Course # 909

SECO2025
THE EDUCATION DESTINATION™

Student Board Review Study Group: Retina & Vitreous

Bobby Saenz, OD, MS, FAAO

Please Silence All Mobile Devices.

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1

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Disclosure statements:

Oyster Point: Consulting Fees

All relevant relationships have been mitigated.

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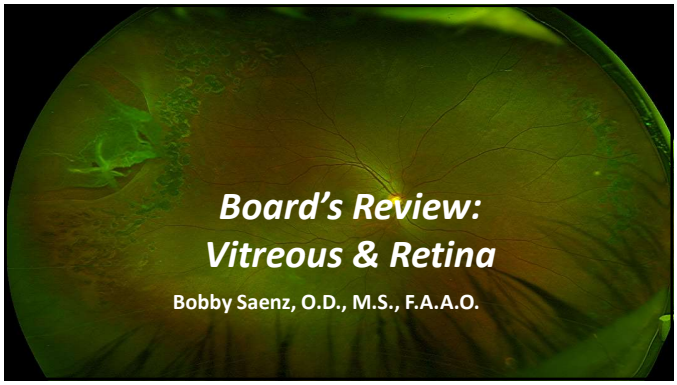

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Financial Disclosures

Company	Role	Received
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Johnson & Johnson	Consultant/lecturer	Honoraria
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Lumenis	Consultant	Honoraria
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Glaukos/Glaukos corneal health	Consultant/lecturer	Honoraria
Ocular Therapeutix	Consultant/Research	Honoraria/Research Support
Sight Sciences	Consultant/Lecturer/Research	Honoraria/Research Support
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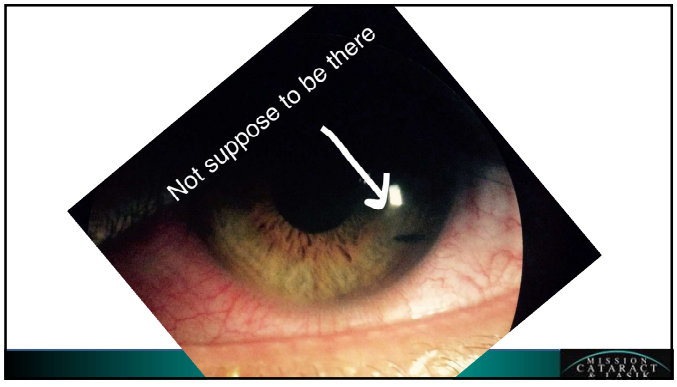

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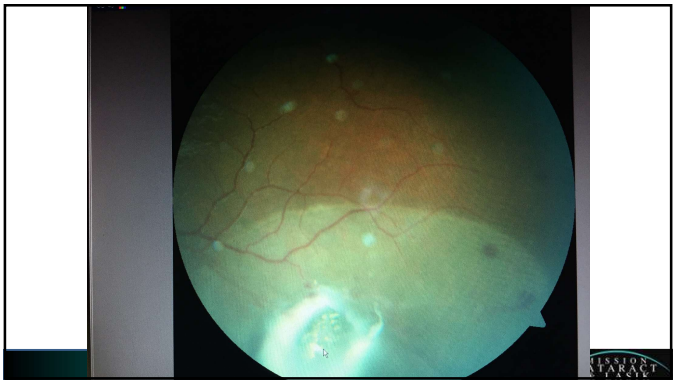

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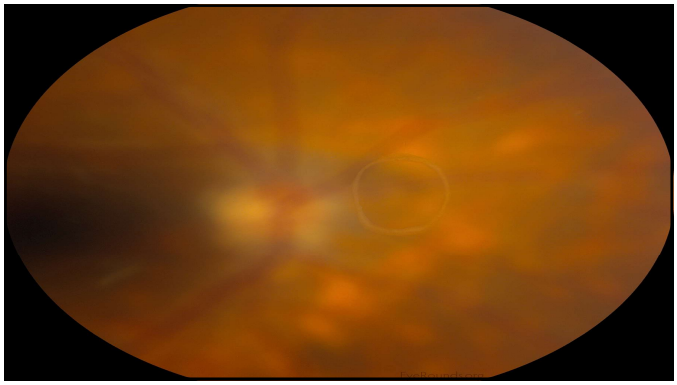

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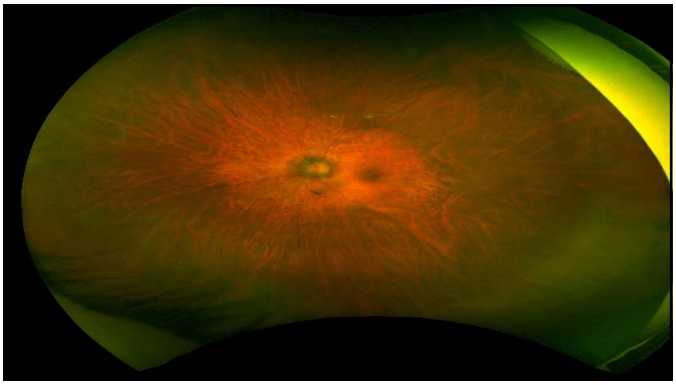

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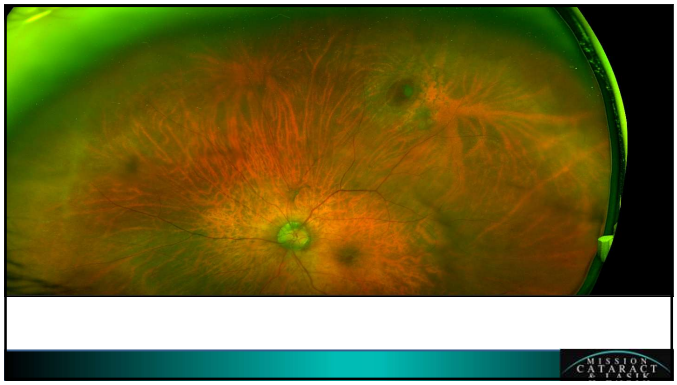

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PVD OD – (-) breaks today. RTC 1mo for DFE. RD precautions. Call asap with changes.

