VR Emergencies

14th October 2020

Topics

- Retinal tears
- Retinal detachment
- Endophthalmitis
- Submacular haemorrhage
- Trauma

Practical Tips, Atypical features & Mx

Retinal tears

- F+F/shadow - Hx – Trauma? Myopic? Previous ocular Sx? Check PVD/TD/tears
- Horseshoe tears – standard slit lamp retinopexy
- Tears – unable to reach anterior edge – will need indirect retinopexy / cryotherapy
- Vit haem – B-scan / laser retinopexy/cryotherapy / PPV
- Haem PVD (no tears) – observe up to 6/52

Atypical Retinal tears

- Lattice degeneration (+/- holes within the lattice) – no Rx / D/C
- WWP – no Rx/ D/C
- Retinal holes (+/- operculated) – FLAT – no Rx / D/C
- Retinal holes (+/- operculated) with pigmentation – no Rx / D/C
- Retinal holes with traction – laser retinopexy
- Large retinal holes > 1 DD – laser retinopexy
- VH without tears on B-scan – observe for a week and not improving – PPV
- VH with tears on B-scan – urgent PPV

Atypical F+F

- Young patient with no refractive error – think of:
- Subtle retinal pathology – may have some form of intermediate/posterior uveitis
- Migraine

- Good clinical practice – scleral indentation (do not use 3-mirror if you intend to refer for VR opinion on same day), usually a good superfield lens will pick up most tears.

Retinal detachment

- The obvious is VERY obvious – mac on versus mac off.
- Hx – similar to retinal tears
- Exam:
- 1) Mac on versus mac off – unsure – do OCT macula. If VA < 6/9 (if there is no other ocular pathology), it is usually mac off.
- 2) Location of tears
- 3) Age of pt
- 4) PVD – slit lamp (Weiss ring), OCT macula
- 5) GA / LA / meds (anticoagulants)

Atypical retinal detachments

- Is it retinoschisis? – Hypermetrope, B-scan/OCT, ILB/OLB
- If no tears found but has RD – check for TD/PVD – if not present - think of exudative RD – do a B-scan (rule out underlying choroidal mass), shifting fluid
- Bleed under RD – B-scan – CNVM? Vasoproliferative dis?
- Chronic RD with pigmentation line (usually inferior) – barrier laser top up
- TRD whether diabetic/non-diabetic related – need VR clinic visit first usually within 2-3/52 before any Sx.

Endophthalmitis

- Exo versus Endo
- Hx – post surgery/injection/trauma (exo). Immunosuppressed (endo)
- Exam

1) Very painful red eye with hypopyon
2) Severely reduced VA

Atypical endophthalmitis

- Painless with hypopyon post Sx – think of TASS or RD.
- Severe uveitis
- Post IVTA can present similarly
- When in doubt, treat as endophthalmitis

Treatment of endophthalmitis

- Std Tx – Vit tap/biopsy. AC tap (if possible). Intravitreal Abx – cef/vanc
- Review 24 hrs – improving? Not improving? Further Intravitreal Abx
- Oral steroids if fungal ruled out.
- Oral Abx
- When to do PPV? – controversial – depends on surgeon. My preference – if RD present ASAP. Otherwise, after 2 weeks.
- Maybe …

Submacular haemorrhage

- AMD related – tpa/gas +/- PPV then prompt antiVEGF once gas reabsorbed.
- Macroaneurysm – depends on location of it. May cause significant VH with tPA/gas. Results unpredictable due to trilayer bleed
- DM related – usually posterior hyaloid (rather than subretinal) – so will need PPV at some point if not regressing.

- In all cases, visual prognosis is very poor and pt must be told about it.

