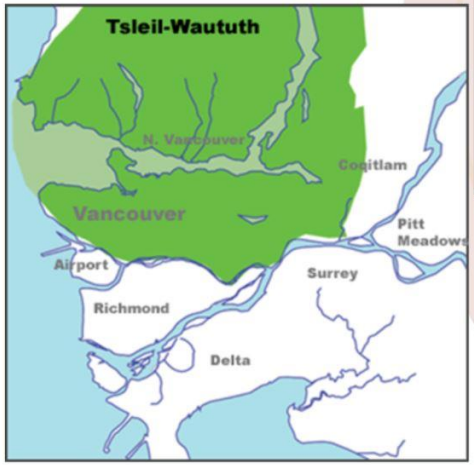
We would like to acknowledge that we are gathered today on the traditional territories of the Musqueam, Squamish and Tsleil-Waututh peoples.

Source: www.johomaps.net/na/canada/bc/vancouver/firstnations/firstnations.html



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This program has NOT received financial support.

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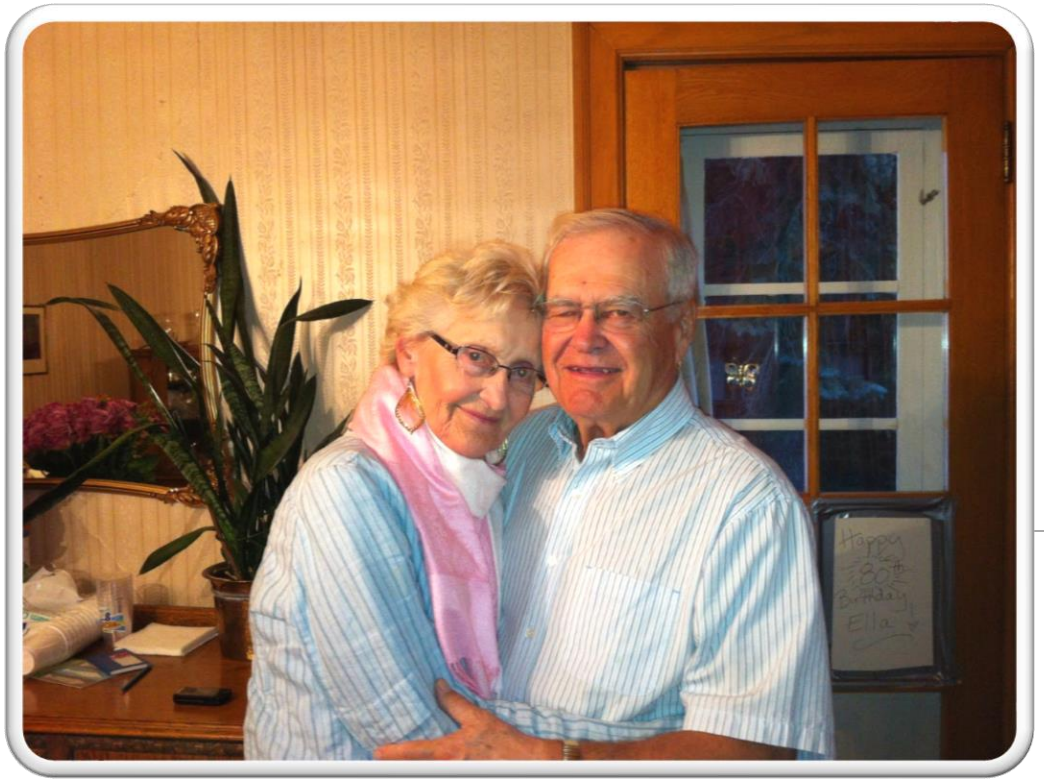
Common ophthalmic concerns in the older adult.



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How you want to be treated.

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OUR TEAM.

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Dr. Stephanie Wise

Academic Position:
Clinical Instructor, UBC Department of Ophthalmology, UBC Faculty of Medicine

Outline

Demonstrate critical elements of the office based physical exam for ophthalmic concerns

Diagnose key blinding emergencies

Articulate an approach to lid disease in the office

Navigate the care trajectory for cataract, glaucoma and AMD.

Hopefully leave lots of time for questions – Zoster,

OFFICE exam

Vision

- Calibrate your chart
- One eye at a time
- Use a pinhole

Pupils

Movements

Fields

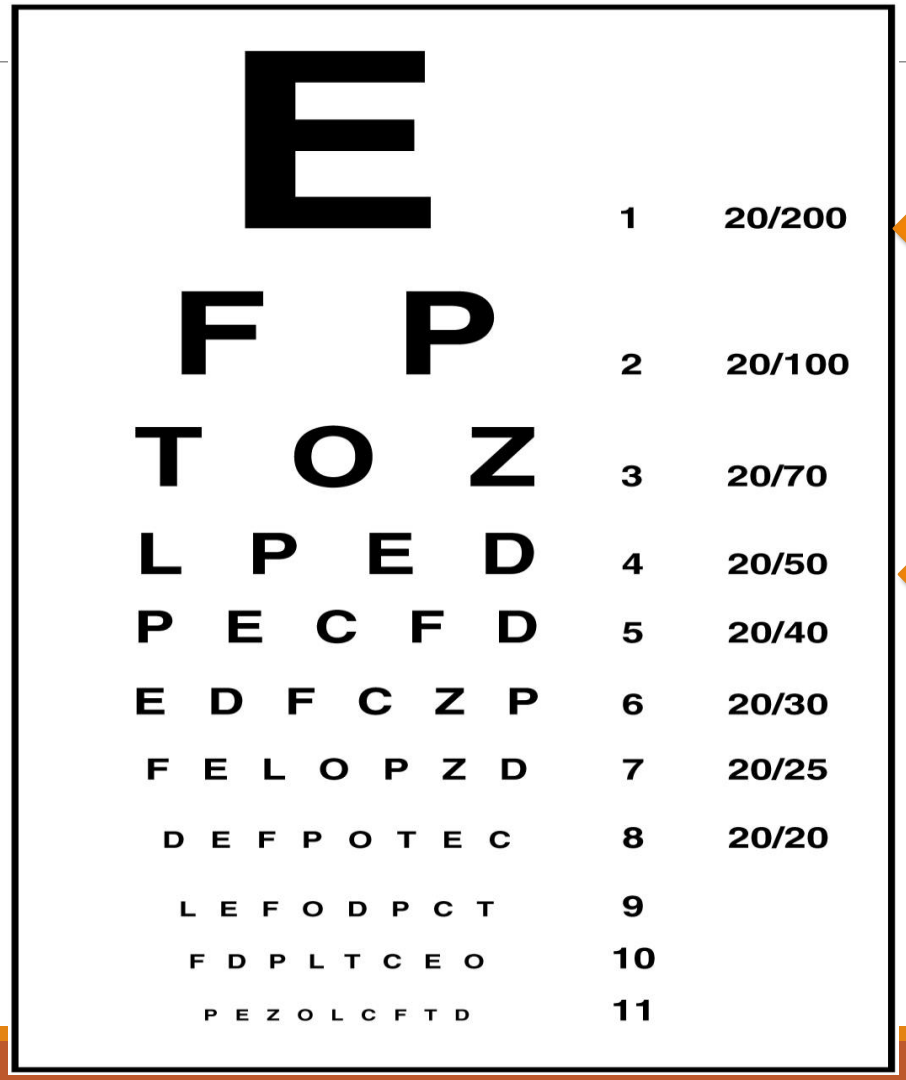
inspection

Fundoscopy

- NLP (no light perception)
- LP (light perception)
- HM (hand motions)
- CF (count fingers 1’,3’,6’)