- Careful exam of the retina (DFE OU necessary)
- Discuss signs/symptoms of RD
- If no flashes/hemorrhages/pigment/holes/tears
  - see in 3 weeks
- If flashes/higher myopia/lattice
  - See back 1 week

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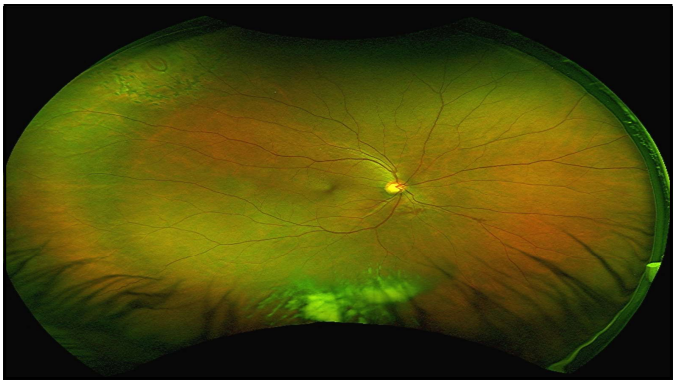

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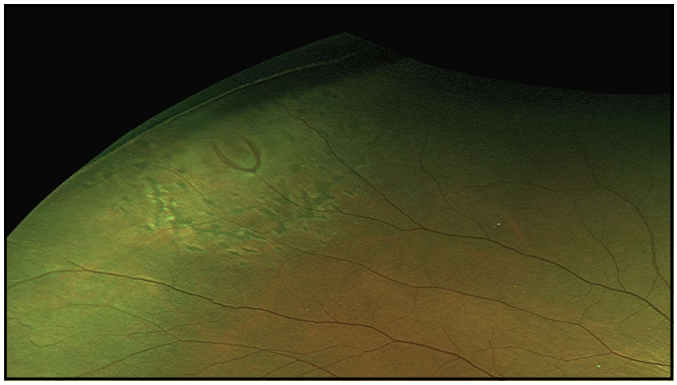

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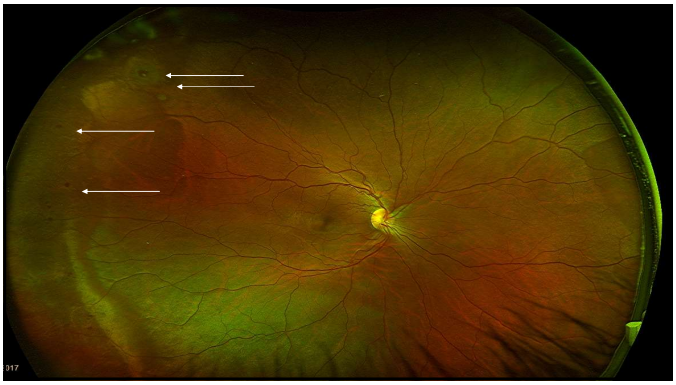

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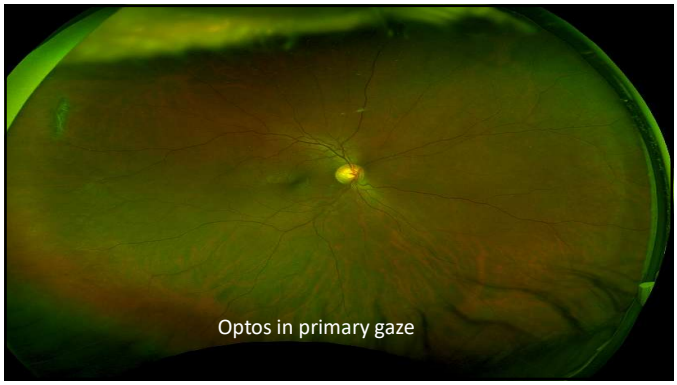

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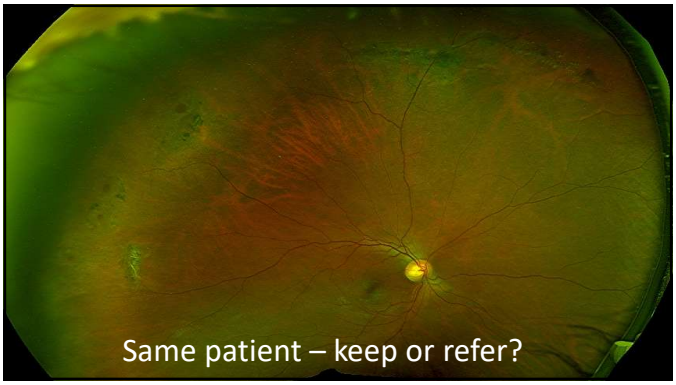


16

Do atrophic holes need laser?
Does lattice need laser?

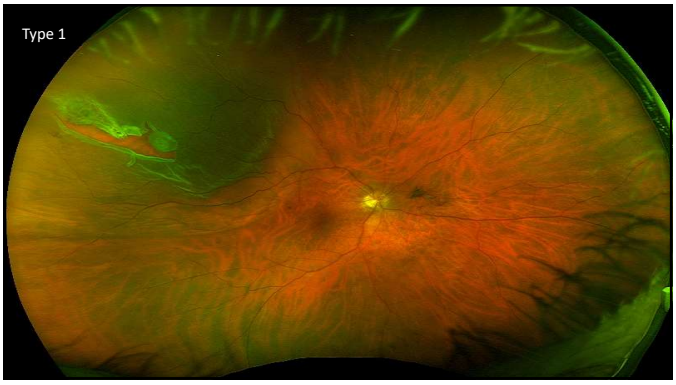
A) 67yo patient with PVD

B)15yo football player without a PVD

C)30yo myope without a PVD

-Family history of RD

17



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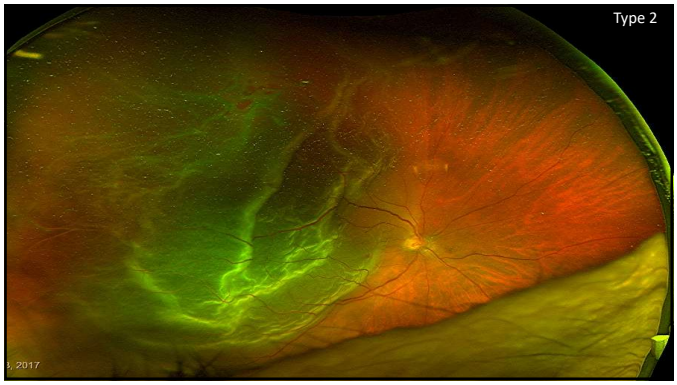


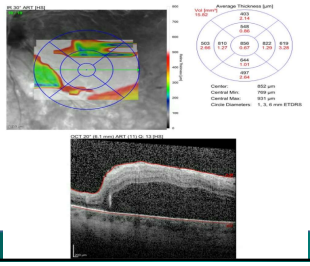
19

Retinal Breaks Referral Guidelines

	Asymptomatic	Symptomatic
PVD		1-2 weeks
PVD with vit heme		48 hours
PVD with pigment in ant vitreous		24 hours
Acute horseshoe tear		Call office same day
Hole with fluid cuff	1-2 weeks	2-3 days
Atrophic hole	1 month	1 week
Lattice with holes	1 month	1 week
Operculated hole	1 month	2-3 days
Lattice	N/a	1-2 weeks
Retinal detachments		Call office same day
Retinal detachment mac on inferior		Call office same day

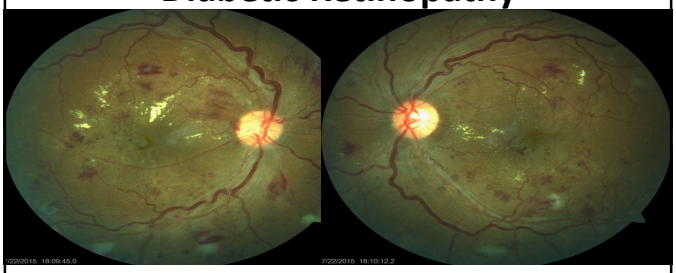
20

ARE mac off – diabetic tractional retinal detachments ASAP referrals?



