Dr Sean Every

Ophthalmologist and Vitreoretinal Surgeon

Southern Eye Specialists

Christchurch

Dr Jo-Anne Pon

Consultant Ophthalmologist and Oculoplastic Surgeon

Southern Eye Specialists

Christchurch

Dr John Rawstron

Ophthalmologist

Southern Eye Specialists

Christchurch Hospital

Christchurch

Sunday, August 11, 2019

(Room 4)

8:30 - 9:25 WS #150: Ophthalmology Update

9:35 - 10:30 WS #160: Ophthalmology Update (Repeated)

What happened to my referral?

Dr Lucy Kim
Dr Jo-Anne Pon

Southern Eye Specialists

Canterbury District Health Board
Te Poari Hauora ō Waitaha

Disclosures

- Christchurch Hospital Eye Clinic
  - General Ophthalmology & Cataracts
  - Oculoplastics
  - Neuro-ophthalmology
  - Triaging

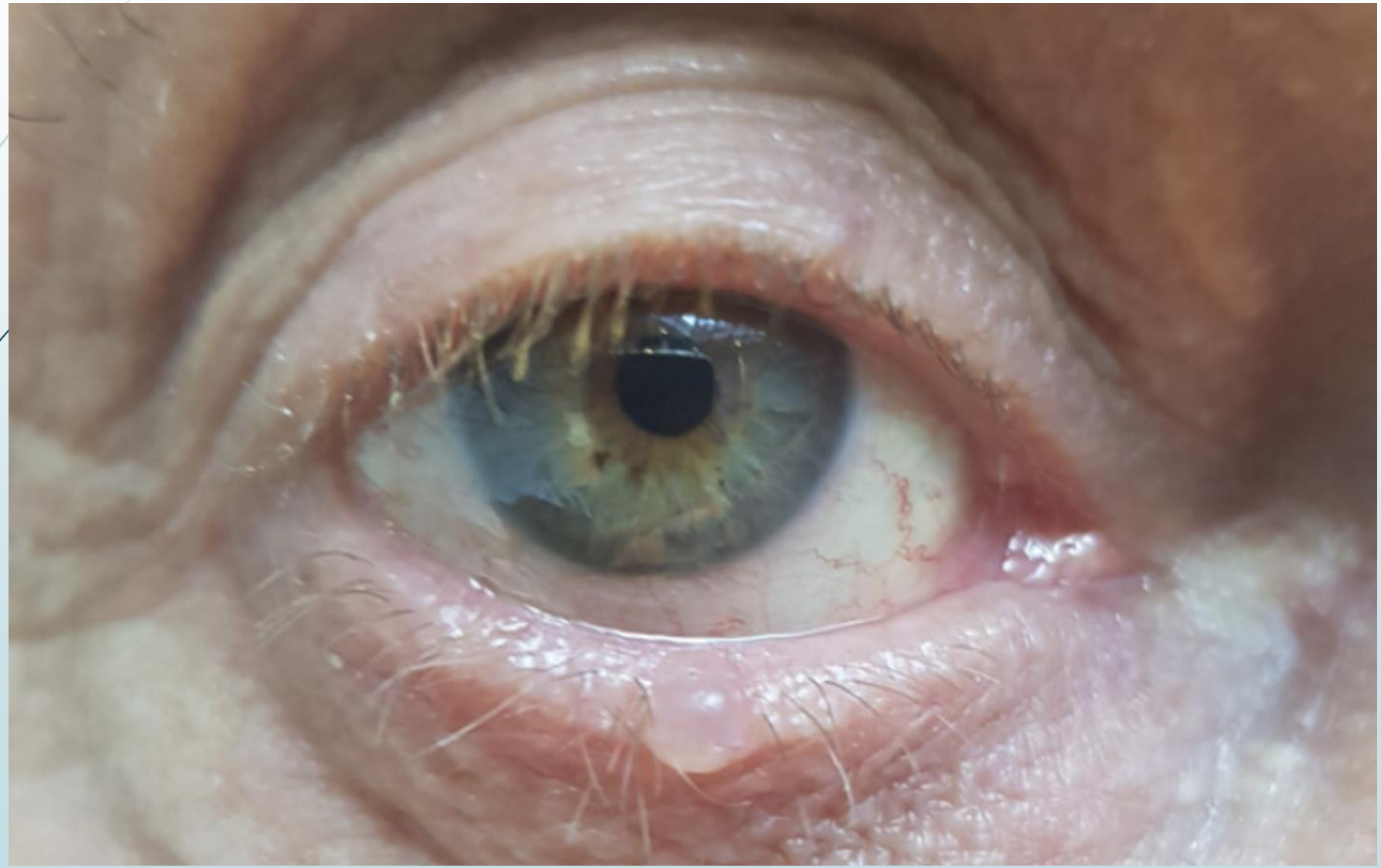
- Southern Eye Specialists

Southern Eye Specialists

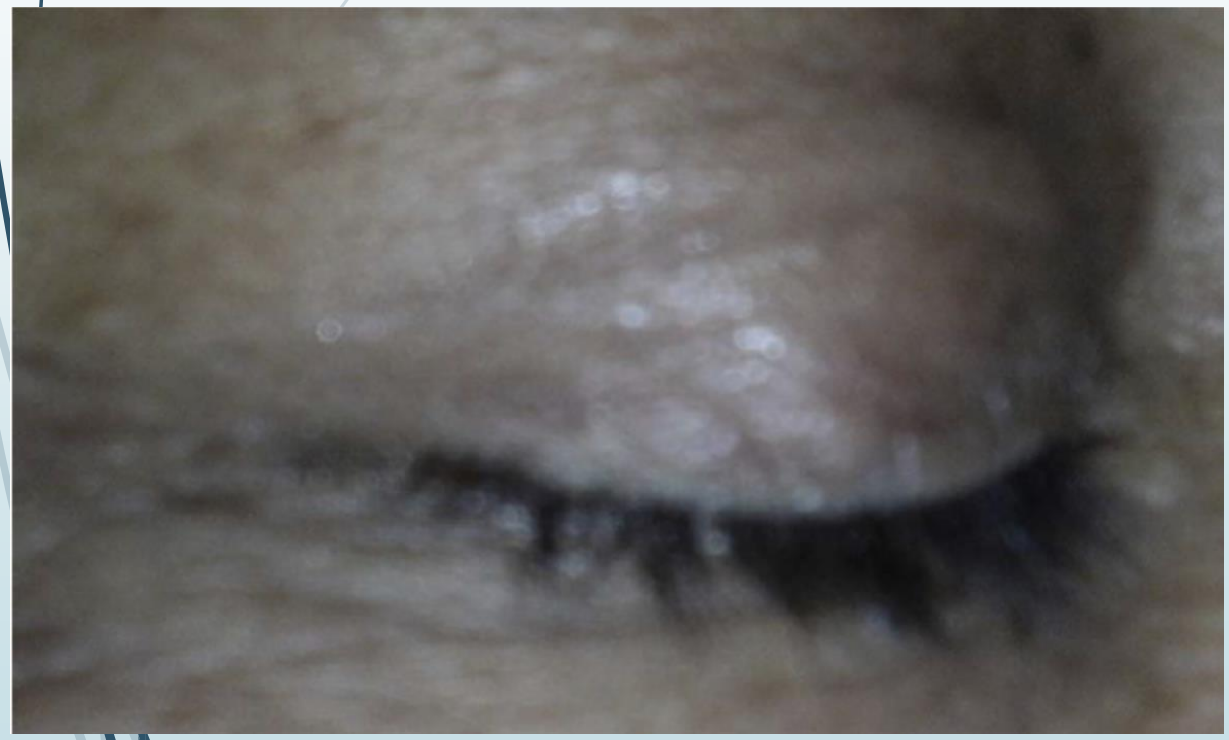
Canterbury District Health Board
Te Poari Hauora ō Waitaha

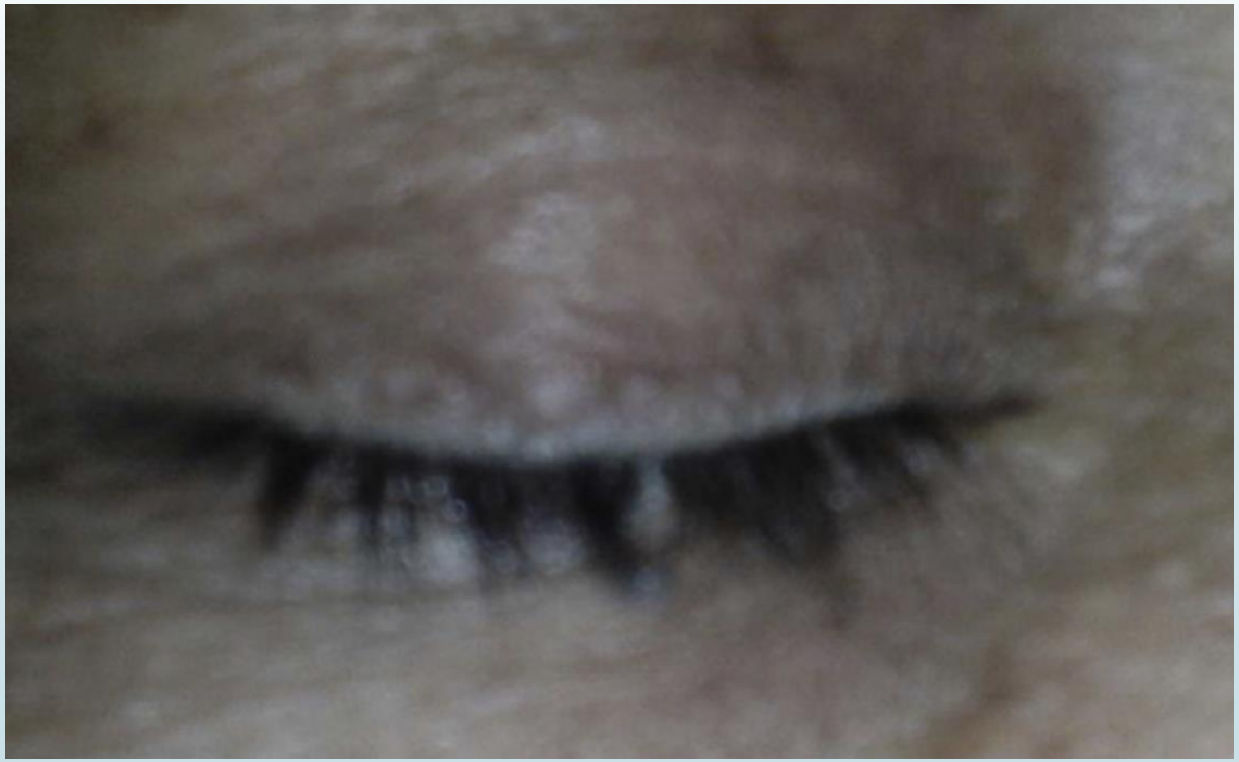
What happened to your case?

