ANTERIOR SEGMENT
OCULAR PHOTOGRAPHY
GRAND ROUNDS

Cled T. Click, O.D.
Therapeutic Optometrist & Optometric Glaucoma Specialist
Amarillo, Texas

Optometric Physician
Clayton, New Mexico

Course Description:
This course presents a variety of ocular conditions found in Primary Care Optometry. Some are relatively rare, and some are fairly routine. When possible, the etiology, diagnosis and treatment options are presented. Medications and dosages are taken from either Wills Eye Manual (5th Edition), The Ocular Therapeutic Handbook or the Handbook of Ocular Disease Management.

Course Learning Objectives:
From a brief case history, examine an ocular photograph and make a diagnosis. Present etiology and treatment options. Hopefully, presentation and discussion of these conditions will help practitioners in their daily practice.

COMMERCIAL DISCLOSURE
• With few exceptions, the content of this course was prepared independently without input from members of the ophthalmic community.
• I have no direct financial or proprietary interest in any companies, products or services mentioned in this presentation.
• The content and format of this course may reflect commercial bias and may claim or imply superiority of a particular commercial product or service.

CPT 92285 – Photo Requirements
• The quality of the image should be of sufficient quality to be clinically relevant and graphically equivalent to a photograph.
• Images can be print, slide or digital.
• Polaroid film is no longer available.

What Can I Photograph?
Conjunctival problems
• Pinguecula, pterygium, FB, pigmentation, pannus, burns, etc.

Corneal problems
• Ulcers, abrasions, neovascularization, keratitis, tear film, etc.

Eyelid problems
• Ectropion, entropion, styne, hordeolum, ptosis, neoplasms, tumors, etc.

Eyelash problems
• Triachiasis, maderosis, bacterial infection, neoplasms, lice, tumors, etc.

Cataract problems
• Central cataracts easier to photograph

Glaucoma problems
• Gonioscopic photography

Pupil/Iris problems
• Coloboma, iritis, pigmentation, neovascular, trauma, etc.

WRITTEN INTERPRETATION & REPORT FORM
• (see end of notes for sample)

PHOTOGRAPHY RELEASE FORM
• (see end of notes for sample)
How to take QUALITY Anterior Segment Ocular Photos?

- Using DSLR equipment, kit lenses with supplemental lenses, dedicated macro lenses and proper lighting
- Significantly Improved Depth of Field
- Detailed information is a separate CE course.

GRAND ROUNDS

- Course Format
- Background information
- Examine photograph
- Diagnose abnormality
- Consider treatment/plan options

CASE #1

- 24 yo white female
- VA 20/20 correctable OU
- Cc: “I have a red spot on my right eye, and it has been there several weeks. I can feel it when I blink”.
- Problem slowly getting worse

Diagnosis?

- Large neovascular conjunctival cyst
- Treatment options?
- Referred to OMD (Ophthalmologist)
- OMD declined to surgically remove cyst
- Patient has never returned for further evaluation

CORNEA - Foreign Body

CASE #2

Diagnosis & Management

- Corneal Foreign Body - ICD9 930.0
- Etiology – high speed grinder, no eyewear
- Seidel test – NaFl
- Check upper & lower lids for retained FB

Treatment

- 1gtt Parcaine 0.5%
- 28 gauge insulin needle to remove FB
- Did not require Alger brush (no rust)
- Tobramycin 1gtt qid x 7 days
- Bacitracin ung for night time x 7 days
- RTC in 24 hours – then 1 week

Clinical Pearls

IF FB encroaches the visual axis

- BEFORE proceeding, counsel patients as to the potential loss of acuity due to unavoidable scarring
- DOCUMENT this conversation well for medical & legal reasons

What if you are unable to rule out the possibility of a penetrating ocular injury?

- Apply a SHIELD – NOT a PATCH
- DO NOT PRESSURE PATCH WHAT MAY BE A PENETRATING WOUND!!
- Refer the patient immediately to a nearby hospital or ophthalmology practice (preferred)

CASE #3

18 yo white female
VA 20/20 correctable OU
Cc: “My left eye hurts BAD, waters, is sensitive to light with eyelashes matted early in the morning. The eyelid is puffy, and it is scaring me.”
Onset: about 1 week ago, getting worse

Diagnosis?