21

Diabetic Retinopathy



When do I need to refer?

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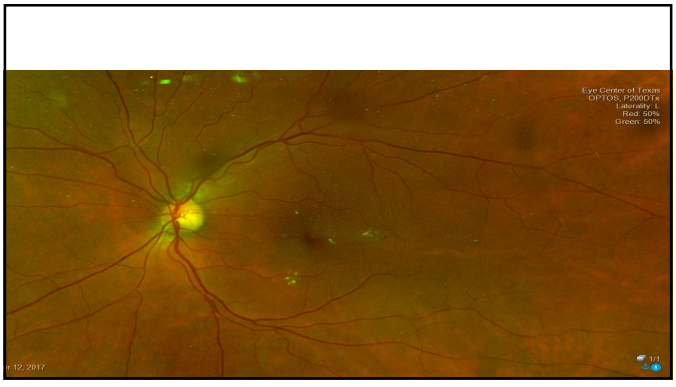
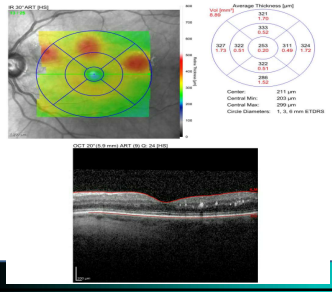
23



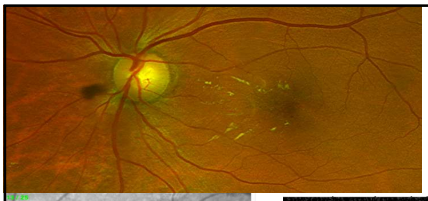
24

Mild NPDR w/……– VA 20/20

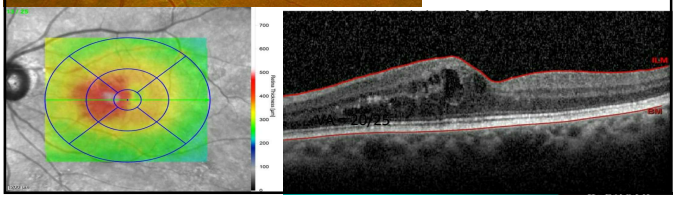


Refer or keep?
BS control!!

25



Diabetic Patient
VA = 20/25



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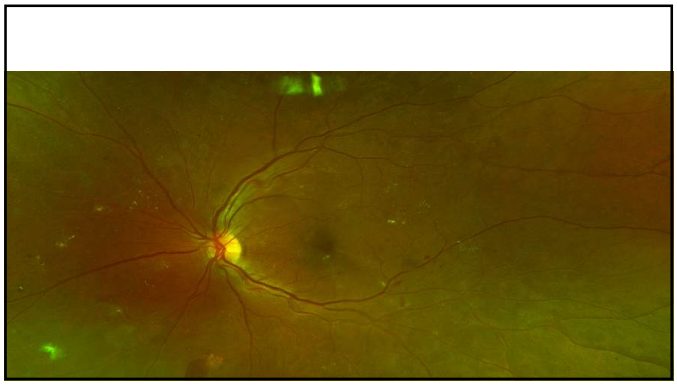

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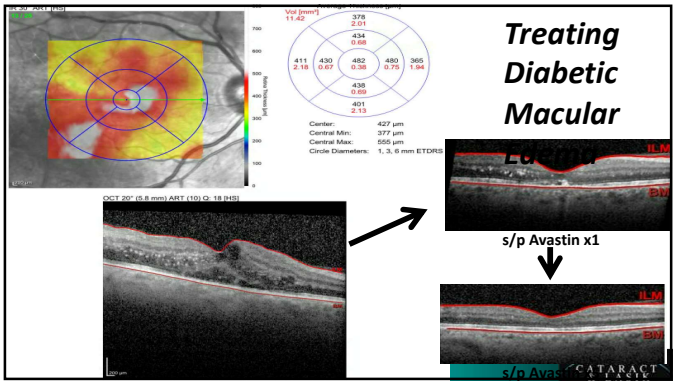

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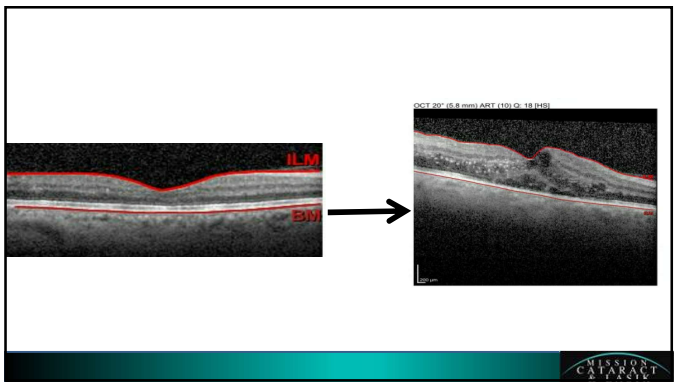
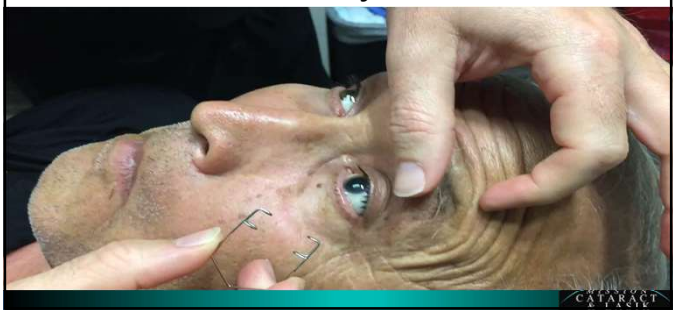


29

Avastin injection



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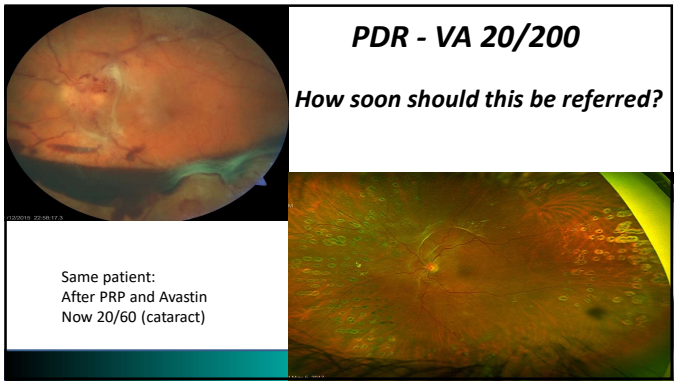
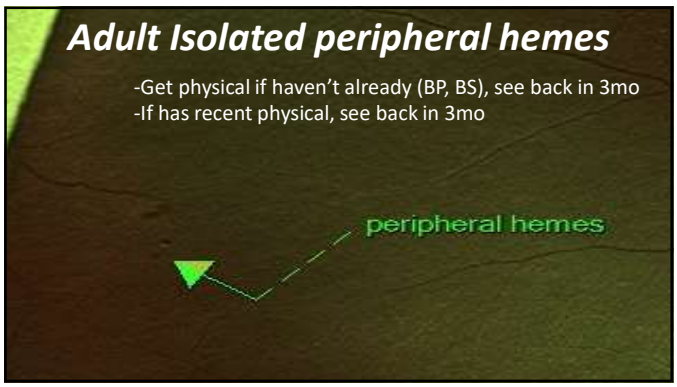


