Have You Sent Out Your Glaucoma HEDIS Letters to PCPs?

http://www.eyelessons.com/letters-brochures/item/glaucoma-letter-to-gps


Have You Sent Out Your Diabetes HEDIS Letters to PCPs?


LET’S HAVE SOME FUN AND LEARN A FEW TAKE-HOMES

- eyelessons.com
- Free....just register
- No sponsors
- Downloadable Articles
- Downloadable Letters
- Downloadable PPTs
- Downloadable Cases
Thursday August 8, 2013 ... From S. Africa... This is all I got...

Larry What is this and what do I do with it?

51 YO F

- CC VISION CLOUDY BUT DOESN'T BOTHER HER UNLESS SHE COVERS OD
- BCVA 20/20 OU
- AG EDGES BLURRED OS AS IF LOOKING THROUGH SOMEONE’S HAND
- RED CAP OS LIKE LOOKING THROUGH A VEIL
- RETINAS APPEAR FINE
- PLEASE REVIEW SCANS
OKAY DOCTORS, TELL ME YOUR OPINION AND WHAT YOU WOULD DO?

I ASKED FOR ALL TESTING THAT HAD BEEN PERFORMED INCLUDING FUNDUS PHOTOS AND VISUAL FIELDS.

I WAS TOLD FUNDUS WAS FINE BUT I SAID JUST INDULGE THIS OLD MAN.

LET’S LOOK AT OD AND OS AT THE SAME TIME.

DO YOU NOTICE ANYTHING NOW?
HERE IS THE “VISUAL FIELD”

WHAT WOULD A REAL VISUAL FIELD SHOW?

THIS WOULD HAVE BEEN TOTALLY MISSED WITHOUT A SCAN.

WHAT DO YOU WANT TO DO NOW?

CASE

• 33 YO WHITE MALE
• BCVA 20/20 O.U.
• NO COMPLAINTS

THE BASIS OF THE EYE EXAM

ASSESSMENT

• YOUNG MAN
• VISION AT 20/20
• SYMMETRY

• TORTUOUS VEINS AND TORTUOUS ARTERIES WITH SYMMETRY = CONGENITAL
• HOWEVER, ENGORGED VEINS = BLOOD ISSUE
EMPLOYING SPECTRAL DOMAIN OCT TECHNOLOGY

What is Going On in These Scans?

THIS APPEARS TO BE FAT IN THE BLOOD VESSELS

HIS TRIGLYCERIDE (ONE OF THE FATS IN THE BLOOD) LEVEL WAS 13,000. IT IS SUPPOSED TO BE 150!

THIS FAT IS ALSO IN THE BLOOD VESSELS OF THE HEART AND BRAIN

ANOTHER LIFE SAVED BY SDOCT
ASSESSMENT

- YOUNG
- VISION AT 20/20
- SYMMETRY OF ANATOMY BUT ENGORGED VEINS

- HAS TO BE BLOOD DISORDER...HYPERTRIGLYCERIDEMIA/LIPEMIA RETINALIS

THIS WOULD HAVE BEEN TOTALLY MISSED WITHOUT A SCAN

CASE

- 72 YO HX DRY ARM
- BCVA 1.25 OD AND 1.25 OS WITH +4.00D CORRECTION
- NOTED FOLDS IN RETINA ON PHOTOS

2013-16 CASE OF THE WEEK
FOLDS IN THE RETINA

Ingebret Mojord, MSc FAAO
EYELESSONS.com 2013

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"WAVY LINES"

**ANALYSIS**

- FOLDS IN RETINA AND CHOROID
- HIGH HYPEROPIA
- BILATERAL AND RELATIVELY SYMMETRICAL USUALLY EQUATES TO CONGENITAL VARIATION
- NO REDUCTION IN VISION
- NO OTHER SIGNS OR SYMPTOMS

**CONSIDER**

- CHORIORETINAL FOLDS-BILATERAL AND SYMMETRICAL
- FOR MORE INFORMATION GO TO http://www.revophth.com/content/d/retinal_insider/i/1299/c/25010/ FOR AN EXCELLENT CLINICAL REVIEW
- MORE OFTEN IDIOPATHIC BUT MAY BE ASSOCIATED WITH TUMORS, HYPOTONY INFLAMMATION, PAPILLEDEMA
A REAL CHALLENGE ..YOU CAN HAVE TWO THINGS AT THE SAME TIME