Preseptal Cellulitis

Differentials

- Orbital cellulitis
- Proptosis, globe displacement, restricted ocular motility
- Necrotizing fascitis
- Chalazion / hordeolum
- Viral conjunctivitis w/eyelid swelling
- Cavernous sinus thrombosis
- Erysipelas (streptococcal cellulitis)

Preseptal Cellulitis vs Orbital Cellulitis

<table>
<thead>
<tr>
<th>Sign/symptom</th>
<th>Preseptal</th>
<th>Orbital</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lid edema (swelling)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Lid erythema (redness)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Pain</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Hx trauma or infection</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Proptosis</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Reduced vision</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Reduced motility/diplopia</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Fever</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Afferent papillary defect</td>
<td>No</td>
<td>Possible</td>
</tr>
</tbody>
</table>

Preseptal Cellulitis - Etiology

- Adjacent infection / trauma

Organisms

- Staph. Aureus & streptococci most common
- Haemophilus influenzae (unimmunized kids)
- Anerobes – if bad odor discharge
- Viral – if associated with skin rash

Preseptal Cellulitis - Rx

Antibiotic Therapy:

Broad-spectrum antibiotic possibilities:

- Augustin
- Amoxicillin/clavulanate 500mg p.o., q8h, or
- Children: 20-40mg/kg/day P.O. in 3 divided doses, OR
- Cefaclor (approx. 50% cost of Augmentin)
- Adult 250-500mg. p.o. q8h, or
- Children: 20-40mg/kg/day p.o. in 3 divided doses (max. 1g/day)
If penicillin/cephalosporin sensitive:
- Trimethoprim/sulfamethoxazole (Bactrim)
- **Children:**
  - 8-12 mg/kg/day trimethoprim, with
  - 20-60 mg/kg/day sulfamethoxazole p.o. in 2 divided doses
- **Adult:**
  - 160-320 mg trimethoprim, with 800-1600 mg sulfamethoxazole 1-2 double strength tablets, p.o. bid

**Note: oral antibiotics maintained 10 days!**
- If case is severe or pediatric refer for possible hospitalization with IV treatment
- Warm Compresses
- **IF** secondary conjunctivitis present
  - Polyvisor (Polymyxin B/bacitracin)
- **IF** sinusitis present
  - Nasal decongestants

**Presseptal Cellulitis - followup**
- Daily until clear & consistent improvement
- Every 2-7 days until totally resolved

**Presseptal Cellulitis**
**Plan for this case**
Patient referred to Ophthalmology because:
- Degree of patient’s immediate pain (moderate to severe)
- Easy access to Ophthalmology care
- Split-time practice with multiple offices
- Unable to follow on a daily basis

**Different Patient**
**Same condition – or is it?**
Hordeola

**Treatment Plan**
- Hot compresses 5-10 min. qid
- **CLINICAL PEARL**
- Use a hard boiled egg as heat source, or
- Boil small bag frozen corn or peas
- Holds heat a reasonably long time
- Keflex 500mg po qid x 10 days
- Reminder – hordeola CAN turn into preseptal cellulitis.

**CASE #4**
- 68 yo white male
- VA 20/20 correctable OU
- Cc: “My upper eyelid began swelling. Now it has a knot or lump in it, and it is painful to touch and hurts when I blink.”
- Onset: about 4 days ago, getting worse

**Diagnosis?**
- Hordeola / chalazion / meibomianitis

**- Hordeola (Internum) - Treatment**
- Diagnosis is made on a clinical basis.
- Tetracycline 250 mg qid p.o. x 3-4 weeks, or
- Doxycycline or minocycline 50-100 mg bid p.o. x 3-4 weeks
- **REMEMBER: NOT appropriate for children under 8 or in cases involving pregnancy**
- Warn about UV exposure
- Decreasing the doxycycline or minocycline to once a day (QD) over a period of months may help to control the condition
- After 3-4 weeks and not resolving...
  - Consider injection of Triamcinolone 0.2 – 1.0mL
  - 40 mg/mL usually mixed 1:1 with 2% lidocaine with epinephrine
- If still not resolving...
  - Consider referral for incision & curettage