No Vision

Terrible Vision

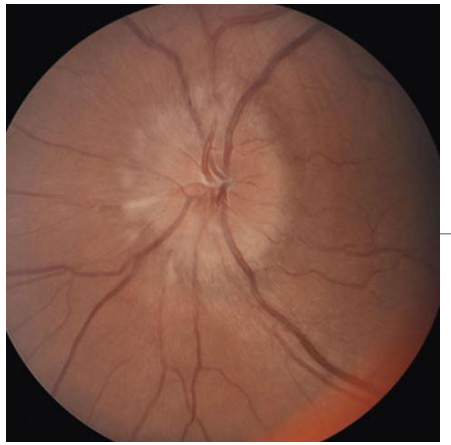
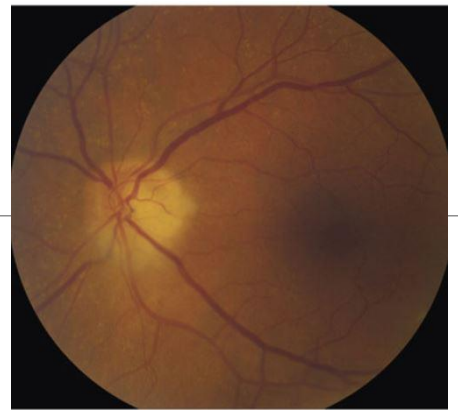
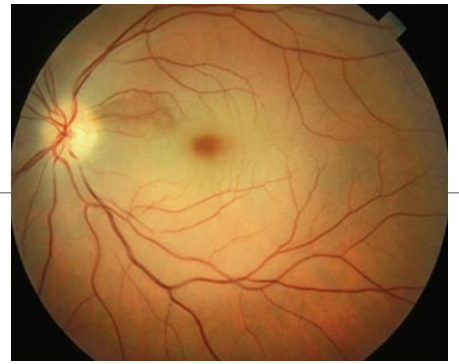
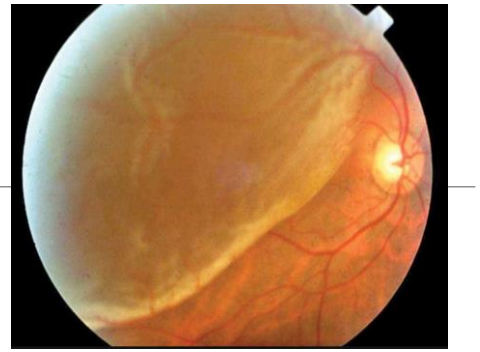


Bad Vision

Be concerned

Good Vision

Photos from: American Academy Of Ophthalmology BCSC clinical series textbook: Neuro-Ophthalmology and Retina AAO 2016

Painless Sudden vision loss

77 y.o WITH PAINLESS LOSS IN HER RIGHT EYE.

HER PINHOLE ACUITY IS 20/200.

- REVIEW HPI, VASCULAR RISK FACTORS, SCREEN FOR HEADACHE, JAW CLAUDICATION, TEMPORAL PAIN.
- DO YOUR OFFICE OPHTHALMIC EXAM
- ORDER CRP
- SEND TO THE EMERGENCY DEPARTMENT OR CALL ON CALL OPHTHALMOLOGY