Lid Cysts

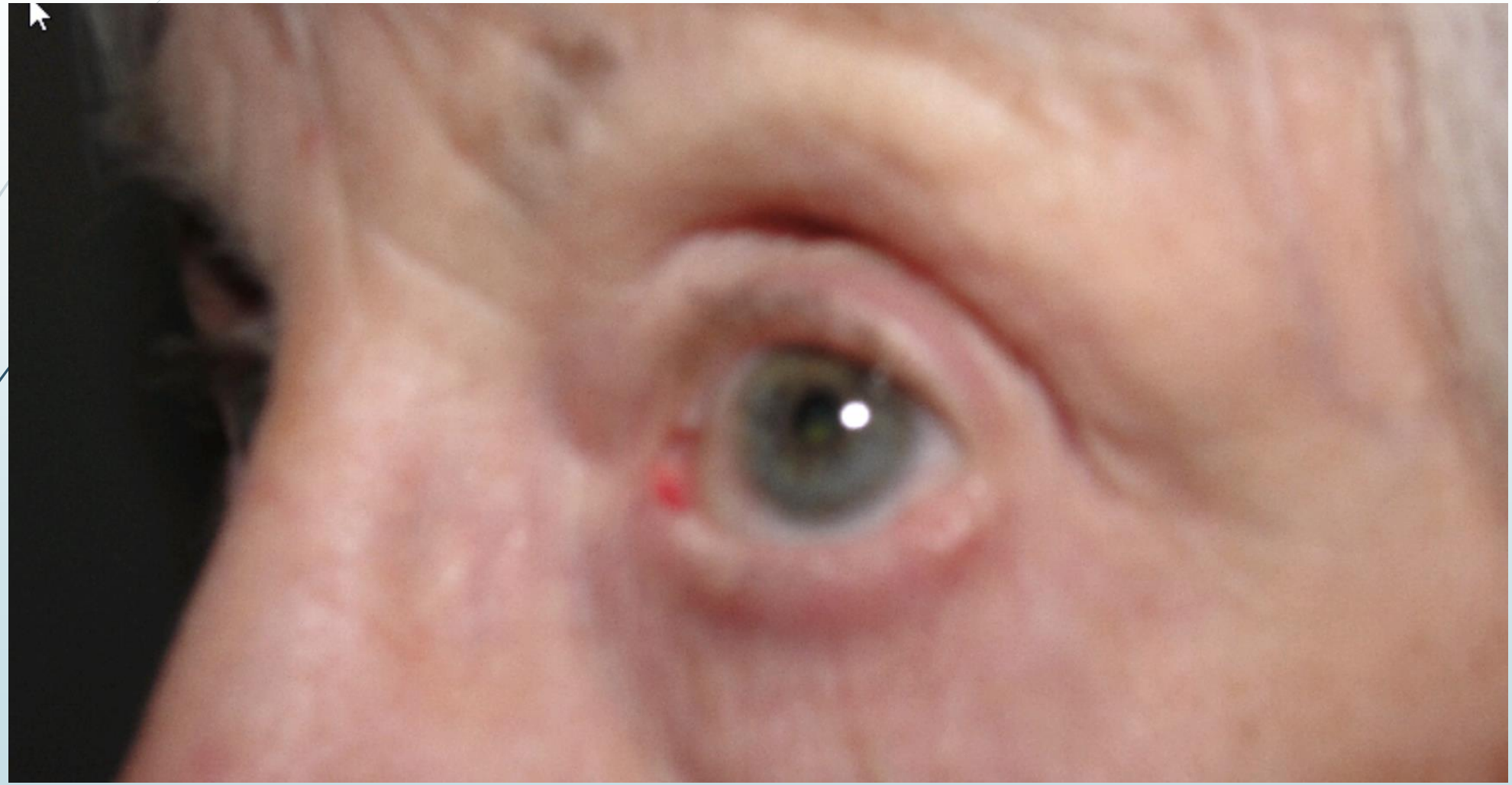


Upper lid cyst

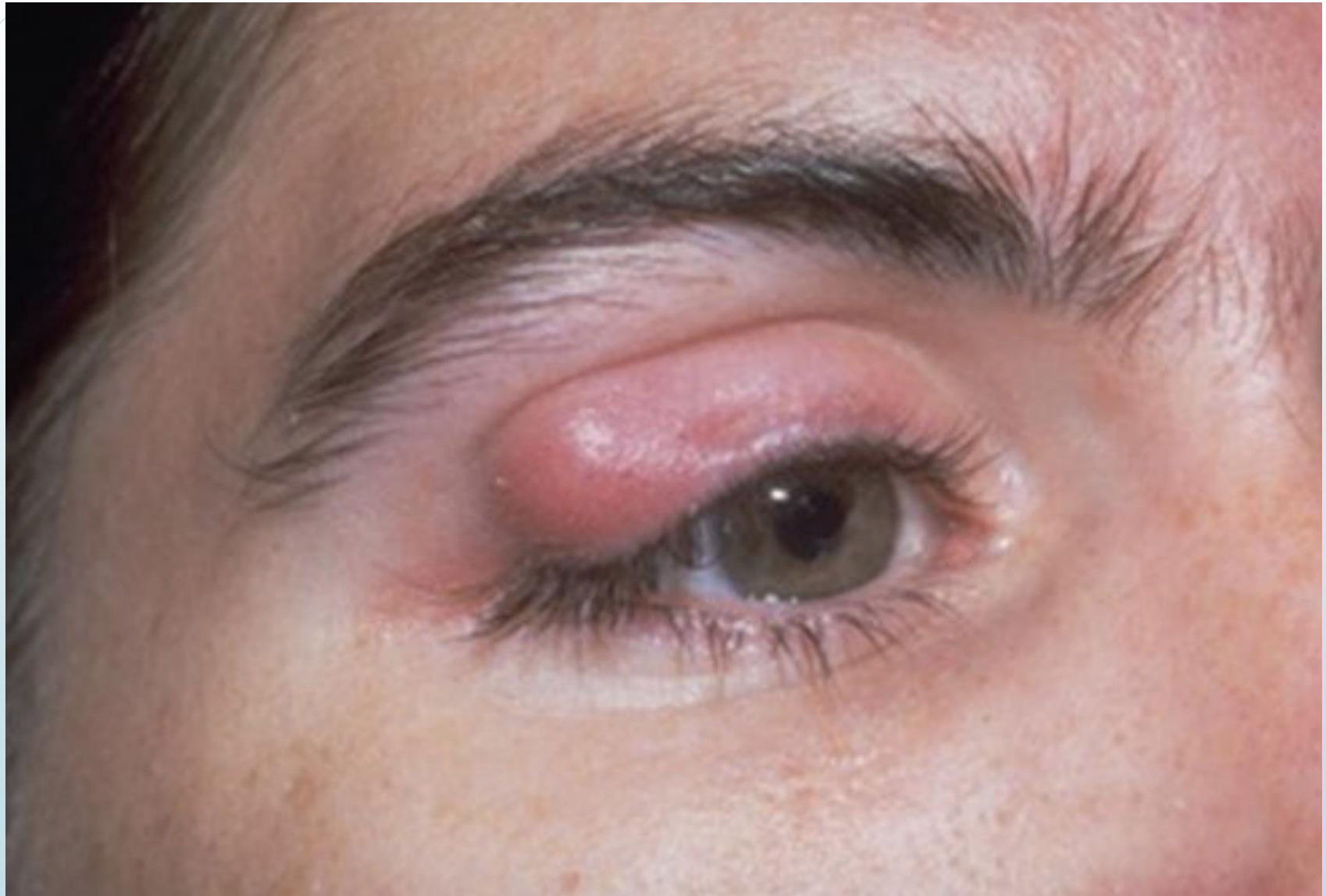




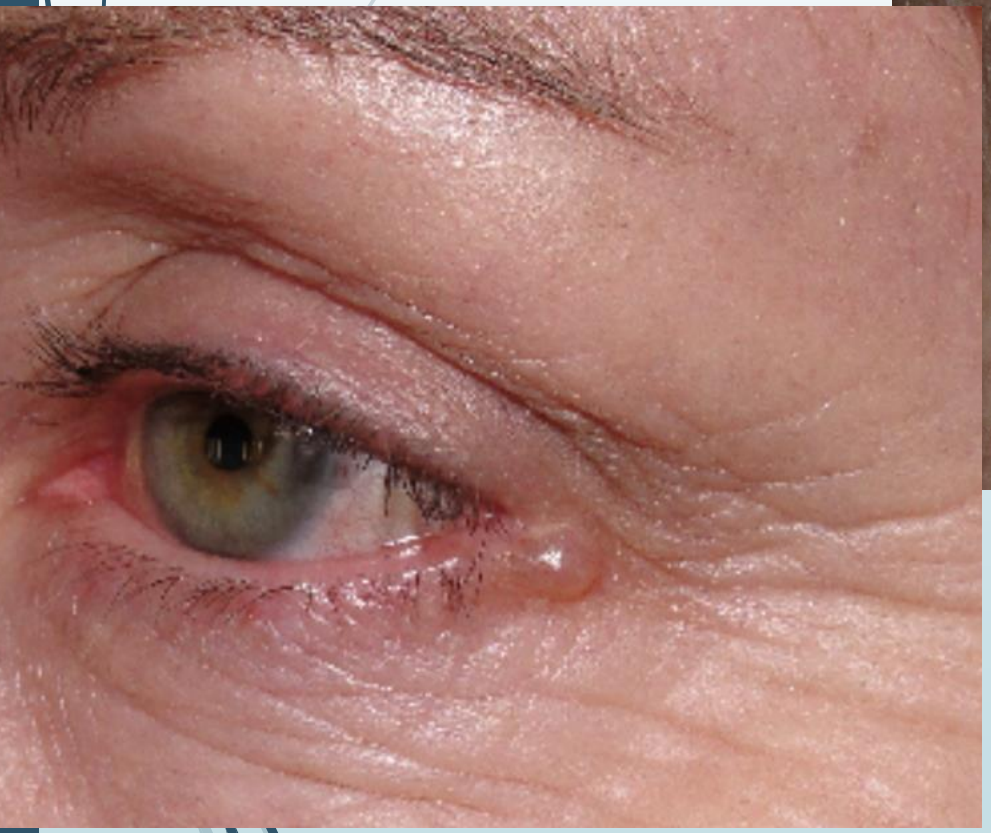
Lateral lid lesion – BCC?

