OPHTHALMIC HOSPITALIST INTEREST GROUP

Volume 2, Number 12 Dec 2022

# OPHTHALMIC HOSPITALIST INTEREST GROUP NEWSLETTER

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## Announcements

### Join the Community!

Read about comments from the Round Table discussion on CRAO, newly published articles on ocular monkeypox, and more!

AAO/OHIG Online Community!

### CRAO Survey Results

Thank you for participating in last month's survey about TPA for CRAO. See pages 4-6 for results.

### OHIG Topic Wishlist

Have a topic or clinical case that you'd like to feature in a future OHIG newsletter? We welcome your ideas and expertise. Feel free to email ohig@ohig.org

### Welcome New Members!

Thanks for joining OHIG! Please verify your information on the OHIG website.

Image Source

## Articles

*Ocular and Ocular Adnexal Injuries Treated by US Military Ophthalmologists During Operations Desert Shield and Desert Storm, Ophthalmology, 1993*

A review of war injuries resulting in ocular/adnexal trauma.

*Ocular Trauma and TBI on the Battlefield: A Systematic Review After 20 Years of Fighting The Global War on Terror, Military Medicine, July 2022*

A review of ocular injuries sustained by US serviceman including widespread use of improvised explosive devices (IED's).

*Ballistic Eye Protection: Why Are Soldies Reluctant to Use Them?, Military Medicine, Mar-April 2019*

Soldiers can be reluctant to use protective eye wear during combat due to imposed visual field restriction. Eye protection with wider lenses or no frame should be considered along with education and instruction.

# PEARLS

### AAO's Resource for Wartime Ocular Injuries

First Aid for a Common Target of Wartime Injury: The Eye

By Susanne Medeiros
Mar. 02, 2022

Eye injuries during military operations have skyrocketed over the past decades as newer munitions create increasingly smaller debris that can devastate an eye.

A resource from the AAO and ASOT reviewing eye injuries from wars with a recent focus on Ukraine. Click here

### Eye Protection on New Year's Eve

How To Pop a Champagne Cork Without Harming Your Eye

A champagne cork can fly up to 50 mph as it leaves the bottle! Tips from the AAO to help ensure a quieter call Click here

### Ophthalmologist Hosts a Party

Dr.Glaucomflecken on new year's eye safety (ha ha)

Click here

# CONSULT ROUNDS


Richard Stutzman, MD
Associate Professor
Casey Eye Institute, Cornea Division
Oregon Health & Science University

We wish to sincerely thank **Dr. Richard Stutzman** for sharing about his previous hospital-based consult experiences at Walter Reed Army Medical Center, Walter Reed National Military Medical Center as a resident and eventual faculty attending.

**Q1)** How are inpatient/ER consults structured at a military hospital?

**A1)** There are 2 residents assigned to ophthalmology consults. A PGY-2 is assigned as the triage officer. This person has the responsibility of reviewing all outpatient consults, including those from the Emergency Department. A PGY-3 is assigned to manage inpatient consults. This responsibility is combined with another rotation.

The volume and complexity of inpatient consults increased dramatically during the wars with Afghanistan and Iraq. The system for consultation was then modified and became a shared responsibility for all of the trainees. Typically there was a rotating PGY-4 resident that would assign the inpatient consults, ensuring a fair, even distribution.

**Q2)** Do you have residents, fellows, faculty, or community physicians who provide hospital-based care?

**A2)** At Walter Reed Army Medical Center, Walter Reed National Military Medical Center, there is not an ophthalmic hospitalist. The PGY-3 resident would be responsible for inpatient consults and would present cases to the respective subspecialty attending provider(s).

**Q3)** What type of consult requests do you typically receive? Do you feel that this is different from what is typically seen in a non-military hospital setting?

**A3)** The outpatient consultations are very similar to what a resident in a civilian program would experience. There was a wide variety of patients, encompassing all of the ophthalmic subspecialties. This, in my opinion, provided some of the greatest resident learning opportunities.

The inpatient consultations were often fewer, hence, the lack of need for a dedicated rotation. As the inpatient census increased during the two referenced wars, the number of consults increased. Many of the consults were relevant to ocular trauma. Many were related to visual dysfunction related to traumatic brain injury.

**Q4)** How is your trauma coverage set up at your facility? Are there particular types of ocular trauma cases that are more frequent?

**A4)** Interestingly, at Walter Reed Army Medical Center and Walter Reed National Military Medical Center, the trauma experience was rather limited. Globe trauma often was limited. As we became involved in Iraq and Afghanistan, the complications of ocular trauma became a frequent part of the resident education. Of note, the traumas were not primary for the resident learner, as the primary closure had been done in the theater of operations.

All faculty members were available to assist residents in the management of trauma patients. Often times, trauma care was multi-specialty and we worked together in teams. I think this is truly unique care offered by the military more so than in the civilian sector. Frequently trauma patients involved simultaneous care with other non-ophthalmic specialties.

