

OPHTHALMIC HOSPITALIST INTEREST GROUP

NEWSLETTER

Donna Kim, MD | Maggie Hymowitz, MD

Announcements

Join the Community!

Have a question or topic about inpatient/ER consults? Share on the [AAO/OHIG community](#)! Log in with your AAO username.

OHIG Round Table Discussion at AAO Meeting 2024

Save the date for the OHIG Round Table Discussion at **AAO 2024** in Chicago, **Sat 10/19/24 @ 4:00-5:00pm**, Society Relations Office. More details to come. We hope to see you there!

OHIG Topic Wishlist

Have a case you would like to feature in an OHIG newsletter? We welcome your ideas and expertise. Email ohig@ohig.org.

Welcome New Members!

Thanks for joining OHIG! Please verify your information on the [OHIG website](#).



Photo Link

Articles

[Impact of Automated OCT in a High Volume Eye Urgent Care Setting, BMJ, 2019](#)

Expanded access to automated OCT in a high volume after hours setting shows promise for improving the accuracy and timeliness of diagnosis, which can be critical for patient outcomes.

[Six Month Longitudinal Comparison of a Portable Table Perimeter with the Humphrey Field Analyzer, AJO, 2018](#)

A portable iPad perimetry app correlates strongly with a standard automated visual field tests and holds promise for obtaining visual fields in an ED/hospital.

[Reproducibility of Portable OCT and Comparison with Conventional OCT, Diagnostics, 2024](#)

Promising results showing that portable OCT may be a suitable alternative to conventional OCT. Could this be useful in your hospital or ED?

PEARLS



Smartphone Retinal Imaging Using VR Headset Mount



Find it hard to capture fundus photos with your smartphone? Check out this video from the AAO demonstrating a smartphone attachment to a virtual reality headset which can be worn by an examiner to capture retinal images.

[Click here](#) to view.

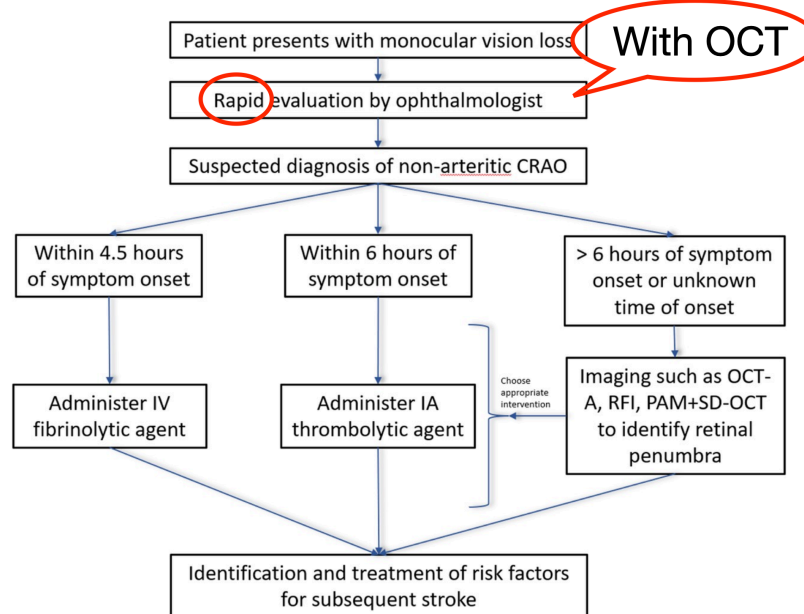
Handheld OCT Clinical and Research Applications



Symposium highlights from the University of Leicester in the UK providing an instruction about handheld OCT and its clinical utility

[Click here](#) to view.

CONSULT ROUNDS



[Diagram Link](#)

Scenario 1: It is a busy day on consults and you are the on-call ophthalmologist for multiple hospitals and ED's. You receive a page about a 45 year old female with vascular risk factors including DM, HTN, HLD, Afib, who just showed up to an ED with near complete vision painless vision loss in her left eye x 3 hours. Her vision is LP and the ED pages you for an urgent consultation to evaluate for CRAO. Stroke is also waiting for your diagnosis as she might be a candidate for TPA.