Blepharitis and Meibomian gland dysfunction

Eyes often red

Eyes feel Tired & heavy

Frequent tearing

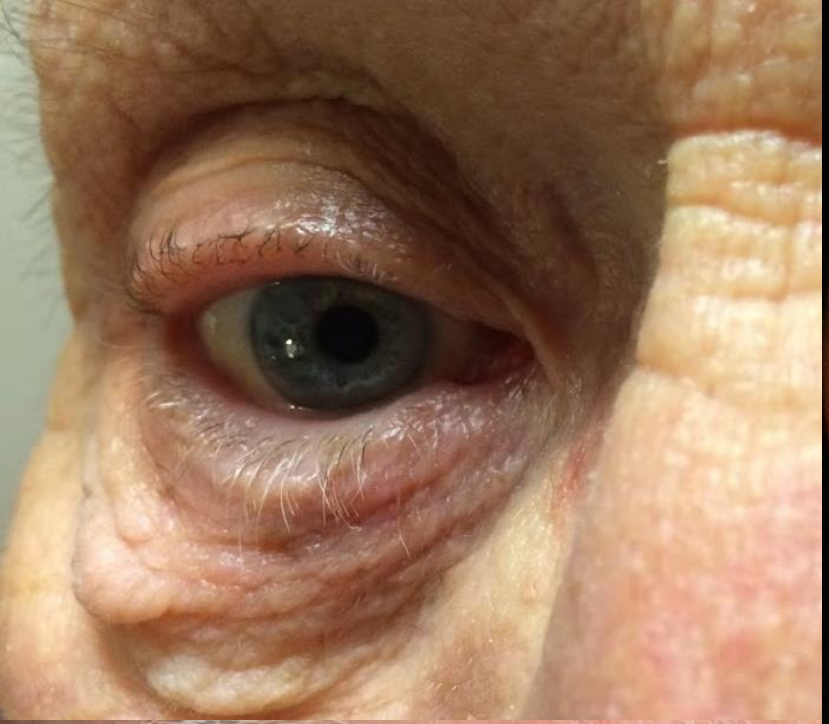
Sharp pains

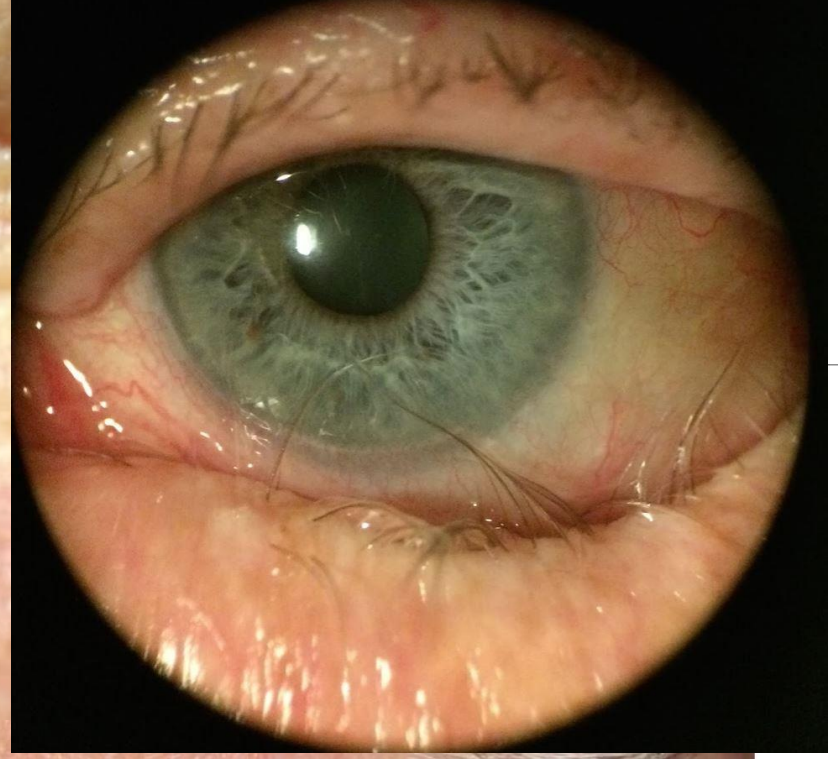
Blur that gets better with blink

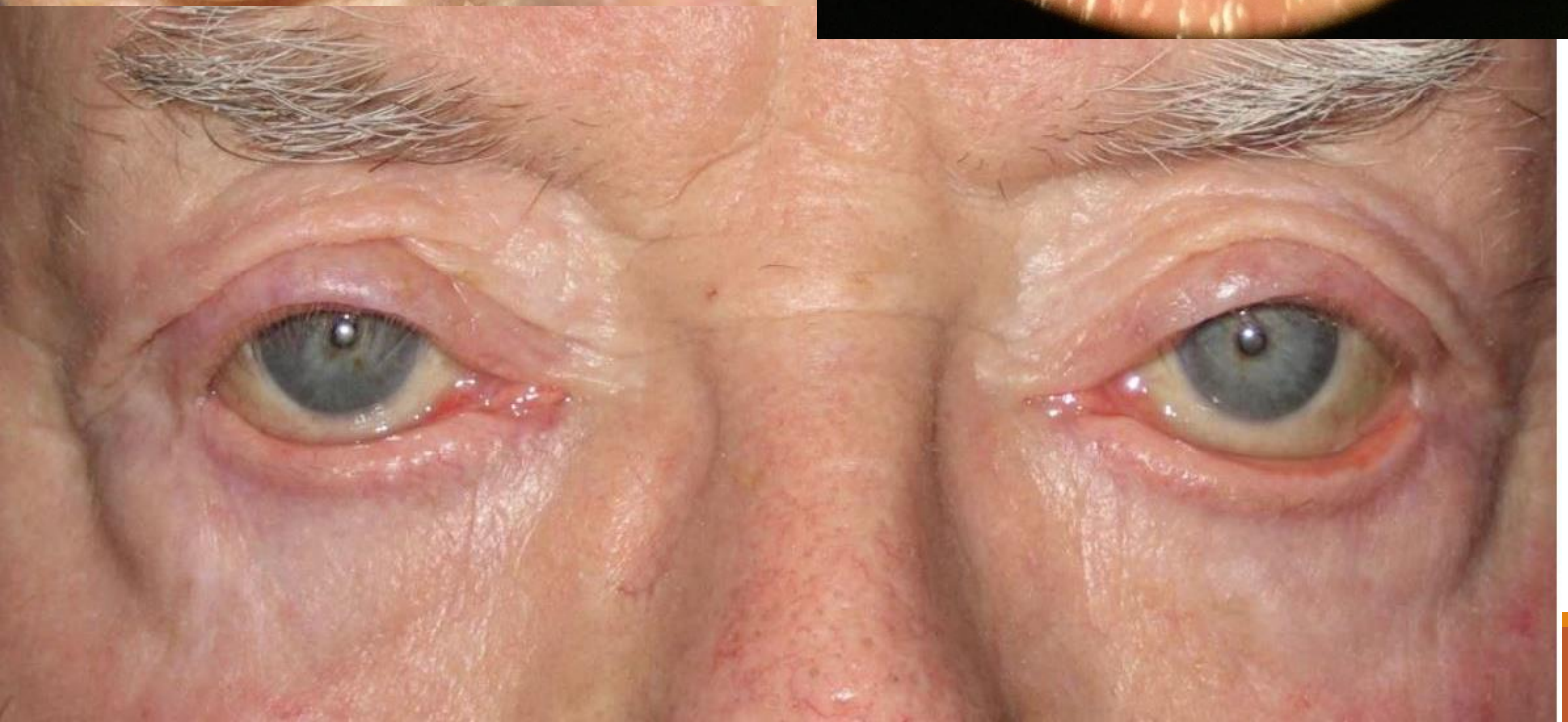
Burning

