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Bulletin

NEXT MEETING

June 9, 2020 7:00 pm

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

Know Your Chances: An Evidence Based Approach to Clinical Decision Making

This course will give a better understanding of medical literature and reduce the confusion of medical statistics. By understanding the numbers and knowing the right questions to ask, the optometrist can use evidence-based medicine to make wiser, yet easier clinical decisions in medical Optometry

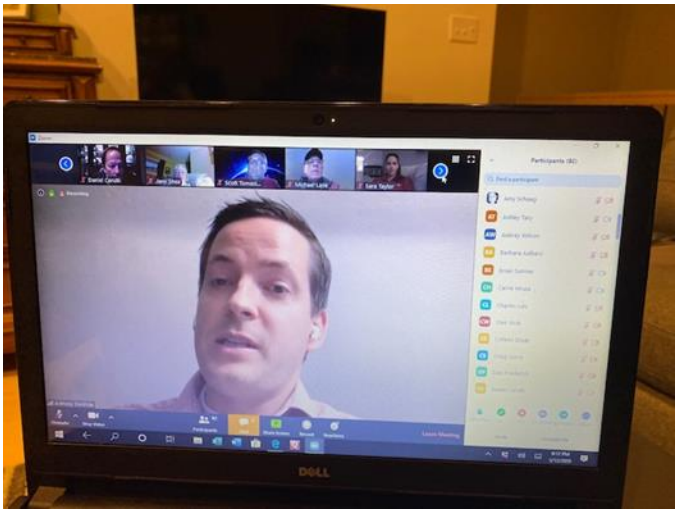
This Event will be presented by :
Jordan Keith, OD, FAAO

This will be a 2 Hour CE Course

This will be a ZOOM meeting. As information develops you will receive an email giving you instruction on how to register. After you register you will receive another additional email with the link to use the night of the meeting. Please be sure to **preregister and RSVP.** Pre-registration will generate the link you will need to access the event on June 9th. You must Pre-register to receive the automated email that provides the link.

If you have any questions, please contact me.
paula@stlouisoptometricsociety.org or call or text
314 725-2020

Another Great Meeting. Thank you, Dr. Anthony DeWilde OD, FAAO



OCT Grand Rounds:

Presenter: Anthony DeWilde**,** OD, FAAO

Submitted by: Steven Brandstetter, O.D.

. Three goals of the presentation are to improve the diagnosis of common and uncommon conditions with OCT, determine what we're seeing with OCT and what to do with referrals, and how to utilize OCT for patient education.

Case 1 was a 58 year-old white male with a complaint of blur in his left eye. His BCVA was 20/20 OD and 20/40 OS. He had no systemic conditions and normal anterior segment. The OD OCT showed a PVD and a normal foveal pit. It is important to view the RPE and inner/outer segment line, or photoreceptor integrity line (PIL). The OS foveal pit did not look as normal. The vitreous had a point of contact and was still attached to the macula and pulling out with force. This is called vitreomacular traction (VMT) or vitreomacular adhesion (VMA). This force causes disruption to the PIL and results in worsening acuity. The treatment for this patient was to monitor. At 4 month follow-up the OCT was completely normal. The vitreous had completely detached from the adhesion and released the traction on the foveal pit, resolving the fovea back to normal contour.

The vitreous has strong adhesion to the optic nerve, macula, and ora serrata. VMT is a posterior vitreous detachment everywhere but the fovea, where it is still attached and pulling with force. This causes distortion, blur, and metamorphopsia. Options for treatment include observation, ocriplasmin (Jetrea), and Pars Plana vitrectomy.

Case 2 was a 64 year-old white male with a chief complaint of blur OS. His BCVA was 20/25 OD, 20/40 OS. Systemic conditions include diabetes and hypertension. He had a normal anterior segment. The OCT OD revealed the vitreous had an adhesion to the macula and the foveal pit was not normal.

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There was an empty space in the foveal pit that did not go all the way to the photoreceptors. The OS looked the same but had two pockets where the foveal pit should be. This patient had bilateral impending lamellar macular holes. You can see large cystic areas and it has a “reverse anvil” appearance. What makes this impending is the tissue is still remaining on top. 5 years later this patient looked exactly the same. If you take the tissue off the top, this would be considered a true lamellar hole.