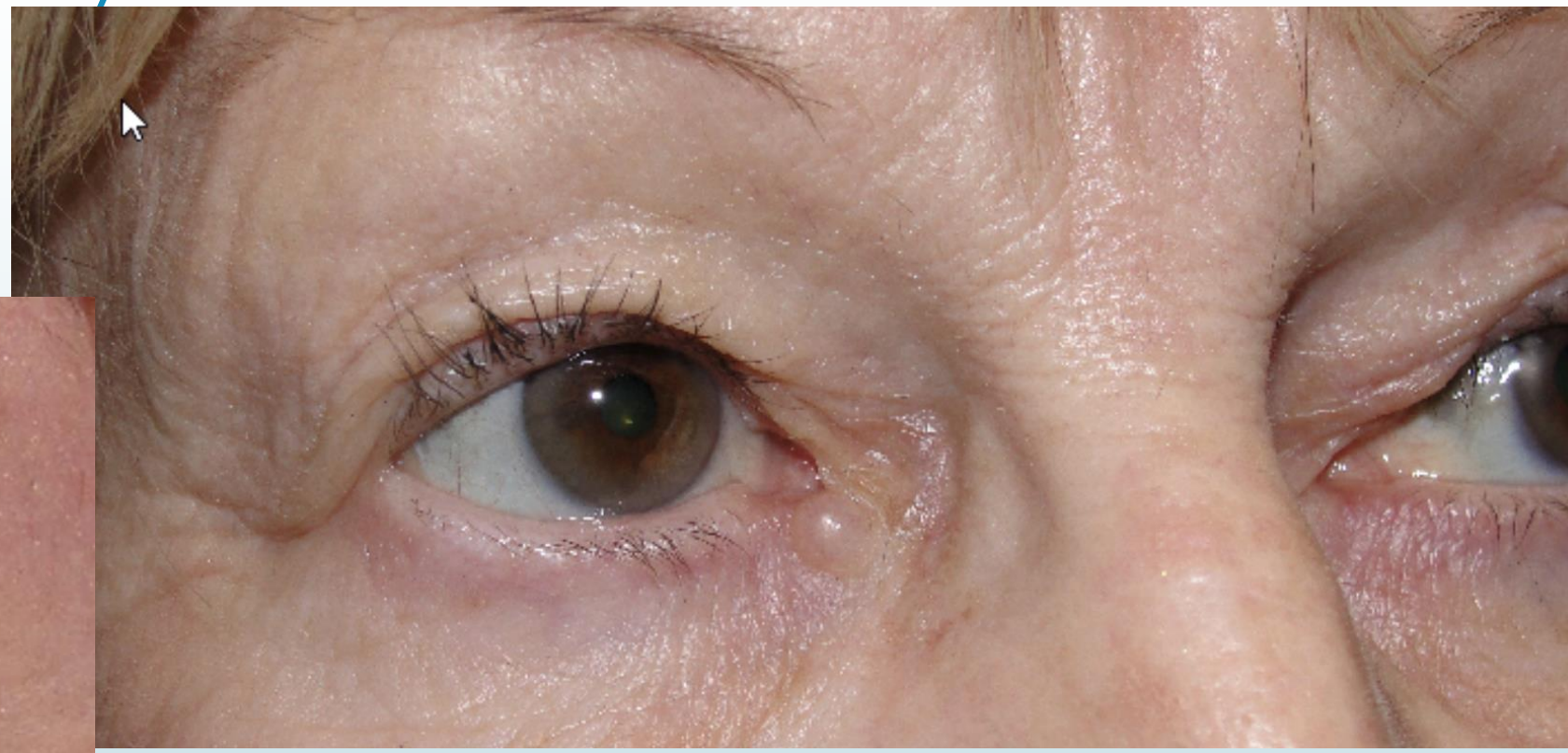


Chalazion

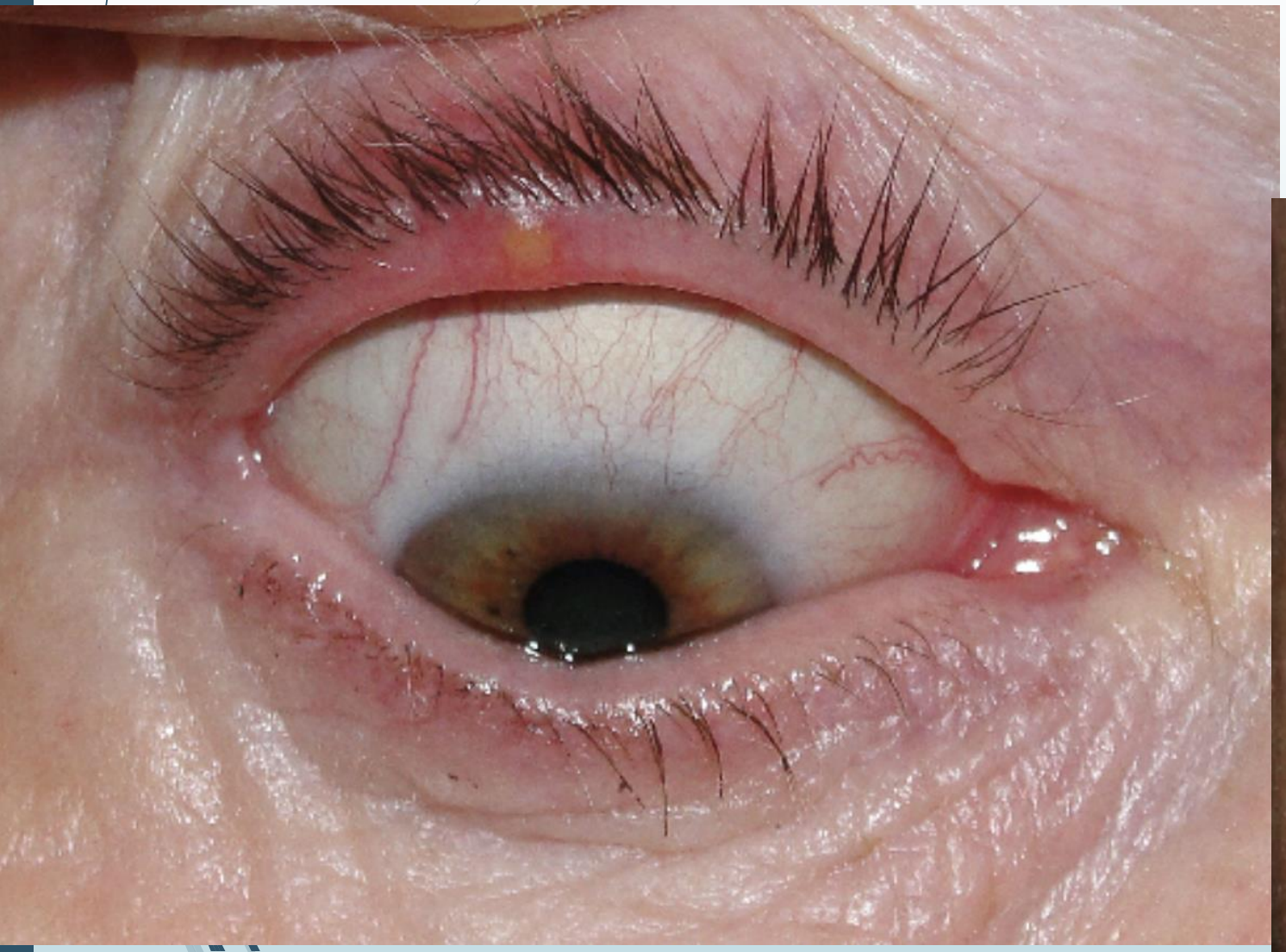


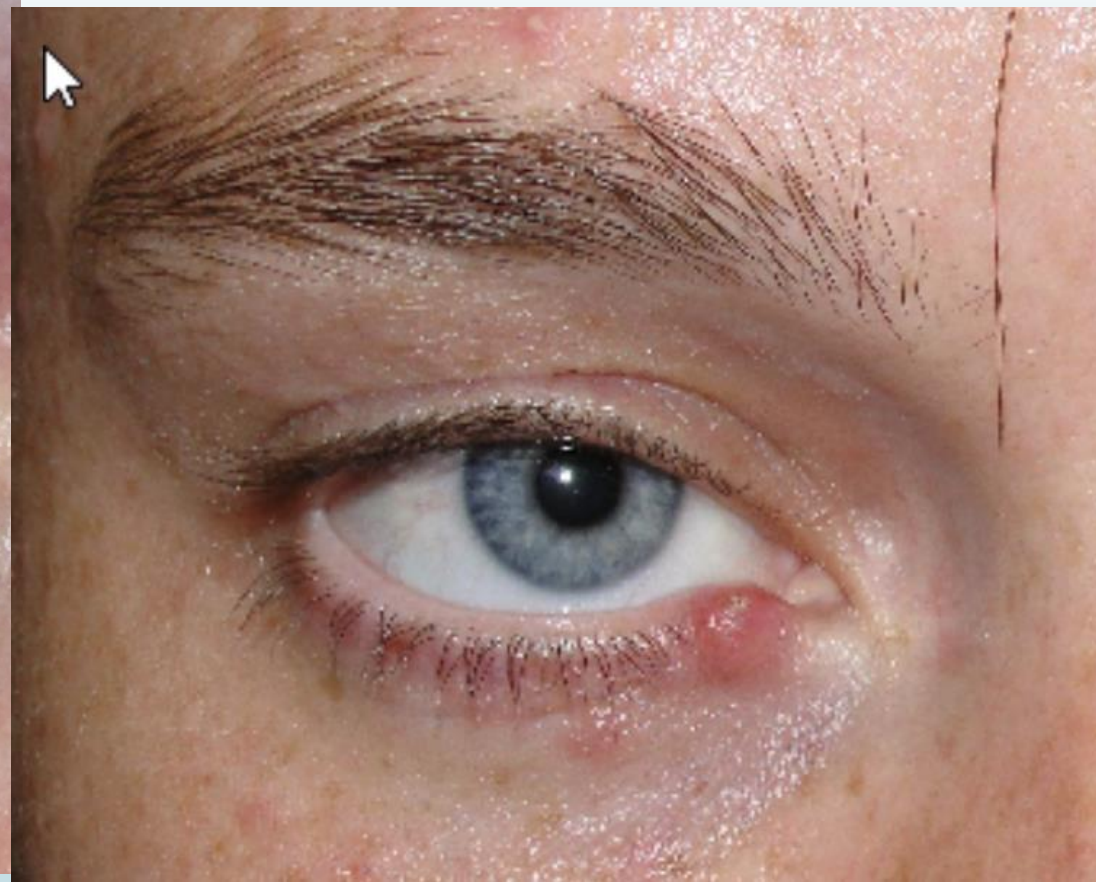
Benign cysts



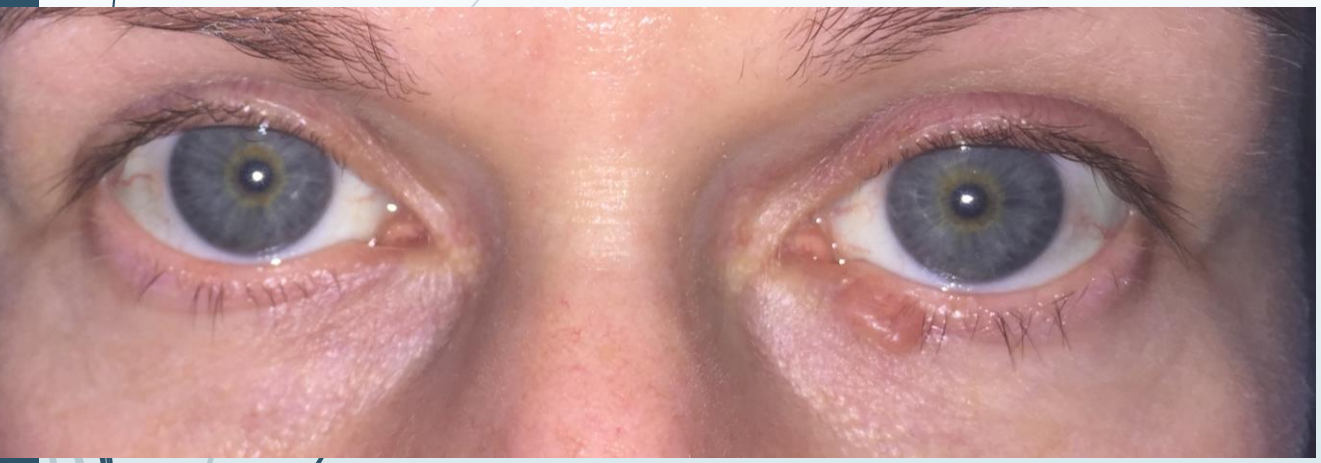


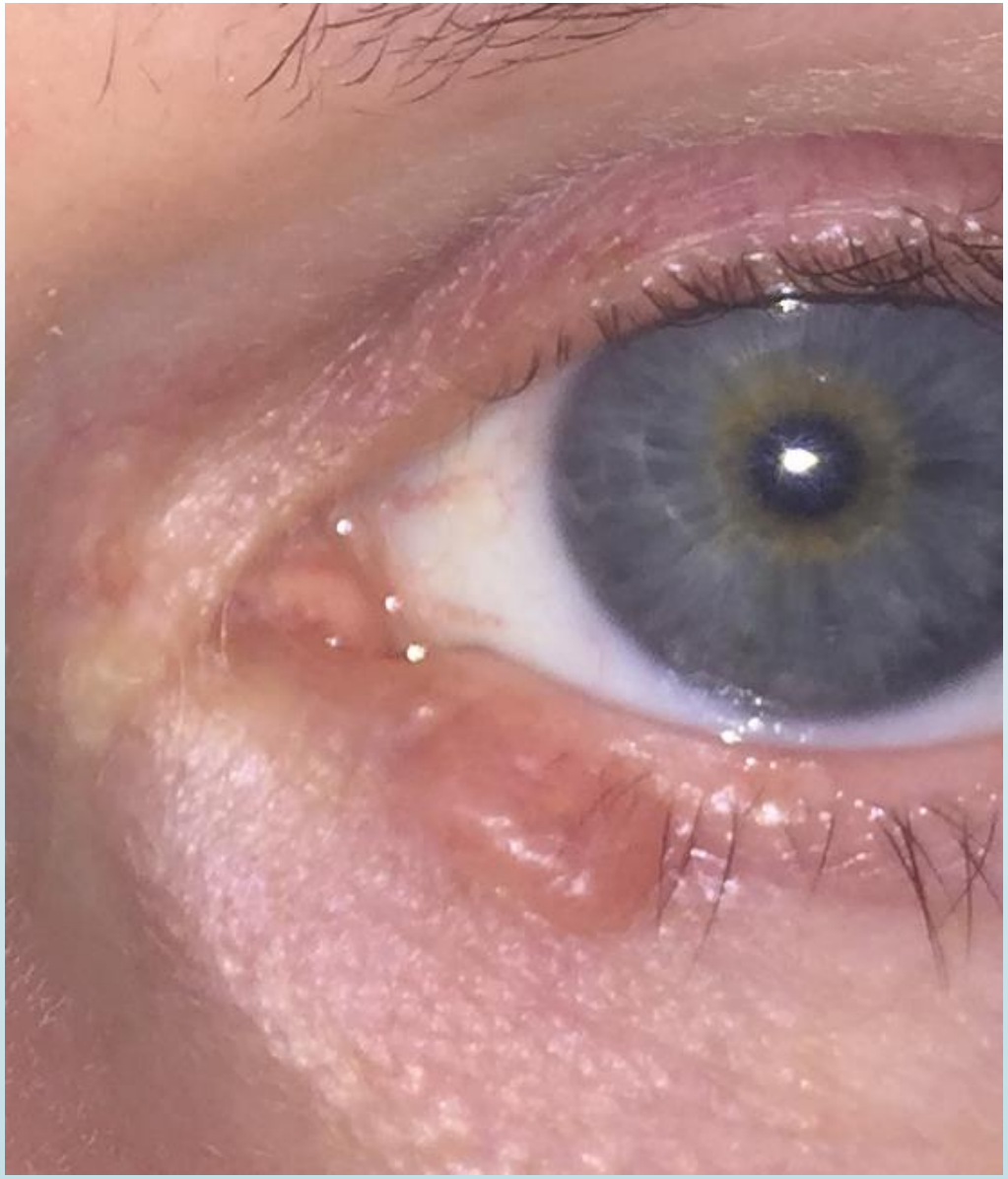
Lid Margin chalazion





BCC
40yo. Adjacent to inferior punctum.





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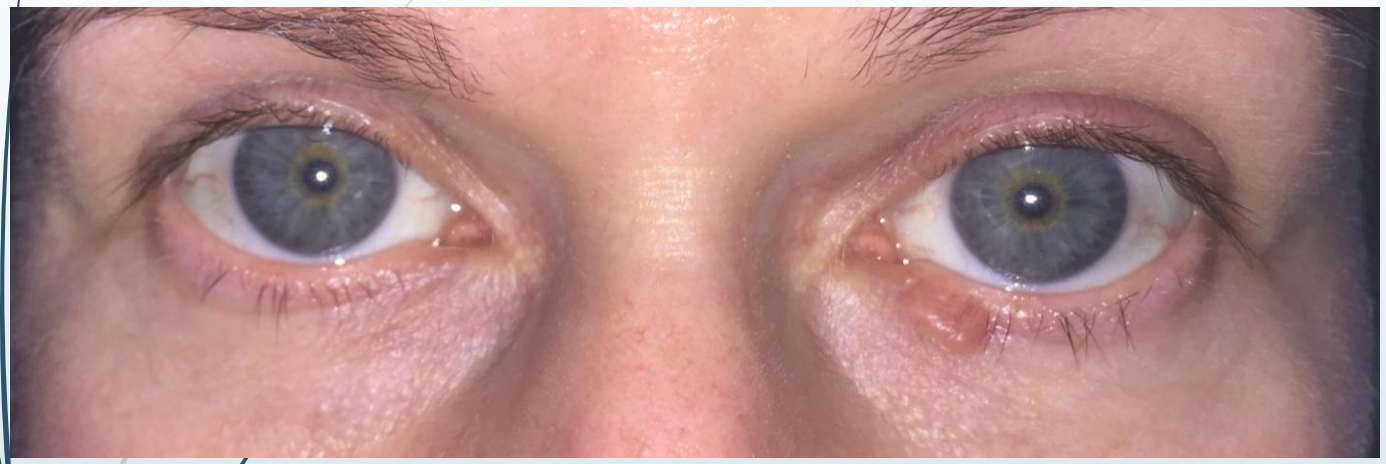
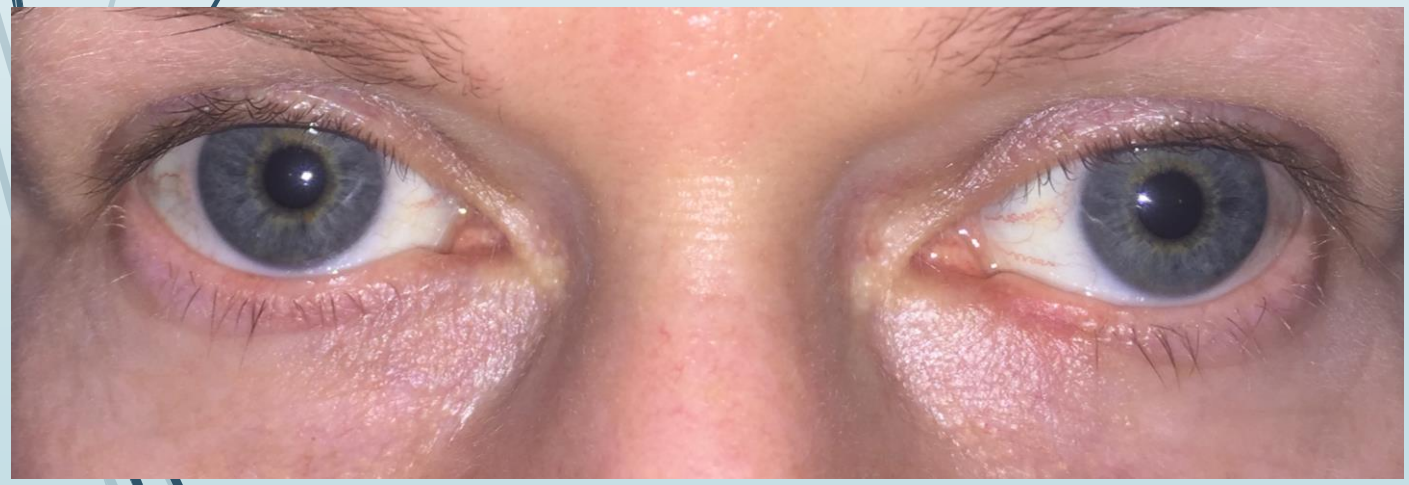


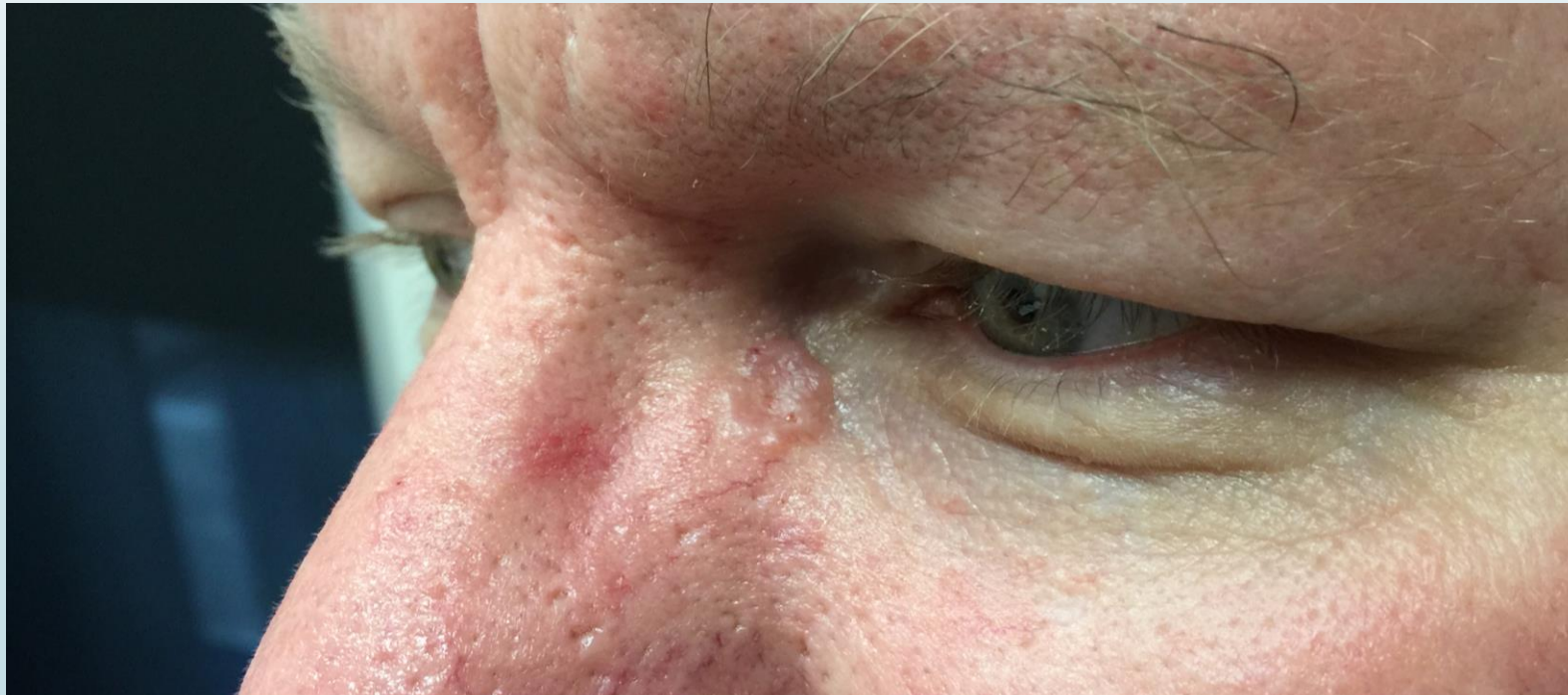
- Mohs Surgery
- Reconstruction
- Excision complete,
- Inferior punctum preserved