31

Diabetic Referral Guidelines

	(-) No ME	Non central ME	(+) CSME
Mild	6-12mo	3 months	Refer (1mo)
Moderate	6 months	3months	Refer (1mo)
Severe	2-4 months	Refer (1mo)	Refer (1mo)
PDR	Refer (2wks)	Refer (2wks)	Refer (2wks)

32



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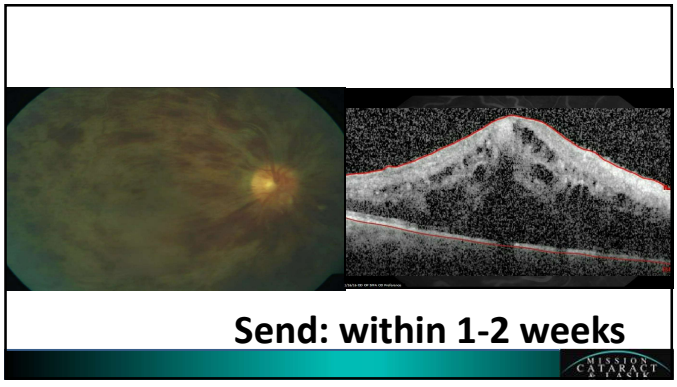

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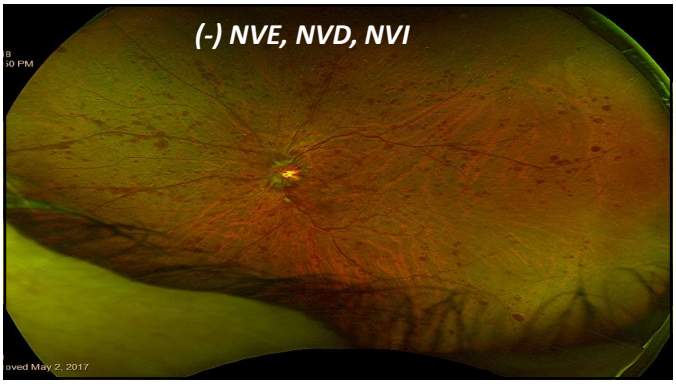

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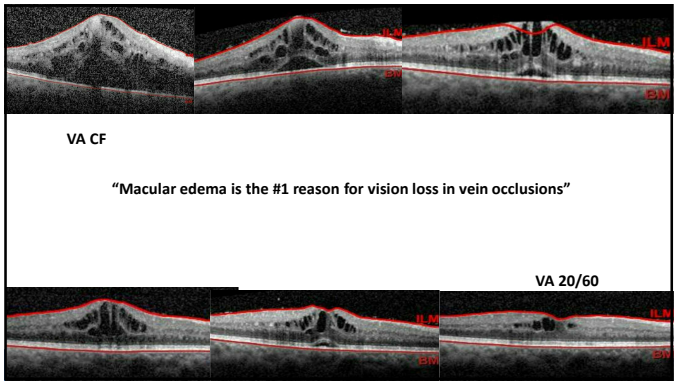

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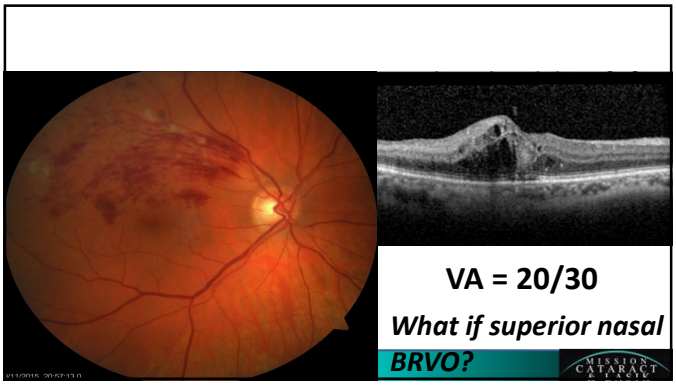

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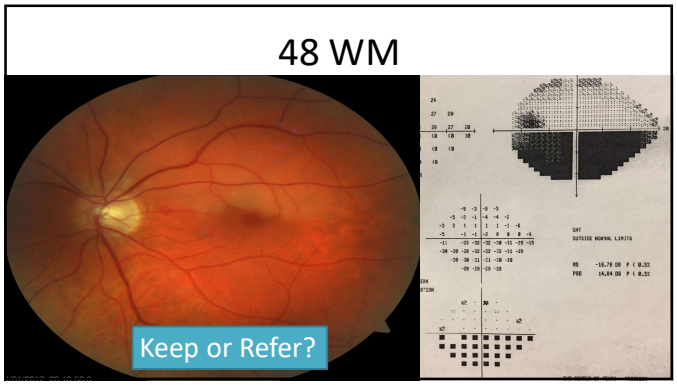

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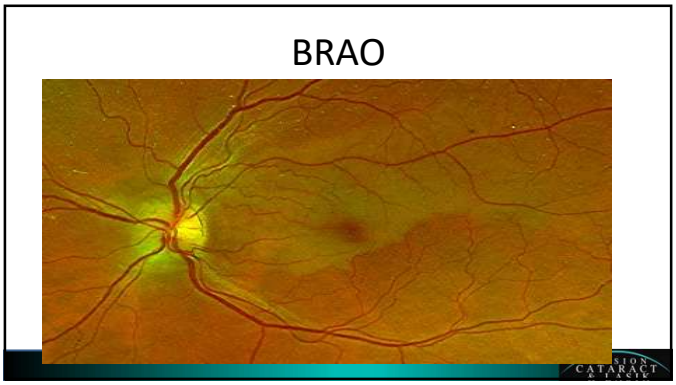

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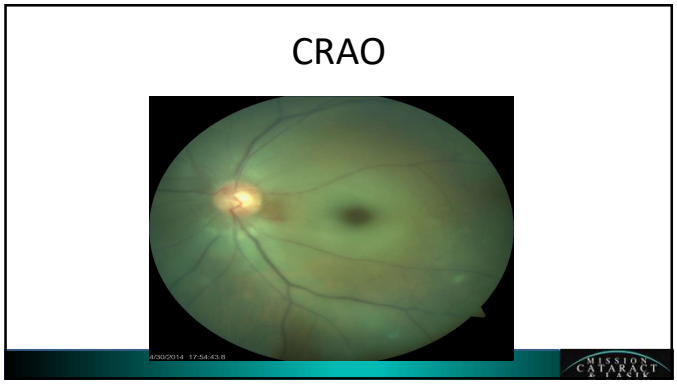

