Top Ten Conditions You Can't Afford to Miss

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Post operative endophthalmitis

- Hallmark feature is cells in vitreous
- Usually within 3-5 days of procedure
- Pain and blurring of vision, usually rapidly progressive
- Refer any patient with pain or reduced vision within 2 weeks of procedure urgently back to the surgeon

Retinal Tear Tips

- Dilated exam
- Remember weaknesses of UWFI (especially inferiorly and superiorly)
- Tobacco dust = retinal tear till proven otherwise
- Superotemporal most common site- double check
- Risk stratify your patients
  - High risk:
    - Myopes or reformed myopes
    - Pseudophakes especially complicated surgery
    - Young high myopes who have had cataract surgery/ lens exchange!

Anterior Uveitis Tips

- Cells in the anterior chamber required before making the diagnosis
- Don't make a diagnosis of anterior uveitis until you are sure there is no posterior segment inflammation
- Could the eye disease be part of systemic disease?
  - Always consider systemic associations in uveitis
  - Consider the demography of your patient- most anterior uveitis is in young adults
  - Anterior uveitis
    - HLA B27 associated
    - Rarely infectious TB, sarcoid syphilis

Assessing a choroidal naevus: What do you look for

- Thickness > 2mm
- Fluid - subretinal fluid
- Symptoms- photopsia
- Orange pigment
- Margin of naevus at disc
- "To Find Small Ocular Melanomas"

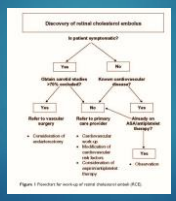
- Risk stratification
  - none of these features risk of melanoma at 5 years small
  - 1= 40%
  - 2= 50%

Shields CL et al Ophthal 1995 102: 1351-61

Tips: Transient Vision Loss

- Monocular or binocular
  - Monocular- retinal, optic nerve or carotid circulation
  - Bilateral- neuronal depression (migraine), posterior circulation
- Age
  - <50 yo vasospasm/ migraine more common
  - > 50 yo vascular disease, GCA
- Duration of vision loss
  - Vascular disease acute onset, usually lasts 1 to 10minutes
  - Seconds: Papilloedema
- Associated symptoms
  - Headache, positive visual phenomena – migraine
  - Headache, jaw claudication, scalp tenderness - GCA

Approach to a Retinal Cholesterol Embolus



Vanner P Clinical Optometry 2015;5:15–21

Tips: Giant Cell Arteritis

- Suspected GCA is an ophthalmic emergency
  - Risk to fellow eye
  - Risk to life
- Symptoms and blood tests are often non specific
- Be concerned about any patient >60 yo presenting with transient visual symptoms or severe painless vision loss
- Symptoms
  - HA, temporal tenderness
  - Jaw claudication
  - Scalp tenderness
  - Muscle stiffness, pain

Tip: Longstanding Type 1 Diabetics

- Beware longstanding Type 1 diabetics!
- More likely to have a very ischaemic fundus with minimal signs than type 2 who tend to have an exudative fundus

Tips: Papilloedema

- True papilloedema v pseudopapilloedema can be difficult to distinguish
- Is the disc hyperaemic?
- Are there microvascular abnormalities on surface of disc?
  - Dilatation/telangiectasia/ flame haemorrhages on disc surface
- Is there blurring of the retinal blood vessels?
  - In pseudo swelling the blurring of the disc usually results from deeper abnormalities (e.g. buried drusen) so the retinal vessels, which are superficial, are clearly visible as they cross the disc margin. In true papilloedema the vessels may be obscured due to swelling of the more superficial retinal nerve fibre layer

Tips: "Unexplained" Vision Loss

- Field defects obeying vertical meridian need neuroimaging
- All patients with unexplained vision loss should have visual field and OCT
- Where the vision does not "tally up" remember to double check:
  - Cornea: Keratoconus
  - Lens: Subtle Cataract/ (Blood glucose level)
  - Macula: OCT
  - Optic Nerve/ Visual pathways: Visual field and RAPD

Honourable Mentions!

- Acute Angle Closure Glaucoma
- Pupil involving third nerve palsy