Itching

Commonly worse at the end of the day







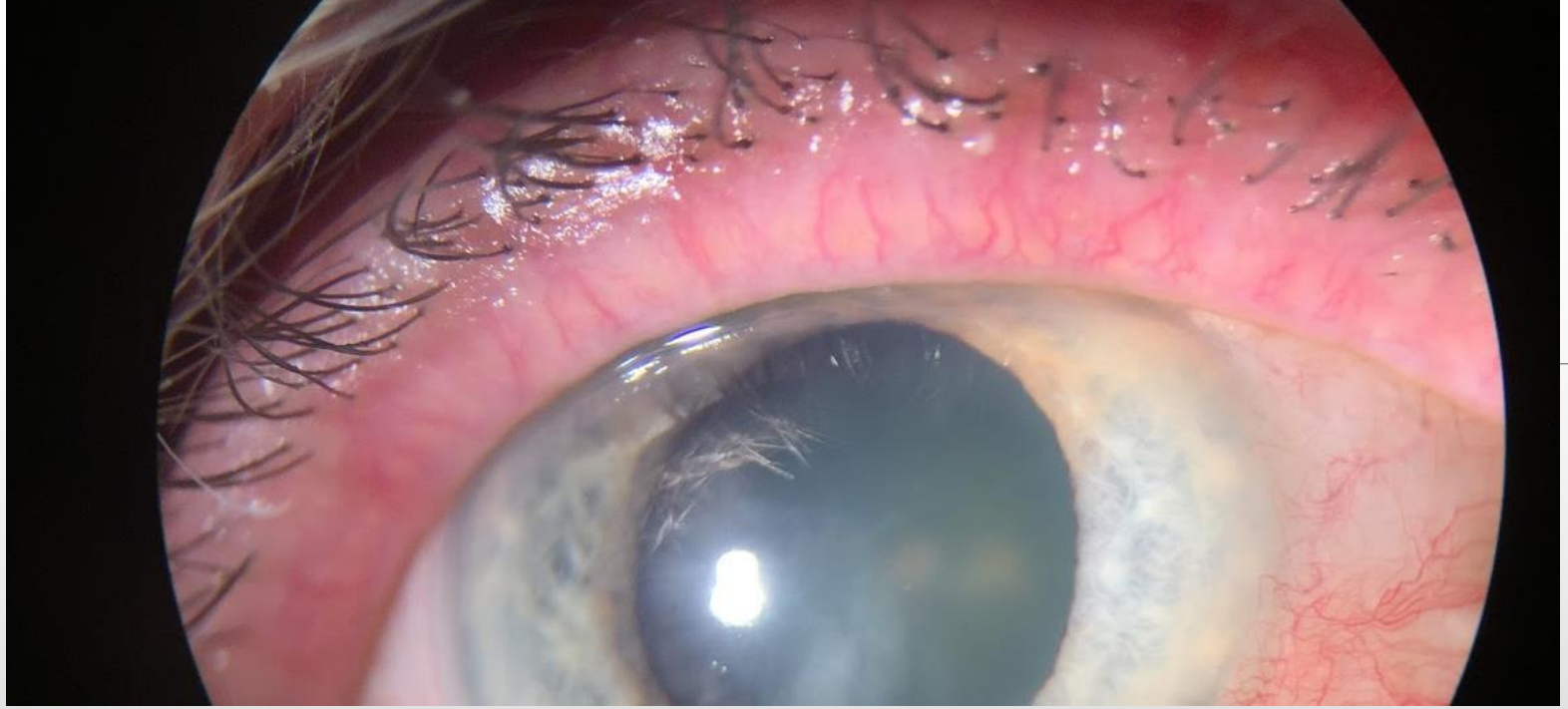
Blepharitis: What next

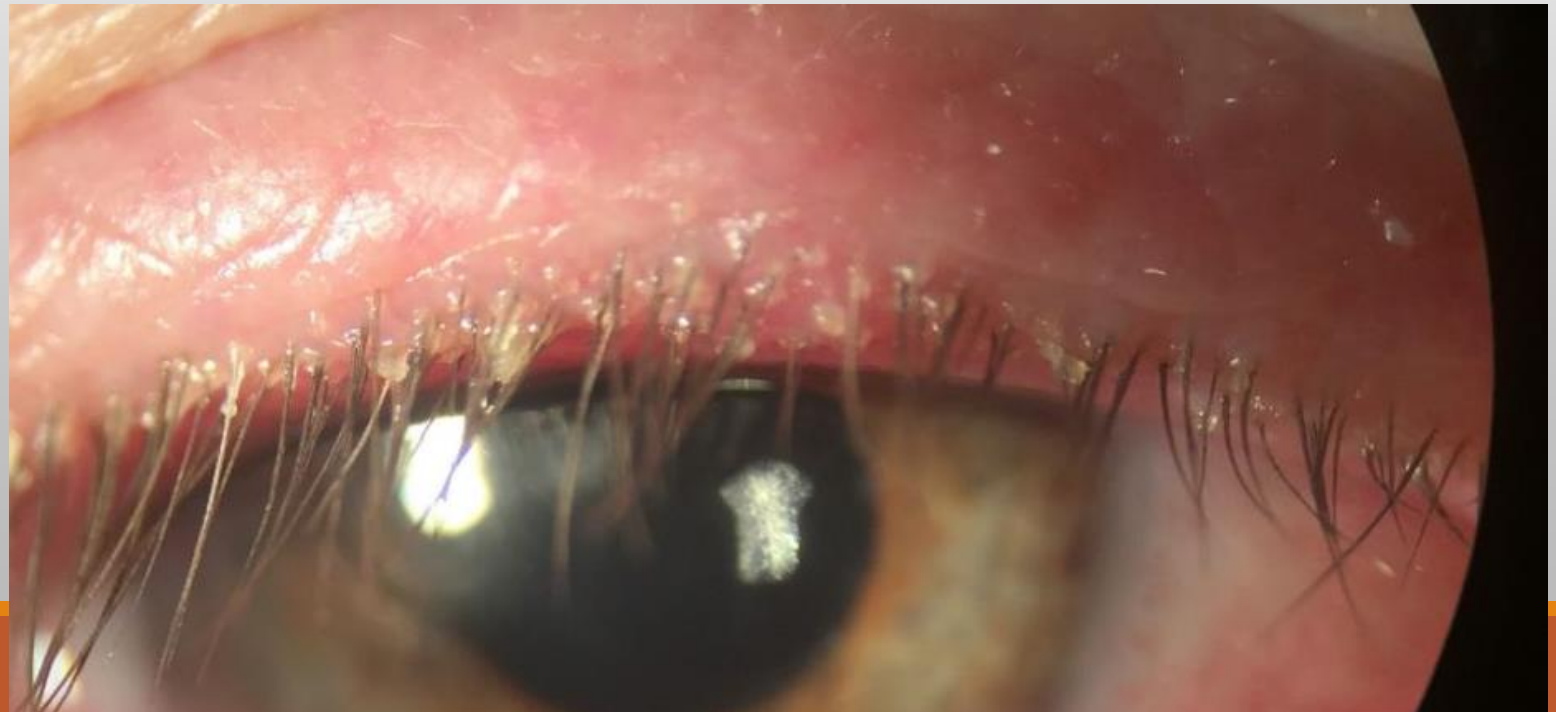
Rule out lid malposition

Entropion – rolling in of the lid. Have the patient squeeze

Ectropion – rolling out of the eyelid.