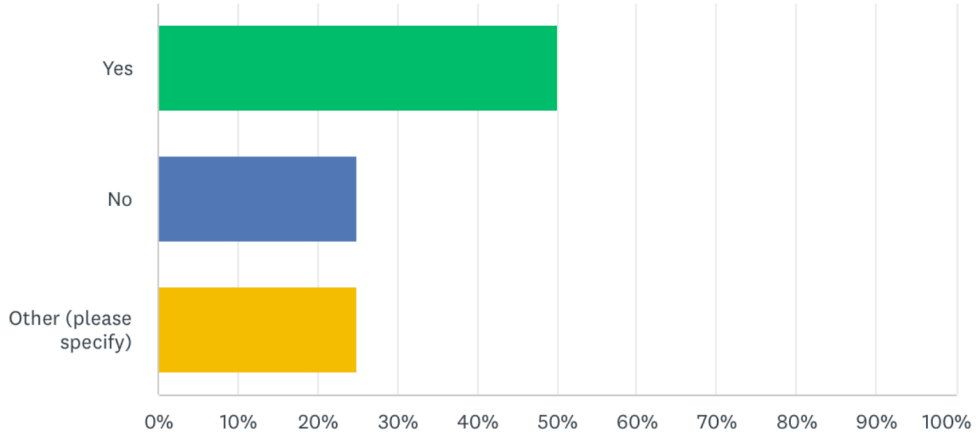
Based on this, most of the trauma we experienced in the DC area was combat related. This experience is different for my colleagues that practiced in San Antonio TX in which they had a shared relationship with the local civilian program.

**Q5)** Are there any other comments or advice you would like to share about your experience?

**Q6)** It was truly an honor to be able to serve those that have fought, allowing us the freedoms we often take for granted. I am truly humbled by the opportunities that have been afforded to me professionally. It is truly my honor to be able to share my experiences, what I have learned with the next generations of ophthalmologists.

# CRAO Survey Results

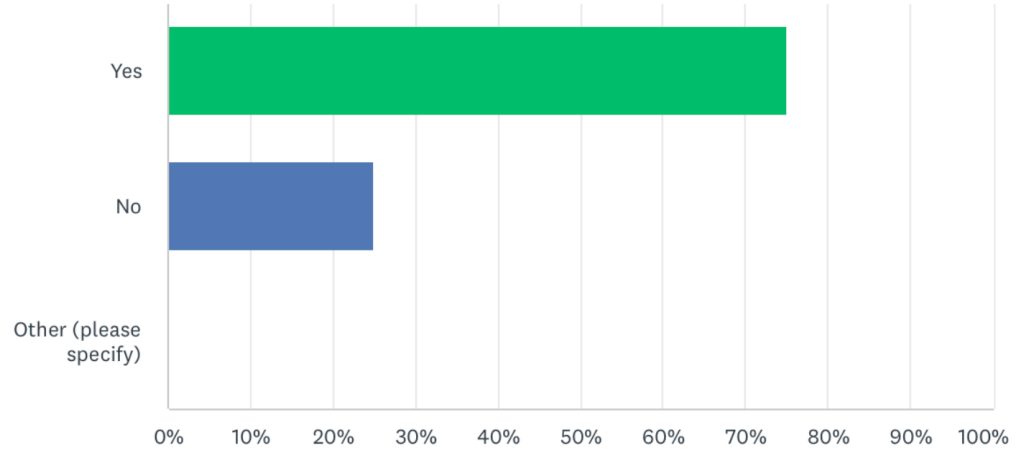
## Do you provide stat eye exams for all patients with suspected CRAO who are potential candidates for TPA therapy?




| ANSWER CHOICES | | RESPONSES |
|---|---|---|
| Yes | | 50.00% |
| No | | 25.00% |
| Other (please specify) | Responses | 25.00% |

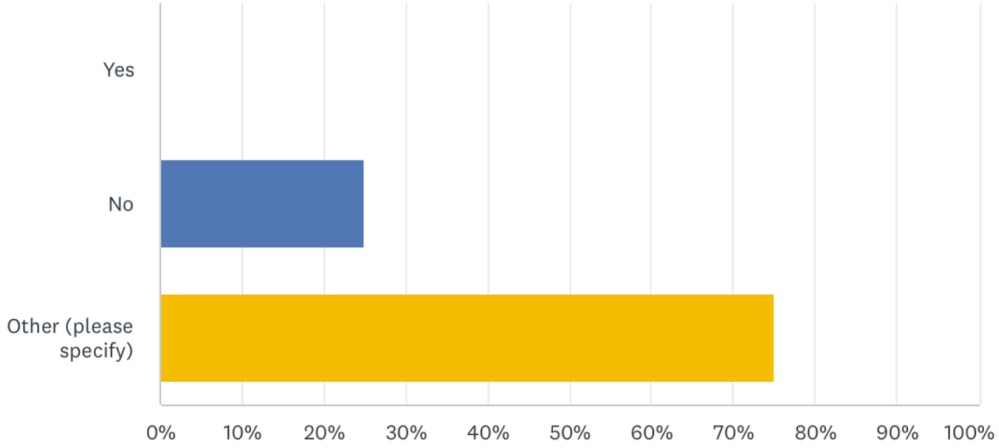
Yes, but I have never seen a patient within the 4.5 hours of symptom onset. I have always been called well after that time frame, for various reasons.

## Does your institutional stroke service offer TPA for patients with a diagnosis of an acute CRAO?




| ANSWER CHOICES | | RESPONSES |
|---|---|---|
| Yes | | 75.00% |
| No | | 25.00% |
| Other (please specify) | Responses | 0.00% |

# Among your CRAO patients treated with TPA, have you noticed visual improvement following the procedure?




| ANSWER CHOICES | | RESPONSES |
|---|---|---|
| Yes | | 0.00% |
| No | | 25.00% |
| Other (please specify) | Responses | 75.00% |

n/a

11/20/2022 05:14 PM View respondent's answers Add tags

don't know outcomes

11/20/2022 05:02 PM View respondent's answers Add tags

TPA is available at our institution, however it has never been used to treatment a patient that we have diagnosed with a CRAO

11/15/2022 04:50 PM View respondent's answers Add tags