**Triamcinolone Warning**
**Wills Eye Manual 5th Edition**
- “A steroid injection can lead to permanent depigmentation or atrophy of the skin at the injection site.”
- “The manufacturer of triamcinolone has recently recommended against its use **intraocularly** and in the **peri orbital region**.”
- “Vigorous injection can rarely result in retrograde intra-arterial injection with resultant central retinal artery occlusion.”
- “Use of triamcinolone injection for chalazion treatment must include a detailed discussion between physician and patient, as well as adequate documentation in the patient’s record.”
Triamcinolone (TA) Ophthalmic Uses

- Papillophlebitis and CME
- Diabetic macular edema
- Macular edema from CRVO
- Florid proliferative diabetic retinopathy
- Complications:
  - cases going back to 1982 creating CRAO

Triamcinolone (TA) vs Incision & Curettage (I&C)

Goldschleger Eye Institute
Sheba Medical Center
Tel Hashomer, Israel

American Journal of Ophthalmology
Published January 2011

- Randomized, clinical trial
- 94 patients
- “Complete resolution” defined 95-100% regression
- Tx considered failure if no resolution after 1st attempt I&C or TA injection.

Of 94 patients:
- 42 underwent I&C
- 52 underwent TA
- Complete resolution
  - 79% of I&C
  - 81% of TA
- P=.8, chi-square analysis

TA - Average time to resolution
- 5 days;
- 92% received single injection
- 8% two injections

TA - precipitates found in 11.5%
- Resolved spontaneously

No complications
- i.e. no eyelid depigmentation, no increased IOP, no loss of visual acuity

CONCLUSIONS
- Intralesional TA injection is AS EFFECTIVE as I&C in primary chalazia.
- Injection may be considered as an alternative FIRST-LINE treatment where diagnosis is straightforward and no biopsy is required.
- Another study indicated that TA worked well on chalazia <6mm in diameter but only about 50% as well on chalazia >6mm in diameter.
- PEARL? Consider referral for I&C on chalazia >6mm diameter?

CASE #5
- 16 yo Hispanic female
- Cc: SEVERE pain OD

- Admits to sleeping in CL for several DAYS after repeatedly being warned not to
- “Positive washcloth sign”
- Acute pain, photophobia, lacrimation, blepharospasm, foreign-body sensation, blurry vision and a history of contact lens abusive wear

Diagnosis
- Large corneal ULCER
- ICD9 370.03 corneal ulcer, central
- Corneal Disorder due to Contact Lens
- 371.82
- Raging endophthalmitis w/ total corneal ulcer!
- Immediate, urgent referral to Ophthalmology
- General Ophthalmology referred to Texas Tech Medical School – Dept. of Ophthalmology
- Considered enucleation!
- IV antibiotics saved the eye
- Complete scarring of cornea resulted
- Corneal transplant is only hope of salvaging VA

LEGAL CONSIDERATIONS
- DOCUMENT, DOCUMENT, DOCUMENT
  - What happened, when, how
  - CL instructions (recommended wearing schedule, replacement schedule, etc.)
- Know YOUR limits
  - ethically and medically
- Refer appropriately and timely, if needed
- If you get in over your head – hope you know your lawyer well.

CASE #6
- 58 yo white female
- Not particularly blurry vision
- Cc: Pain in scalp, forehead & around OS
- Onset: Gradual, getting worse, headache
- Never had anything hurt like this before
- Worried

Diagnosis?
- Herpes Zoster Dermatitis of Eyelid
- ICD9 053.20
- Dendrite present on eye?
- If Herpes Simplex – NO STEROIDS!!
- HZ causes up to 13% of facial palsies.
- Caucasian 400% more likely to have HZV

IF it is HZO - Treatment
- ORAL antiviral agents are mandatory
- Antiviral drugs for at least 7 days
- Best if started within 48-72 hours of the rash
1. Acyclovir 800 mg p.o. 5 times per day, or
2. Famiclovir 500 mg p.o. tid, or
3. Valacyclovir 1000 mg p.o. tid
   • Reduce dosage in patients with renal insufficiency.
   • Erythromycin or bacitracin ointment bid for 1 - 2 weeks for prophylaxis
   • Warm compresses
   • Burrow's solution 5% aluminum acetate tid-qid for skin lesions
   • Skin lesions often heal within 4 weeks

Note: There is no role for TOPICAL antiviral drugs in the management of herpes zoster

• Topical Viroptic (trifluridine) or Zirgan (ganciclovir gel) are appropriate for Herpes Simplex

CASE #7
• VA usually not affected
• Cc: Panicked - "Doc, I think my eye is bleeding"
• Onset: Sudden, may be getting worse
• Tried Visine, but it burned like fire

Diagnosis?
• Subconjunctival Hemorrhage
  o (hyposphagma) ICD9 372.72
• Record Facts – when, where, what happened
• Record VA – with & w/o Rx (if applicable)
• Has it happened before?