Jason M. Paist, OD
Limerick Eye Associates
EYELESSONS.com 2013
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52 YO

• CC: BLURRED VISION AT NEAR, RECENT HEADACHES HERE OR THERE BUT NOTHING OUT OF ORDINARY
• CURRENTLY WEARS OTC FOR READING
• REVIEW OF SYSTEMS WAS UNREMARKABLE
• NO REPORTED MEDICATIONS OR ALLERGY TO MEDICATIONS
• PAST HX OF METALLIC FOREIGN BODY INJURIES

• UNCORRECTED VA 20/30-1 OD AND 20/20-1 OS
• VISUAL FIELD WAS FULL IN ALL QUADRANTS OU TO FINGER COUNT
• NO APD WAS NOTED
• EOMS FULL AND INTACT
• COLOR VISION WAS NORMAL
• REFRACTION +0.50-0.75 X 100 OD 20/25+1 OD
• OS +0.75-0.75 X 076 20/20 OS ADD +1.75 OU
• WORTH 4 DOT TESTING WAS NORMAL

• SLIT LAMP EXAM WAS UNREMARKABLE EXCEPT FOR EPITHELIAL BASEMENT MEMBRANE DYSTROPHY SUPERIOR OS
• IOP 15 OU AT 3:16 PM
• DILATED EXAM SHOWED HEALTHY FUNDI
• C/D OD 0.15/0.15 WITH MILD TEMPORAL PALLOR OS 0.15/0.15, NO NOTICIBLE PALLOR

FOLLOW UP DX TESTING ONE WEEK LATER

• ACUITIES REMAIN THE SAME IN EACH EYE
• IOP 14 OU 9:54 AM
• 24-2 SHOWS A NASAL STEP OD AND ARCUATE DEFECT INFERIOR ALONG WITH A NASAL STEP OS
• OCT TESTING SHOWS REDUCED NFL AND GCC, NOTE THE INTER AND INTRA ASYMMETRY ON GCC AND INTER ASYMMETRY ON NFL
• OCT OF RETINAS WERE NORMAL OU
• REFERRAL MADE TO LOCAL NEURO-OMD

MORE PALLOR OD THAN OS

FUNDUS O.U.
WHAT AREAS CAN CAUSE PALLOR?

SDOCT ADDS A SIGNIFICANT AMOUNT TO THE DIAGNOSIS

OCT NFL PRE-NDB

NOTE SIGNIFICANT ASYMMETRY

OCT GCC-PRE-NDB

NOTE SIGNIFICANT ASYMMETRY

OCT RETINA OD
OCT RETINA OS

DISPOSITION

NEURO-OMD ORDERS MRI WHICH REVEALS:
1. LEFT PARIETAL WHITE MATTER LESION SUSPICIOUS FOR A DEMYELINATING PLAQUE.
2. PITUITARY ADENOMA CAUSING MILD PITUITARY INFUNDIBULAR DEVIATION TO THE RIGHT.

PATIENT HAD SURGERY ON 05/23/13. HE STATES THAT HE HAS LOST 10 LBS. NEUROSURGEON NOT CONCERNED ABOUT MS.

RTO IN NEXT FEW WEEKS FOR VEP/PERG-CONTRAST.

VEP ONE MONTH PO

pERG ONE MONTH PO

OCT NFL OD ONE MONTH PO

REVEALING STABILITY
56 YO

- COMPLAINS OF MILD DECR VA
- IOP 15/16
- FAILED FDT
- ANGLES 20-23 DEGREES WITH SLIGHT NARROWING NASALLY
- BCVA 20/25 OU

Caveat: When using any guidelines one must consider correlation with other patient characteristics and other clinical tests such as but not limited to: chief complaint, age, gender, ethnicity, refractive status, family history, associated medical conditions, current medications, pachymetry, visual field testing, angle assessment.

The following caveat could not be better illustrated than by this case. The clinician must pursue all avenues to generate a diagnosis but in this case it all started with the observation of disc pallor asymmetry.
SO WHAT’S UP???

