OPHTHALMIC HOSPITALIST INTEREST GROUP

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OPHTHALMIC HOSPITALIST INTEREST GROUP NEWSLETTER

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Announcements

Join the Community!

Have a questions or topic about inpatient/ER consults? Share on the AAO/OHIG community! Log in with your AAO username.

OHIG Zoom Meeting - On Call Coverage and Transfers

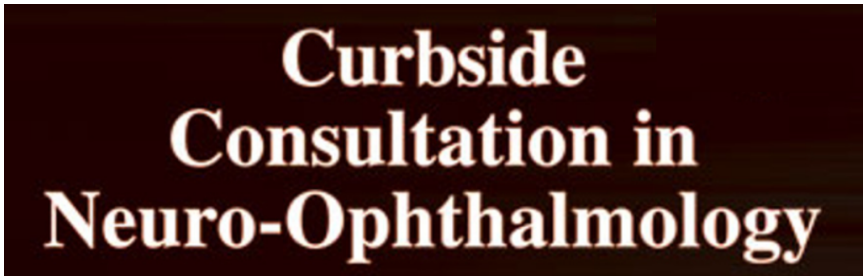
Save the date for an OHIG discussion about community call coverage, transfer trends, hospitalist fellowship models, ER tele-consult aids, and consult research. **Thursday June 13 @ 5:00pm-6:00pm PST**.

OHIG Topic Wishlist

Have a topic or 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.



Articles

Neuro-ophthalmology ED and Inpatient Consults at a Large Academic Referral Center, Ophthalmology, 2023

ED /inpatient neuro-ophthalmology consult patterns and patient outcomes at major referral center. With subspecialist shortage, the study highlights a need for technological and diagnostic aids for greater outpatient access.

Demographics, Practice Analysis, and Geographic Distribution of Neuro-ophthalmologists in the US in 2023, Ophthalmology, 2024

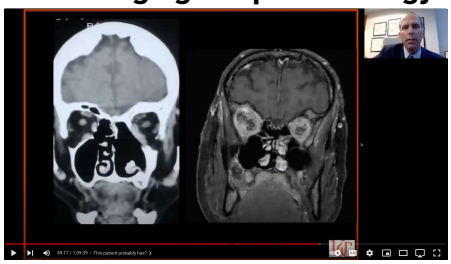
Public database reviews from AAO and NANOS showing characteristics and geographic distribution of neuro-ophthalmologists across the US. Practitioners are mostly male although there are a rising trend of younger females. Individuals are often trained in more than 1 subspecialty and tend to be located in metropolitan coastal areas around academic centers.

A Neuro-ophthalmologist's Perspective on Neuroradiology, Seminars in U/C/MRI, 1998

To achieve a proper diagnosis, clinicians must have a close working relationship with radiologists to choose appropriate imaging studies and correctly focus the study based on clinical findings.

PEARLS

Neuroimaging in Ophthalmology



Dr. Karl Golnik, from Univ of Cincinnati provides a webinar covering neuro-ophthalmic indications for CT, CTA, MRI, MRA, and other relevant imaging modalities.

Click here

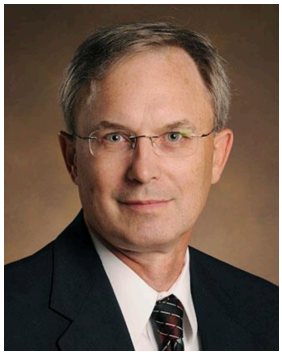
Virtual Neuro-Ophthalmology

Do you have a shortage of Neuro-ophthalmologists in your area? Portable virtual goggles by **Olleyes** can provide s remote option for checking VA, pupils, EOM's, color vision, and visual fields from your ED or hospital.

Click here

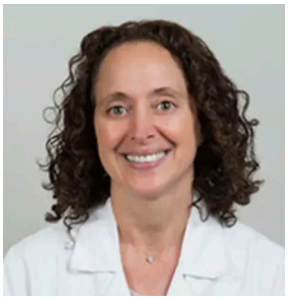
CONSULT ROUNDS

Neuro-ophthalmic conditions represent a large proportion of inpatient/ER ophthalmology consults. We are excited to highlight a growing number of Neuro-ophthalmologists who have integrated roles on hospital-based consults. Their expertise is essential for the management of vision and life-threatening conditions that often require multi-disciplinary care.