Refer to ophthalmology If your patient has a lid malposition





Inciting Factor

Inflammation blockage

Treating Blepharitis

Warm compresses

- By heating the eyelids with a clean wet warm face cloth you decrease the viscosity of the oil and free up the debris that is contributing to inflammation

Lid scrubs

- Using a q-tip, lid care wipe or the cloth, gently scrubbing the lash margin massages glands to promote flow and removes any lash debris

Artificial tears

- Up to four times per day, artificial tears will improve ocular surface comfort while the patients own Meibomian function improves – Gel at night

KEY POINT

If you give your patient an rx they will not do the warm compresses, lid scrubs and artificial tears.

First and Always: warm compresses, lid scrubs and artificial tears

If you can see the debris on the lash line adding an antibiotic ointment bid is a reasonable adjuvant. (polysporin or erythromycin ung)

Doxycycline, 5% tea Tree oil therapy, ivermectin. Lipiflow, Intense pulsed light therapy

Steroid ointment may be indicated in some patients where the inflammation is severe... But this should only be prescribed if you can check the patients iop.

Steroid induced glaucoma is asymptomatic until the patient is legally blind and the vision loss is irreversible.

More tips for “Eyes like Sacks of Acid”

What Helps

Trial demodex tx: Cliradex

Bruder Mask

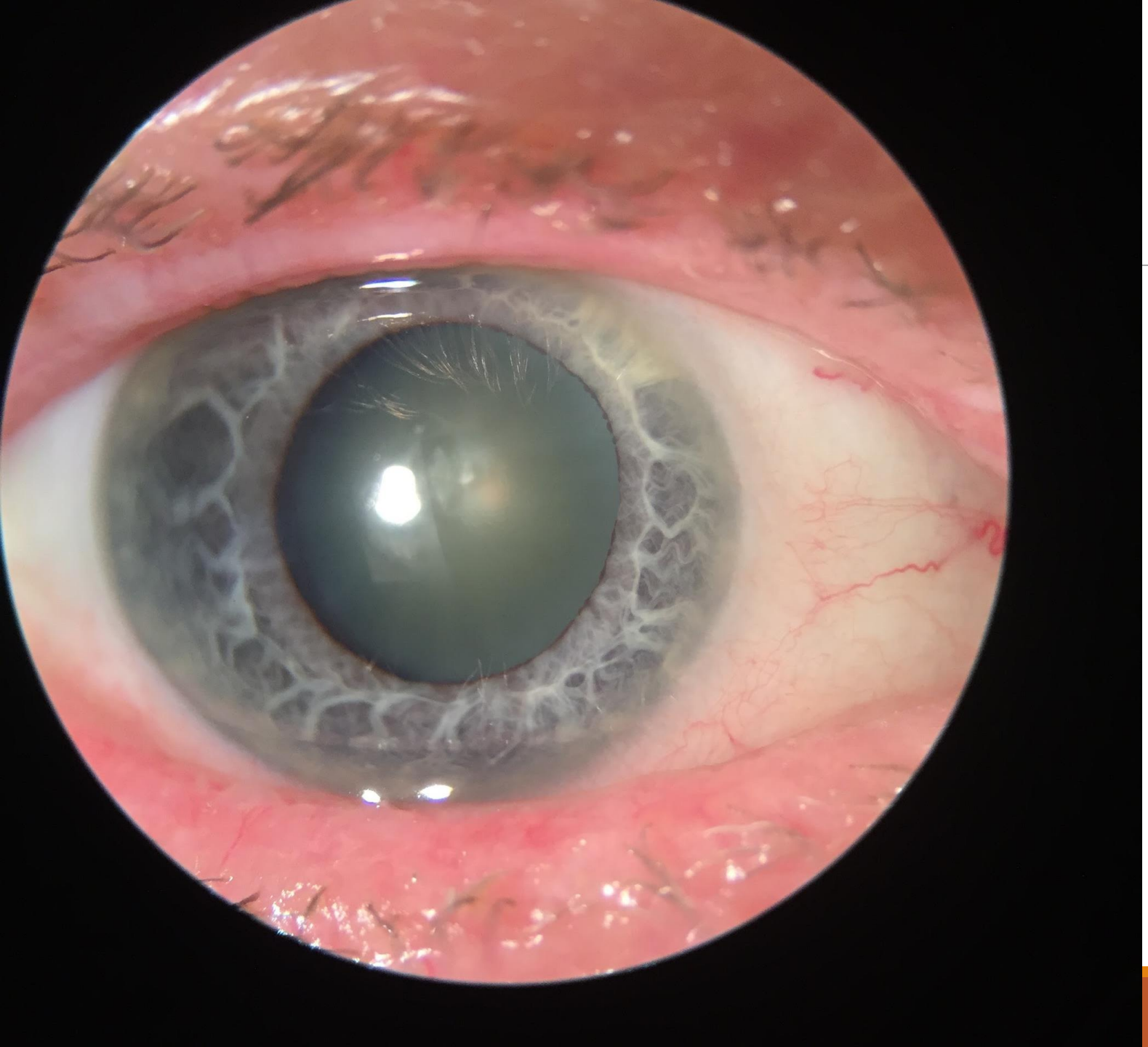
Parkinsons patients have a reduced blink rate, aps and reminder tones to squeeze and break from screens, 20/20 rule

Ophthalmologist – punctal plugs, cyclosporine, lifitegrast, Tacrolimus

What doesn’t HELP

Blue light filters

Visine / clear eyes- tetrahydrozoline



cataract

History: Gradual onset of decreased acuity, trouble in dim or very bright light, bothered by haloes and glare.

On office exam:

When should cataracts be removed:

When the patient is symptomatic: Acuity less than 20/50 or resulting in an impairment in function.

If surgery will be complicated by waiting

If the patient is at risk of angle closure

THE GLOBE AND MAIL

HOME » INVESTIGATIONS Doctors charging both government and patients privately in illegal double-dippi SUBSCRIBE

INVESTIGATION

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of diagno

urgery

Post-operative follow-up

Cataract surgery is covered by MSP and your patients are NOT required to pay to have their cloudy lens removed. They also don't pay for the insertion of a high quality foldable lens implant!

They may choose to pay for refractive diagnostics and procedures that are not covered by MSP, but this is elective and should never influence their care.

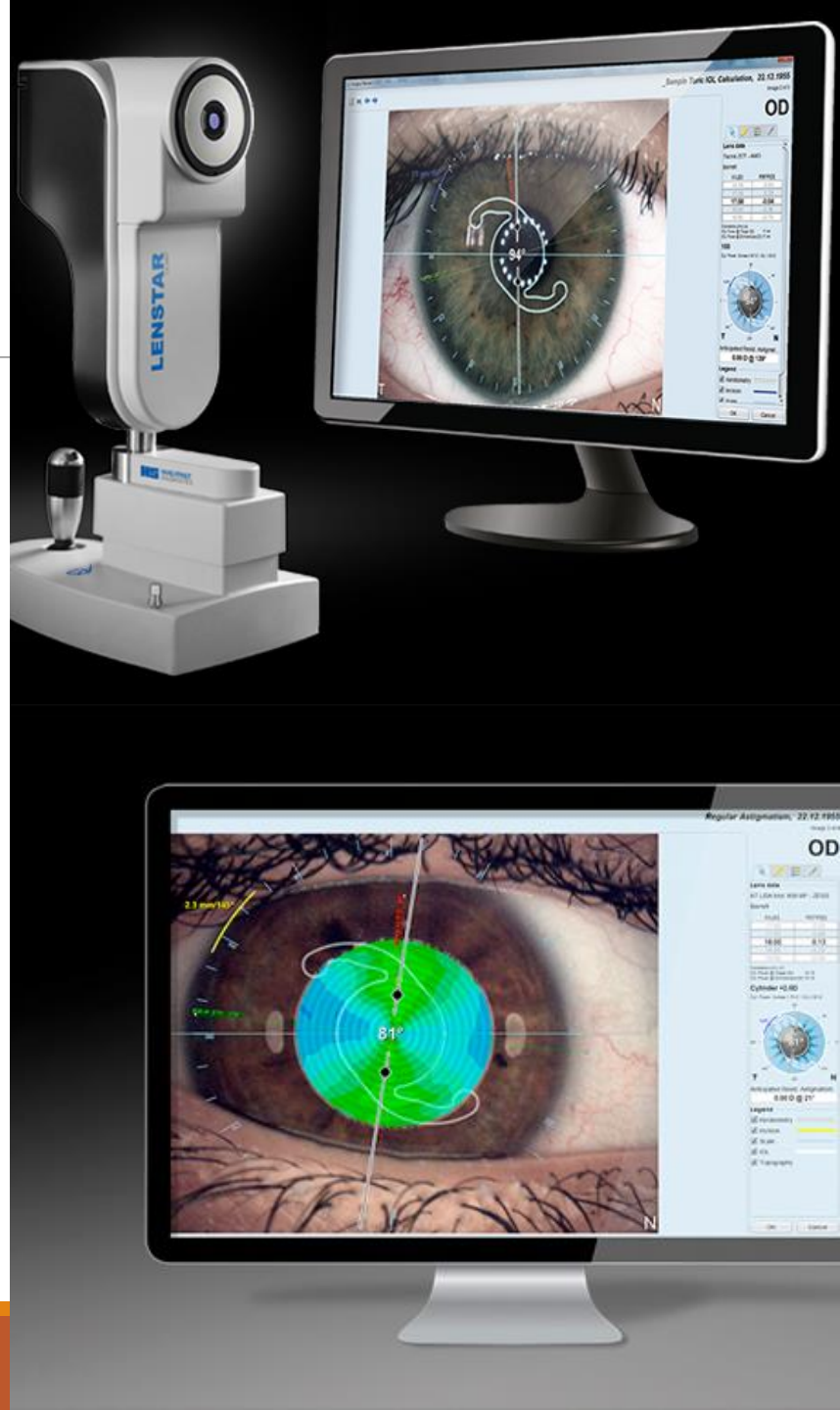
What's the deal with my patient paying money at one of these visits?