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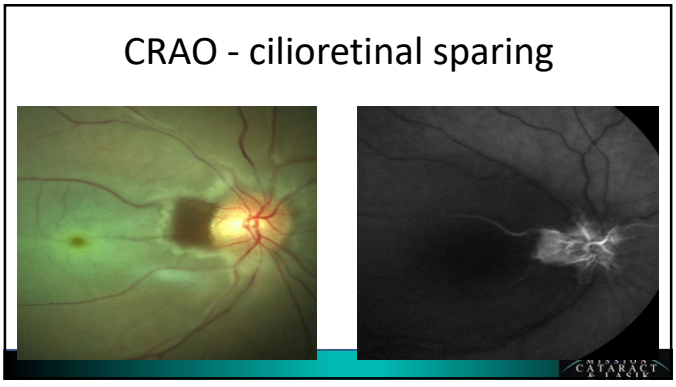


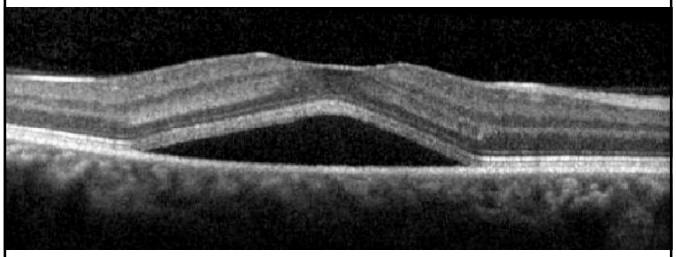
42

Artery occlusions

- IF <18-24 hours, call ASAP
  - If >24 hours, still CALL
- FIND THE SOURCE
- Is there anything we should do in the office?
  - Aspirin? Lower IOP? Message?
- We send to ER with a note for stroke work up ASAP – leave straight there from our office
  - ECHO, carotid, MRI, etc

43

Keep or Refer?

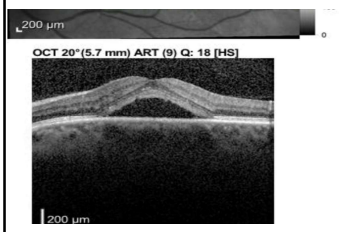


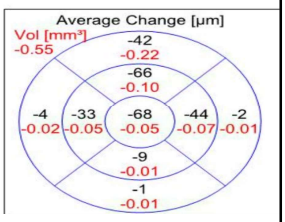
If CSR start on NSAID, follow up in 1mo

But how long does it take to resolve? What happens after t

44

1 mo later - improved





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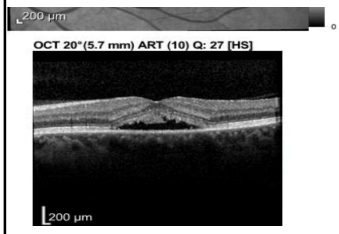
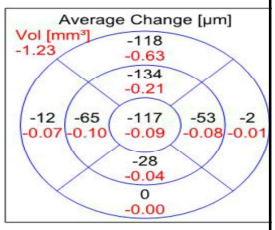
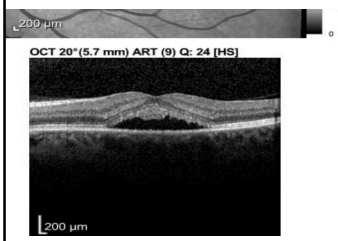
2 mo later - improved

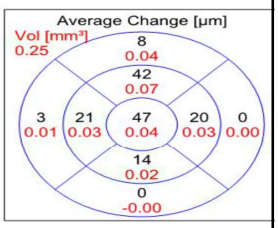




46

3mo later … Increased SRF

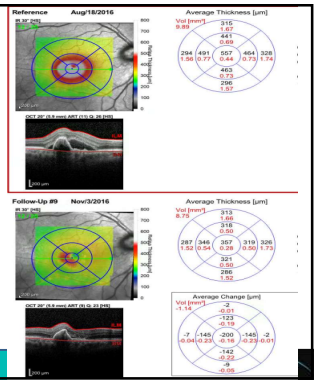




Now WHAT?

47

PDT example



48

Ways to Treat CSR?

Ways to NOT Treat CSR?

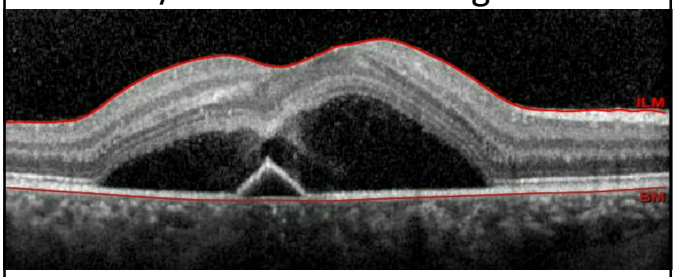
49

Can use steroids for macular edema

Can't use steroids for macular edema

50

CSR w/PED – same management?



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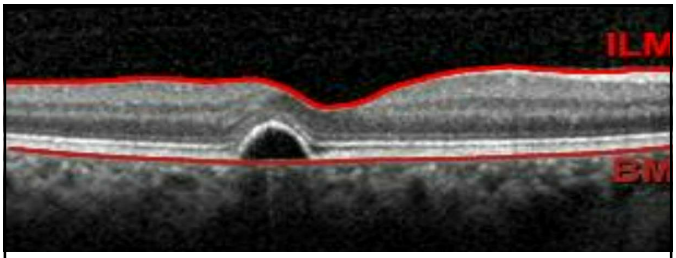

Resolved SRF

Now how often do I see this patient back?

52

How about these?

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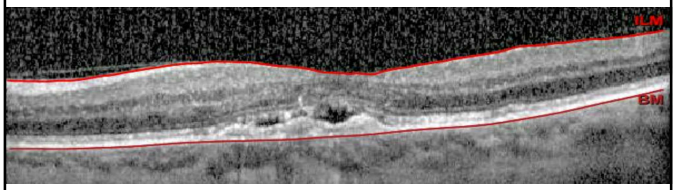
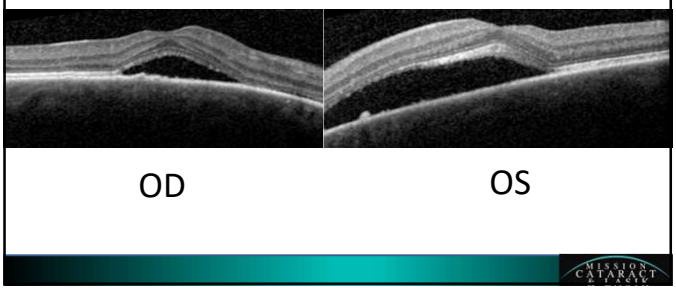