You are all the way across town at another hospital seeing a patient with a retinal detachment. Even with your best efforts, it would take you over 2 hours to finish up with this patient, get them on track to see retina, get in your car, drive to the other local ED across town, dilate the new patient, and then examine for CRAO - in which time it may be too late for TPA consideration.

You imagine how this could be very different if that ED could send you an OCT. You could potentially provide an accurate and timely diagnosis without even driving or examining this patient.

Scenario 2: You are paged about 4 year old girl in the ED with unexplained bilateral vision loss.

Up until recently, she was acting normally, seeing well, and playing at home. She caught a mild cold from her brother and developed symptoms of a URI with mild fever, cough, nasal congestion.

Over the next 3 days later she began to stop watching TV, bumping into walls, and eventually told her parents “I can’t see”. She is seen by her pediatrician who wonders about functional vision loss but opts to send her to the ED for urgent evaluation with ophthalmology.

In the ED, the patient is sitting calmly, staring at the wall, and is verbally communicative. She is LP in both eyes. Both pupils are sluggish but reactive without APD. Her motility is full without pain on eye movement. Funduscopy exam appears wnl.

An MRI Brain and Orbit is requested to evaluate for potential optic neuritis or other pathology - which is negative.

At this point, you wonder what to do next since you don’t have a clear diagnosis for this 4 year old girl’s vision loss. Luckily, your ED is somewhat connected to the eye clinic through a convoluted route through the hospital. You don’t often transport ED patients to clinic but in this particular circumstance you opt to get further ophthalmic imaging just to be safe. Functional vision loss is on your mind but would be a diagnosis of exclusion.

The patient is transported to the eye clinic for OCT imaging which demonstrates severe and striking bilateral retinal abnormalities. Her OCT imaging is reviewed by pediatric retina and uveitis who feel that the patient’s imaging findings are highly unusual and reportable. With permission from the family, the patient’s OCT imaging is quickly distributed to other retina and uveitis specialists at other academic centers who similarly have no diagnosis for this case.

In the end, the patient is felt to have some form of an unusual and aggressive post-viral retinopathy. There is extensive discussion with the family about the risks and unknown benefits of empiric therapy. Within 24 hours the patient is admitted to the hospital and started on empiric IV Acyclovir and eventual systemic and local steroid. Unfortunately there is no improvement in her vision.

As the on-call ophthalmology consultant, you wonder how this case would have gone if you didn’t have immediate access to OCT for your ER patients.

Case Comments: Ophthalmic imaging is not always readily available in many ED/inpatient settings. Barriers to implementation include a lack of physical space for devices, financial cost, data security concerns, need for telemedicine infrastructure, etc. Yet, there are many instances where ophthalmic

imaging in the ED/hospital could make a real difference in terms of accurate and timely diagnosis and visual outcomes. What would it take to get ophthalmic imaging in your hospital or ED?

AAO/OHIG Online Community Survey Question

Question: What forms of ophthalmic imaging do you have for inpatient/ED consults at your institution? How do you incorporate imaging into your consult workflow? Click all that apply:

- A) We have no access to ophthalmic imaging on consults
- B) External photos
- C) Portable fundus camera
- D) Standard OCT
- E) Handheld OCT
- F) Clinic transport for photography, OCT, FA, formal b-scan
- G) Portable b-scan
- H) ED/hospital patient images are uploaded to EHR using a smart phone camera app
- I) ED/hospital patient images are uploaded to EHR via a dedicated imaging service
- J) ED/hospital patient images are uploaded to the EHR via an ED staff
- K) ED/hospital patient images are sent securely via telemedicine portals
- L) We bill for consult imaging
- M) Consult imaging often fails to get billed
- N) Other

Share your responses on the [AAO/OHIG community page](#)!