- GLAUCOMA
- NA-AION
- SUB ACUTE ANGLE CLOSURE
- NOTHING
SYM-METRIX™....Ocular Disease from a Different Direction

"We tend to see what we expect to see or what we decide we have seen." - Edwards

DO YOU LOOK

BUT NOT SEE

IS THERE SOMETHING WRONG WITH THIS KID?

HOW DO YOU KNOW?
YOU LOOK FOR BALANCE IN LIFE

THE OPTIC NERVE AND ASYMMETRY

IS OD A MIRROR IMAGE OF OS?

HEMI-STRUCTURE

DISEASE IS OFTEN MANIFESTED AS INTER-EYE AND INTRA-EYE STRUCTURAL ASYMMETRY

INTRA USUALLY REFERS TO ASYMMETRY OF THE SUPERIOR DISC AND THE INFERIOR DISC AND INTER REFERS TO BETWEEN THE EYES

Example of a Congenital Optic Pit in the Right Eye and the Left Eye With a Difference in Disc Sizes. There is Inter- and Intra-Disc Structure Variation.

Example of An Acquired Variation-Glaucomatous Optic Neuropathy in the Left Eye More Advanced Than the Right Eye. Note The Inferior Notch OS. There is Inter- and Intra-Disc Structure Variation.

HEMI-STRUCTURE

INTER-EYE AND INTRA-EYE STRUCTURAL ASYMMETRY
ALSO MANIFESTS IN DIGITAL IMAGE AND VISUAL FIELD TESTING

DISC SIZE DIFFERENCE IS A GREAT INDICATOR OF A CONGENITAL VARIATION BUT CAN ALSO INDICATE DISEASE..

LOOK AT THE CONTEXT...OS IS PROPTOTIC

IS OD A MIRROR IMAGE OF OS?

THE RETINA AND INTER-EYE ASYMMETRY

IS OD A MIRROR IMAGE OF OS?

THE RETINA AND INTER-EYE ASYMMETRY

IS OD A MIRROR IMAGE OF OS?

RETNAL SYMMETRY IS A GREAT INDICATOR OF A CONGENITAL VARIATION OR DYSTROPHY

IS OD A MIRROR IMAGE OF OS?
Retinal symmetry is a great indicator of a congenital variation or dystrophy. Is OD a mirror image of OS?

Retinal asymmetry is a great indicator of acquired disease. Radiation retinopathy. Is OD a mirror image of OS?

Retinal asymmetry is a great indicator of acquired disease. Ocular ischemic syndrome. Is OD a mirror image of OS?

Retinal asymmetry is a great indicator of acquired disease. Ocular ischemic syndrome. Is superior a mirror image of inferior?
THE RETINA AND INTRA-EYE ASYMMETRY

WHAT IS THE FIRST QUESTION YOU MUST ASK?

STANDARD TELEMEDICINE QUESTION.. WHAT IS THIS AND WHAT DO I DO WITH IT?

IS OD A MIRROR IMAGE OF OS?

IS SUPERIOR A MIRROR IMAGE OF INFERIOR?

STANDARD TELEMEDICINE QUESTION.. WHAT IS THIS AND WHAT DO I DO WITH IT?

WHAT IS THE FIRST QUESTION YOU MUST ASK?

STANDARD TELEMEDICINE QUESTION.. WHAT IS WRONG WITH THE ONH AND WHAT DO I DO WITH IT?

WHAT IS THE FIRST QUESTION YOU MUST ASK?

ANSWER: NEED MORE INFO BUT OD IS MIRROR IMAGE OF OS.....BUT WHAT ABOUT THIS!

2013-22 CASE OF THE WEEK

WHASSUP?

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44 YO

- **CC:** ROUTINE EVALUATION
- **PEH/FEH:** UNREMARKABLE/ FATHER & PGM RETINAL DETACHMENT
- **PMH:** PSORIATIC ARTHRITIS, HTN
- **MEDS:** CELEBREX, METHOTREXATE SODIUM, FOLIC ACID, NUCYNTA
- **BEST CORRECTED VISION 20/25 +/- O.U.
- **IOP:** 12,11 MMHG

**FUNDUS O.U.**

TEMPORAL PALLOR O.U....WHY??

