1 UNUSUAL URGENT CARE CASES
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5 CASE #1

6 CASE #1: CHIEF COMPLAINT

- 29 year old female
- Over the past year, she developed intermittent left exotropia that later became frequent for 6 months.
- Three months ago: Ophthalmologist initially diagnosed her with suspicious optic nerve swelling OS. This later resolved.
CT Head, MRI Brain and Neurology consult WNL.
Diagnosis from ophthalmologist 3 months prior:
  • Exophoria OS = Reassured patient. No treatment. RTC PRN.

CASE #1: HISTORY & EXAM
  • Medical History: Spinal Stenosis and degeneration, polycystic ovarian syndrome
  • Ocular History: No previous amblyopia or strabismus
  • Meds: metformin

CASE #1: EXAM
  • Entering VA with correction 20/30-2 OD, 20/30 OS
  • BCVA with manifest 20/20 OD, 20/25 OS
  • Pupils, EOM and CVF WNL OU
  • Anterior segment: WNL

  • Cover Test: 8-10 diopters left exotropia
  • Posterior segment:
    • C/Ds OD 0.05 OD, OS 0.00 with myelination; no optic nerve edema

OPTIC NERVE
PERIPHERY OD
PERIPHERY OS
12 **ASSESSMENT/PLAN**
- Previous Assessment: Exophoria = no treatment needed.
- Complacency breeds failure!

- New assessment: Peripheral Retinal Fibrosis OS>OD
- Retinal Consult 24 hours

13 **PERIPHERY F.A. OD**

14 **PERIPHERY F.A. OS**

15 **FEVR**
- Rare hereditary ocular disorder characterized by a failure of peripheral retinal vascularization which may be abnormal or incomplete.
- Cases can be autosomal dominant, autosomal recessive, or X-linked.
- The retinal avascularity is probably present from birth and generates sequelae that stabilize in early adult life or progress in later life.
- If there is a significant degree of retinal ischaemia, then secondary neovascularisation can occur leading to fibrosis, traction of the posterior pole structures, retinal detachment (RD), retinal folds, or complete retinal dysplasia in the most severe cases.

16 **CASE #2**

17 **HISTORY**
- 30 year old female
- No recent trauma
- No pain
- No discharge
- Red x 1 day. It just appeared spontaneously.
VA 20/20 OD, 20/20 OS
SLE: Subconjunctival hemorrhage OS
All other anterior segment findings WNL OU
IOPs 16mmHg OD, 17mmHg OS at 2:05pm

ASSESSMENT
Assessment: Subconjunctival Hemorrhage OS
- Patient reassurance
- Cold compresses
- Artificial tears
- RTC PRN

Complacency breeds failure!

Blood Pressure: 180/110, 170/115
Sent patient to Urgent Care next door for management of uncontrolled hypertension.

RECENT CAUSES OF SUBCONJUNCTIVAL HEMORRHAGE (SCH)
Major current risk factors for SCH
- Young Patients: trauma and contact-lens induced injury in younger patients
- Older Patients (>60 years old): hypertension 47.5%, unknown etiology 39.4% and then diabetes 13.1%

Contact Lens Induced Subconjunctival Hemorrhage
- Conjunctivochalasis
- Pinguecula

CASE #3
- 90 year old female
- CC: Both eyes are red and itchy for 5 months.
- Patient was in last month with an ophthalmologist for
epilation of lower lashes OS. States symptoms of redness and irritation are persistent despite epilation.

21 MEDICATIONS

■ Systemic Meds:
  ▪ Tarceva x 6 months
  ▪ Claritin for allergies
  ▪ Lorazepam for anxiety
  ▪ Ferrous Sulfate for iron deficiency
  ▪ Diovan for HTN

■ Ophthalmic Meds:
  ▪ Systane Balance artificial tears 2-3 times a day OU
  ▪ Pataday QD OU

22 HISTORY

■ PMHX:
  ▪ Lung Cancer
  ▪ Seasonal Allergies
  ▪ Hypertension

■ NKDAs

■ POHx:
  ▪ Congenital syphilis causing diffuse corneal scars OU

■ FOHx and FMHx: unremarkable

23 EXAM

■ VAcc: CF OD, 20/40 OS PHNI

■ SLE:
  ▪ L/L: Thickened, abnormally long and curly upper and lower eyelashes OU
  ▪ Cornea: Diffuse Scars OU
  ▪ Lens: PCIOL OU without capsular fibrosis OU
- C/D .35 OD, .30 OS
- Vit: +PVD OU

24 💻 LASHES GONE WILD

25 📜 ASSESSMENT/PLAN
- Trichiasis lower eyelid OU
- Epilated eyelashes

- Complacency breeds failure!
- Eyelash Trichomegaly secondary to Tarceva medication
  - Advised patient to trim eyelashes if possible
  - Return in 1 month for recheck.

26 📜 VISITS TO THE OFFICE FOR EPILATION

2012 Visits (10 Visits)
- 2/20/2012
- 3/7/2012
- 4/25/2012
- 6/6/2012
- 8/13/2012
- 8/20/2012
- 9/20/2012
- 11/12/2012
- 11/19/2012
- 12/19/2012

2013 Visits (4 Visits)
- 4/29/2013
- 8/14/2013
- 8/22/2013
- 9/11/2013
27 2014 AND 2015
  - 5/2/2014 Trichomegaly still present but no trichiasis

30 TARCEVA
  - Tarceva is approved for advanced-stage non-small cell lung cancer and advanced-stage pancreatic cancer and is an epidermal growth factor receptor (EGFR) inhibitor.