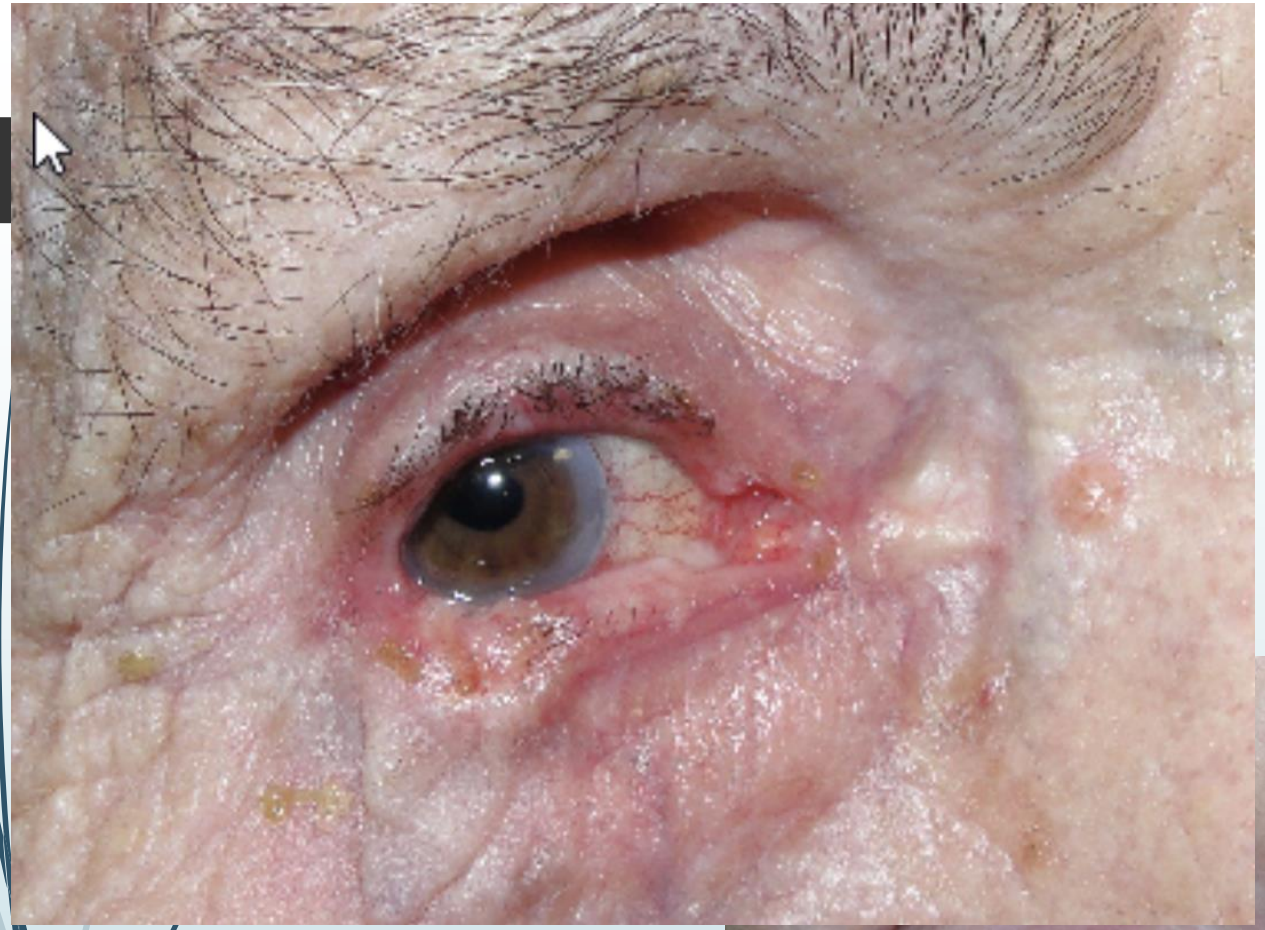
Post-op

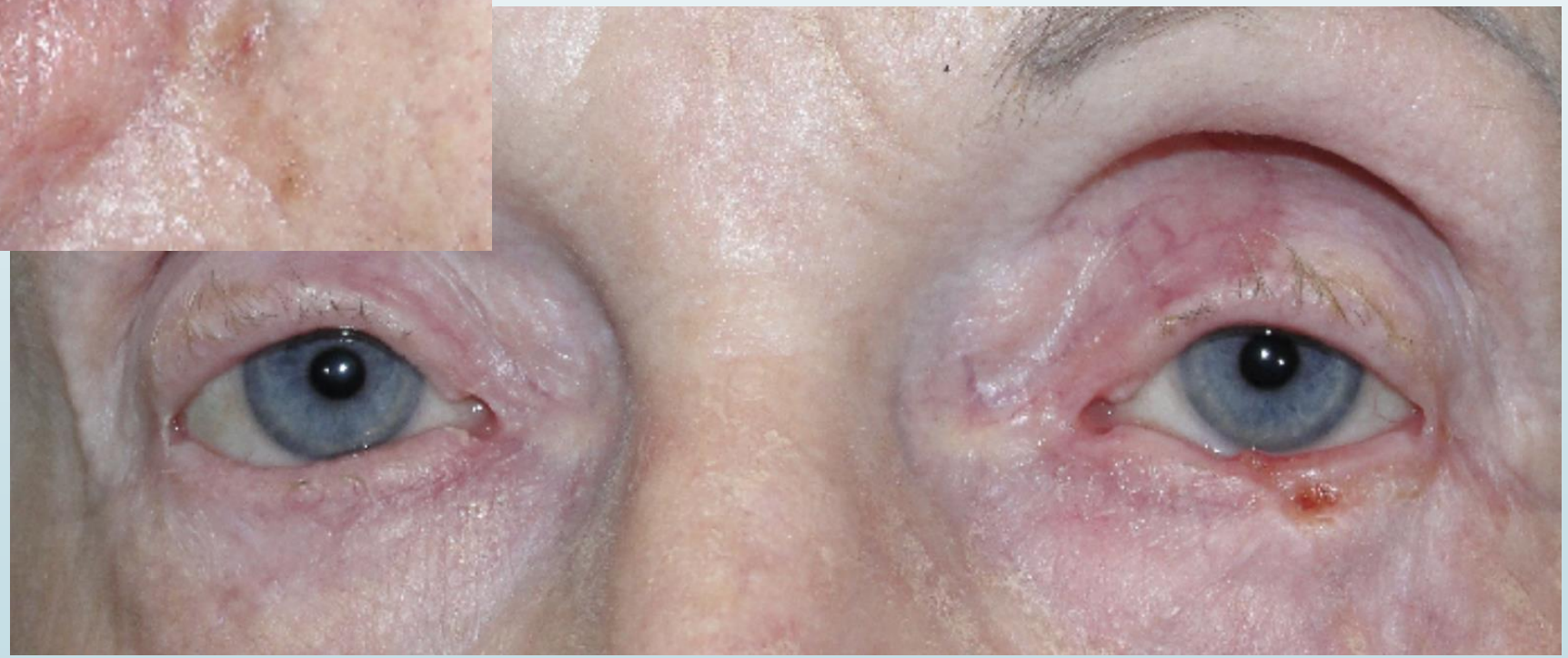
BCC

- Central ulceration
- Raised pearly edges
- Telangiectasia
- Lesion persists, grows



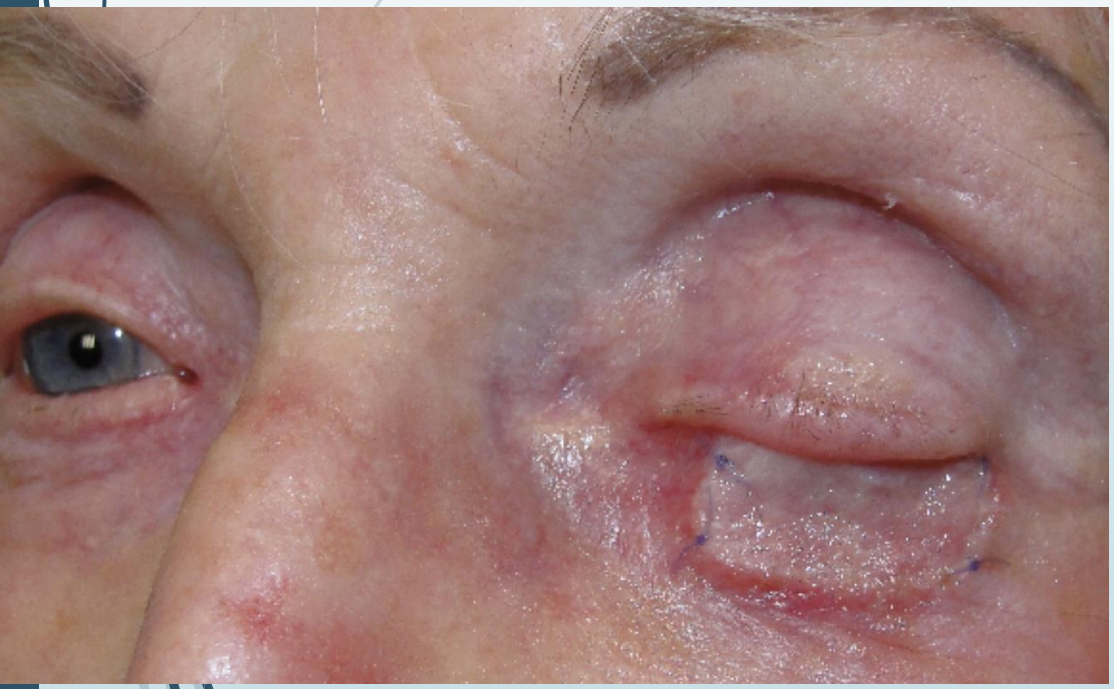
BCC



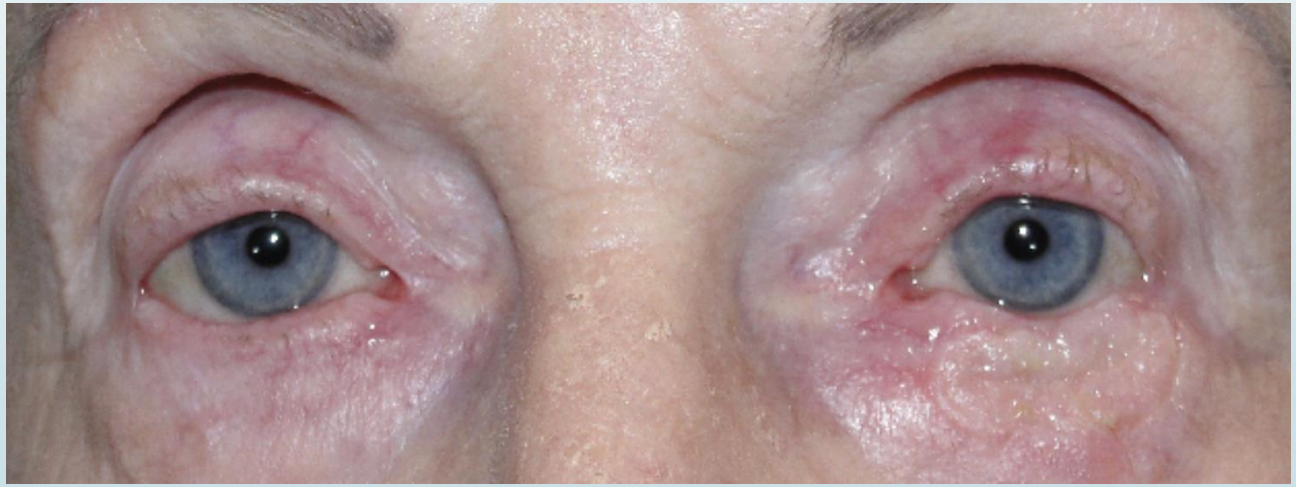


BCC Excision and reconstruction with Hughes Flap and FTSG

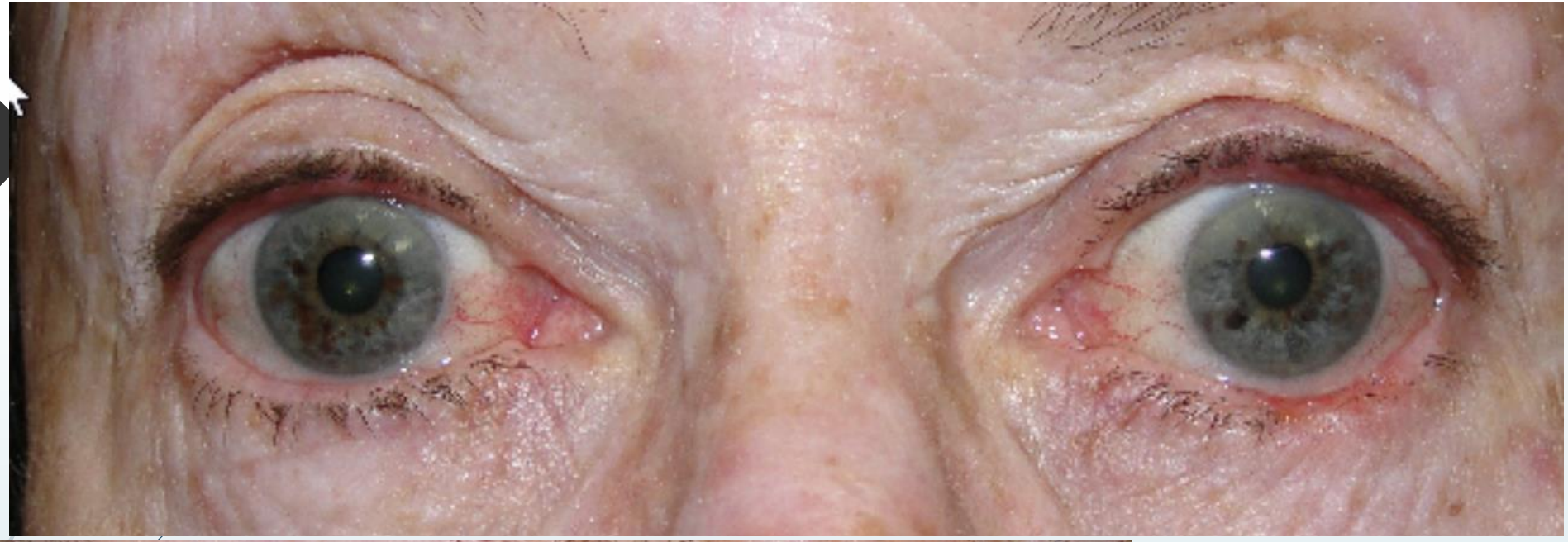
FTSG reconstructs the anterior lamella

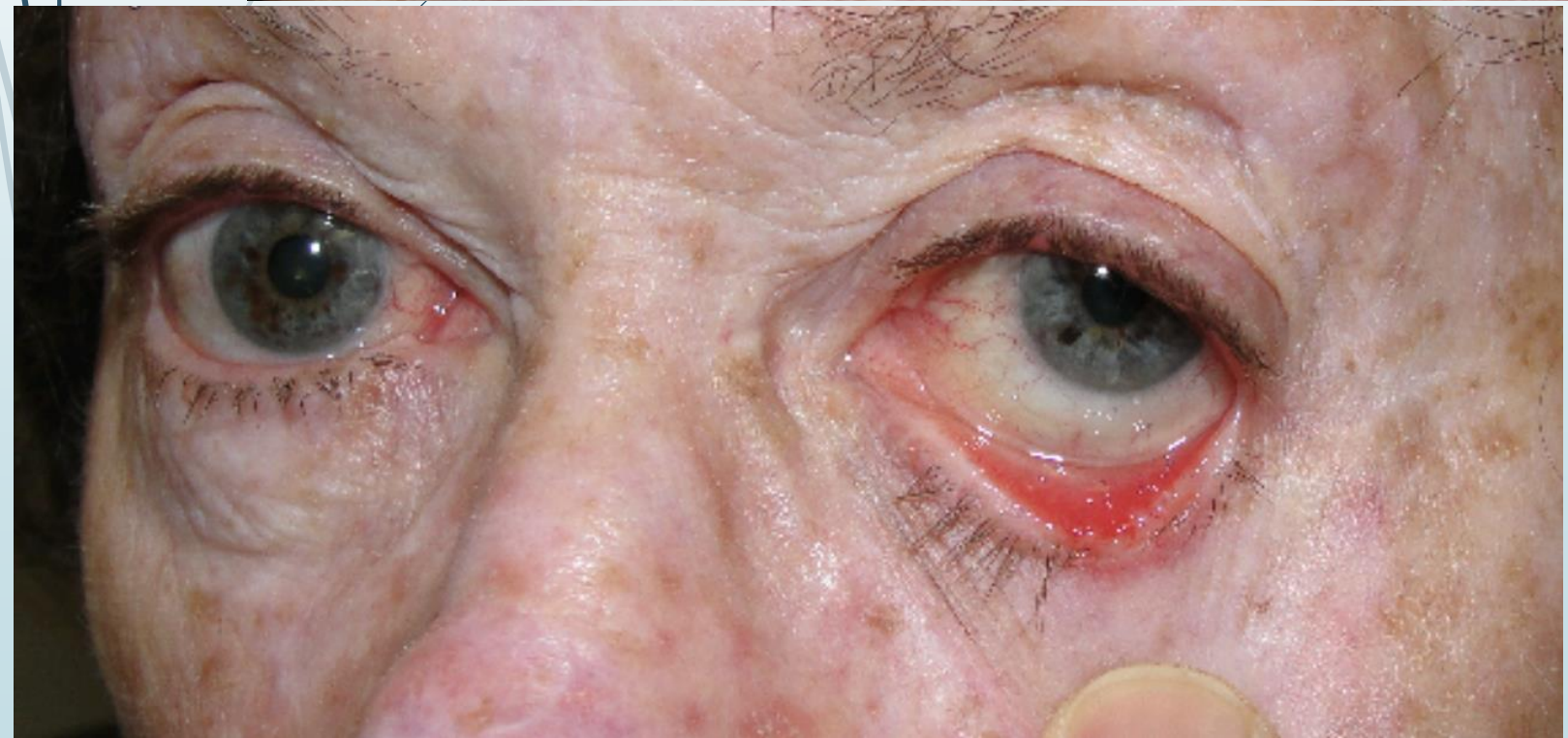


1 month post-op (2nd stage)