Sub-Conj. Hemorrhage Treatment
• Usually non-emergency
• DON'T "trivialize" condition
• Express concern, palliative support, reassurance
• No meds required
• Analgesics, ocular astringents, cool compresses, and lubricants may help
• Typically resolve in a few days
• Ask if they are on blood thinners
• Advise NO use of Aspirin
• IF problem persists or frequently reoccurs refer appropriately for medical workup
• Use ocular antibiotics ONLY if bacterial conjunctivitis accompanies presentation

Sub-Conj. Hemorrhage
CAUTION – WARNING!
• Subconjunctival hemorrhage is the HALLMARK sign of AHC – acute hemorrhagic conjunctivitis
• Cornea may show a fine punctuate epithelial keratitis with mild subepithelial infiltrate similar to an adenosinal infection
• EXTREMELY CONTAGIOUS
• 1-2 day incubation period
• Quarantine patient for 7-10 days

• Self-limiting viral disease

CASE #8
• 69 yo white male
• VA variable - getting worse
• Cc: "My eyes feel really dry, hurts and my right eye gets very tired when blinking".
• Onset: Gradual, but getting worse
• OTC lubricants give little relief

Diagnosis?
• Symblepharon ICD9 372.63
• An attachment between the palpebral conjunctiva and bulbar conjunctiva
• Frequently associated with OCULAR CICATRICAL PEMPHIGOID ICD9 694.61
• Ultimately ocular surface keratinization occurs secondary to severe dry eye syndrome

OCP - Background
• Occurs at an incidence of 1:12,000 - 60,000
• Occurs twice as frequently in women
• Usually occurs in patients older than 55
• 25 to 30% of affected individuals ultimately become BLIND

OCP – Clinical signs
• Stage 1 - Fibrosis of palpebral conjunctiva, conjunctivitis, keratitis
• Stage 2 - Conjunctival shrinkage with fornix foreshortening
• Stage 3 - Symblepharon, lagophthalmos, entropion, trichiasis, keratopathy
• Stage 4 - Ankyloblepharon and severe dry eye syndrome
• Other signs may include stenosis, distichiasis, blepharitis, keratitis, corneal perforation, and endophthalmitis

OCP – Treatment
• Therapy for associated dry eye syndrome, keratitis, meibomianitis, blepharitis, trichiasis, and distichiasis
• Ocular lubricants, punctal occlusion, warm compresses, lid hygiene, systemic and/or ophthalmic antibiotics, and trichiasis/distichiasis epilation may help
• Refer to OMD, as needed

SOME CATARACTS CAN BE PHOTODOCUMENTED

CASE #9
• 57 yo male
• VA – mostly age related visual changes.
• Cc: “My eyes feel swollen and my eyelids feel tired. No pain. I can see a little bump on the side of my eye.”
• Onset: Gradually getting worse… over a period of years.
• Nothing seems to help.

Diagnosis?
• Herneated Orbital Fat
• ICD9 374.34 (fat pad)
• Differentiate between herneated orbital fat and dermolipomas
• (limbal dermoids)
• Usually occurs in ADULTS
• Due to acquired weakening of Tenon’s capsule by:
  o Aging
  o Trauma
  o Surgery

CLINICAL SIGNS
• Yellow / pink, soft, mobile mass
• Can be indented with cotton-tip applicator
• Convex anterior border
• Appears larger with pressure on globe
• More common in males
• Average onset age 65

Herneated Orbital Fat & Lipomas
• Are NOT choristomas
• Lipomas of orbital fat are primary tumors
• Excision is indicated and pathology evaluation is necessary – malignant?