20/25

**N-30-2 FDT Screening**

DATE: 07-29-2013 11:13 AM

LEFT EYE

RIGHT EYE

TEST SPEED: NORMAL

TOTAL DEVIATION

TEST DURATION: 30 Sec.

FIXATION Accuracy: 90%

NOTES:

NOTES:

INFERIOR INCONGRUOUS RIGHT QUADRANTIC DEFECT...BUT DANGER AS THIS IS FREQUENCY DOUBLING TECHNOLOGY

SDOCT CONFIRMS THE ATROPHY
**INTERPRETATION**

Fields Suggest

**RECOMMENDATIONS?**

- VEP???
- MRI???
- CT???

Awaiting Results

---

**THE FOLLOWING CAVEAT COULD NOT BE BETTER ILLUSTRATED THAN BY THIS CASE.**

**THE CLINICIAN MUST PURSUE ALL AVENUES TO GENERATE A DIAGNOSIS BUT IN THIS CASE IT ALL STARTED WITH AN EYE NOT CORRECTED TO 20/20 AND THE OBSERVATION OF TEMPORAL DISC PALOR CONFIRMED BY SD-OCT.**

---

**62 YO**

- **CC:** CHRONIC RED EYES USING PREFRIN B.I.D., ASTHMA
- **BEST CORRECTED ACUITY 20/20 O.U.**
- **IOP 29/27 mmHG**
- **MEDS:** PREMARIN, THEOPHYLLINE, VENTESE, SEREVENT, QVAR
OCT RETINA OD
RPE DISEASE AND DEPOSITS

OCT RETINA OS
RPE DISEASE

OCT NFL OD
MILD TEMPORAL THINNING

OCT NFL OS
“NORMAL RNFL”
OCT GCC OD PERIFOVEAL THINNING

OCT GCC OS PERIFOVEAL THINNING

INTERPRETATION

• 20/20 VISION
• RETINAL THINNING IN MACULAR AREA
• SYMMETRICAL RADIATING RPE CHANGES IN MACULA CONFIRMED BY SDOCT
• PERIFOVEAL GANGLION CELL THINNING
• A DYSTROPHY OF SOME SORT...SYMMETRY
• PROBABLE VARIATION OF MULTIFOCAL PATTERN DYSTROPHY SIMULATING FUNDUS FLAVIMACULATUS

INTERPRETATION

• ELEVATED IOP PUTTING PATIENT AT RISK FOR GLAUCOMA
• POSSIBLE STEROID INDUCED...QVAR
• http://www.eyelessons.com/articles/item/inhaled-corticosteroids

THE FOLLOWING CAVEAT COULD NOT BE BETTER ILLUSTRATED THAN BY THIS CASE. THE CLINICIAN MUST PURSUE ALL AVENUES TO GENERATE A DIAGNOSIS BUT IN THIS CASE IT ALL STARTED WITH THE OBSERVATION OF SYMMETRICAL MACULAR PIGMENTARY CHANGES AND ELEVATED IOPS.

2013-23 CASE OF THE WEEK

48 YO MAN WITH ISSUES

Caveat: When using any guidelines one must consider correlation with other patient characteristics and other clinical tests such as but not limited to: chief complaint, age, gender, ethnicity, refractive status and best corrected acuity, family history, associated medical conditions, current medications, pachymetry, visual field testing, angle assessment.
48 YO

- CC: ROUTINE EVALUATION
- PEH/FEH: UNREMARKABLE
- PMH: SLEEP APNEA WITH D/C BI-PAP, “DIET CONTROLLED DIABETES”, ANXIETY, BIPOLAR, BPH, HTN, HYPERLIPIDEMIA, HYPOTHYROID
- MEDS: CELEXA, LEVOTHYROXINE, PRAVASTATIN, RAMIPRIL, SAPHRIS, TRILIPTIX, VISTARIL
- BEST CORRECTED VISION 20/20 O.U.
- IOP: 16 MMHG O.U.
- PACHYMETRY 627/612 AND NORMAL COLOR VISION

THE PRE-EMPTIVE WELLNESS SCANS

FUNDUS O.U.

TEMPORAL PALLOR O.S. > O.D. WHY??