Posterior lamella: upper lid tarsal plate, 2 weeks to heal in, eye can't open

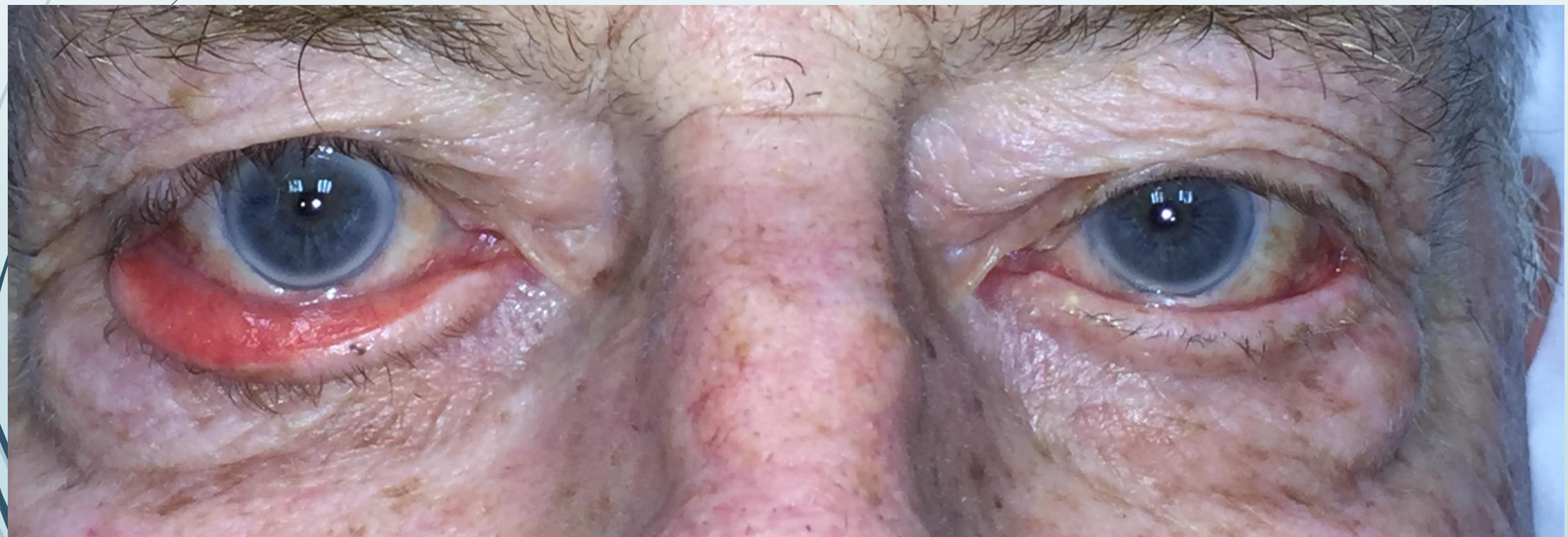




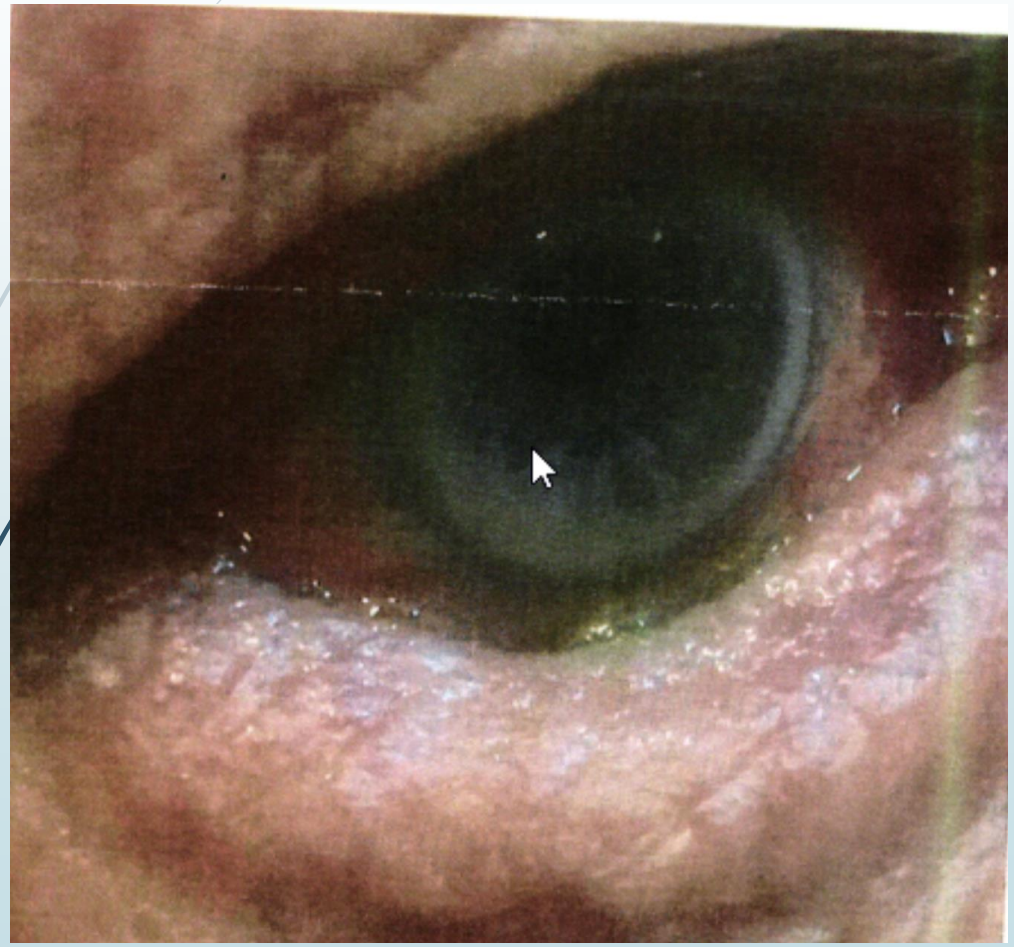
- Lid margin destruction
- Madarosis (loss of lashes)

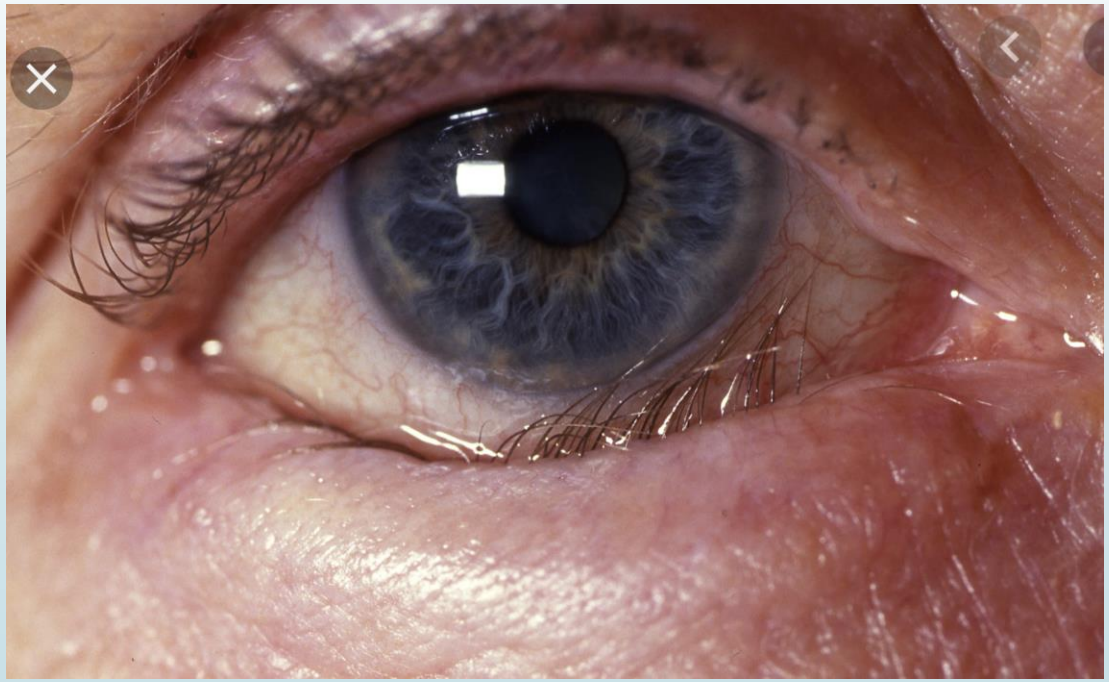
Ectropion

- Only Tarsal plate ectropion – accepted at the eye clinic
- Exceptions: only eye, obscures vision – falls risk, hinders ability to work