VANDERBILT UNIVERSITY MEDICAL CENTER

John Bond, MD
Neuro-ophthalmology
Vanderbilt University
Nashville, TN



UCLA Health

Laura Bonelli, MD
Neuro-ophthalmology
University of California Los Angeles
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KELLOGG EYE CENTER
MICHIGAN MEDICINE

Tatiana Deveney, MD
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CASEY EYE Institute
OHSU

Amanda Redfern, MD
Neuro-ophthalmology
Oregon Health and Science University
Portland, OR

Q1) How did you become involved with hospital-based consults?

Bond: I was in private practice in 2009 when Vanderbilt ophthalmology chair asked if I might be interested in staffing consults. Apparently, the need emerged and none of the faculty were agreeable. He created a part time position for me that has since morphed into a full time position. There is faculty call for evenings and weekends, largely to address ocular trauma. There is also a subspecialty call schedule. My role has largely been to mitigate other faculty exposure to hospital related problems. The pgy2s are on the front lines. So, my other job is teaching these young physicians early in their training for ophthalmology.

Bonelli: When I started at Stein Eye Institute UCLA there was a need for a faculty to help with inpatient consults. As time went by I became more involved and now I am the one running our inpatient consult service for our two main hospitals.

Deveney: My mentor, Dr. Jonathan Trobe, is a neuro-ophthalmologist and ran the ophthalmology consult service at the University of Michigan for many years. I learned an enormous amount from him as a resident and fellow and really enjoyed my consult rotations. When I joined the faculty, I was excited to have an opportunity to become involved in consult care. It has been an honor to follow in his footsteps and now I help run the consult service.

Redfern: I was splitting my time 50-50 between neuro-ophthalmology and comprehensive. I ended up not enjoying my comp practice because I was commuting to a distant satellite site and I only operated a half-day every other week, which wasn't enough for me to maintain my confidence in the OR. As I searched for alternative options, I lucked into the opportunity to join the ophthalmic hospitalist service part-time.

Q2) What is your clinical set up or schedule? Do you have an outpatient clinic/OR responsibilities in addition to consult coverage?

Bond: We have a day consult resident and a night float resident. The day consult resident's "shift" ends a 4:30 PM. I will round with the resident after that. Presently, I have neuro-ophthalmology clinic two days a week, a day at the VA as well as other administrative and teaching responsibilities spread out at other times.

Bonelli: I have neuro-ophthalmology clinic in the morning and see inpatient consults with residents in the afternoon. At Ronald Reagan Medical Center (RRMC) we have a PGY2 resident and at at Santa Monica Medical Center (SMMC) we have a PGY3 who triages consults. The residents see the patients during the AM and we round in the PM daily at RRMC and Monday, Wednesday and Friday at SMMC. If there is an emergency we would go to SMMC as needed but this is usually not necessary.

Deveney: I have several outpatient neuro-ophthalmology clinics each week in addition to consults coverage. We have a neuro-ophthalmology clinic in the hospital (right next to the emergency room). I see clinic patients in the morning and am also able to staff emergency department and inpatient consults. The residents, medical students and myself round as a consult team in the afternoon. The location of our clinic is great – the consult team has access to a full ophthalmology clinic including visual field and OCT testing. The clinic also serves as a home base for the consults service with space for discussion and teaching.

Redfern: I have 4 half-day sessions of neuro-op clinic spread over 3 days. The other two days are dedicated to consults (i.e. no other clinical duties). I decided to give up surgery altogether partly due to concern about keeping up skills with infrequent procedures and partly to remain outside of the surgical call pool.

Q3) How has your background in neuro-ophthalmology influenced your role on consults? Are there specific pros/cons?

Bond: Patients with neurologic problems represent a substantial number of ED and inpatient consults, probably about 30%. So, neuro-ophthalmology background is helpful. I can handle most non neuro-ophthalmology related problems but have good subspecialty support when needed. The number of ophthalmology consult requests have grown and grown, now to the point where it is challenging for only one attending to cover. I can imagine switching things around so that a comprehensive ophthalmologist sees most things requesting subspecialty backup when needed, including neuro-ophthalmology. I am not sure which side of the fence is greener.

Bonelli: Ronald Reagan Medical Center is a level 1 trauma center with a busy transplant service and neurosurgery department. Being a neuro-ophthalmologist has been extremely helpful in dealing with the high complexity of cases we encounter daily. Neuro-ophthalmologists are very good clinicians and are trained to do thorough, complete ophthalmologic exams. A strong knowledge of patient comorbidities is also essential for our subspecialty. The main con I see is that most neuro-ophthalmologists do not do surgery or do very little so we depend on our colleagues to help with conditions that require surgical management.