Dermolipoma
CLINICAL SIGNS
• Soft, pinkish-white or pinkish-yellow
• Non-mobile mass
• May have fine hairs on surface
• Cannot be indented with cotton-tip swab

Dermolipoma
CLINICAL SIGNS
• Does NOT change in size with pressure on globe
• Anterior border generally straight or slightly concave.
• Is a congenital lesion
• Demonstrates no sexual preference
• More common in younger ages

Dermolipoma
• The Classic “limbal dermoid”
• Often cause functional problems
  o astigmatism, FB sensation and dellen
• Ambloplia possible

• Can leave significant corneal stromal scarring
• Clinical association with Goldenhar’s syndrome

Dermolipomas and lipoderoids
• ARE choristomas composed of both ectodermal and mesodermal elements
• The most common peribulbar tumors of childhood

PLAN
• Refer to OMD
• Monitor thereafter

CASE #10
• 26 yo white female
• Cc: “A few weeks ago I saw a white spot on my right eye that hadn’t been there before. It doesn’t hurt, but I’m concerned.”
• VA – 20/25+ corrected… wears soft contact lenses… denies overwearing
• Onset: Acute, now going on 3 weeks
• Hx: recently visited family in Arkansas
• Admits being in places that didn’t seem sanitary (wash rooms, farm buildings)
• Not sure about contact with vegetative material to the eye
• Site only MILDLY stains with NaFl
• No pain, no discharge, no crusting or matting of lids or lashes

Diagnosis?
• Initial thought – “fungal keratitis”
• Remember 2006?
• CDC Fusarium keratitis outbreak
• 130 cases
• 60% B&L Renu w/Moisturelock
• What happened with the other 40%?
• What about cases no CL wear at all?
• Nearly impossible to differentiate bacterial keratitis from fungal keratitis on clinical judgment alone.
• History of vegetative injury NOT necessary to develop fungal keratitis!

Treatment?
• Natamycin (Pimaricin)1gtt q2h during waking hours for 48 hours, then 1gtt 8 times a day for 5 days
• REMINDER: Natamycin is the ONLY FDA approved topical ophthalmic product for fungal infections.
• All other antifungal medications must be adapted for ophthalmic use from systemic drugs = considerable ophthalmic toxicity.
• ADDITIONAL Rx of Zymar (Gatifloxacin 0.3%) 1gtt q2h during waking hours - not to exceed 8 times a day x 48 hours
• then 1gtt qid x 5 days and RTC in 24 hours for follow-up
• Why? – in case it isn’t fungal but bacterial
• NO STEROIDS…. why?
• Will exacerbate (worsen) the disease

NEXT DAY (24 hours) - No change

Treatment Plan – (cont.)
• No change… looks the SAME
• Add ORAL fungal med
• Why?… because topical Natamycin is not particularly good at corneal penetration
• Added Ketoconazole 200mg PO bid x 30 days
  o systemic fungal medication
  o Avoid antacids for 2 hours after taking medication and avoid alcohol completely
• RTC in one week

One week follow-up
• No change… looks the SAME
• No NaFl staining of site
• Continue use of Natamycin until bottle is empty
• Continue Ketoconazole
  o Remind patient to avoid antacids for 2 hours after taking medication and avoid alcohol completely
• RTC in two weeks

One month follow-up
• No change… STILL looks the SAME
• VA still good at 20/25+
• No NaFl staining of site
• Continue use of Natamycin until bottle is empty
• Discontinue Ketoconazole
• RTC in one month

Two month follow-up
• No change… STILL looks the SAME
• VA remains 20/25+
• No NaFl staining of site
• Discontinue all meds and monitor
• Advised patient to call or report ANY change
• RTC in another month

Revised Diagnosis?
• Large sterile infiltrate – ICD9 code?
  o No code exists for corneal infiltrate!
• To report this diagnosis, choose between one of the following two codes:
  o Corneal Opacity, Peripheral – 371.02
  o Corneal Opacity, Central – 371.03

Diagnosis & Plan
• Large sterile infiltrate – ICD9 371.03
• Patient says no new signs/symptoms have developed since last visit – no problems
• Requires no continued medication
• Dismiss patient
• Monitor annually or sooner if problem

What do FUNGAL infections and ulcers look like on the cornea?
Let’s see some examples...

