OPHTHALMIC HOSPITALIST INTEREST GROUP NEWSLETTER

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Re-Opening Q&A

The country is re-opening! How will this look for inpatient and ER consults? See responses from OHIG members in this newsletter!

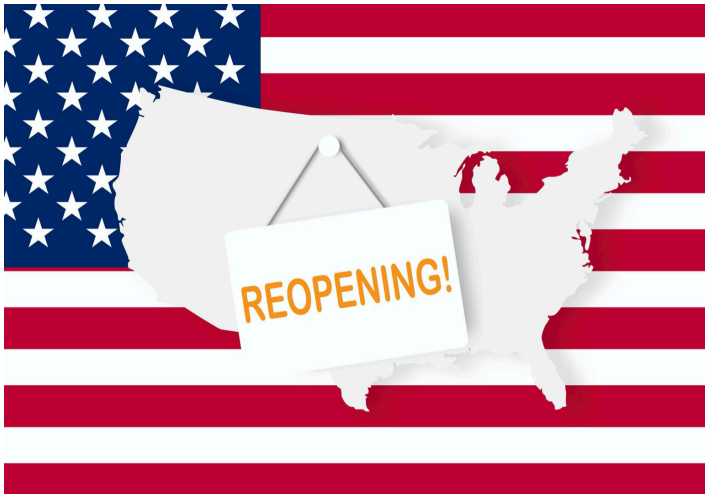
OHIG Website

We are excited to share our new OHIG website! Future Q&A's, podcasts, and videos are coming.

Feel free to take a look: https://ohig.org

Next Zoom Meeting

Join us to discuss start up advice for people considering a career as an ophthalmic hospitalist.
Friday June 19th @ 9am PST/ 12PM EST



Articles

Important Coronavirus Updates for Ophthalmologists, AAO, May 2020

Recent guidance from the AAO regarding patient triage for both urgent and routine conditions during the nationwide re-opening.
https://www.aao.org/headline/alert-important-coronavirus-context

The Coronavirus Crisis, A Regimen for Re-entry, The New Yorker, May 2020

Another insightful editorial from Atul Gawande regarding re-entry strategy from a health provider perspective.
https://www.newyorker.com/science/medical-dispatch/amid-the-coronavirus-crisis-a-regimen-for-reentry?

Sorry I'm an ICU Ophthalmologist!, Eye, May 2020.

Perspectives from a 4th year ophthalmology resident who was deployed to the ICU in London for the COVID-19 pandemic.
https://www.nature.com/articles/s41433-020-0914-0

*PDF copies of articles also attached to the newsletter email

PEARLS

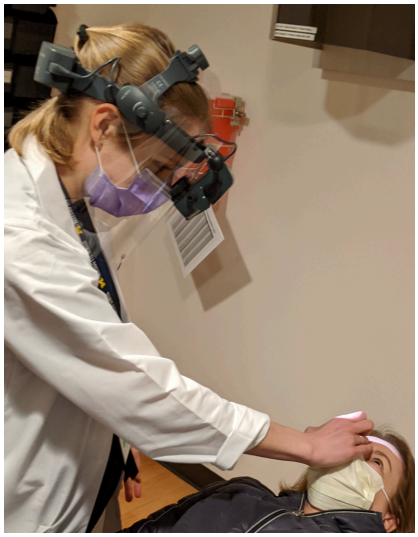
PPE remains essential for re-opening! Here are some options for both commercial and DIY face shield options that can be mounted to a slit lamp or indirect.

Slit lamp Face Shield
https://www.zeiss.com/meditec/int/c/slit-lamp-breath-shields.html

https://www.youtube.com/watch?v=U4B4vJ_oDM0

Indirect Face Shield for Keeler
https://www.youtube.com/watch?v=RmhYqWJ_xHU

Indirect Face Shield for Heine
Blueprints courtesy of University of Michigan included on page 5 of the newsletter



CONSULT ROUNDS

64 yo woman with a h/o HTN, DM2, HLD, Hep C, ESRD on HD, and hypothyroidism c/o funny feeling in her right eye 2 days prior to admission. She states that she rubbed her eye and her vision went completely black. She has a frontal headache x 1 week and 1 month of diarrhea. No eye pain, redness, flashes, or floaters. She also reported fevers, Tmax 104, and dry cough x 1 week. Oxygen sats were 88% on RA and she was found to be COVID-19 PCR positive.

