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Bulletin

NEXT MEETING

Marriott West
600 Maryville Center

April 14, 2020

Hope all of you are staying safe and taking precautions in all areas of your life.

Obviously, we will not be meeting in April. We have been enjoying some great meetings: with delicious food, stellar CE and camaraderie with fellow Optometrists. Efforts are being made to explore the possibility of continuing the CE so that we can all stay in contact during this time. We will continue to keep you abreast concerning changes in our profession as they come to us.

Feel free to contact me, Paula, or any of the board members with thoughts and concerns.

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Please Contact Emily Pike if you are interested in Serving on a committee
pikeev@gmail.com

Historical Review and Current Concepts in Stargardt's Disease

Presenters:

Clayton Scanlon M.D.

Submitted by: Steven Brandstetter, O.D.

Dr. Scanlon started with the case report of Jim Bernadrin, a 12 year-old boy in Florida who had increasingly blurry vision. Slowly the central vision faded in both eyes. His sisters became symptomatic with similar findings. All three ended up being diagnosed with Stargardt's Disease.

Karl Brun Stargardt found the condition in the early 1900's. He described bilateral, slowly progressive lesions confined to the macula, occurring familially, starting in youth and leading eventually to loss of central vision. In 1909, he had 7 patients from two families. All seven had vision loss with minimal to no macular changes. Eventually atrophic macular degeneration changes occurred. Variable yellowish macular and posterior pole flecks were observed. The patients had normal peripheral fields and no night blindness. The appearance varied between patients and can show a considerable difference in families. Macular atrophy always occurs.

In Stargardt's original publication from 1909-1916 he noted a probable autosomal recessive onset in the 1st or 2nd decade. Initial loss of vision occurred before macular changes. Eventual progressive atrophic macular degeneration; variable macular/posterior pole were also noted. Patients had essentially normal peripheral fields and night vision throughout life and mild color vision loss even with fairly severe vision loss.

Stargardt's Disease became renamed in the 1960's when the emphasis shifted to flecks from macular atrophy. Conditions designated as Juvenile Macular Degeneration (Stargardt's) included; Vitelliruptive Macular Degeneration, X-Linked Juvenile Retinoschisis, X-Linked Vitreoretinal Degeneration with myopia, Cone Degenerations, and Fundus Flavimaculatus.

Fundus Flavimaculatus was a term that emphasized fuzzy, soft, deep, yellow flecks in the posterior pole. Patients were put into 2 groups. Group 1 had no macular degeneration, but may develop central acuity loss due to direct invasion of fovea with deposits. Group 2 had macular atrophy and subsequent flecks (which could resolve) and no cone dysfunction. This was the most common form of Fundus Flavimaculatus. The ERG and color vision were normal.

Pure Fundus Flavimaculatus is described as no, or late macular involvement, occurring in adults

*****Continue on next page*****

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Atrophic Macular Dystrophy with Fundus Flavimaculatus (Stargardt's 1909 description) occurred in juveniles. Behr was the first to emphasize the importance of age as primary differentiating factor. Further categorization described Fundus Flavimaculatus as Stargardt's Disease with Peripheral Involvement.

The current description of Stargardt's and Fundus Flavimaculatus is "variable phenotypic expression of the same genetic mutation in ATP-binding cassette (ABC) transporter gene ABCA4 located on chromosome 1p (allelic mutations and combinations lead to various phenotypes)." Abnormal ABCA4 protein function leads to build up of lipofuscin in RPE, limiting function and viability. The prevalence is rare; estimated at 1:10,000. It is the most common inherited juvenile macular dystrophy. Likelihood of effected child is less than 1%. It effects men and women equally.

Clinical signs and symptoms include vision loss before viable signs, loss of foveal reflex or distortion, foveal swelling and graying of reflex giving metallic sheen "Beaten Bronze" appearance, "Bullseye Maculopathy", Pisciform flecks surrounding atrophy, and separated by a zone of unaffected RPE.

The hallmark is previous normal vision. Symptoms can be reported at age 3. The average age of presentation with central macular involvement is the mid teens. Presenting without macular atrophy and only midperipheral flecks usually occurs in early to mid adulthood. Patients can be 20/200 within 5 years of being 20/40.

Diagnostic studies such as fluorescien angiography present a central ovoid hypofluorescence surrounded by zone of blotchy hyperfluorescence. Central lesions lose metallic sheen with atrophy, resulting in hyperfluorescence. Ring of flecks often early hypofluorescence with late hyperfluorescence and eventual disappear corresponding to RPE atrophy. No leakage occurs unless there's a secondary CNVM. EOG and Visual fields are typically normal but can be decreased in extensive RPE changes. Abnormalities in both fast and slow oscillation can be present. Amplitude is more affected than time course. Likely reflects changes in photoreceptor/RPE function. Visual field is usually normal and can develop relative or absolute central scotoma. Annular scotoma occurs with more advance disease.

OCT shows extensive foveolar thinning and macular volume loss. Diffuse retinal atrophy and loss of photoreceptor inner and outer segments.

*****Continue on next Page****

*********Continued from Last Page**********

Management options include surveillance of choroidal neovascularization, vision rehab, low vision and warn about trauma as these patients can have a severe Commotio-like disorganization. Minimize UV/light exposure/oxidative stress, limit vitaimin A consumption, and recommend good general health and diet, avoid tobacco.