O.S. DISC LARGER THAN O.D. DISC

SUGGESTION OF INFERIOR INCONGRUOUS RIGHT QUADRANTIC DEFECT... BUT THIS IS FREQUENCY DOUBLING TECHNOLOGY... WATCH FOR NEURO ISSUES

ALERT: GCC THINNING O.S. > O.D. WHY??
FURTHER DIAGNOSTIC SDOCT AIDS IN THE INTERPRETATION

APPARENT THINNING OF RNFL O.D. > O.S.

GCC EVALUATION

APPARENT THINNING OF GCC O.S. > O.D.

INTERPRETATION

• BILATERAL OPTIC ATROPHY O.S. > O.D.
• BILATERAL RNFL THINNING O.D. > O.S.
• BILATERAL GCC THINNING O.S. > O.D.
• SUGGESTION OF VF DEFECT BY FDT....DANGER
• MULTIPLE MEDICAL ISSUES AT A VERY YOUNG AGE

THE FOLLOWING CAVEAT COULD NOT BE BETTER ILLUSTRATED THAN BY THIS CASE. THE CLINICIAN MUST PURSUE ALL AVENUES TO GENERATE A DIAGNOSIS BUT IN THIS CASE IT ALL STARTED WITH THE OBSERVATION OF AN WELLNESS SCAN SUGGESTING GCC THINNING

Caveat: When using any guidelines one must consider correlation with other patient characteristics and other clinical tests such as but not limited to: chief complaint, age, gender, ethnicity, refractive status and best corrected acuity, family history, associated medical conditions, current medications, pachymetry, visual field testing, angle assessment.
54 YO

• ROUTINE EYE EVALUATION
• KNOWS DOCTORS WERE CONCERNED ABOUT HER EYES YEARS AGO AND HAD ORDERED CT AND MRI ALL OF WHICH WERE “NORMAL”
• BEST CORRECTED VA OD 20/20 OS 20/20
• CCT 533, 537 IOP 17
• WELL DEFINED INFERIOR VF DEFECTS

Optic Nerve and RNFL

ARE THEY MIRROR IMAGES?

Ganglion Cell Complex

ARE THEY MIRROR IMAGES?

WHAT DOES SHE HAVE AND WHAT DO YOU DO?

Is it congenital or acquired?

Does the RNFL match the GCC?

Is there any relationship to glaucoma?

35 YO

• 14 YEAR HISTORY OF DIABETES WITH HEMOGLOBIN A1C OF 6.4
• BEST VA OF 20/20 O.U.
• NORMAL IOP NOT BEING TREATED FOR GLAUCOMA
WHERE IS THE RNFL?

ARE THEY MIRROR IMAGES?

O.D. Inferior Arcuate Loss
O.S. Inferior Arcuate Loss

ARE THEY MIRROR IMAGES?

RNFL, Optic Disc And GCC Results

Superior RNFL and GCC loss OD

The Cup

The Rim

Abnormal RNFL Parameters O.U.

Abnormal GCC Parameters O.U.

Abnormal RNFL TSNIT graph O.U.

WHAT DOES SHE HAVE AND WHAT DO YOU DO?

Is it congenital or acquired?

Does the RNFL match the GCC?

Is there any relationship to glaucoma?

CONGENITAL

Topless Disc Syndrome or Superior Optic Nerve Hypoplasia

Case 1: 80 YO M

- HX DRY ARM TAKING OCUVITE SINCE 2005
- BCVA 20/20- OD AND 20/25 OS
- REPORT INCREASE IN APPEARANCE OF HARD CRYSTALLING MACULAR DEPOSITS
WHAT SHOULD I DO?

• IS IT WET OR DRY?
• DNA TESTING?
• CHANGE FROM OCUVITE TO SOMETHING ELSE?
• PERFORM FAF?
• PERFORM FA?
• DO PHP?
• DO NOTHING?
• GET A RETINAL CONSULT?

• HOW ABOUT A LITTLE MORE INFORMATION?
WHAT SHOULD I DO?

- IS IT WET OR DRY?
- DNA TESTING?
- CHANGE FROM OCUVITE TO SOMETHING ELSE?
- PERFORM FAF?
- PERFORM FA?
- DO PHP?
- DO NOTHING?
- GET A RETINAL CONSULT?

YOU CAN REALLY SCREW UP WITH THE NEW TECHNOLOGY IF YOU DO NOT PAY ATTENTION!