32 TARCEVA ADVERSE EFFECTS
  Most common >20%
  - Diarrhea 62%
  - Rash 56%
  - anorexia
  - fatigue
  - dyspnea
  - cough
  - nausea
  - infection
  - vomiting

33 MEDICATIONS CAUSING TRICHOMEGALY
  - EGFR Inhibitors: erlotinib (Tarceva), cetuximab, panitumumab, gefitinib
  - Interferon-a2b
  - Zidovudine
  - Phenytoin
  - Diazoxide, minoxidil
- Acetazolamide
- Cylosporine, tacrolimus
- Topiramate

34 AFTER 5 MONTHS ON RESTASIS:

35 FUNCTION OF EYELASHES

- Protective Function by defending the eye against debris and triggering the blink reflex.

36 AERODYNAMIC EFFECT OF EYELASHES

37 GOLDEN RATIO: 1/3 RULE

- To divert airflow, the ideal length of eyelashes = roughly one-third as long as the width of the eye.
- If lashes are LONGER than 1/3 eye width:
  - Funnels more air toward the eye. More dry eye problems!
  - Causes more evaporation than if there weren’t any eyelashes at all.

38 CASE #4

CC: 56 year old female complains of curtain Veil effect OD x 1 day. Also noticed flashing lights but no floaters.

VA without correction:
OD: 20/30
OS: 20/70, PH 20/40

Tonopen IOP 15mmHg OD, 18mmHg @2:40pm
Pupils, CVF, EOM WNL OU
Slit lamp: NS 1+ OU
Dilated exam: +PVD OD but no pigmented cells OU
C/D .30 OU
Mac 1+drusen OS
Periphery flat 360 with scleral depression OD.

39  OPTOMAP OD (1ST VISIT)
40  OPTOMAP OS (1ST VISIT)
41  ASSESSMENT/PLAN
   ■ Acute PVD OD
   ■ RD warnings advised
   ■ Return PRN?
      ▪ Photos WNL
      ▪ Scleral depressed exam WNL
      ▪ Complacency breeds failure!

   ■ RTC 1 month for dilated fundus exam or sooner if symptoms worsen.

42  1 MONTH FOLLOW-UP VISIT (2ND VISIT)
   ■ 1 month F/U PVD OD:
      ▪ Complains of curtain/veil vision same as last visit.
      Flashes of lights are less frequent than last visit. No increased/new floaters.

      ▪ VA with correction:
         ▪ OD: 20/20-2
         ▪ OS: 20/20-1

      ▪ Exam findings anterior segment and posterior segment same as last finding except for one....

43  DAYTONA OS (2ND VISIT)
44  **DAYTONA OD (2**\textsuperscript{ND VISIT})

45  **ASSESSMENT/PLAN**

- Retinal Tear OD
- Photodocumented – no signs of retinal tears OU.
- Based on photos and symptoms – seemed unlikely to have a retinal tear.
- Complacency breeds failure!

- Retinal Tear OD diagnosed by clinical exam. Not viewed in photos.
- Schedule for retinal consult Same Day Add-on.
- Horseshoe Retinal Tear OD – Retinopexy same day surgery

46  **PVD**

- Retinal tears occur in 10-15\% of patients with acute, symptomatic PVDs.
- Hemorrhagic PVDs = 50-70\% chance of underlying retinal tear.
- Dilated exam with scleral depression within 12-24 hours for patients experiencing symptoms of RD.
- Scleral depression and 3-mirror contact fundus lens can also be helpful in the evaluation of the peripheral retina.
- Dilate both eyes – retinal tear in one eye may suggest a predisposition for additional tears in the contralateral eye.

47  **PVD**

- Sixty-five percent of people over the age of 65 will experience a PVD.
- Up to 26\% of patients with an acute PVD will present with a concomitant retinal break at the time of the initial
presentation.

- The chances of developing a retinal break following the initial presentation of an acute PVD is 2% to 5%.
- Flashes seem to represent a more ominous symptom than floaters.
- Approximately 50% of those with symptomatic flap tears will develop an RRD.

FOLLOW-UP PVD

- Similarly, according to guidelines published by the American Optometric Association, a patient with a symptomatic posterior vitreous detachment should be followed at least every two to three weeks until the condition becomes asymptomatic and no concomitant retinal tears are found.
- Patients with acute PVDs should be advised to return immediately if they experience an increase in signs or symptoms such as flashes, floaters or a curtain in their vision.

AMERICAN ACADEMY OF OPHTHALMOLOGY GUIDELINES

BIO LENSES

PVD MALPRACTICE CLAIMS

- The most common error is failing to detect a retinal detachment associated with the PVD
- Failing to recognize that the PVD separation is incomplete and thus capable of causing detachment
- Failing to warn the patient of the symptoms of detachment
- Failing to schedule the patient for follow-up in 2-4 weeks

QUESTIONS

- Any questions?