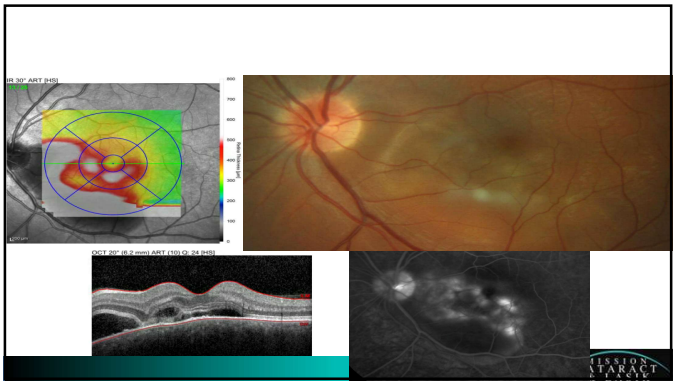
54

Bilateral



OD OS

55

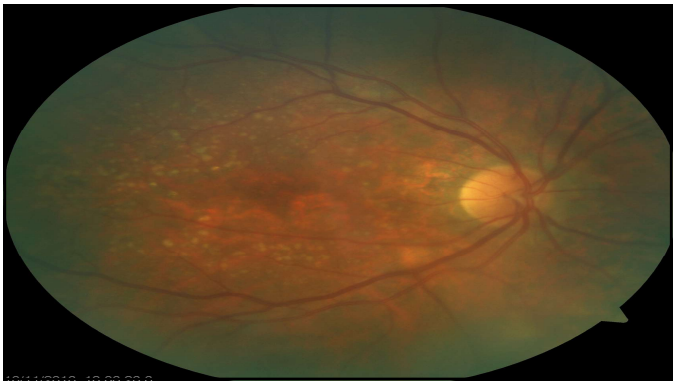


56

CSR

- Follow monthly – Use NSAID
- Refer if
  - Vision doesn't match
  - Demographics don't match
  - Not improving after a month
  - It's atypical
  - Possible CNV

57



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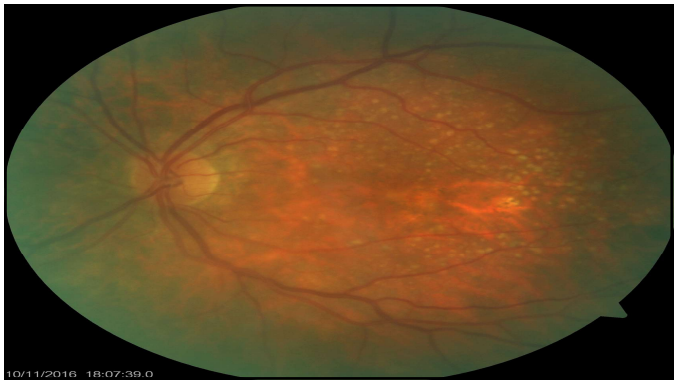

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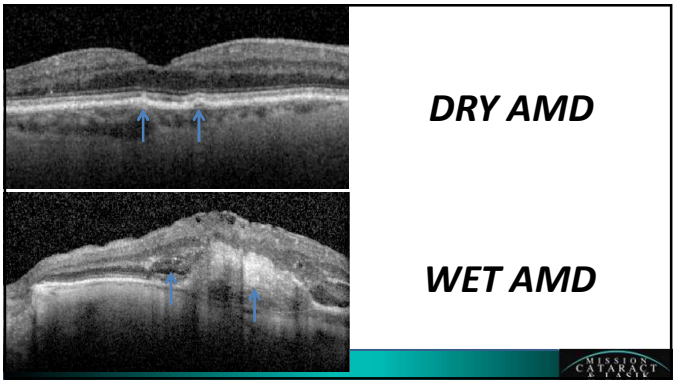

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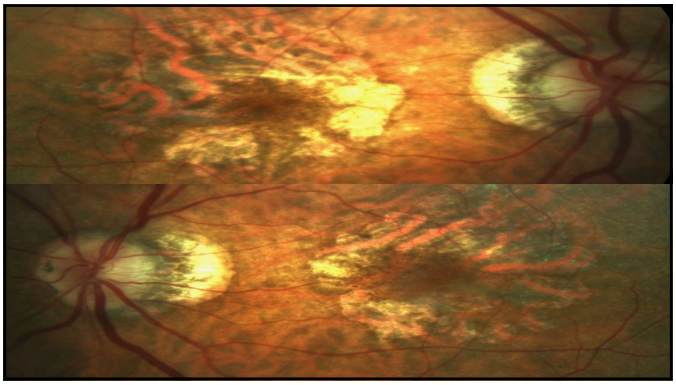


62

AMD Management

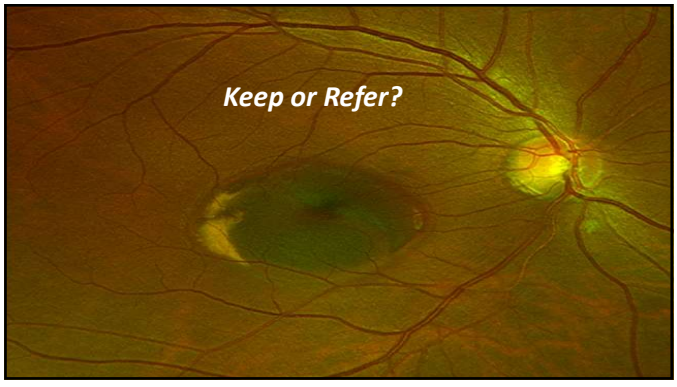
- Follow with OCT
  - Mild DRY AMD: yearly
  - Moderate DRY AMD: q6mo
  - Severe DRY AMD: q3mo
  - Geographic atrophy: q3mo
  - If converts to WET: Referral within 1 week
    - Will need FAFP

63

DRY AMD

- Amsler, AREDS, no smoking, sunglasses, hat
- Return sooner if
  - Amsler grid changes
  - decreased visual acuity
  - any hemorrhage near the macula or nerve
  - for macular elevation, edema or discoloration

64



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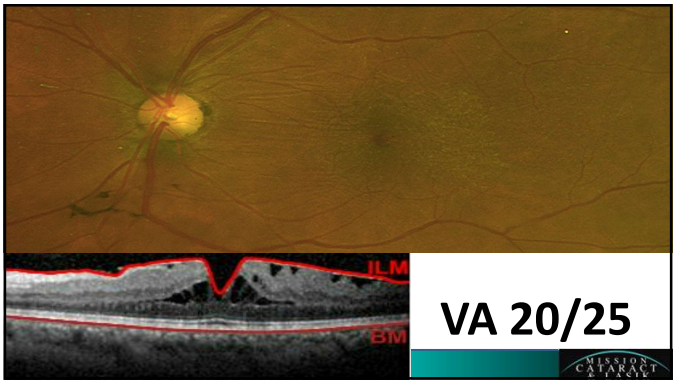

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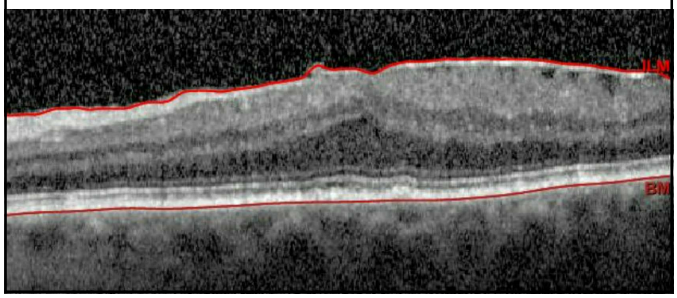
VA 20/25