THE DANGERS OF LOOKING ONLY AT THE DEFAULTS.

59 YO

- ROUTINE EXAM
- COMPLAINING OF INSIDIOUS REDUCTION OF VISION IN THE LEFT EYE
- TENTATIVE DIAGNOSIS WAS CENTRAL SEROUS

INTRODUCE SD OCT TECHNOLOGY-THE DIAGNOSIS AND MANAGEMENT CHANGES
59 YO

• ROUTINE EXAM
• INSIDIOUS REDUCTION OF VISION IN THE LEFT EYE
• NOTE SOME ISOLATED SOFT DRUSEN IN BOTH EYES
• BY VARYING THE LOCATION OF THE SCAN THE CHOROIDAL NEOVASCULAR NET IS UNCOVERED. IT WAS TOTALLY OVERLOOKED BY OPHTHALMOSCOPY

53 YO

• RECENT PHACO OU, OS LAST
• NO COMPLAINTS EXCEPT THE P/O GTTS
• IOP 15 MM HG OU AT LAST POST OP

ANYTHING WRONG HERE?
IS OD A MIRROR IMAGE OF OS?

SIGNIFICANT ASYMMETRY

RNFL THINNING

GCC THINNING OS > OD

53 YO

- RECENT PHACO OU, OS LAST
- NO COMPLAINTS EXCEPT THE P/O GTTS
- IOP 15 MM HG OU AT LAST POST OP
- WE NOW HAVE EITHER LOW TENSION GLAUCOMA OR NA-AION

22 YO F

- SUDDEN LOSS OF VISION OD SPLITTING FIXATION WITH INFERIOR VF LOSS
- SENT FOR CONSULTS. MRI NEGATIVE, FLUORESCEIN ANGIOGRAPHY NEGATIVE. CONSULTANTS DO NOT KNOW WHAT IS GOING ON.
- POLYCYSTIC OVARIAN SYNDROME ON ORAL CONTRACEPTIVES. TYPE 1 DIABETES
IS THERE A DIFFERENCE?

IS OD A MIRROR IMAGE OF OS?

INTRODUCE SD-OCT TECHNOLOGY—THE DIAGNOSIS AND MANAGEMENT CHANGES

IS THERE COMPROMISE OF RNFL?

NASAL THINNING. A SCANNING ABERRANCY…GARBAGE IN—GARBAGE OUT

IS THERE AN ALTERATION OF RETINAL THICKNESS?

NOTE SIGNIFICANT OVERALL THINNING OF RETINA OD

NOTE SIGNIFICANT OVERALL THINNING OF SUPERIOR RETINA OD

NOTE SIGNIFICANT INNER RETINAL THINNING
NO SIGNIFICANT INNER RETINAL THINNING

NOTE VERY SIGNIFICANT GCC THINNING SUPERIORLY

WHAT IS THIS?

NOTE NO GCC THINNING

INFERIOR ALTITUDINAL DEFECT IN MACULAR ZONE

FLIPPED VERTICALLY AND HORIZONTALLY. VF LOSS MATCHES GCC THINNING
22 YO F

- SUDDEN LOSS OF VISION OD SPLITTING FIXATION WITH INFERIOR VF LOSS
- SENT FOR CONSULTS. MRI NEGATIVE, FLUORESCINE ANGIGRAPHY NEGATIVE. CONSULTANTS DO NOT KNOW WHAT IS GOING ON.
- POLYCYSTIC OVARIAN SYNDROME ON ORAL CONTRACEPTIVES. TYPE 1 DIABETES
- DIAGNOSIS NOW NA-AION

37 YO

- ROUTINE EYE EXAM
- RECENT BOUT WITH RED EYE OS NOT TREATED BECAUSE OF NO INSURANCE
- NOW OS HAS REDUCED VISION
- CANNOT DILATE BECAUSE PUPIL FIXED AND 3 MM WITH MUTTON FAT KPS
- VERY POOR RETINAL VIEW WITH OPHTHALMOSCOPY

INTRODUCE CUTTING EDGE TECHNOLOGY-THE DIAGNOSIS AND MANAGEMENT CHANGES
NO EVIDENCE OF RETINAL ISSUES
52 YO

- ROUTINE EVALUATION
- C/O MILD REDUCTION IN VISION
- 20/25 + OU

ARE THEY MIRROR IMAGES?