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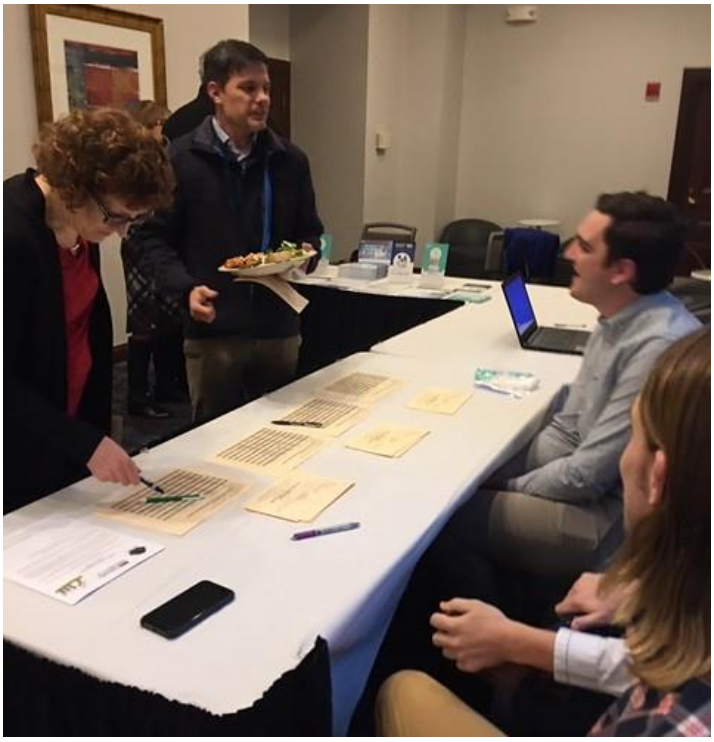

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MOA Report January 2020

Submitted by: Jason Riley, O.D.
Jenna Osseck, O.D.

Legislative Update:
SB942 (Introduced by Sen. Jeanie Riddle) and HB2382 (Introduced by Rep. Dean Plocher) Definition of Surgery Bill: submitted by medicine and aimed at nurse practitioners and nurse anesthetists. MOA testified against this bill on March 2nd and killed the bill on March 10th. This was due in part to the success of the keypersons system - which is imperative to protect our scope of practice. Thank you to all who are keypersons for our legislators.

Upcoming Events:
Vision Awareness Patch for Girl Scouts and Boy Scouts for Save Your Vision Month is now available. Patches can be ordered/purchased through the MOA ($1.00 each) for doctors and practices that want to take part in this event. Those interested are to approach scout leaders to let the troops know about the Vision Awareness Patch and coordinate with an event at your practice. For more details and information, please see the MOA Memo from 2/20/20 or contact Dr. Erin Sullivan (eclearysullivan@me.com).

The Special Olympics Vision Screening is cancelled for Saturday, March 21st.

The **MOA Leadership Retreat** will be **June 5-6th** in Kansas City. The team building event on Friday will be axe throwing at Blade & Timber, as the MOA competes against the KOA. Cost to attend is $65 with lunch and drinks included. Committee meetings will be held on Saturday afternoon for those serving on a committee. Please contact Dr. Lee Ann Barrett if wanting to attend the team building event.

On **August 22nd**, the MOA and IOA will be teaming up for the **Cards-Cubs game** at Wrigley Field at 3:00pm. The MOA is trying to get a headcount for those interested in attending before purchasing tickets. Please see previous email Dr. Lee Ann Barrett sent with the link to RSVP. There are also plans for 2 hours of continuing education, as well, to make the trip more cost effective.

The 2020 **MOA Convention** will be in Branson this fall, **October 15-18th** at the Chateau on the Lake.

****

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Technology Report:

Submitted by: John Bush, O.D.

The use of Artificial Intelligence has been officially approved by The American Diabetes Association to screen patients for diabetic retinopathy. The Idx-Dr is the first stand alone device to be approved for this task. A retinal photo is acquired using a Top con retinal camera. An AI program then analyzes the image and provides one of two results: 1) More than mild DR, refer to a professional or 2) No DR, return in 12 months This device makes screening decisions without the need for a clinician to be present to interpret the data.

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The Physicians of THE RETINA INSTITUTE

Dear Colleague,

The 6th Annual **Spring Retina Update** will take place on **April 18th** at 8 am as an **online meeting**. Although saddened we will not meet in person, we are pleased to be able to still offer this educational opportunity. A total of 4 COPE, CME or CE credits will be awarded to those who register and attend remotely. During this activity, participants will be able to interact with the presenters and panelists via a chat feature, and we hope you will be able to join us. Log-in information and instructions on how to obtain continuing education credits will be made available in the weeks to come.
There is no need to register again if you have already done so. You may update your registration status anytime online at TRI-STL.com or by using the link at https://docs.google.com/forms/d/1JCTpxNYDM4WN8L1AUrb6tYmeF0CqWmtfcEAEyyEzNqo/edit .

The agenda follows:

8:00 AM: Welcome –Bradley T. Smith, MD

8:05 AM: Results of the PRO Retinal Detachment Repair Study – Daniel Joseph, MD, PhD

8:35 AM: Update on Central Serous Chorioretinopathy– Bradley T. Smith, MD

9:05 AM: Injection Complications: Infection/oil—New Observations- Kevin J. Blinder, MD

9:35 AM: OCTA in Macular Degeneration- Sabin Dang, MD

10:05 AM: Break

10:35 AM: Drug-related Retinal Toxicity – Gaurav K. Shah, MD

11:05 AM: Case Presentations and Discussion – The Physicians of The Retina Institute

12:35 PM: Concluding Remarks

Please feel free to contact Nancy at Nancy.bolozky@rc-stl.com if you have other questions, comments, or other concerns about this symposium.

The Physicians of THE RETINA INSTITUTE

UPCOMING EVENTS

NEXT MEETING
SLOS Meeting
April 14 the Meeting Canceled at the Marriott

April 18, 2020 - 7:00 am-12:30 pm
6th Annual Spring Retina Update
See Previous Page for more information and Registration details

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