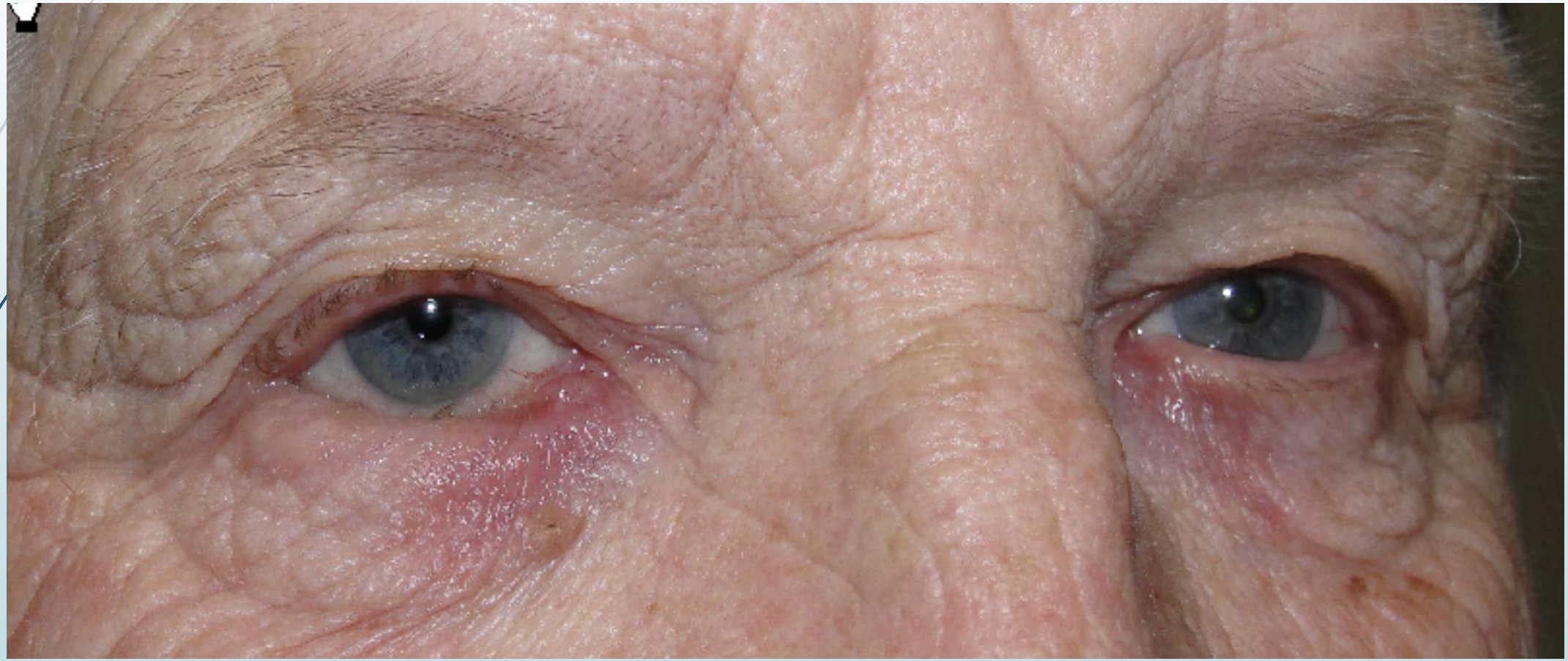


Entropion



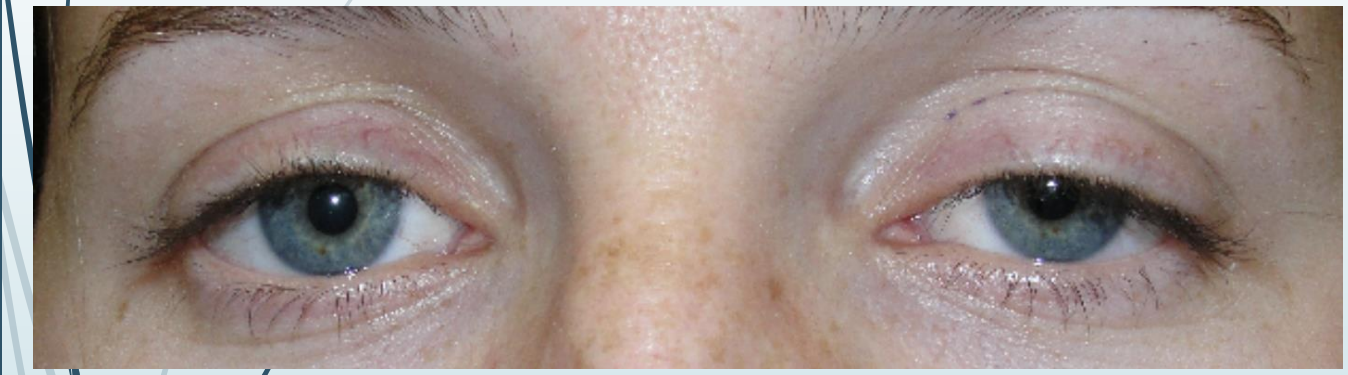


Entropion

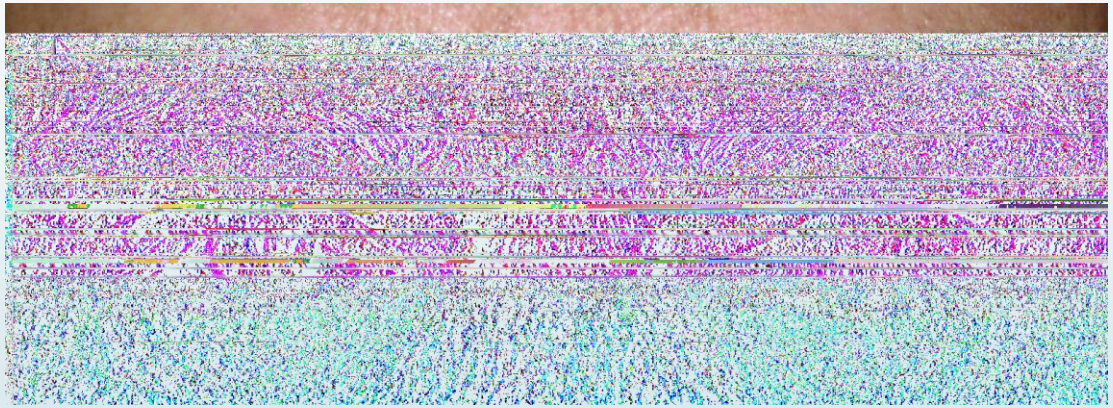


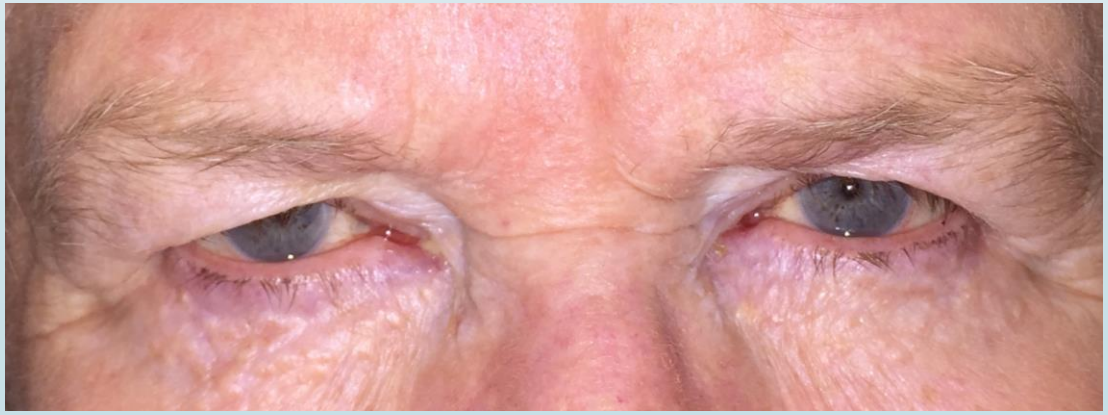
Ptosis and dermatochalasia

Below threshold



Meets threshold

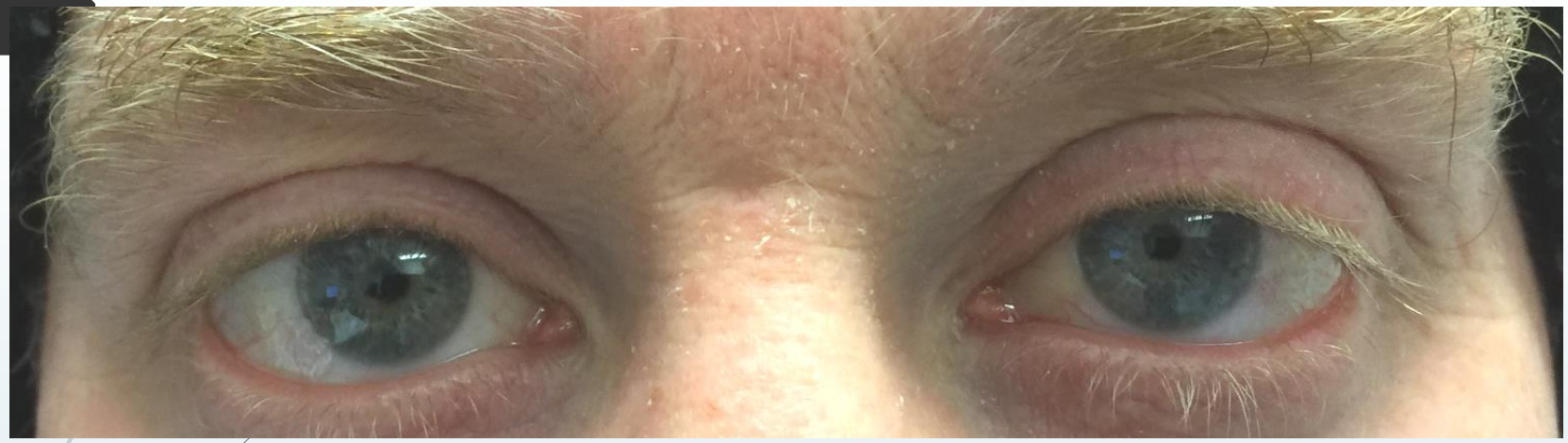




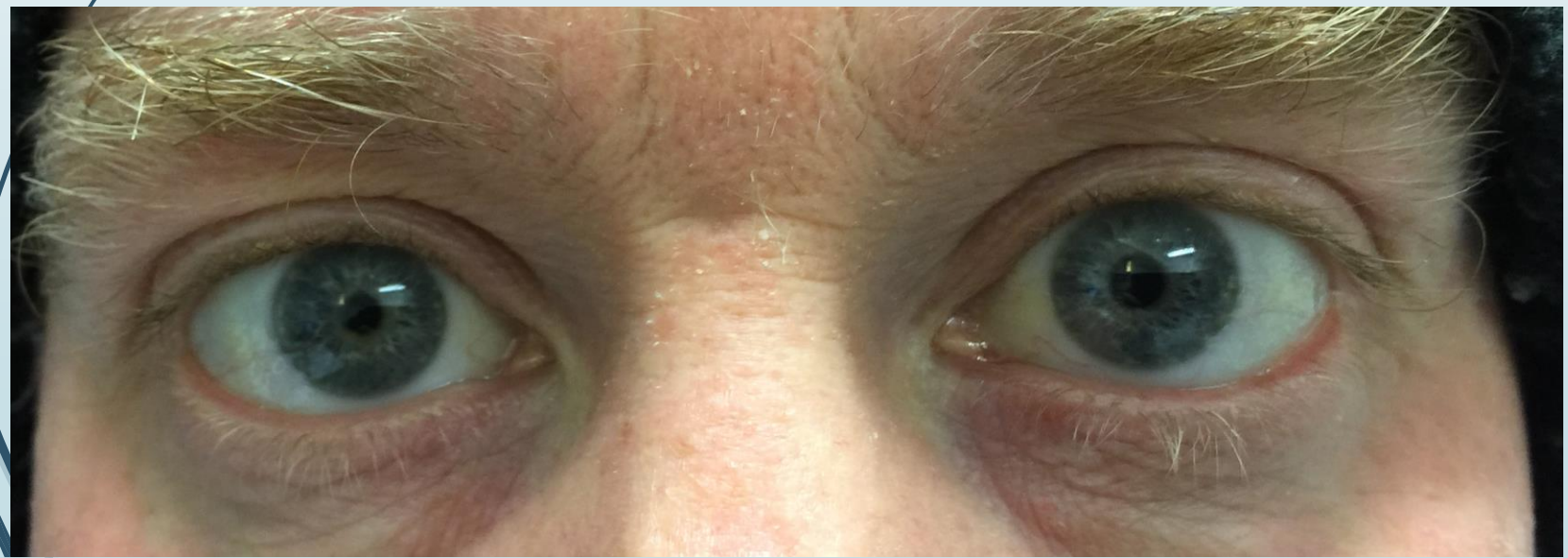
Ptosis

- Many causes
- Important clinical signs:
- Anisocoria
  - Dilated pupil = CN III palsy
  - Constricted pupil = Horner's Syndrome
- Ocular motility issues
  - CN III palsy
  - Myasthenia Gravis
- Other neurological signs, other cranial nerve involvement

Horner's Syndrome



Apraclonidine test – reversal of anisocoria



- Miosis
- Ptosis
- Anhydrosis

Pterygium (HealthPathways)

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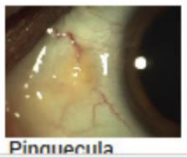
Pterygium

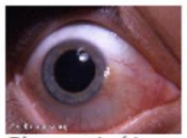
Background

About pterygium and pinguecula

Assessment

1. History:
   - Often bilateral, extend onto corneal surface nasally, and are chronically red.
   - Occasionally increase in size over years.
   - Most common symptoms are redness and irritation.
2. Examination:
   - Band of redness and thickening extends from cornea as a wedge.
   - A pinguecula is localised and does not extend onto the cornea.


Pinguecula


Pinguecula (does


Pterygium

Pterygium

Management

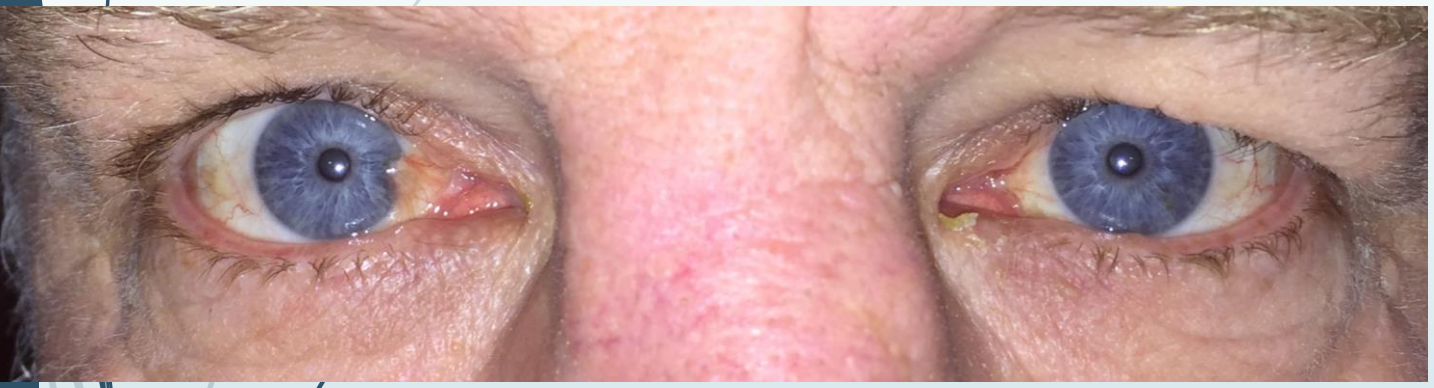
1. Advise simple measures which help most patients' symptoms:
   - Lubricant drops when needed help irritation, and redness over time.
   - An NSAID drop (e.g. diclofenac sodium eye drops 4 times a day for 1 to 2 weeks) may help chronic inflammation. It is normal for it to sting, and safe to use for repeated courses.
   - Wearing sunglasses.
2. Redness or irritation are not indications for excision, unless significant and unresponsive to the above treatment.
3. Consider referral if:
   - patient has vision symptoms or is noting growth, extension onto cornea of ≥ 3 mm.
   - vision threatened with the pterygium edge at or beyond the edge of the pupil in normal room lighting.

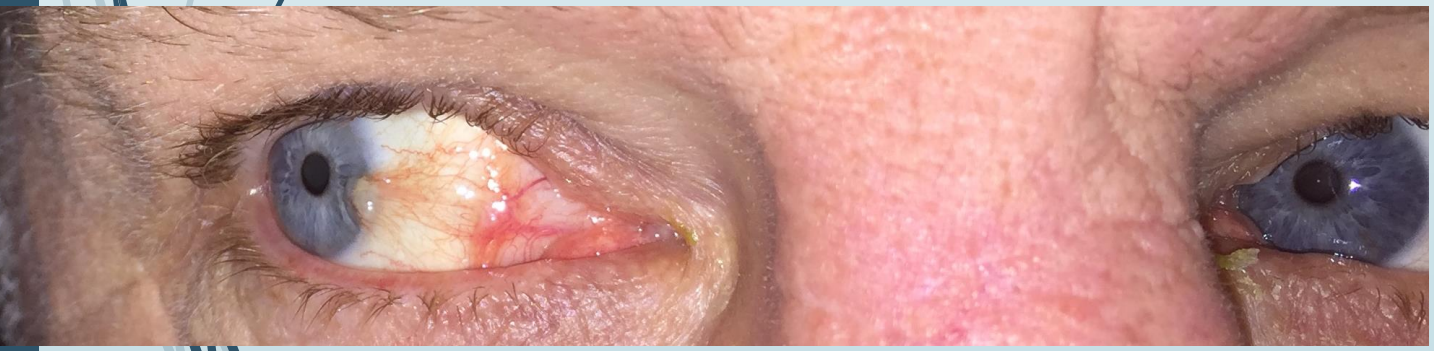
Request

- If decreased vision due to the pterygium or the edge of the lesion is at or beyond the edge of the pupil in normal room lighting, request non-acute ophthalmology assessment. The Ophthalmology Outpatients Department will only accept a small number of referrals documenting a significant threat to vision.
- Optometrists can assess and manage some of these conditions. Warn patients of cost and that on-referral to an ophthalmologist may be required.

Pterygium

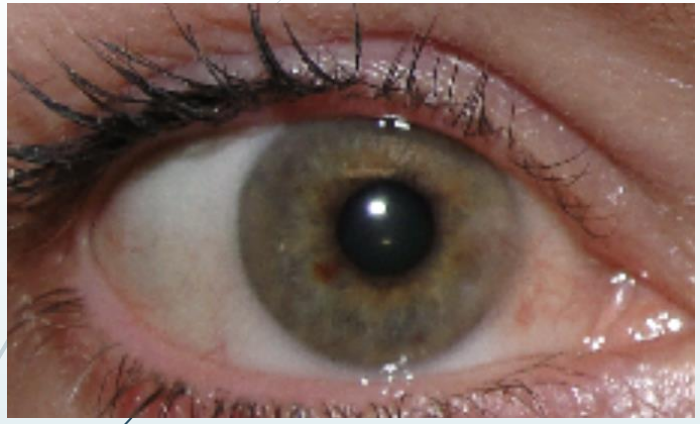
Please send a photo with your referral

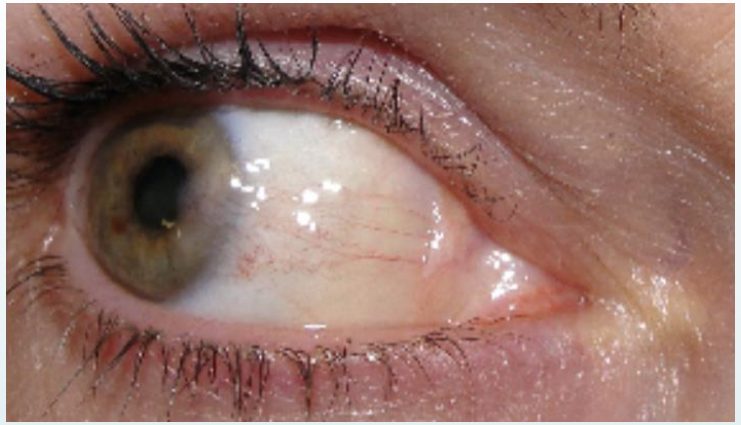




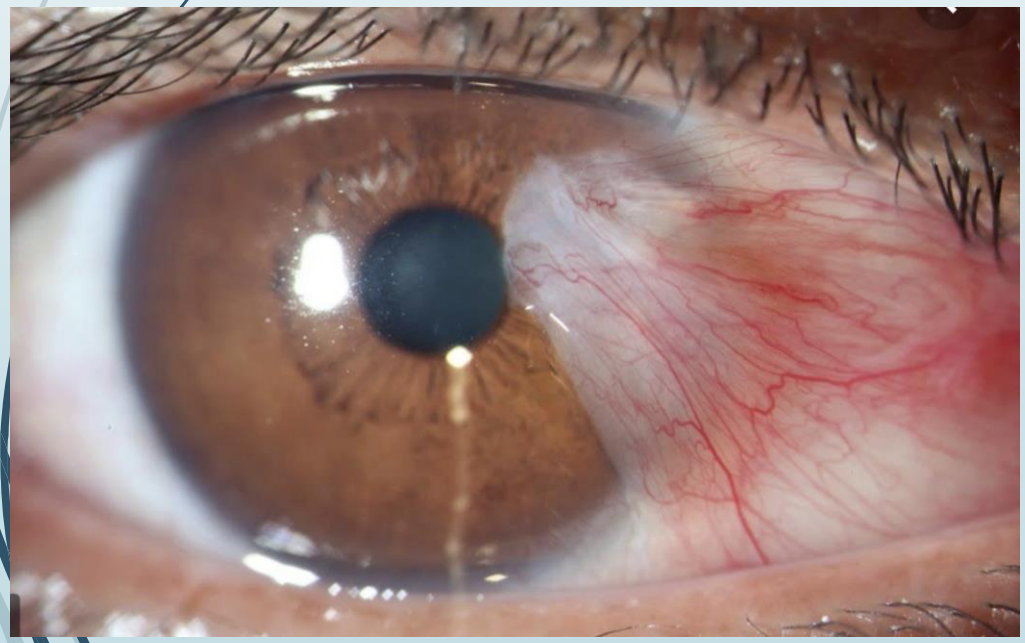
- Redness irritation not reasons for surgery, unless significant and unresponsive to treatment
- Treatment:
  - G lubrication QID PRN
  - G voltaren QID
  - Wear Sunglasses
- Refer if:
  - Vision symptoms/growth – 3mm onto cornea
  - Pterygium edge at or beyond pupil edge in normal room light