So if they do pay, They are paying to reduce their reliance on spectacles after surgery

Topography and OCT are not covered in pre-op cataract patients

Toric & multifocal lenses must be purchased from the health authority and range from $505.00 to $2000.00

Many surgeons will charge a fee related to the time needed to analyze measurements and plan lens placement, including the possible need to re-position the lens if the axis of the lens shifts.



What is glaucoma?

The term *glaucoma* refers to a series of heterogenous disorders. All glaucomas have the hallmark of progressive optic neuropathy and loss of visual field

This loss of vision is *permanent*

but virtually always *preventable*

Need to know

The defining feature of glaucoma is ‘glaucomatous optic neuropathy’

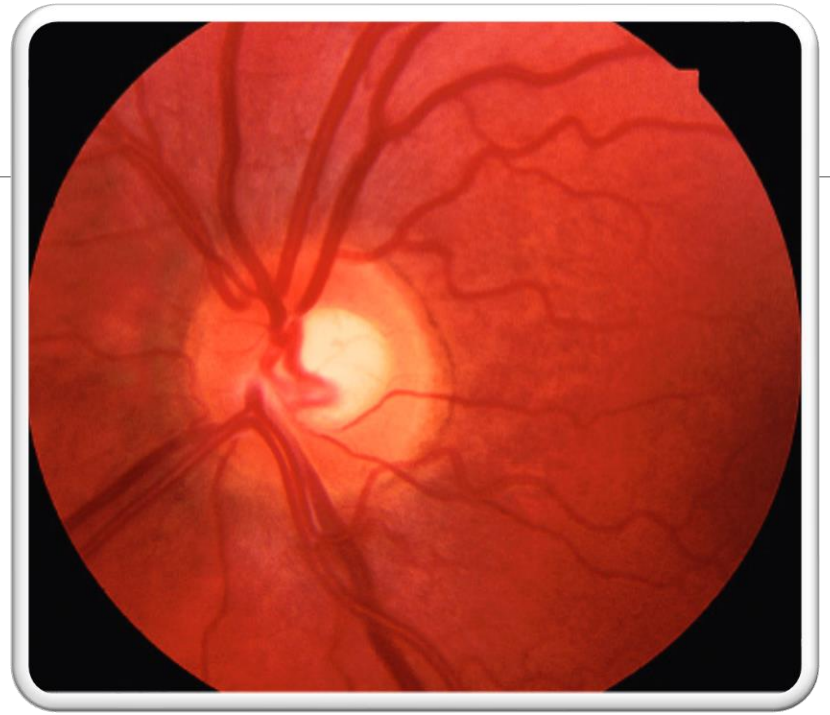
Characterized by damage to the optic nerve (cupping)

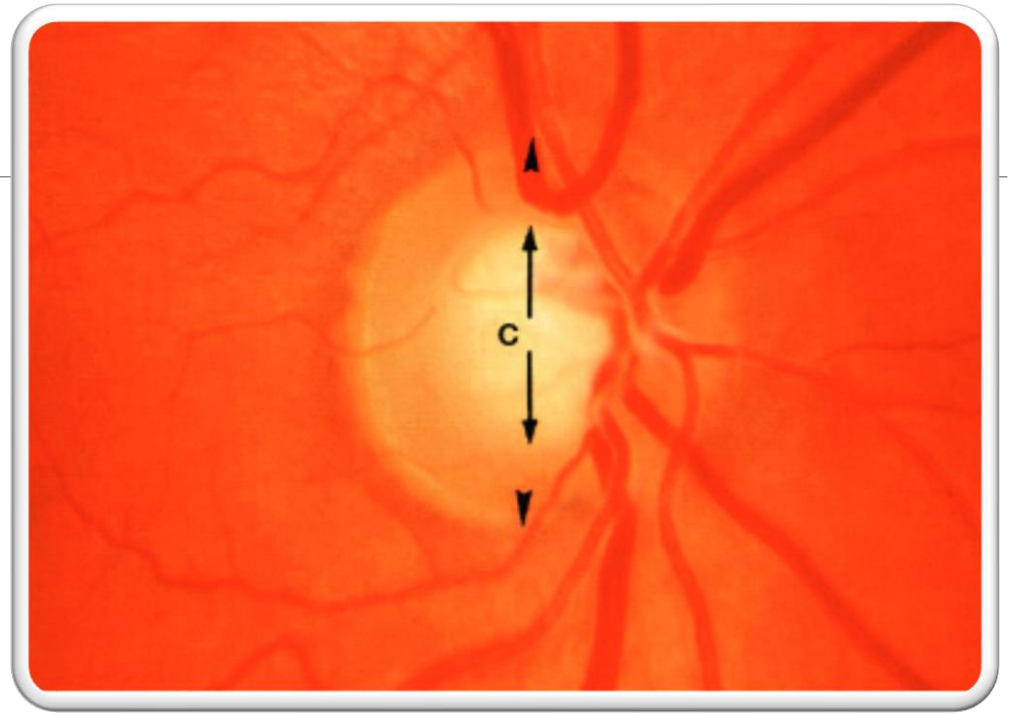
Visual field defects result from progressive optic nerve damage

Field defects are initially often peripheral

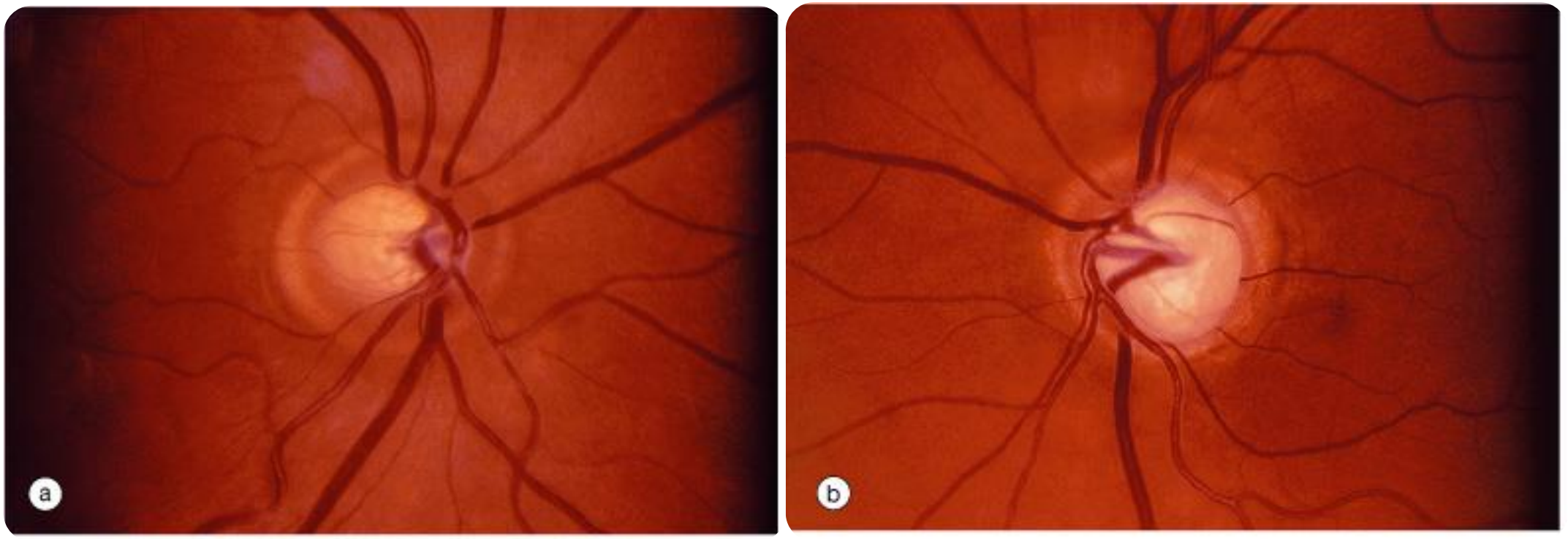
Central vision is often preserved until late in disease course, so disease is asymptomatic

We classify glaucoma as OPEN or CLOSED based on the anatomy of the angle.