On exam she was 20/40 OD, NLP OS, + RAPD OS. Normal anterior segment OU. Her posterior exam was significant for 360 degrees blurring disc margins with 2 peripapillary disc hemorrhages OS, wnl OD. No TA tenderness, good TA pulses. ESR=90, CRP=5.1, platelets=153. Head/orbital CT was negative. MRI/MRA imaging was also requested along with stroke work up with a neurology consult. No acute findings were noted.

Based on the patient's age>50, HA, severe vision loss, unilateral optic disc edema with a disc hemorrhages, and elevated ESR and CRP, a presumed diagnosis of Giant Cell Arteritis (GCA) was made until proven otherwise. She was admitted to the hospital and started on 500mg IV solumedrol. Vascular surgery was consulted for a TA biopsy, however the consult was declined since the service was only performing emergent, life-threatening procedures during the COVID-19 pandemic.

Since the biopsy was unable to be obtained, a TA ultrasound was performed which showed "Bilateral common superficial temporal arteries, as well as their frontal and parietal branches, are normal in appearance and flow velocities. No significant intimal medial thickening noted."

After interdepartmental discussion with rheumatology, ophthalmology, and internal medicine, it was decided to continue the patient on prednisone due to the degree of vision loss and the lack of a definitive diagnosis.

Questions:
1) Given various limitations during this COVID-19 pandemic, should temporal artery ultrasound be considered a reasonable diagnostic alternative to temporal artery biopsy for GCA?

2) The AAO has listed various "urgent or emergent" procedures, including temporal artery biopsy for suspected cases of GCA. How do we navigate a difference in in opinion among various hospital services in regards to the urgent need for diagnostic biopsy?

The use of ultrasound for GCA diagnosis remains a topic of ongoing controversial debate. Here are some articles to consider for the case.

AAO Guidelines for Emergent or Urgent Procedures during COVID-19 Pandemic
https://www.aao.org/headline/list-of-urgent-emergent-ophthalmic-procedures

The Use of Ultrasound as an Aid in the Diagnosis of GCA: A Pilot Study Comparing Histologic Features with Ultrasound Findings, Eye, 2003.
https://www.nature.com/articles/6700350

Limited Value of Temporal Artery Ultrasound Examinations for Diagnosis of GCA: Analysis of 77 Subjects, The Journal of Rheumatology, May 2020.
http://www.jrheum.org/content/37/11/2326.long

Consult Considerations During Re-Opening
Virtual Meeting Responses from Members of OHIG

Thank you to all those of you who participated in our recent Zoom session!

Q1: *What are you doing differently since re-opening after COVID? Any changes to your PPE or disinfectant guidelines or drops?*

A1: Order dilation drops that can be administered by nursing staff in advance so that the eye exam can be consolidated into a single visit for COVID positive patients. If there is need for a pupil exam, this can be done another time.

A1: Discard all medications bottles that are used for COVID positive patients. Single use dilation drops unfortunately are not readily accessible in the US.

A1: Batch COVID positive consults for the end of the day to reduce exposures for vulnerable hospitalized patients.

A1: Use N95 masks and goggles when evaluating all consult patients due to the close proximity of our exams and pending/unknown COVID status of many patients.

A1: Request that all hospitalized and ER patients wear a mask when being evaluated by the ophthalmology service

Q2: *How will you decide when to expand your consult coverage to include more routine requests?*

A2: Providers are still tending to operate under their emergent/urgent triage consult policy for COVID until more definitive data is available regarding the success of re-opening.

A2: In general, people have been noticing a marked increase in consult volume for both inpatient and ER requests. This could reflect the early shut down of other community practices and ASC's resulting in increased referrals to larger academic centers.