Pterygium

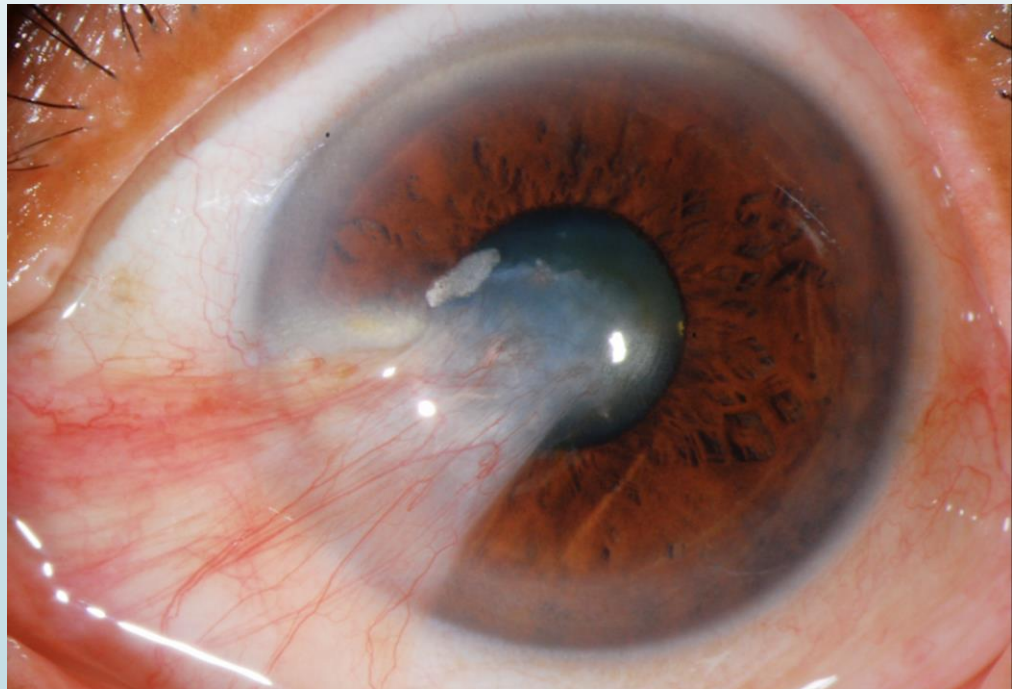




Surgery not indicated



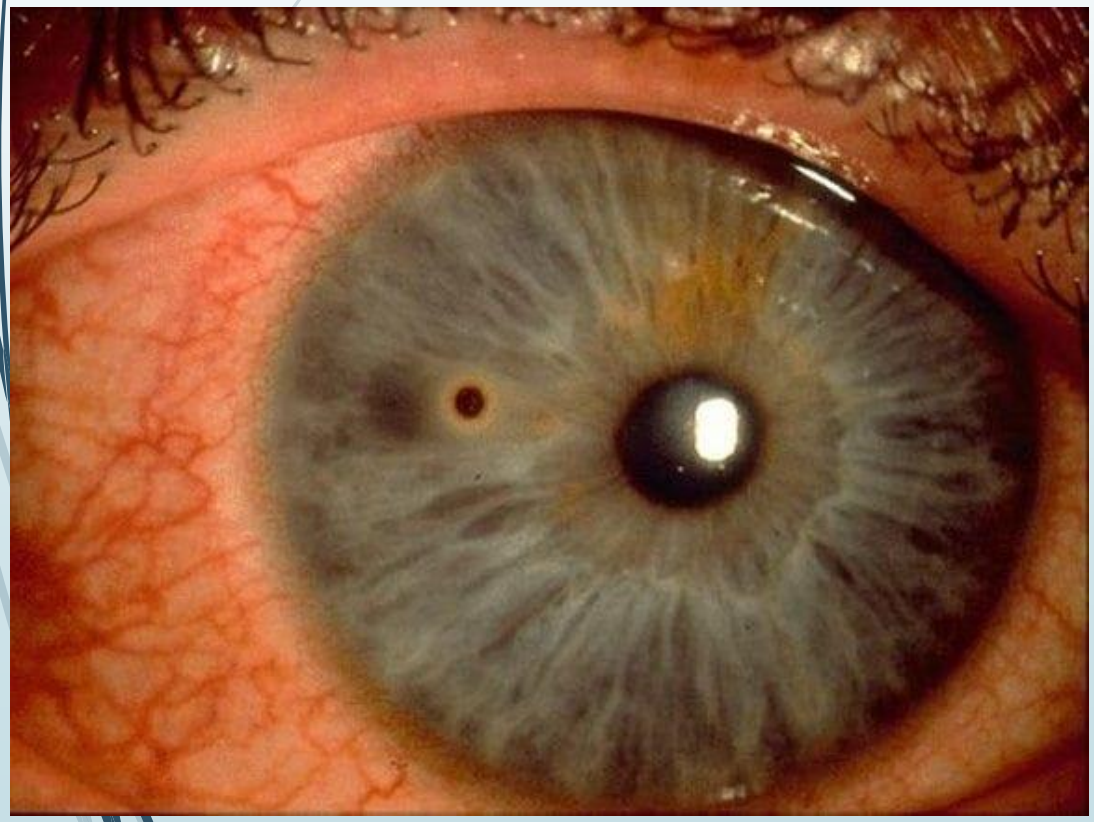
Surgery indicated

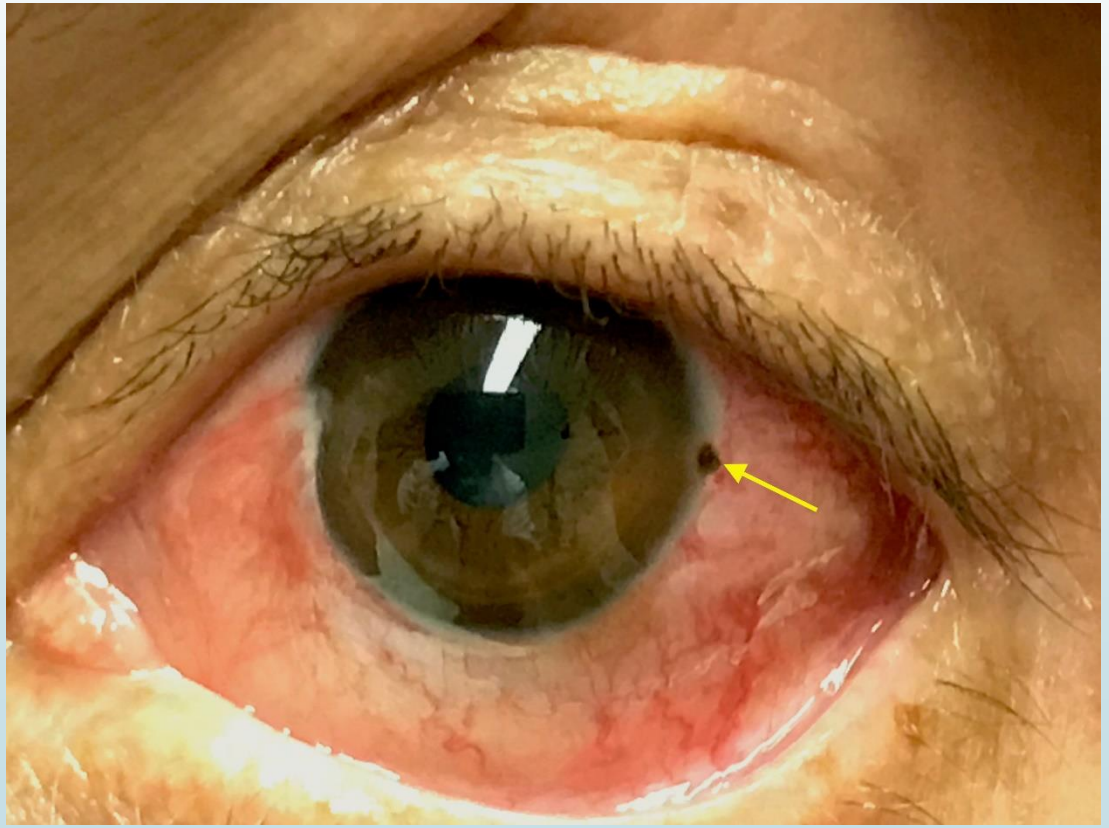


Case 1: Acute Red Eye

- 27yo male presented to ED with painful red left eye.
- Vision slightly blurry but 6/6 on testing
- No ophthalmic history. No medical history
- Been lifting some furniture at home over the weekend

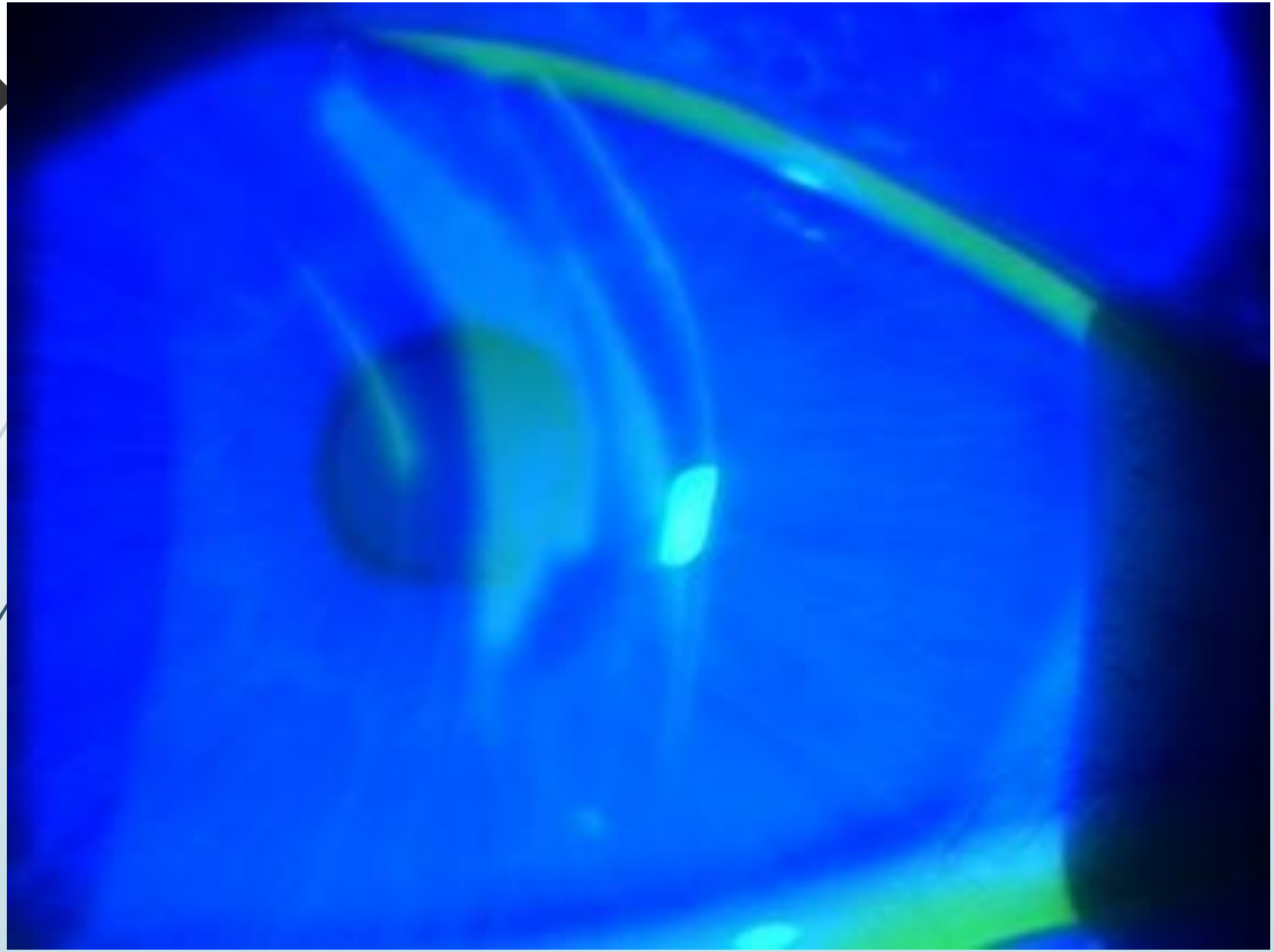
Metal Foreign Body and Rust ring



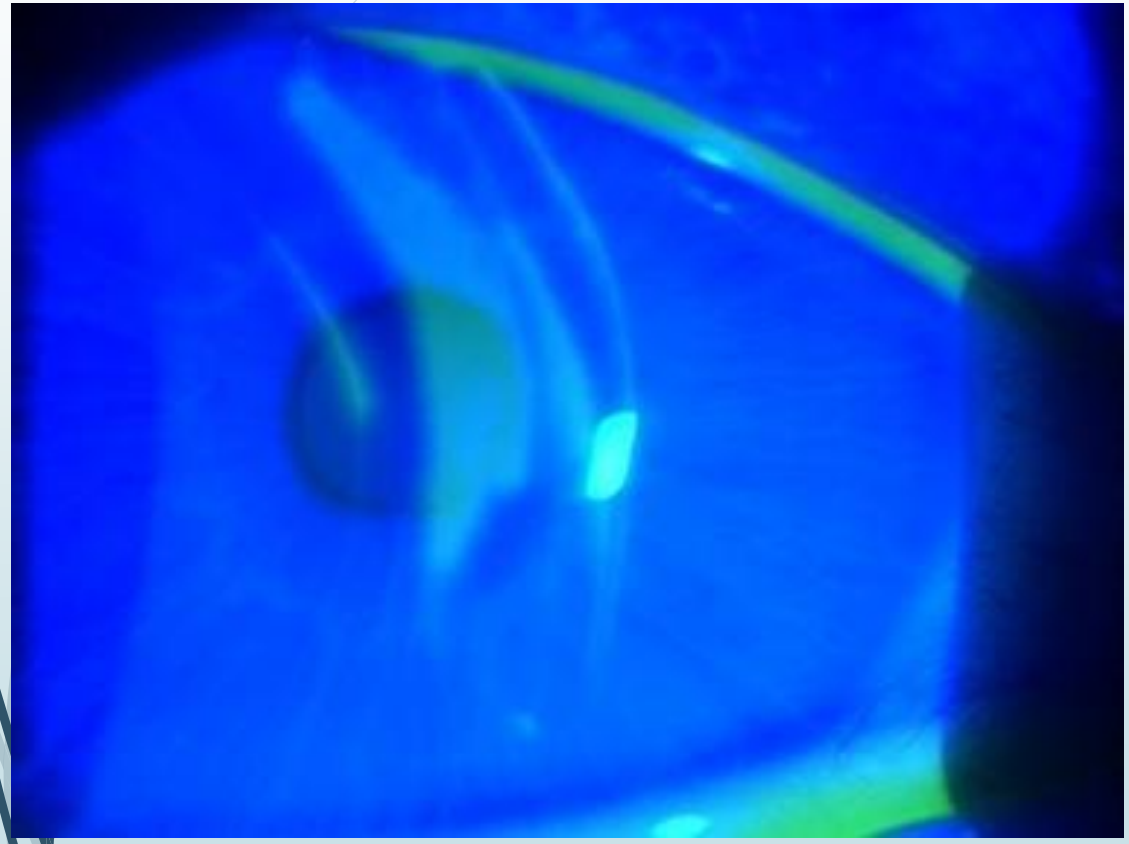


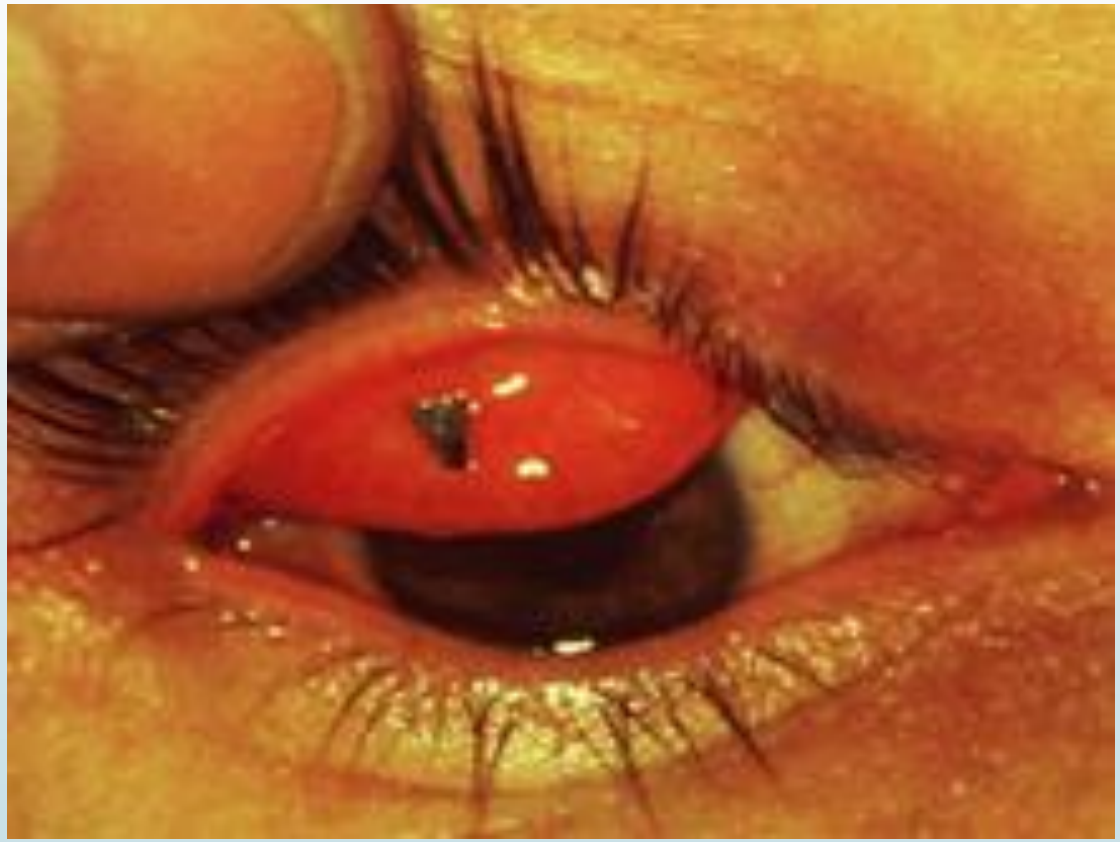
Case 1 Continues

- ED removed the FB
- Ongoing irritation and redness. FB sensation for 3/52
- Vision blurry now 6/24 (ua), improving to 6/9 (ph)
- Came back to ED 4 times – noted small corneal abrasions only
- Referred to Ophthalmology



Look under the eyelids!