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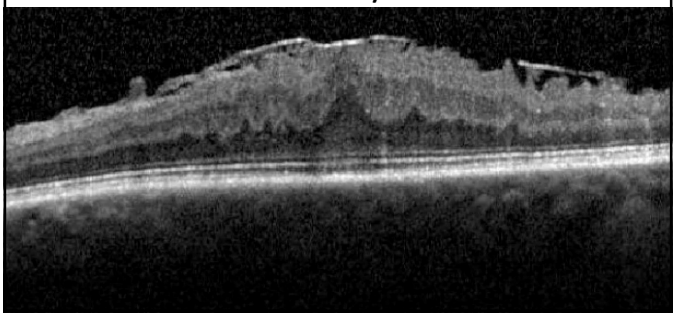

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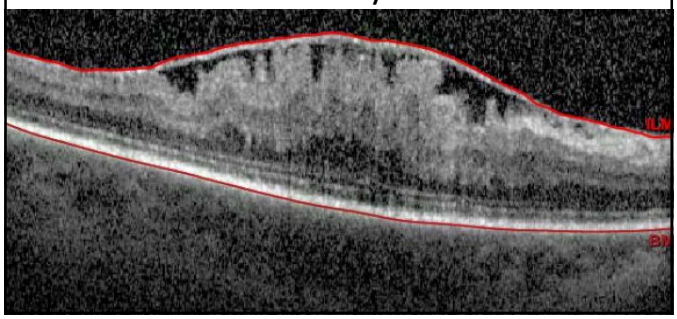

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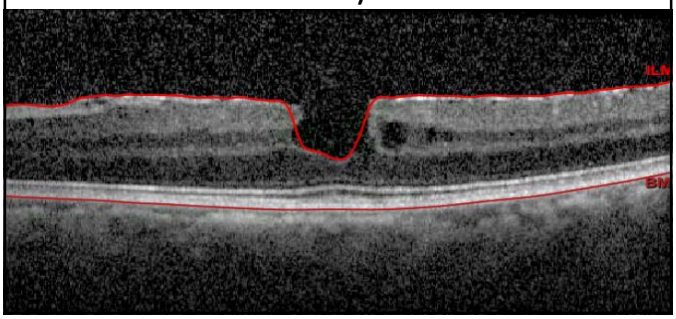

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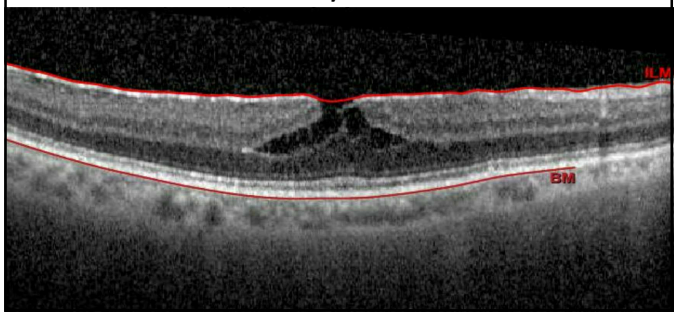
20/30

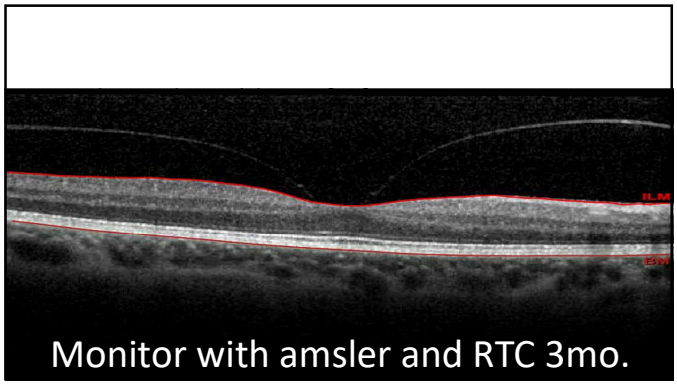


71

ERM

- When do I recommend surgery?
  - 20/50 or worse
- How often should I be following them?
  - Q3mo until beginning
  - Q6mo until stable

72



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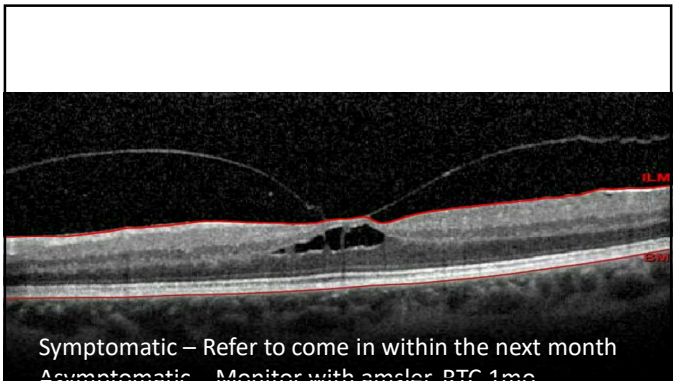

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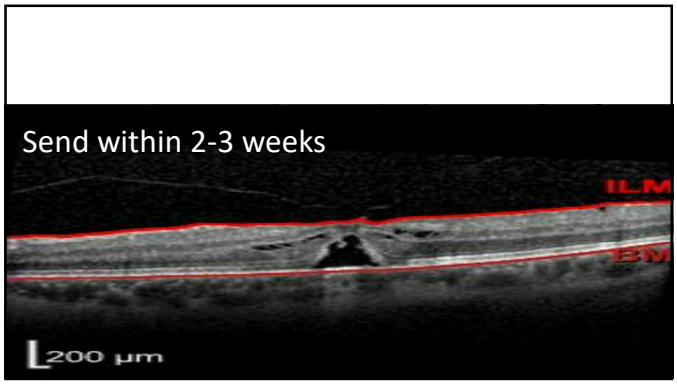

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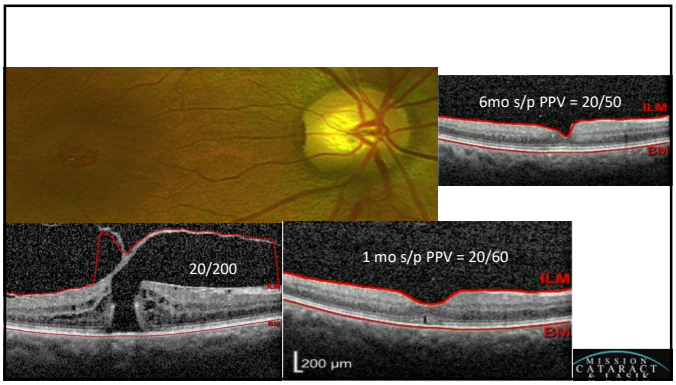


76

77

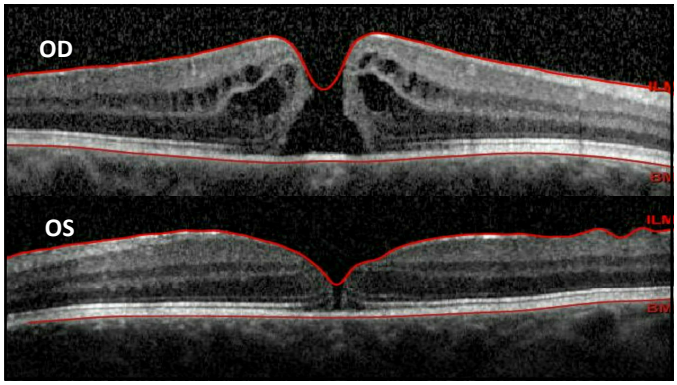
MACULAR HOLE

How urgent is referral? Acute v Longstanding?