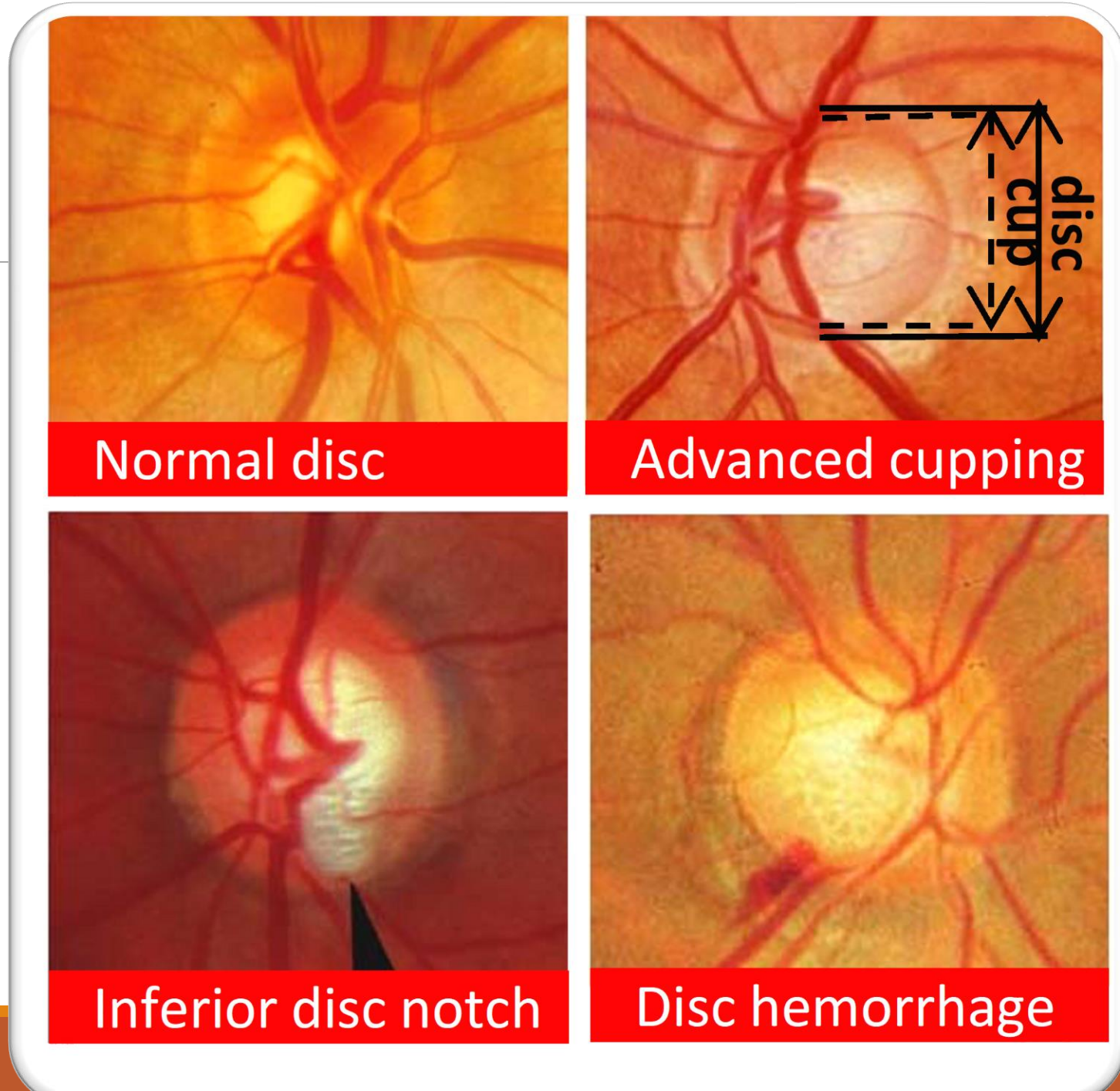


Optic Nerve

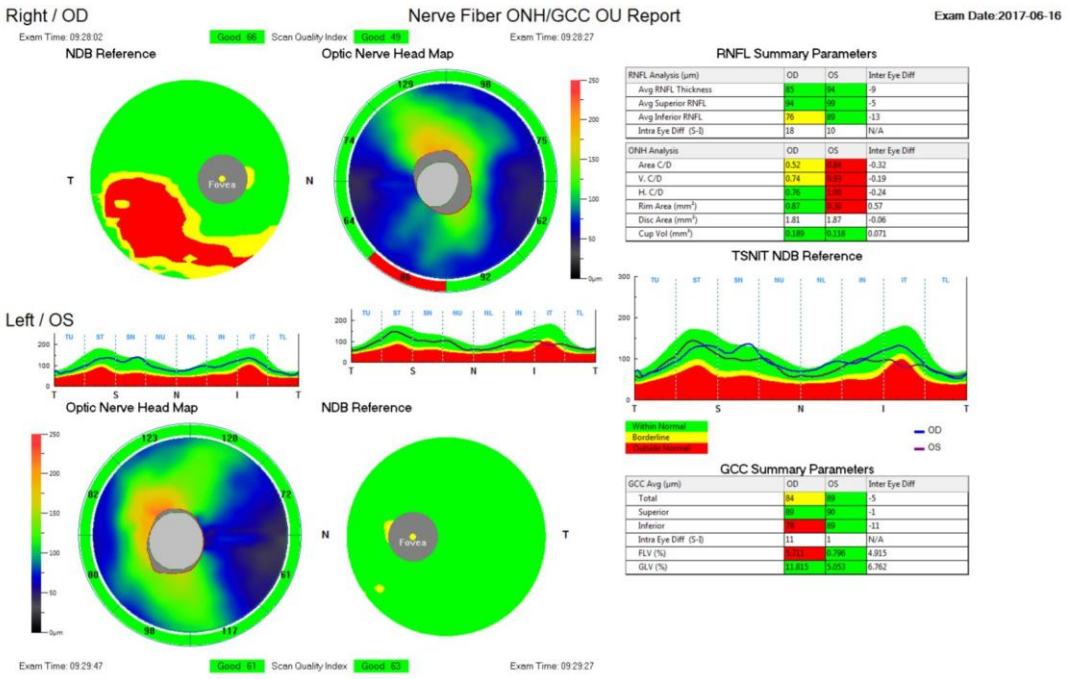


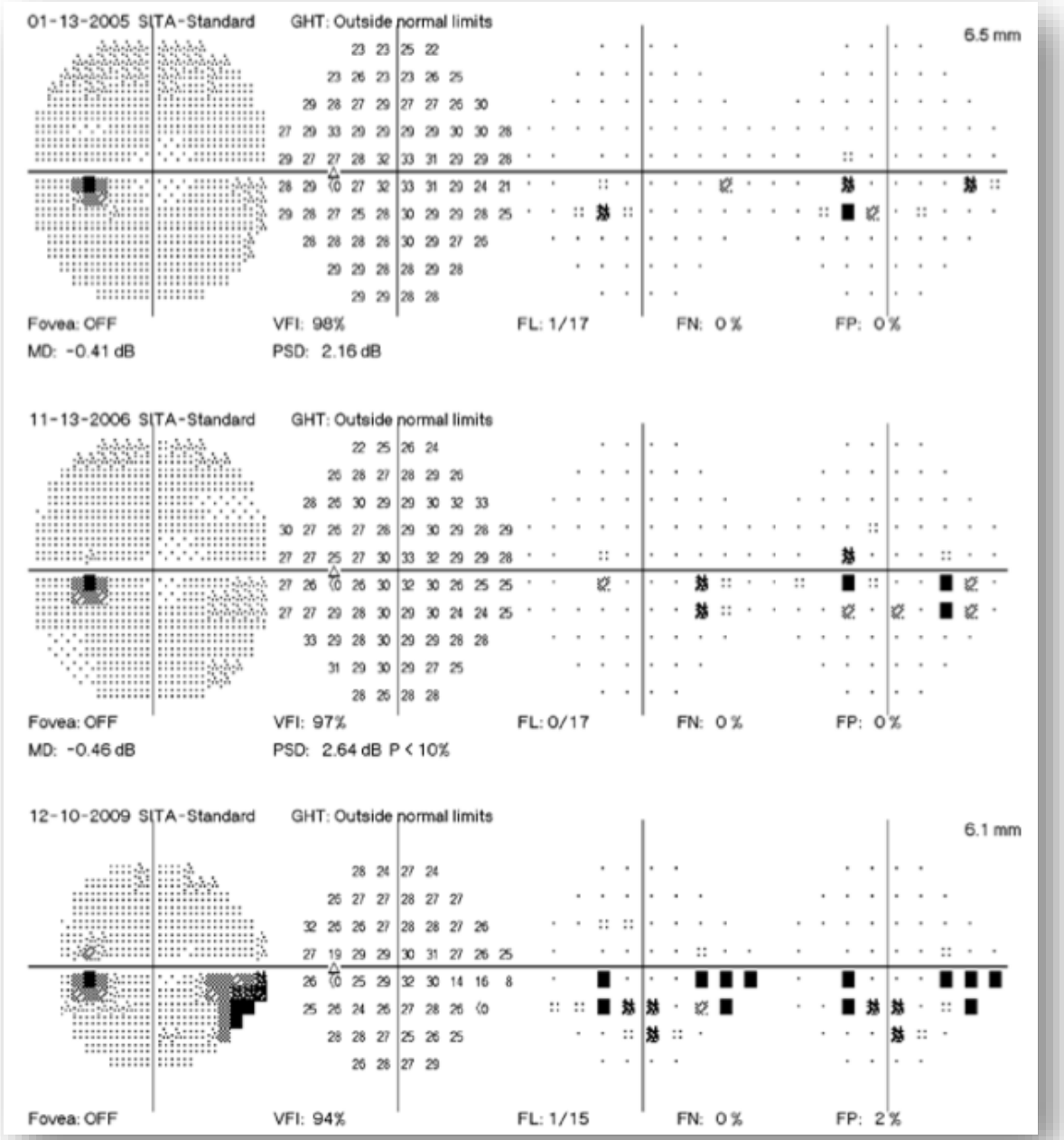
Optic Nerve Asymmetry

Glaucomatous Nerves



Visual Field Testing & Optic Nerve Scans Help to detect progression





Diagnosis

Diagnosis made when nerve appearance and visual field damage are characteristic for glaucoma (disc cupping and field defect)

Patients may be termed open angle glaucoma ‘suspects’ if they have:

- visual field changes
- increased intraocular pressure, or
- suspicious nerve appearance

Treatment

Despite the many risk factors in glaucoma, the only modifiable risk factor is IOP

Medical Therapy

- Topical IOP lowering agents

Laser Therapy

- Laser Trabeculoplasty

Surgical Therapy

- Fistulizing procedures

If your patient runs out of glaucoma medicine, it is safe to refill until they see their eye specialist

Don't refill steroid drops! These can cause pressure rise and need to be monitored

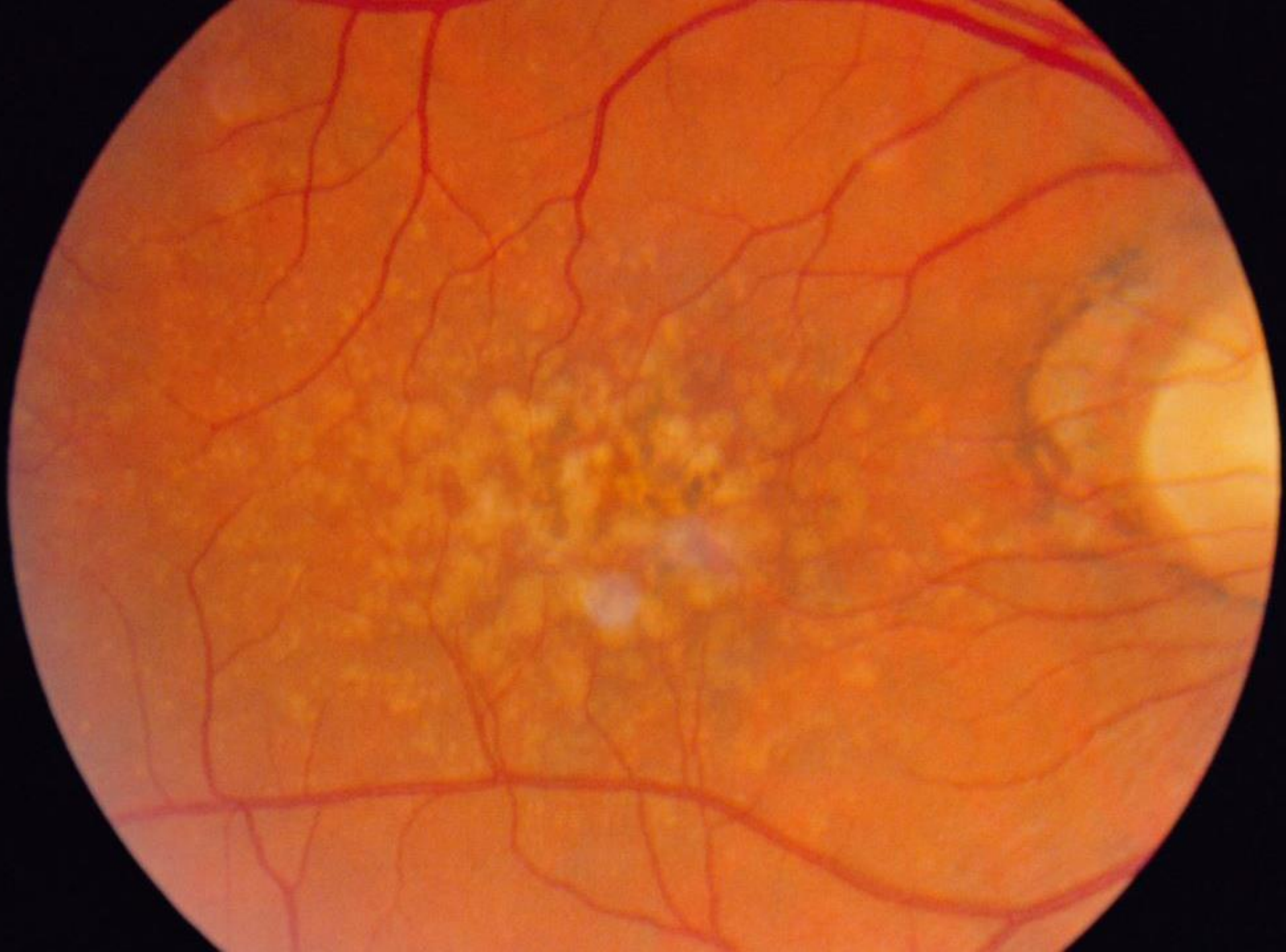
Age related Macular Degeneration (AMD)