Case 3 was a 74 year-old hispanic male with blurry reading. His BCVA was 20/40 OD, 20/25 OS. His systemic conditions include diabetes and hypertension. His anterior segment had grade 1 NSC OU. This patient’s OCT showed a lamellar macular hole OU. Macular holes are defined as a defect in sensory retina. A full-thickness macular hole would have a defect in sensory retina that would go all the way down to the photo-receptors and RPE. A lamellar hole doesn’t go all the way to the PR/RPE, has irregular borders, and a majority will have ERM’s causing tangential traction. These are often observed with ERM and VMT.

Lamellar macular holes visual acuity range from 20/20 to 20/60. They are difficult to treat because the patient is often not satisfied after vitrectomy and membrane peel. They may still complain of poor vision, distortion, and metamorphopsia. When deciding surgery the surgeon will often want to know acuity at distance and near and how bad they are bothered functionally. Is it an 80 year-old patient who loves to do crosswords and read versus an 80 year-old who never reads and just really watches television? When a membrane peel is performed they are peeling the ERM and ILM to relieve tangential traction.

Case 4 was a 64 year-old male golfer with a chief complaint of trouble reading. His BCVA was 20/20 OD, 20/25 OS. He had a bare cataract OU. At this visit, the cataract was thought to be the reason for the blurred vision. The patient returned 2 months later. His BCVA was 20/20 OD, and 20/50 OS. His OCT revealed ERM OS>OD.

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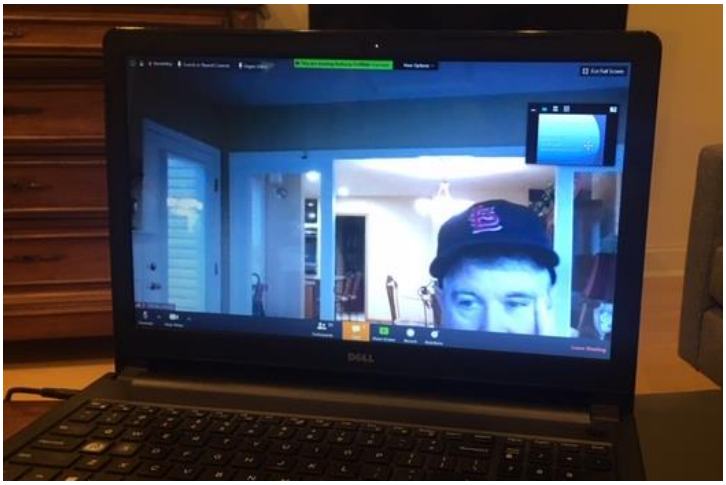

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6 months later his BCVA was 20/30 OD and 20/50 OS. He now had a moderate ERM OD and severe ERM OS. 1 year later his BCVA was 20/50 OD and 20/100 OS. The OCT showed no foveal pit OD. There was a lot of vitreal adhesion causing tangential traction which pulled the macula so tight that it disturbed the foveal pit. The OS ERM was even worse. This case shows how bad and how fast ERM's can progress. This patient was referred for a vitrectomy OS. His acuity after surgery was 20/40 OS.

ERM or macular pucker creates traction of the retina. It can induce edema, typically cystic. The theory is the tangential traction pulls the retina away from the RPE which pumps water out of the retina. Another thought is the retinal vessels become stretched and leaky and leak plasma. ERM's occur from vitreous detachments which allow tissues to develop along the ILM (glial cells).

ERM patients will complain of blurred vision, distortion, metamorphopsia. Acuity can range from asymptomatic to 20/400. Most normally stay stable, but they can progress. Symptomatic patients are treated with an ERM peel, ILM peel, and vitrectomy. These patients need to be told that they will need cataract surgery after the vitrectomy if they are still phakic.