Trauma

- Concentrating on non obvious penetrating eye inj / IOFB cases
- Good history – beware of high velocity injury
- Exam – subtle signs – SCH, low IOP, AC diff, dilated fundal exam
- B-scan – gentle
- Any suspicion of penetrating eye injury or IOFB – CT scan

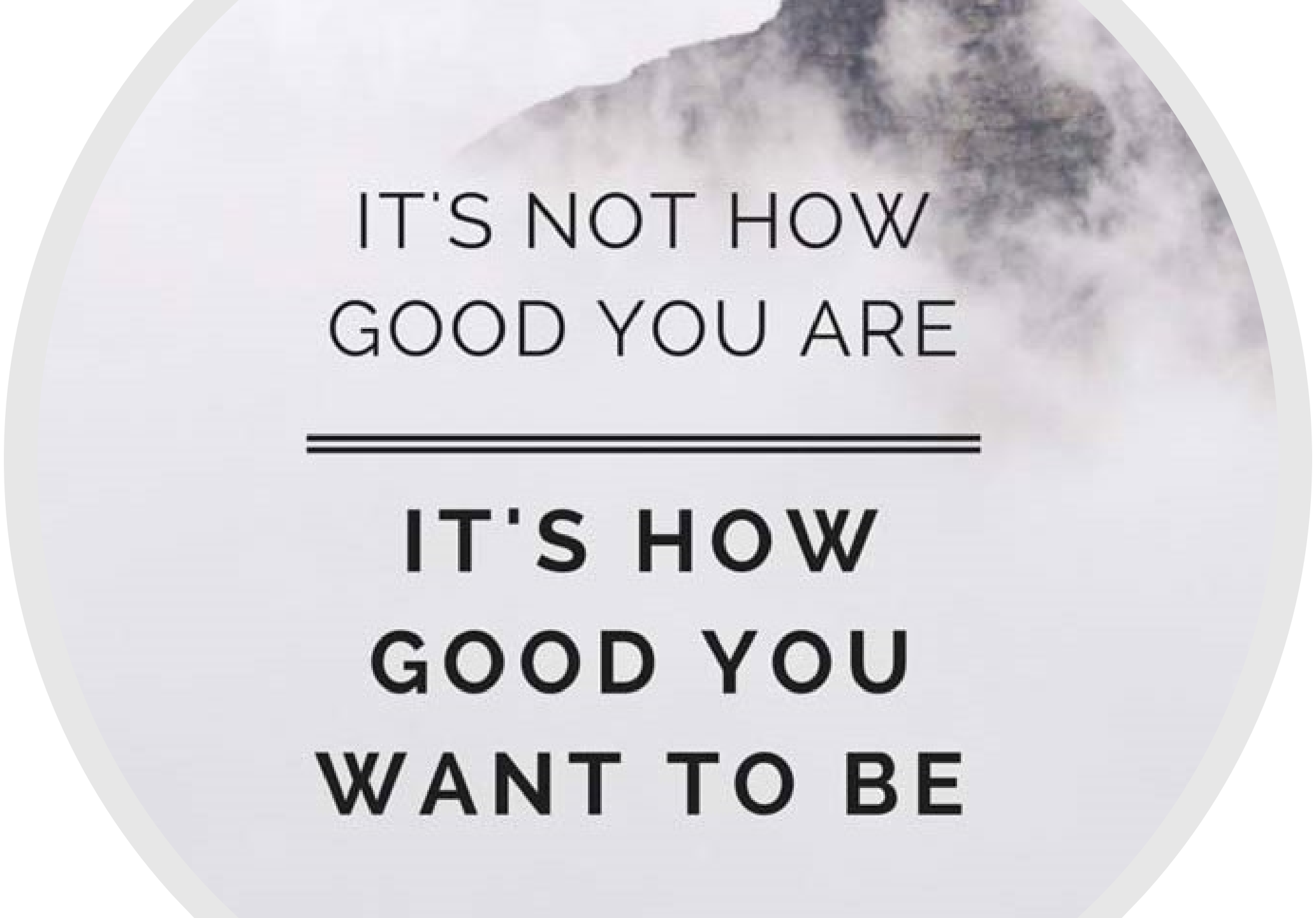
Final words…

- Referrals to follow up on post laser retinopexy or for retinal detachment surgery (other than mac on) – please do not give a timeframe.

- Any doubts – VR fellows are easily contactable or look for your favourite VR consultants who are always “supervising” around either in clinic / theatre / VR Coordinator room next to the kitchen in theatres

- Anyone interested in learning on how to indent or learn more about VR surgery – the VR team is always happy to accommodate and teach.

- www.doctorchng.com / www.bhameyecas.org


IT'S NOT HOW
GOOD YOU ARE
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GOOD YOU
WANT TO BE