CASE #11
• 32 yo Hispanic female
• Cc: severe pain OD after multiple attempts to remove soft contact lens
• “Positive washcloth sign”
• Acute pain, photophobia, lacrimation, blepharospasm, foreign-body sensation, blurry vision and a history of contact lens wear
• Thinks maybe she lost her right SCL
• Wants to know if CL is still in eye
• Doesn’t speak any English
• Rx +6.00 SPH OU
• VA OD 20/400- OS 20/25

Diagnosis?
• Large corneal abrasion (self inflicted)
• ICD9 918.1 corneal abrasion

MEDICAL TREATMENT
• Adequate cyclogepia
• Topical antibiotic (your choice)
• Pain Management
• Monitor

Treatment Plan
• Cycloplegic (preferably long lasting)
• 1gtt q2h to qid initially; tid or bid later
  o (manage ciliary spasm pain)
• Zymar (gatifloxacin 0.3%) – 1gtt qid x 7 days
• or any 4th generation fluoroquinolone
  o Reminder – DO NOT TAPER 4th generation fluoroquinolones

PAIN MANAGEMENT
• OTC – acetaminophen 400mg, up to qid
• OTC – ibuprofen 400mg, up to qid
  o Note: combination of these two OTC has analgesic effect similar to TYLENOL III w/codeine but w/o drowsy effect! (Source: Jill Autry, OD, RPH)
• If severe pain, topical NSAID
  o (such as Voltaren or Acular)
• Consider thin, low water bandage SCL
MEDICAL TREATMENT
- Pressure patch no longer standard of care
- Study of 18 patched, 17 non-patched
- No significant difference in results
- AVOID pressure patching most CL prob.
  - Threat of microbial keratitis
  - Bacteria loves warm, dark, moist places

CASE #12
- Almost any age, predominately female
- Cc: I have to clean my CL frequently, and very soon they are “dirty” again
- Usually deny overwearing, but purchase records frequently contradict that claim
- Often admit to having “oily” skin
- VA variable

Diagnosis?
- Protein deposits on CL surface
- Primarily front surface soft CL
- Both surfaces, RGP and PMMA

Treatment Plan
- Good hygiene
- Change solutions?
- Lens cleaners?
- More frequent change of lenses?
- Change type of lens?
- Don’t forget to evaluate blink pattern!

“False or Incomplete” blink
- Common problem with RGP/PMMA
- Washes debris to upper/lower 1/3 of lens
- More common in high-water hydrogels
- Silicone hydrogels tend to accumulate protein the least, but accumulate lipids more

Other deposit causes
- Tear film potassium deficiency
- High fat diets
- High alcohol consumption

Treatment Plan
- Remind patient to blink completely
- Rub and rinse CL
- Completely change soaking solution daily
  - No “topping off” of case
- Use alcohol-based cleaner
  - (dissolves lipids better)
- Change lenses more frequently?
- Change lens type?

CASE #13
- 16 yo white female
- Cc: OD intermittent ocular irritation
- No Hx of ocular injury or allergy
- VA – normal 20/20 OU corrected
- Wants to know IF she can wear CL

Diagnosis
- Dermoid Conjunctival Cyst ICD9  224.3
- Hair growing out of large temporal dermoid cyst
- Hair is LONG and moves with blink
- After more questioning discovered this patient also had a tooth grow in the roof of her mouth!

Treatment
- Option 1 – epilate hair (it WILL grow back)
- Option 2 – refer for electrical current or radio wave treatment of hair root
- Chose option #2, referred to local OMD
- Denied patient’s request for CL

AFTER 6 MONTHS

Treatment (cont.)
- OMD eiplated and did NOT kill hair root!
- The hair DID grow back and has been removed again
- Recommend patient see different doctor and have hair root killed
- Due to size/location of dermoid cyst & hair regrowth still NO CL for this patient

Treatment (Update)
- Saw different OMD and had hair follicle killed by electrolysis
- Still wants soft CL
- After careful consultation and warnings, patient was successfully fitted with SCL.
- BTW (by the way)... Rx? -0.75 SPH OU!
- Lesson? Never underestimate a patient’s desire to wear CL! (or dislike of glasses)

CASE #14
- 33 yo Hispanic female
- Cc: “my left upper eyelid looks strange”
- No Hx of ocular injury
- VA – normal 20/20 OU corrected