Case 5 was a 75 year-old white male. His BCVA was 20/50 OD, and 20/100 OS. Systemic conditions included diabetes, hypertension, and COPD. His anterior segment was normal and he was pseudophakic. His OD OCT revealed a full thickness macular hole. This is a defect in the sensory retina all the way down. How is he still 20/50? It depends how large the gap is between the space. Most full thickness macular holes are around 20/100 or worse. His OS has a worse full thickness hole. He was advised on vitrectomy, but deferred due to face down time and feeling like he couldn't do it due to his COPD.
The treatment is similar to lamellar holes. A vitrectomy with broad ILM peel and ERM peel is the treatment. The ILM peel is relatively new and helps relieve tangential traction. Patients with ILM peels had better results postoperatively with acuity and staying closed versus those without. It increases success rates of closure from 90%-97%. Patients need to stay face down because

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we want the gas bubble to float up and push up against the RPE. Modern treatment is less time face down. Normally 3 days mostly face down and try sleeping on their side.

Case 6 was a 67 year-old black male. BCVA was 20/40 OD and 20/30 OS. He had glaucoma OU and PCIOL OD x 1 month and NSC OS. OCT revealed a lot of edema OD at his 1 month post op visit. This is cystoid macular edema (CME) or Irvine-Gass CME. Treatment was initiated which was prednisolone and an NSAID. He was brought back at 1 month but explained that this could take a few months to resolve. At 5 months this patient was back to 20/50 with some mild cystic edema.

Irvine-Gass occurs in 2.5% of phaco patients. You need to make sure it's not from something else. Other causes of CME include vein occlusions, diabetic macular edema, VMT, retinitis pigmentosa. To distinguish DME vs Irvine Gass FA would show a hyperfluorescent optic nerve.

Case 7 was a 71 year-old white male in for a glaucoma follow-up. IOP was 8/10. He complained of blur at near. OCT revealed one small druse. Under the PIL it appears there's an accumulation of something. This is Adult Vitelliform. This is an adult form of Best's disease, but much more mild. Most patients are asymptomatic. These patient's aren't very likely to get choroidal neovascularization. This is caused by an accumulation of waste product and lipofuscin.

Case 8 was a 56 year-old white male. He was 20/20 OD, OS and complained of his vision fluctuating from dry eye. OCT revealed a normal foveal pit OU, but elongated cystic spaces were observed. This is juvenile retinoschisis. Treatment was a carbonic anhydrase inhibitor but gave no benefit. This is an X-linked condition. It is difficult to diagnose funduscopically It can be an amblyopia masquerader. Variable layers can be affected and have a variable appearance.

Case 9 was a 58-year-old black male. His BCVA was 20/20 OD, 20/25 OS. He complained of blur at near. He had a normal anterior segment. In the fundus, the fovea had a dark, semicircular horseshoe pattern. The OCT revealed a normal foveal pit and a missing piece in the photoreceptor layer. This was Solar Maculopathy. ##########

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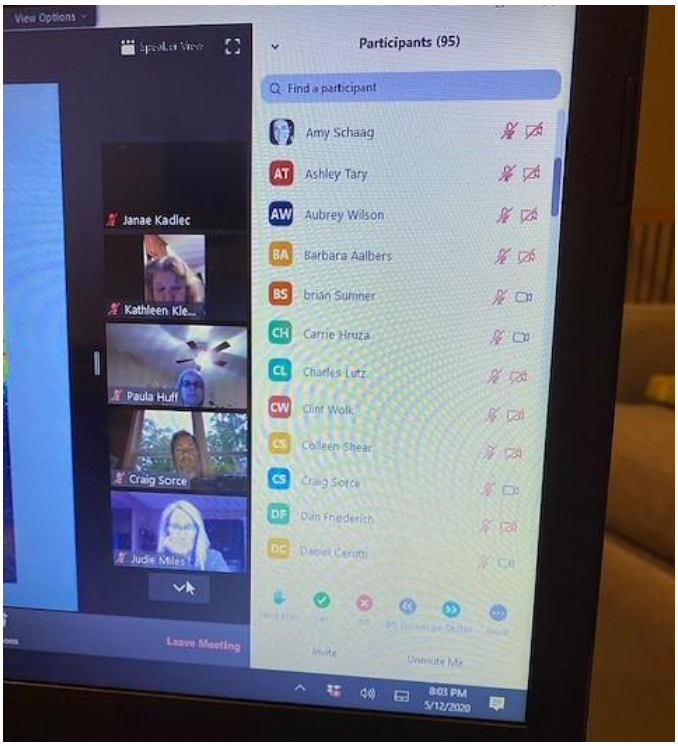