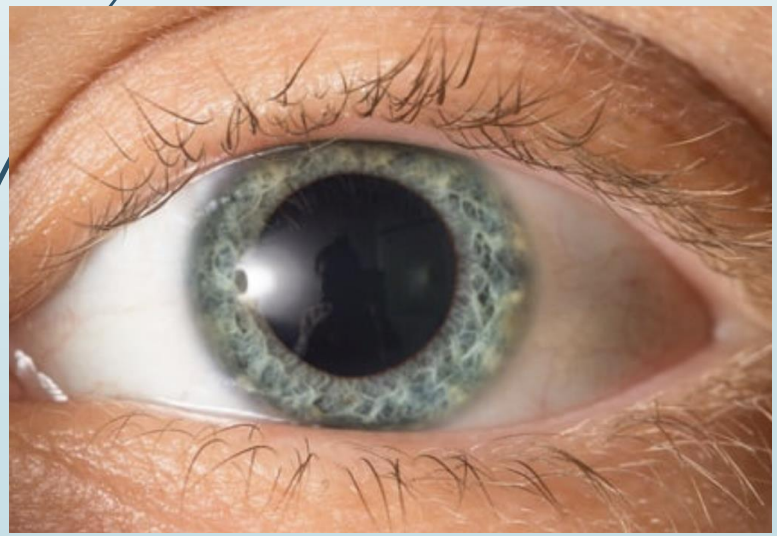


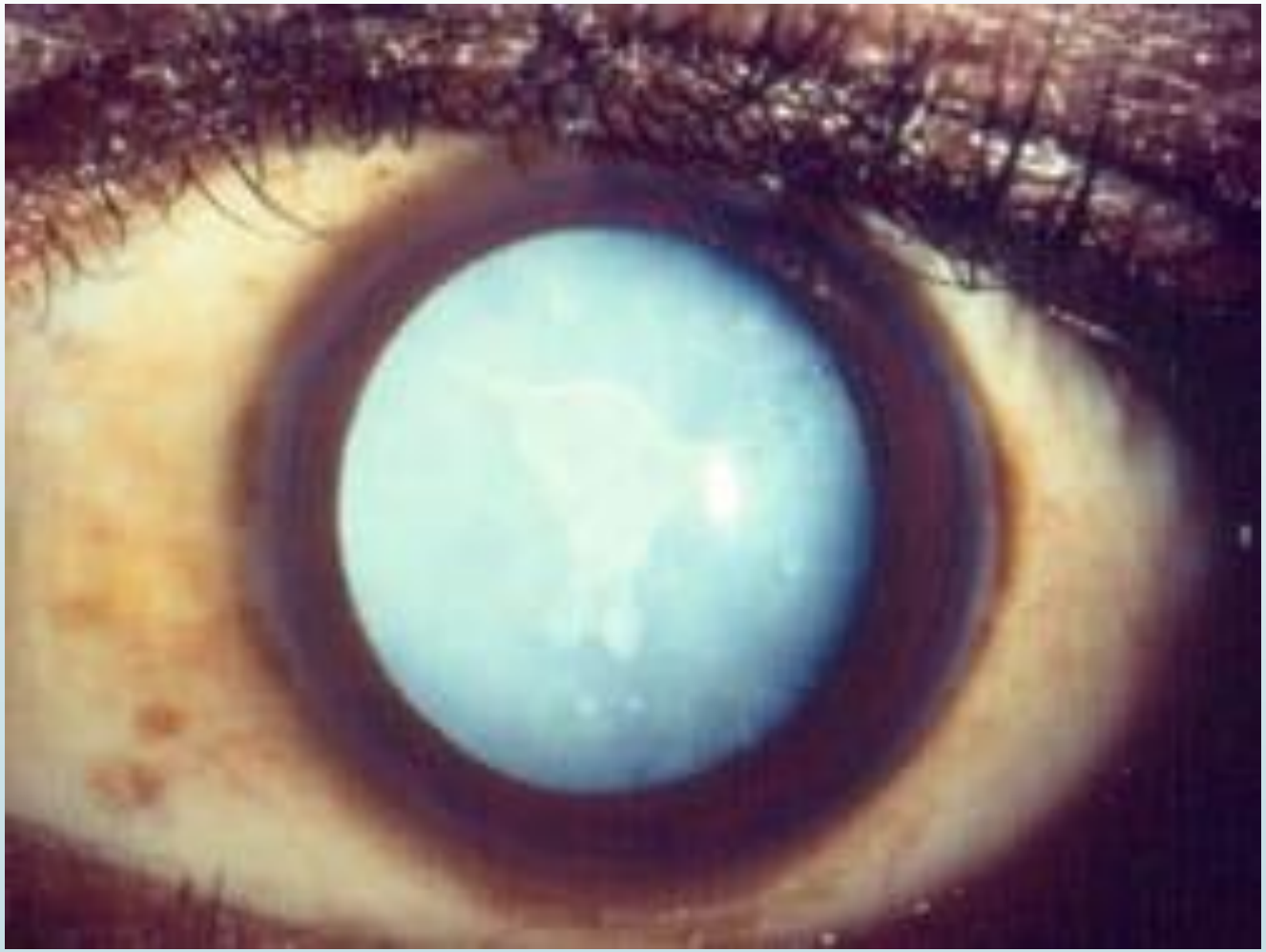


Case 8

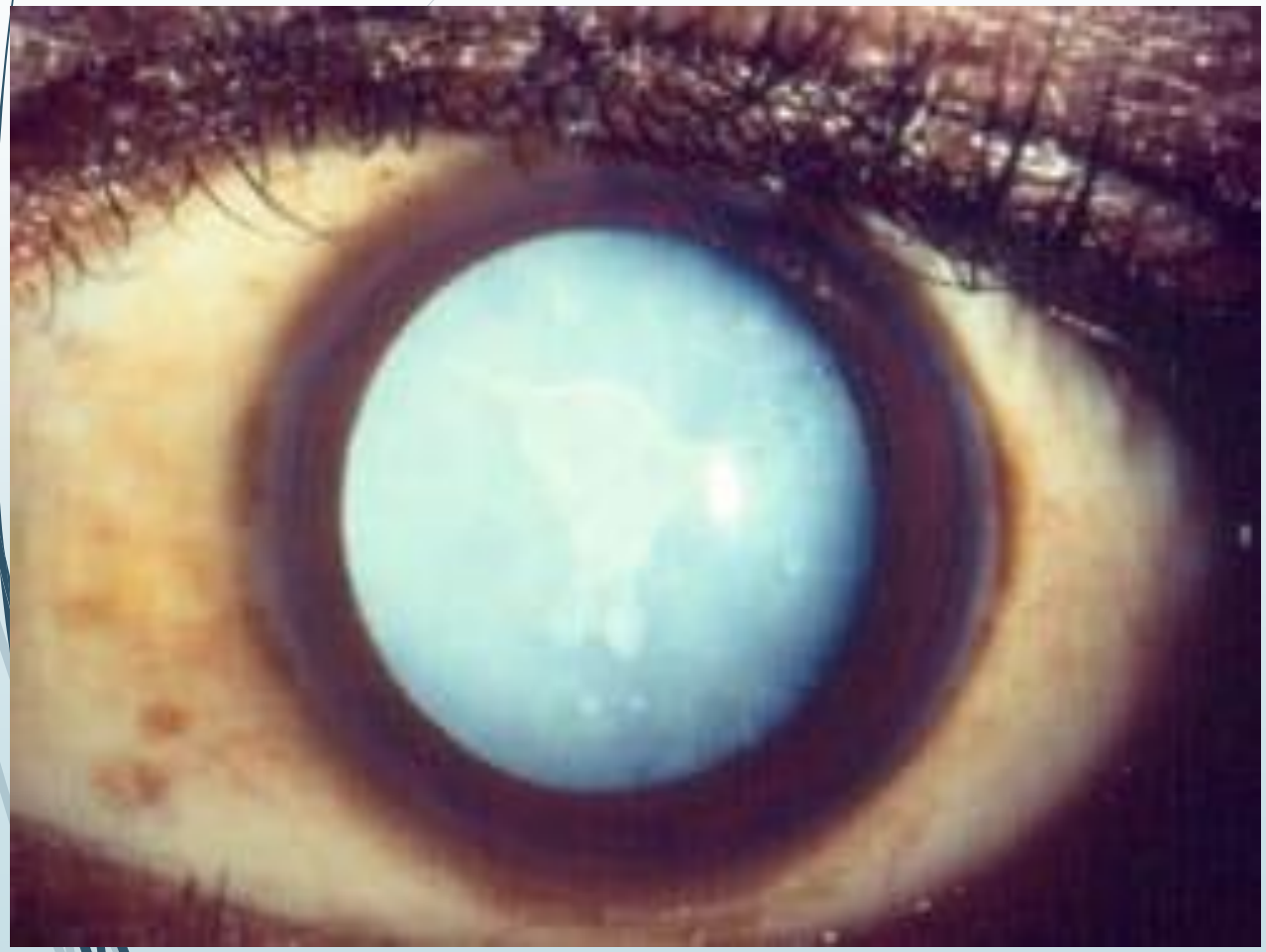
- 42yo male with no previous ophthalmic Hx
- ?rapid loss of vision in left eye over 3 day period
- Possibly vision may not have been the greatest for 3 months
- May have seen something 'wiggling around' 2 weeks ago in the same eye
- L VA HM, normal IOP
- L RAPD
- No trauma but does get hayfever – rubs his eye often

Normal



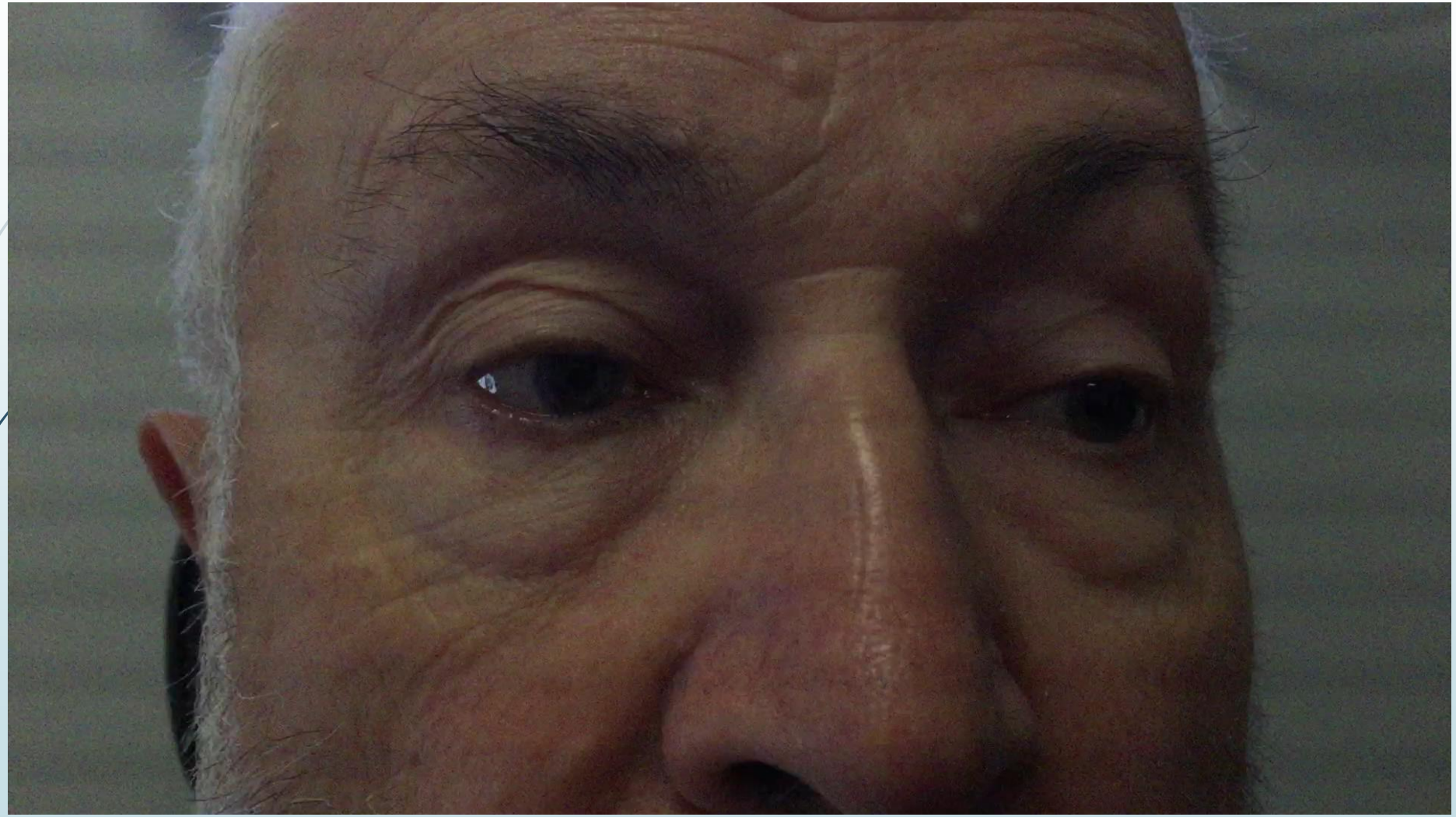


White cataract only, why RAPD?

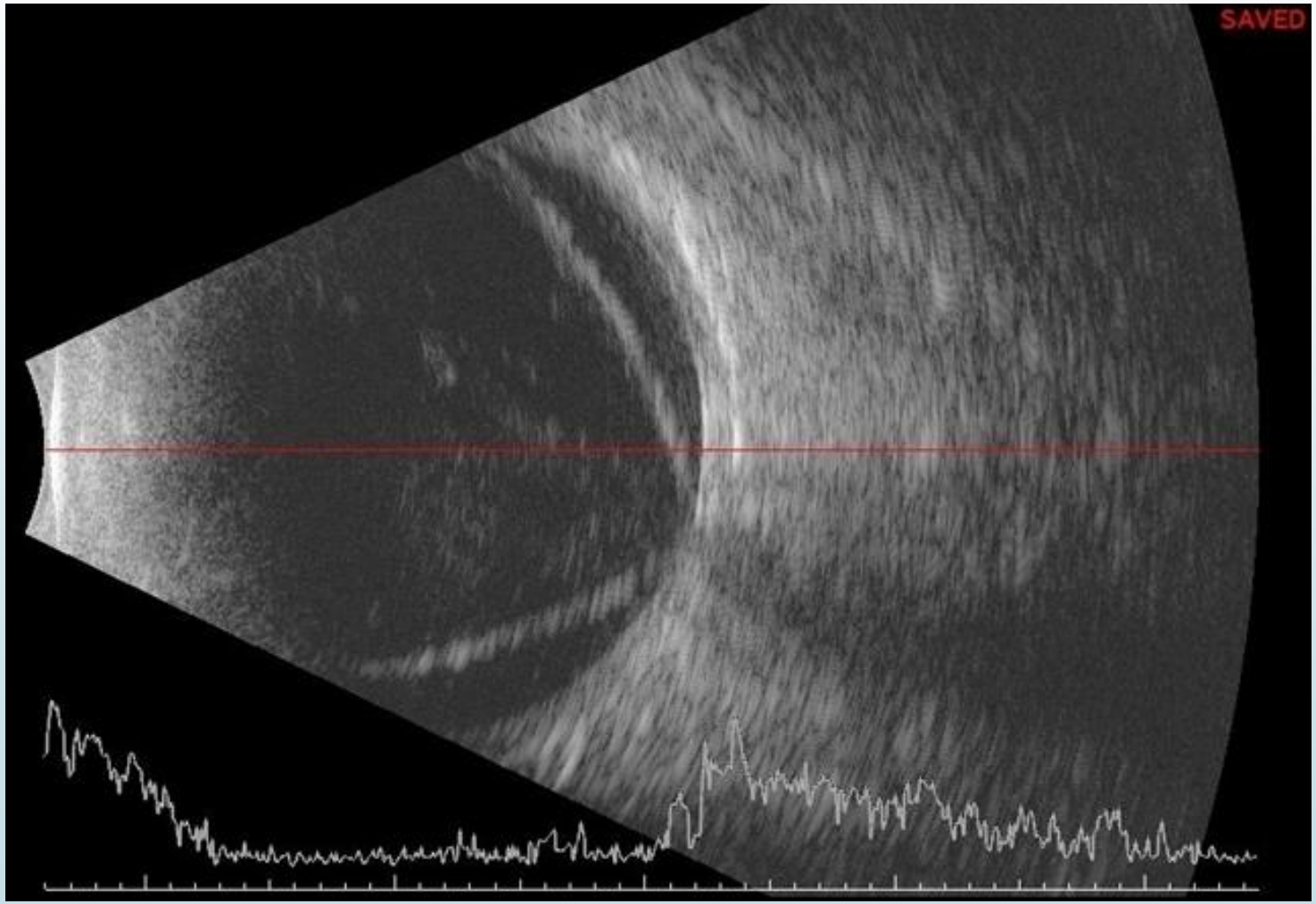


- Optic nerve dysfunction
- Retinal pathology
  - Needs to be extensive involvement
- Dense amblyopia
  - Mild RAPD
- Not with cataract

RAPD (Relative afferent pupillary defect)



?White cataract only
B-Scan (US) shows retinal detachment



Thank you