60 YO

- PRESENTS FOR COMPREHENSIVE EXAMINATION
- OCULAR HISTORY- NEGATIVE
- MEDICAL HISTORY- GOUT, BORDERLINE HTN
- MEDICATIONS- COLCHICINE, ALLOPURINOL
- VA 20/20 OU
- PUPILS- ? MG PUPIL OD
- TA 29/28 9AM
INTER AND INTRA EYE ASYMMETRY

- OD MEGALOPAPILLA
- VERTICALLY ELONGATED CUPPING OD
- INFERIOR RNFL DEFECT OD
- OS APPARENTLY NORMAL

ONH Scans: RNFL & Optic Disc Analysis

INFERIOR TEMPORAL RNFL DEFECT OD
TEMPORAL RNFL DEFECT OS

Visual Fields Results

BOTH FIELDS ARE UNRELIABLE BECAUSE OF FIXATION LOSSES

Pachymetry Scan

PACHYMETRY SHOWS AVERAGE TO THICK CORNEAS OU
61 YO

• ROUTINE EYE EXAM
• IOP 19 MM HG OU
• HX STROKE
• WHAT IS WRONG?

ASYMMETRY OR SYMMETRY?

ASYMMETRY OR SYMMETRY?

RIGHT INCONGRUOUS HOMONYMOUS HEMIANOPSIA
STRUCTURAL LOSS DOES NOT MATCH FUNCTIONAL LOSS

• PALE DISCS
• RNFL DEPRESSION
• GCC THINNING
• RIGHT INCONGRUOUS HOMonymous HEMIANOPSIA

DIAGNOSIS OR DO YOU NEED MORE INFORMATION?

ANALYSIS

• GCC PROGRESSION

DIAGNOSIS OR DO YOU NEED MORE INFORMATION?

More Information Please.
ANALYSIS

• RECOMMEND FURTHER QUESTIONING. "OH I HAD LASER TO BOTH EYES AND FORGOT."
• FOUND THE YAG PIS UNDER THE LIDS.
• SUBACUTE ANGLE CLOSURE GLAUCOMA TREATED WITH YAG PIS

NOW WHAT? IS MORE TREATMENT NEEDED?

58 YO

• ROUTINE EVALUATION
• NO COMPLAINTS
• BCVA 20/20 OU
• PLEASE SCAN ME
• IOP 12/11 ON NCT

DO YOU SEE ANYTHING WRONG? IS THERE ASYMMETRY?

Right / OD
Glaucome ONH OU Report
Left / OS

Right / OD
Cornea Pachymetry OU Report
Left / OS

OD TSNIT MORE DEPRESSED
INTER AND INTRA EYE ASYMMETRY

VERY THIN CCT OS > OD
ANGLE OPEN

GCC COMPROMISE OU WITH SIGNIFICANT GLV% OS

WHAT IS THIS??? IN GENERAL OS RETINA THINNER THAN OD

EDGE OF EXCAVATION
**DIFFERENTIAL?**

- NTG Variant??
- Focal Choroidal Excavation?

**59 YO**

- ROUTINE EYE EXAM
- NO COMPLAINTS
- PREVIOUS HISTORY OF HEMODYNAMIC CRISIS

---

**DO YOU SEE ANYTHING WRONG?**

**Analysis**

- Disc Size OD > OS
- Inferior Notch

**INTER EYE DIFFERENCE**

**INTRA EYE DIFFERENCE**

**WHICH DISEASES COULD CREATE THIS SITUATION?**

- CONGENITAL
- ISCHEMIC OPTIC NEUROPATHY
- GLAUCOMA
- COMBINATION OF TWO THINGS
INTER EYE DIFFERENCE

INTRA EYE DIFFERENCE

Threshold Sensitivity Corresponding to Ganglion Cell Complex Thinning

Analysis

- OD Inferior RNFL Thinning
- OD Inferior Ganglion Cell Complex Thinning
- OD Inferior Threshold Decreased Sensitivity

Which Diseases Could Create This Situation?

CONGENITAL DISC ANOMALY AND ISCHEMIC OPTIC NEUROPATHY FROM HEMODYNAMIC CRISIS