If it's been there longstanding, do we still recommend surgery?

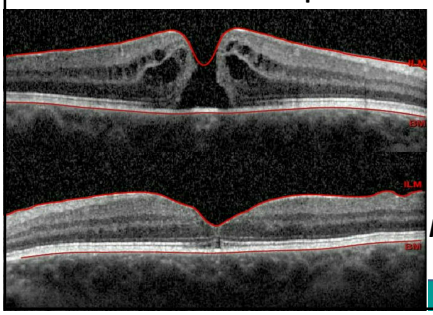
Do you do cataract surgery before the PPV, MP? If so, why?

78



79

After phaco OU



Plan PPV, MP OD

MH OS closed!

80

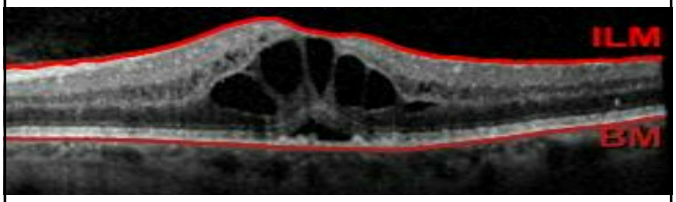
20/40 OU

OD - s/p PPV x 6mo

OS – spontaneous resolution

81

s/p phaco x 6 weeks

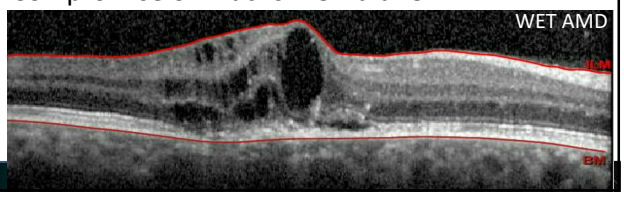


Keep or Refer?

82

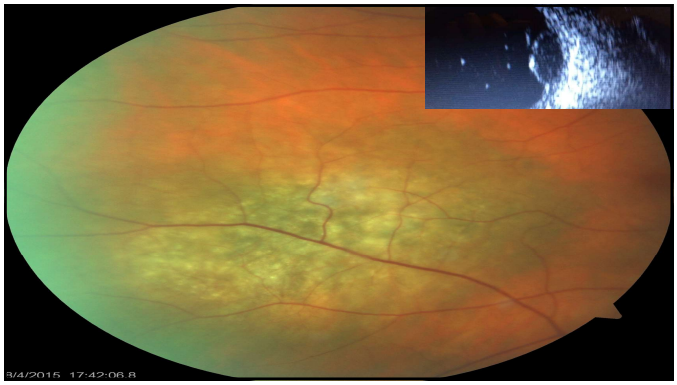
When do I refer CME

- Non – responsive to meds
- Unknown etiology
- Compromise of Bruchs membrane



83

84



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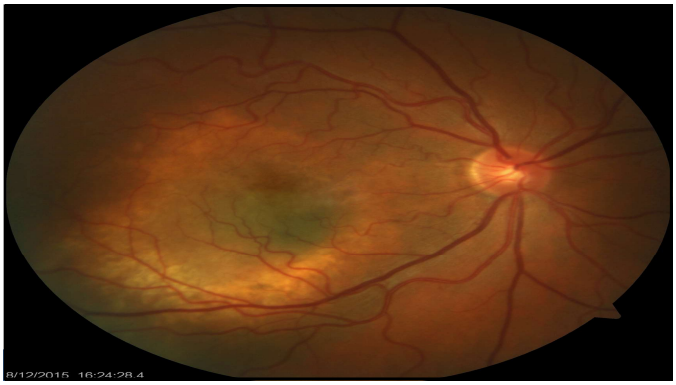

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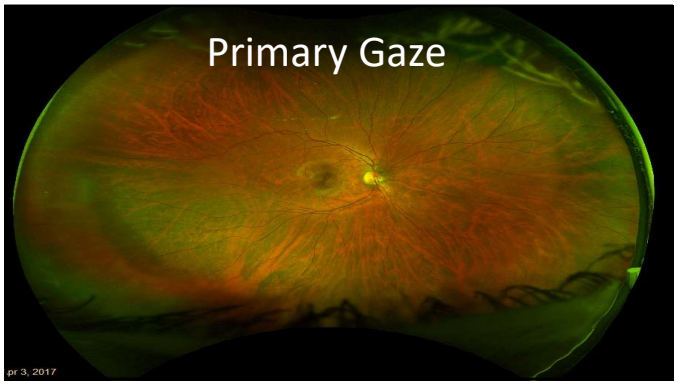

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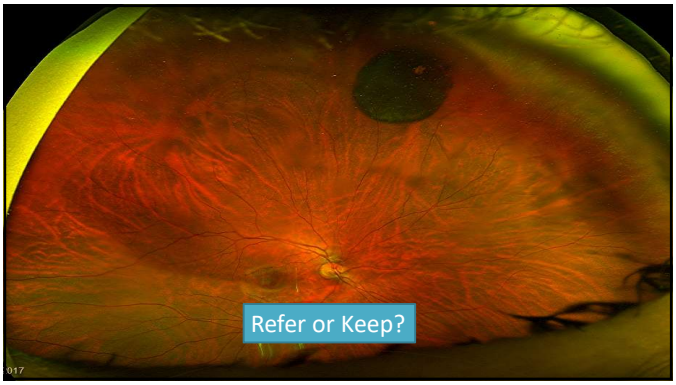

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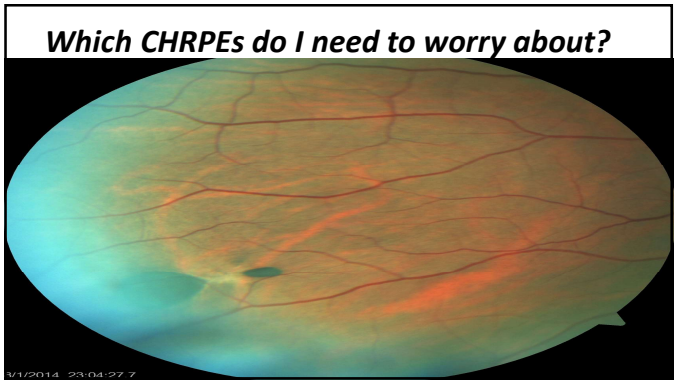

89

90

How to write a Plan

- **P**icture/Exam Recap
- **L**ist Treatments
- **A**nything to look out for patient
- **N**ext steps?

Blepharitis OU – lid margin today photos consistent with diagnosis. Start lid hygeine. Call with any new redness/pain. RTC 1mo

PVD OD – (-) breaks today. RD precatuions. RTC 1mo.

91