Diagnosis
- Vitiligo - Eyelid hypopigmentation ICD9 374.53
- Associated with:
  - Graves’ Disease
  - Granulomatous uveitis
  - Sympathetic ophthalmia
  - V-H-K syndrome (Vogt-Koyanagi-Harada)
- No treatment necessary
- Rule out associations listed above
CASE #15 – skin lesions
A variety of eyelid and facial lesions
- Warts
- Tag warts
- Neoplasms

Skin Lesions - Treatment
- Most of these lesions are benign
- Be watchful for possible cancerous conditions (not only around eyes but on face/ears/neck)
  - Rough surface texture
  - Darkened irregular perimeter
  - Bleeding
  - Scaling
  - Recurrence of formerly treated area
- Refer appropriately and timely

CASE #16
- Older patients – male or female
- “Doc, can anything be done about the large bags under my eyes?”
- What are the “large bags” called in dermatology?
- Answer: FESTOONS
- Let’s look at some before/after photos

Be a “HERO”
- Watch for opportunities to help your patients beyond “vision care”.
- Become a good referral source for Dermatology and Oculoplastic Surgery.
  - Especially: Ptosis, Blepharochalasis, Festoons, Warts, Tag Warts, Neoplasms

UNUSUAL CASE #17
- 65 yo white male
- Cc: “routine exam, maybe dist. blurry”
- Hx of ocular injury w/o loss of VA
- Denies ocular allergies
- VA – 20/20 OU corrected

Diagnosis?
- Blue spot trapped in lower eyelid
  - shotgun pellet
- Gray spots trapped in iris & corneal stroma
  - gunpowder!
- Has been there MANY years w/o discomfort
- No treatment required
- Photodocument and note in patient’s chart
EXTERNAL OCULAR PHOTOGRAPHY
Interpretation and Report

Patient Name ________________________________________________ Date __/__/____

INDICATIONS FOR TESTING

☐ Symptoms _____________________________________________________

☐ Suspected Disease ______________________________________________

☐ Chronic Disease ________________________________________________

TEST ORDERED - 92285

TEST FORMAT TEST RELIABILITY

☐ Right Eye ☐ Photographs ☐ Good

☐ Left Eye ☐ Digital Image ☐ Bad

TEST RESULTS

☐ Anisocoria ☐ Corneal Opacity ☐ Keratitis

☐ Chalazion ☐ Corneal Ulcer ☐ Pinguecula

☐ Conjunctival Cysts ☐ Ecchymosis ☐ Pterygium

☐ Conjunctival Hemorrhage ☐ Entropion ☐ Ptosis

☐ Conjunctival Pigmentation ☐ Ectropion ☐ Trichiasis

☐ Corneal Neovascularization ☐ Foreign Body ☐ Other

☐ Corneal Ulcer ☐ Hordeolum

Baseline Study   Yes / No

Comparative Data

________________________________________________________________________________

Narrative

________________________________________________________________________________

________________________________________________________________________________

RELEVANT CLINICAL ISSUES

Initiate Treatment Yes / No

Change Treatment Yes / No

REFERRAL Yes / No If yes, to whom ________________________________________________

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ADULT

☐ General Use  ☐ Photo-document physical condition

☐ Specific Project ________________________________________________

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Signature: ________________________ Date: _________

Witness: _________________________ Date: _________

MINOR CHILD

☐ General Use  ☐ Photo-document physical condition

☐ Specific Project ________________________________________________

I, (print full name) ____________________________________________, hereby grant permission to Dr. Cled T. Click and his affiliates (if any), to interview, photograph, and/or video me; and/or to supervise any others who may do the interview, photography, and/or video; and/or to use and/or permit others to use information from the aforementioned interview and/or the aforementioned images in educational and/or promotional activities without compensation.