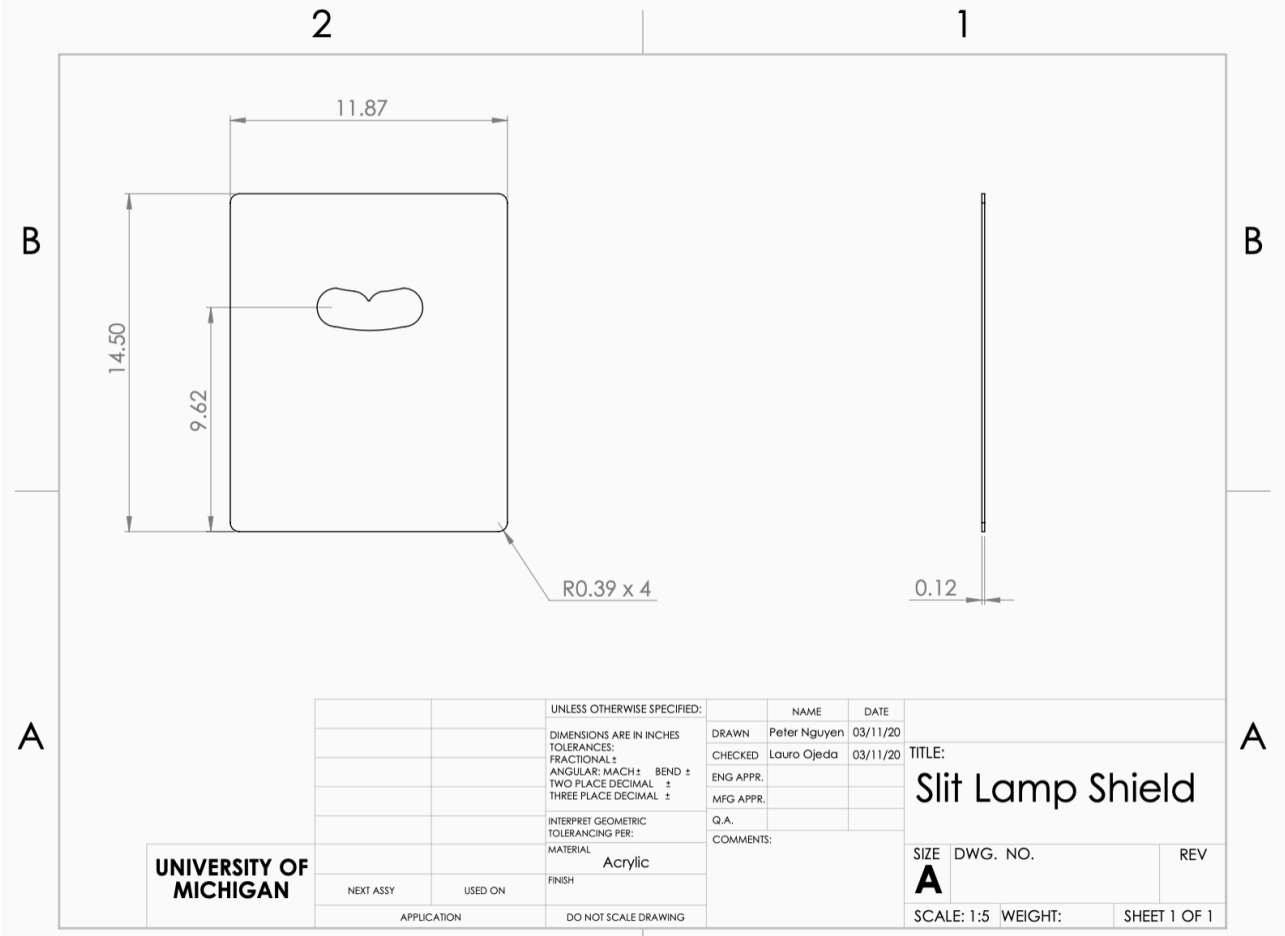
Q3: *Have you incorporated Telehealth in to your inpatient/ER practice?*

A3: Some providers are using photographs and phone calls to help triage consults, but otherwise no one reported extensive use of Telemedicine for hospital or ER patients.