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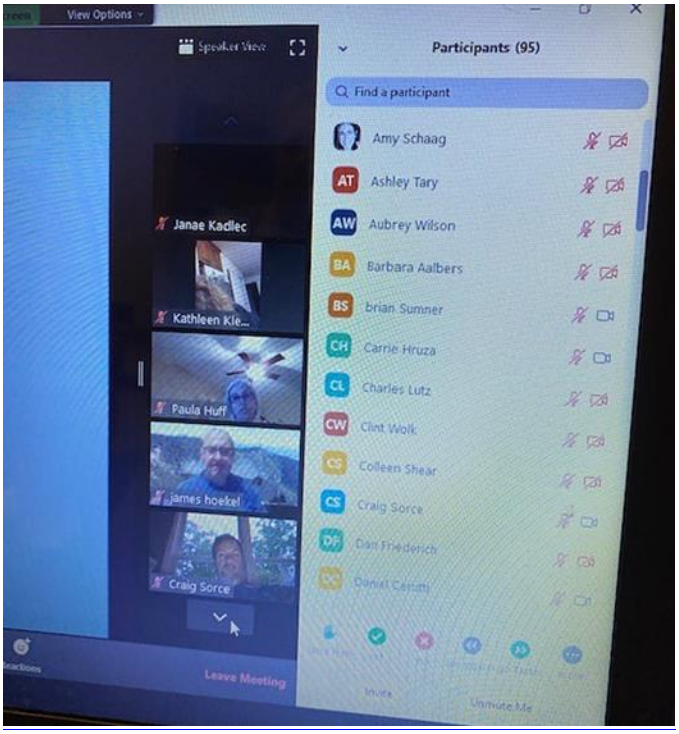

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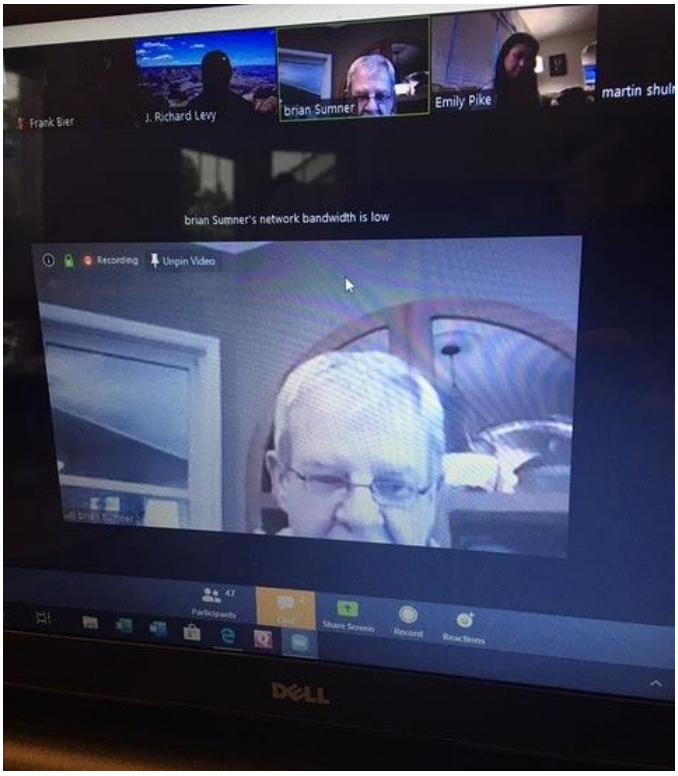

REGISTRATION FOR THE MOA ANNUAL CONFERENCE IS OPEN!!! Thank you to everyone that registered for convention so far and participated in the sponsored webinars. Next one hour webinar will be **May 21st** at 7:00pm sponsored by Neurolens. You will be receiving a link from me to register directly with Neurolens. This will also be a live streamed event and will count as live CE. The title of the lecture is Visually Induced Trigeminal Dysphoria May be the leading source of Headaches, Eyestrain and Dry Eye Sensation. Speakers are Carol Nelson MD and Jeff Krall OD.