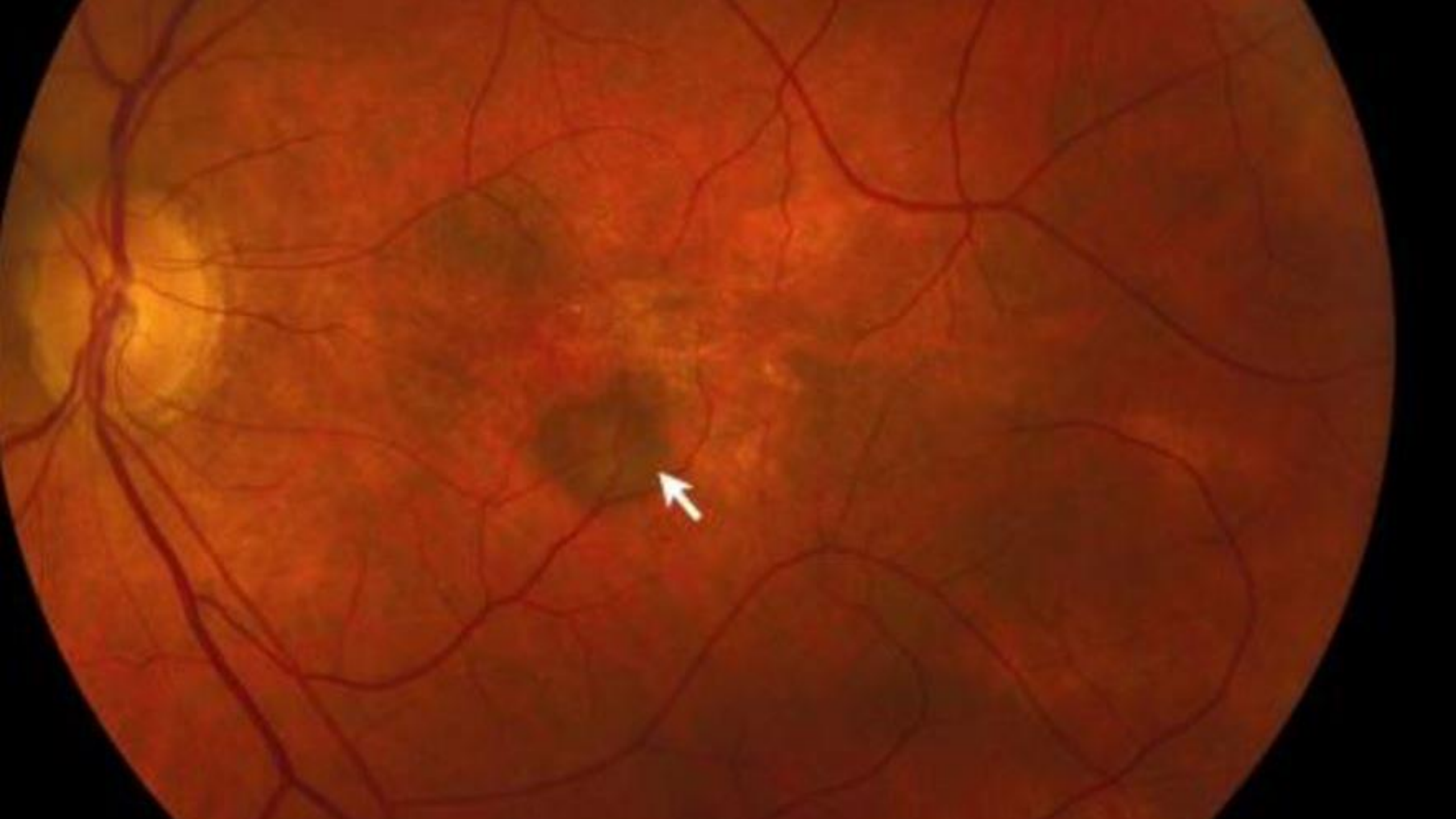
A progressive disease of the central retina

RESULTS IN CENTRAL VISION LOSS

Categorized by dry or wet

- Dry AMD – Characterized by drusen, hyperpigmentation and atrophy
- Wet AMD – Characterized by Neovascular Membranes





Treatment

Modify risk factors

- Smoking cessation
- healthy diet
- Uv protective eyewear

Treatment

Dry

- AREDS2 formulation vitamins
  - Not indicated for patients with “few drusen”
  - 25% relative risk reduction in progression from dry to wet if intermediate to advanced AMD
- Amsler Grid Testing
  - Cover one eye, look at the center of the grid.
  - Follow-up immediately if distortion is present.

Wet

- Anti- VEGF Injections – Avastin (bevacizumab), Lucentis (ranibizumab), Eyelea (aflibercept)
- Vision Stabilizes and often improves.
- Injections always begin monthly and carry on indefinitely until leakage resolves

KEY macular degeneration Points

If your patient is taking vitamins prescribed by an ophthalmologist then they have an eye disease which is progressive and potentially blinding

If your patient is getting monthly injections for amd then it is likely that they may continue to get them for several years

New vision distortion in a patient with dry amd warrants urgent referral

Amd does not result in total blindness but can affect central vision resulting in inability to drive, difficult recognizing faces and significant challenges with adl's.

A final point on glasses

MSP has de-insured routine eye examination for patients ages 19-64.

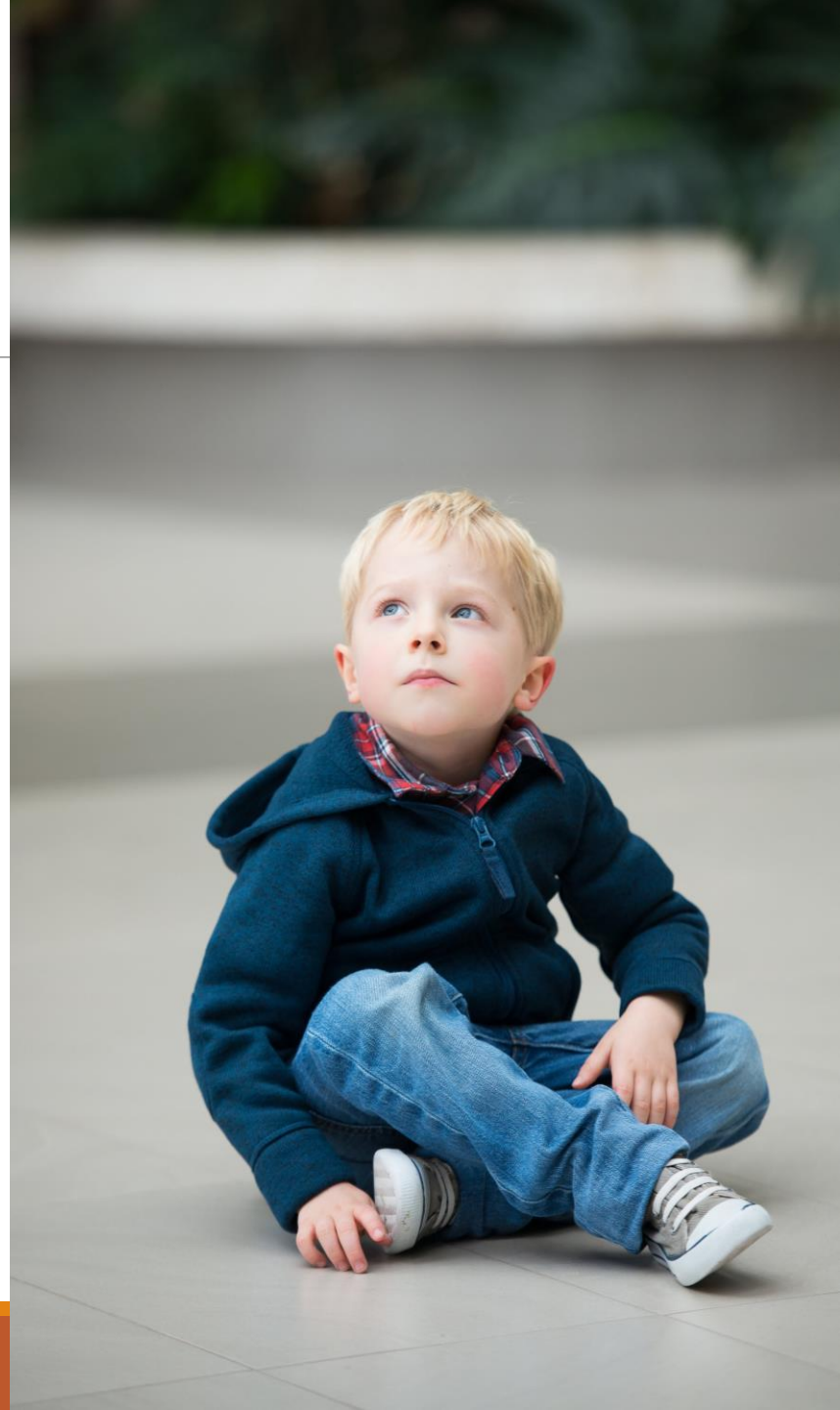
Any patient that is referred with an ophthalmic complaint (other than refractive error – which you generally know from your pinhole exam in the office), systemic disease that can affect the eyes or medications that are known to cause ophthalmic concerns are covered at any age.

Most ophthalmologists will not provide glasses prescriptions.

Thinking you want more ophthalmology knowledge or skill??

Keep a look out on the ubc cme site for a hands on seminar next year at St. Paul's

https://thischangedmypractice.com/patient-with-flashes-and-or-floaters/



Thanks!

References

Ectropion photo: http://www.mrdavidcheung.com/functional/ectropion.html

AAO Basic and clinical science series, retina and neurophthalmology. AAO 2016

Glaucoma Slides adapted with permission from Dr. S. schendel, glaucoma surgeon ubc.