Q4: *As we enter a "new normal", are there any COVID inspired clinical practice patterns you plan to permanently adopt for consults?*

A4: Fungemia consult requests are on the rise again. Some are considering whether or not to expand coverage to alert patients who have no visual symptoms. Some still feel that the likelihood of an acute change in management such as intravitreal injection in this scenario is low due to a lack of vitreous involvement. Recent literature from JAMA Ophthalmology suggests that indiscriminate screening does not seem to be supported by the literature and may in fact lead to additional interventions which could be harmful to patients. It recommends that screening criteria should be re-evaluated: https://jamanetwork.com/journals/jamaophthalmology/article-abstract/2731481

A4: Some institutions receive a significant number of NAT consult requests. Published data suggests that positive retinal findings tend to be found in patients with traumatic brain hemorrhage. Therefore head imaging is typically obtained prior to requesting an ophthalmology consult both during and even potentially after COVID.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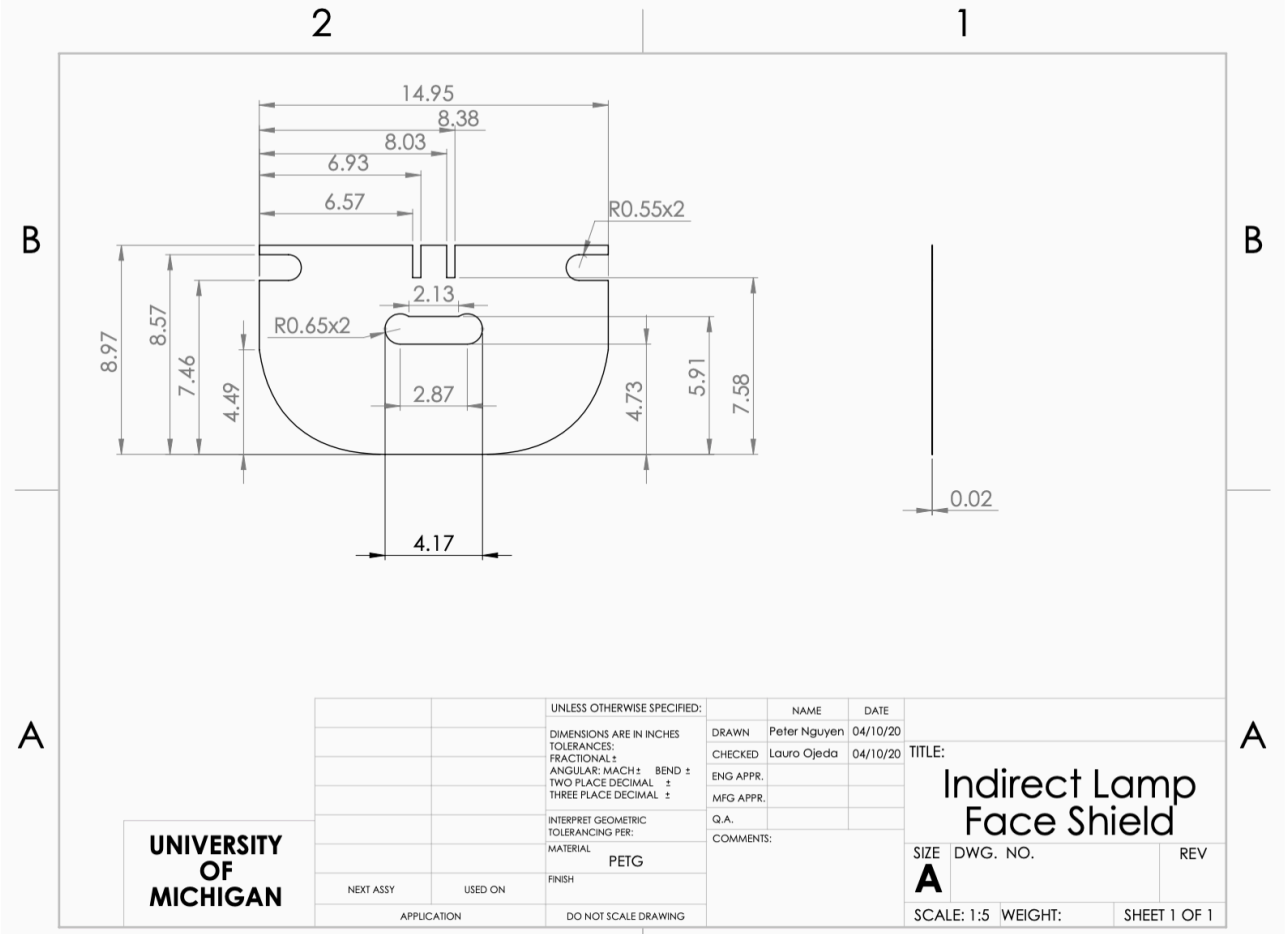
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