You can still register for convention early and get this and the next webinar sponsored by MacuHealth in June for no additional cost. If you would like to purchase the one hour of CE without registering for convention you may do so, just email or call. The cost is $25.00.

Here are the links that take you to conference registration or the webinar registration:

https://www.moeyecare.org/AnnualConferenceAttendeeRegistration

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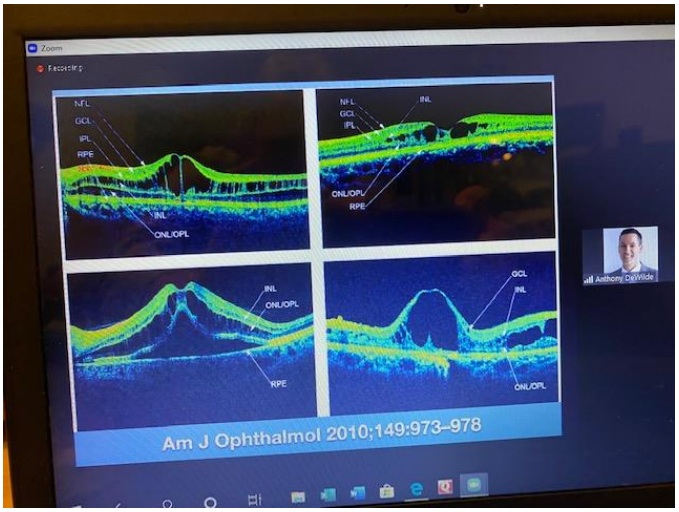

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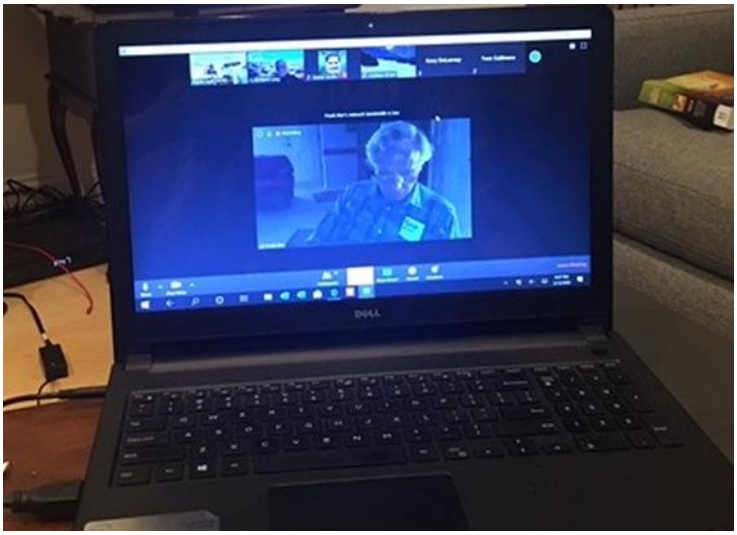

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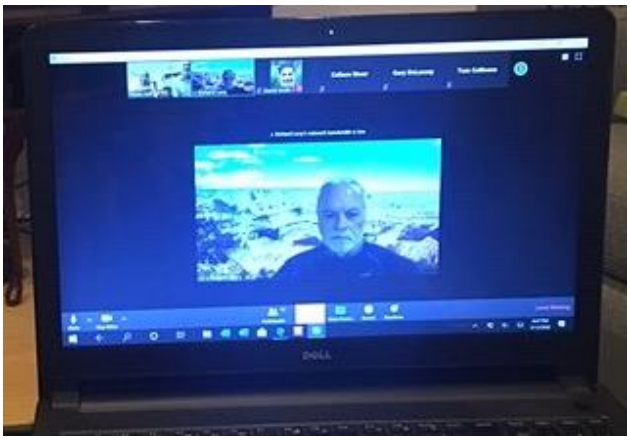

