

Abstract and needs assessment

This course will educate the participant on the most up to date assessment, diagnostic modalities & management of today's retinal conditions.

Objectives

At the conclusion of this course the participant will be familiar with:

- a. Today's EBM and clinical guidelines (i.e. AOA DM & plaquenil new guidelines, etc)
- b. Urgencies vs emergencies, as well as proper referral practical guidelines derived from "real world" data
- c. Spectrum of "real world" retina practical approach in the diagnosis and care of patients with retinal conditions.

Plaquenil screening

AAO 2016 recommended guidelines

Primary tests used today: SDOCT & humprey visual field with white light (10-2 is commonly employ but 24-2 may be implemented in Asian pts)

What are the risk factors?

Proper guidelines for visual field testing and variation of ethnicity

EBM vs real world retina adherence to the guidelines. Are people following standard of care? (readings)

Vitreoretinal disease

Signs of ominous PVD: Vitreous hemorrhage or pigmented cells

Range in follow up

AOA 2004 guideline

AAO 2014 guidelines

Real world retina

Controversies behind scleral depression

Risk to retinal break &/or retinal detachment

Trauma, s/p ocular surgery like cataract surgery/yag capsulotomy, high myopia, RD in contralateral eye, FHx of RD, etc

Proper documentation

Higher risk retinal break: associated fluid, large, symptomatic, what about location? Traction, flap vs operculated vs atrophic, associated retinal or vitreous hemorrhage, etc

Controversy behind floterectomy

PVR: what is it?

Nevus

Signs that increase the chance of growth over the next 5 years are: TFSOM (thickness, fluid, symptoms, orange pigment & margins near the nerve) guidelines that may be associated with a small melanoma

Value of OCT vs ultrasonography

What changes signify possible conversion

ERM

Reason to consider treatment

Patient's symptology is #1 criteria for treatment

What are structural changes Associates with progression ?

Treatment options

CRAO

Our standard of care: real world retina

Since it is commonly an embolitic event work-up includes: heart echo and carotid Doppler, CBC with diff, platelet count and possible ESR/CRP (in older pts with CRAO and an emboli is not noted)

Today's thought: If a pt had a recent CRAO, outside of the tests above, a DWI-MRI should be order STAT

Some in office management: ocular massage, lower IOP (meds vs Diamox vs paracentesis), hyperbaric chambers, ASA, others

Age related macular degeneration (AMD)

Findings associated with chroidal neovascular (CNVM) “Wet AMD”: green lesion, subretinal hemorrhage, OCT shows fluid or subretinal hyperreflectivity, lesion on OCTA, exudates, subretinal fluid on funduscopy evaluation

OCT findings associated with CNVM & clinical findings

i.e Thickening, fluid, exudation, heme, retinal/rpe detachment

How is it different than PCV? When do you consider PCV (DFE vs OCT)?

Most common dosage of anti-vegf is treat and extend

Posterior uveitis

How to work it up?

Common active findings: periphlebitis, CME, retinitis/choroiditis, vitritis, others

Central serous choroidopathy

When to consider referring?

Chronic case & treatment options

Variable treatment options for recurrent or chronic cases

Real world retina & PDT

Common management of ICSC is observed

chronic cases: PDT, laser, Diamox, spironolactone (of note: anti-VEGF therapy is reserve if a CNV develops and not typical standard of care for chronic ICSC)

Retinal vein occlusion (CRVO)

What are the distinct treatments for branch and central RVO with macular edema?

When should I refer a RVO?

What are the common systemic diseases associated with RVO?

CRVO has a strong relationship with glaucoma

What is the follow up guidelines: EBM vs real world retina

Most common treatment employ include antiv-egf over ozurdex

DDx: Retinal macroaneurysms

Systemic association

When to refer

What about hemes like a Roth spots: DM, bacterial endocarditis/anemia (blood dyscrasias), leukemia

Central retinal artery occlusion

Clinical presentation: often described as a “cherry red” spot appearance

How to work up the patient (most commonly associated with an emboli)

The older patient: GCA, echocardiogram, carotid Doppler, HTN/DM/lipid profile/CBC

The younger patient: May need to further evaluate for hyperviscosity syndrome, possibly inflammatory conditions, thrombolytic causes, etc.

When to refer? Is this an immediate referral?

Who are you referring to and for what?

Diabetic retinopathy

Proper follow up according to new AOA 2014 and AAO 2016 guidelines

Is FA a requirement following PRP for PDR: real world retina

Protocol S results

When to refer

DME-central involve (CI) vs CSME and

Timeline for referral

Treatment options and when is each implemented

Steroid injections vs implants

Is focal laser still use?

Standard of care for DME-CI today is Anti-VEGF therapy

Peripheral retinal disease

How is lattice managed?

Macula on vs off RD: timeline of referral

Management of Peripheral tears & holes

What are the variable clinical pictures?

What are problematic signs/symptoms you should look out for: traction, fluids, flashes

What are the risk factors: myopia, family history, contralateral tears/RD, yag/pseudophakia & trauma

When do I refer vs monitor?

Urgency: symptomatic flap tears are urgent referrals

Monitoring schedule based on new 2014 AAOPhthal guidelines

The not so common conditions and their relevance

Polypoidal

Recurrent serosanguineous RPE detachment in darkly pigmented middle-aged pts

Branching choroidal vasculopathies with polyps

Pachychoroid

Pathophysiology and continuum of central serous choroidopathy into pachychoroid neovascuopathy

neovascuopathy & wet macular degeneration

how to measure it and its significance

differential diagnosis & the importance in treatment
management