Signature: ________________________ Date: _________

Witness: _________________________ Date: _________
Anterior Segment Grand Rounds – Crossword Puzzle

Across:
2 - Name of 5% aluminum acetate to relieve pain from skin lesions related to herpes zoster ophthalmicus
4 - Most warts, tag warts and neoplasms around the eye are this condition (malignant or benign)?
8 - Oral antiviral meds should be reduced for patients with what kind of insufficiency?
10 - Name of primary NaFl test for corneal penetration
12 - Type of conjunctivitis for which subconjunctival hemorrhage is a HALLMARK sign (two words)
14 - Trade name of topical ganciclovir gel drug that is appropriate for Herpes Simplex
15 - Type of conjunctivitis that may require ocular antibiotics when it accompanies a subconjunctival hemorrhage

Down:
1 - Causes up to 13% of facial palsies (two words)
3 - Type medication that is inappropriate for children under age 8 and in cases involving pregnancy.
5 - Type of keratitis usually associated with vegetative matter
6 - Ethnicity 400% most likely to have Herpes Zoster Virus
7 - Type corneal injury which should NEVER be pressure patched
9 - One primary source for contaminating contact lenses (two words).
10 – Skin attachment between palpebral and bulbar conjunctiva
11 - Type cover TO use when suspecting possibility of a penetrating ocular injury
13 - What you should ethically and medically do when you reach your limit of knowledge
ACROSS:

16 - Trade name of trifluoridine used to treat herpes simplex
18 - Common temporary procedure for removal of rogue hair/eyelashes.
21 - When to use oral antiviral meds with Herpes Zoster Ophthalmic (HZO)
23 - Acronym for possible serious sight threatening complication from injecting Triamcinolone into hordeola.
24 - Class of medication that should be avoided with Herpes Simplex on the eye
26 - Type of orbital fat that can result in a large smooth pink mass with a convex anterior border on the exterior of the eye that appears LARGER with pressure on the globe
27 - Another name for Natamycin
31 - Type cover NOT to use when suspecting possibility of penetrating ocular injury (two words)
33 - Type of cellulitis with puffy, swollen eyelids with significant discharge and extreme tenderness to the touch
35 - Type of antiviral drug that has no role in the management of herpes zoster
37 - What action (or lack thereof) causes debris to be washed only partially off contact lenses resulting in bands of debris across the lens surface? (two words)
39 - Type fungal medication often added because topical Natamycin is not particularly good at corneal penetration
40 - Name of syndrome associated with conjunctival dermoid (dermolipomas)
42 - Acute infection of Zeiss gland or abscess of Meibomian gland
44 - Type cellulitis which might have an afferent pupillary defect
46 - Socially, what you should do with acute hemorrhagic contagious conjunctivitis patient
48 - Type egg that can be used as heat source for hot compresses (two words)
49 - Eyelid hypopigmentation requiring no medication
51 - Acronym for class of topical drugs used to help manage severe ocular pain (examples: Voltaren and Acular)
52 - Type of debris silicone hydrogel soft contact lenses ten to accumulate the LEAST
53 - Type of soft pinkish-white non-mobile mass on the exterior of the eye with a straight or concave border that does NOT change in size with pressure on the globe

DOWN:

15 - Better disinfectant for ophthalmic tools & equipment - alcohol or diluted bleach
17 - Name of injectable drug commonly used to help dissolve hordeola whose manufacturer recently advised AGAINST its use intraocularly and in the periocular region
19 - Common drug of choice for preseptal cellulitis
20 - The only FDA approved topical ophthalmic med for fungal keratitis
22 - Source of ocular pain usually involving extreme photophobia
23 - Type drug used to manage pain from ciliary spasm
25 - Minimum number of days ORAL antiviral drugs should be prescribed
27 - Type support needed for subconjunctival hemorrhage
28 - Key corneal sign indicating probable/possible herpes simplex
29 - Name of billable procedure to best document the physical condition of the eye and adnexa
30 - Class of antibiotic medication which should NOT be tapered
32 - OTC drug to avoid with subconjunctival hemorrhage
34 - Hard knot in eyelid involving sebaceous gland of cilia (Moll or Zeiss)
36 - Your best defense if sued regarding what you did or recommended for your patient's care
38 - Minimum number of days oral antibiotics are to be used once initiated.
41 - Type contact lens cleaner best for dissolving lipids.
43 - Class of drug to avoid using for fungal infections because it will make the condition worse
45 - 20-30% of patients with ocular cicatricial pemphigoid result in this catastrophic visual outcome
47 - Beverage type to avoid completely when taking oral medications for fungal infections
50 - Type debris silicone hydrogel soft contact lenses tends to accumulate the MOST