 OU symmetric rims
- PFSH & ROS: NL

You Make The Call

- Differential Diagnosis – POAG vs normal
- Additional Testing – VEP
- Diagnosis – Probable POAG OU based on VEP
- Treatment Plan – continue medications, switch to generic latanoprost qhs

Thank you

Missouri Eye Associates

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