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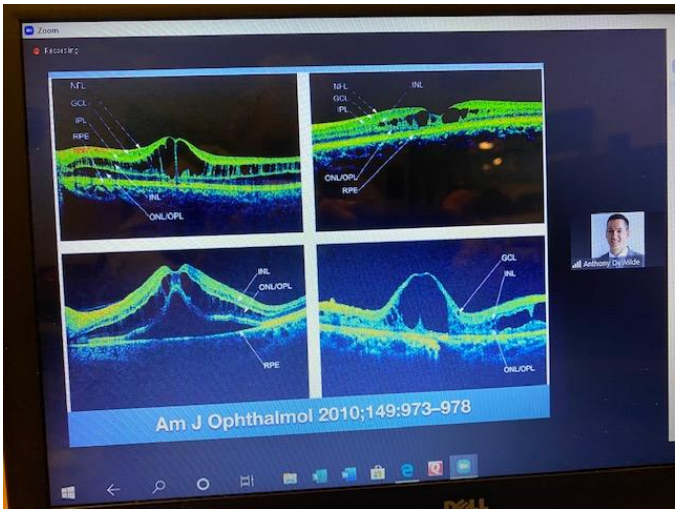

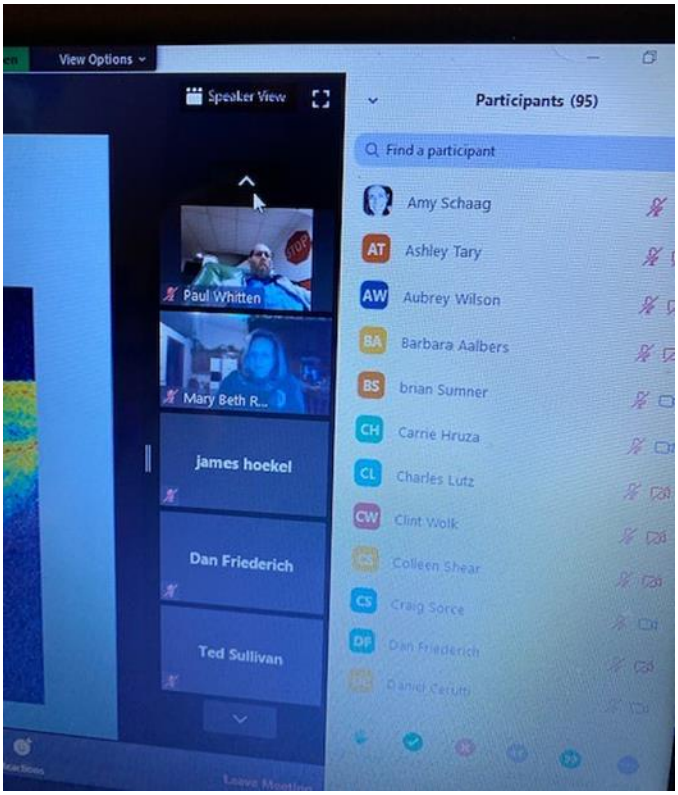

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UPCOMING EVENTS

NEXT MEETING

June 9, 2020 7:00 pm

Know Your Chances: An Evidence Based Approach to Clinical Decision Making

This course will give a better understanding of medical literature and reduce the confusion of medical statistics. By understanding the numbers and knowing the right questions to ask, the optometrist can use evidence-based medicine to make wiser, yet easier clinical decisions in medical Optometry

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The Nominating Committee consisting of:
Dr. Douglas Huff
Dr. Thomas Cullinane
Dr. Kathleen Noonan
Submitted the following slate of Officers that will serve from June 1, 2020 to May 31,2021.
A motion was made and seconded to except this slate of officers. A vote was taken and the motion carried.

Please welcome this years Officers:

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Dr. Paul Luong, President Elect
Dr. MaryBeth Rhomberg, Vice President
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