Deveney: We see a lot of neuro-ophthalmology consults (nearly every day) so my background in neuro-ophthalmology is very helpful. Neuro-ophthalmology can sometimes feel challenging for medical students and residents so I really enjoy having the chance to do bedside teaching for these consults. We get to review specific parts of the neuro-ophthalmic examination (such as checking for an afferent pupillary defect and cover testing) and think through differential diagnosis, work-up and management.

Redfern: The skill set that I use for handling complex neuro-op clinic patients translates really well to inpatient consults. I am quite adept at digging through charts to find pertinent information and I enjoy

doing literature reviews on interesting/unique presentations. On the flip side, being an ophthalmic hospitalist has allowed me to provide much better care to admitted neuro-op patients because I actually get to see and examine them myself as I round, as opposed to staffing consults by phone as they arise. The synergy between the two roles is the biggest pro. I'm hard-pressed to think of a con.

Q4) Do you feel that having an active presence in the hospital makes a difference in terms of your collaboration with other hospital services such as neurology, neurosurgery. Or neuroradiology?

Bond: Yes, those connections help. It is much easier to communicate with radiology and neuro subspecialties than a faculty member who is not familiar with all the related concerns.

Bonelli: Absolutely, we need to work closely together to provide the best possible patient care. Furthermore, I would say that it is not only neurology, neurosurgery and neuroradiology - we also work closely with rheumatology, medicine, hematology-oncology, dermatology, etc. Our presence in the hospital setting has improved and strengthened the relationship with all departments in our medical community

Deveney: Absolutely. Weekday consults coverage is split between myself and Dr. Sangeeta Khanna (also a neuro-ophthalmologist). We often attend team meetings and can give input and guide management for patients, particularly those admitted with neuro-ophthalmology concerns such as optic neuritis. Being present in the hospital really helps make ophthalmology part of multidisciplinary care. It has been really rewarding to get to know and work with other services. We also have a weekly neuro-ophthalmology/ neuro-radiology conference where consult cases are frequently presented.

Redfern: I have not found this to make much of a difference yet, but I do see the potential for it as I continue to build relationships with the inpatient services.

Q5) What is your most memorable Neuro-ophthalmic consult case you have encountered thus far in the hospital?

Bond: There are so many cases to consider. One recent one is a diabetic woman who starts with double vision, then ptosis raising concerns for myasthenia who then develops mental status changes. She had nonspecific brainstem lesions on MRI raising questions of infection, malignancy, vasculitis and inflammatory conditions. The diagnosis ultimately was NMO. Very unusual presentation for NMO. Could have easily been missed.

Bonelli: The first consult case that comes to mind is a young female patient with relatively recent kidney transplant who presented with visual changes and bilateral optic nerve edema. Over the first few days all testing was negative. She eventually developed a bilateral macular star and subsequent antibody testing was positive for Bartonella Henselae. Transplant patients are very challenging given their immunocompromised status with the possibility of developing all sort of conditions.

Deveney: Too many to count! We present consult grand rounds 7 times per year (once per resident rotation block) and we always have interesting cases to discuss (the most challenging part is usually picking just one case). Many of our subspecialty grand rounds cases often start on the consult service as well. The cases I think about most are where the ophthalmology examination really helped make the diagnosis or guided treatment – a patient was referred to the hospital with concern for vision changes secondary to possible idiopathic intracranial hypertension. The ophthalmic examination did reveal optic disc edema. However, there was also subtle ophthalmoplegia and nystagmus. This combination of findings was suspicious for thiamine deficiency/Wernicke encephalopathy. Thiamine replacement was started and symptoms improved.

Redfern: This is a bit hard for me to answer as there have been many interesting cases. But I would say that a lot of the most rewarding patient relationships I have are ones that started in the inpatient setting and continue with me in neuro-op clinic. There is a special bond that forms when you are with someone through some of their scariest times in the hospital and you remain by their side as they work towards recovery and rehabilitation outpatient.

We would like to sincerely thank ***Dr. John Bond, Dr. Laura Bonelli, Dr. Tatiana Deveney, and Dr. Amanda Redfern*** *for sharing their insight and expertise. Their collective responses leave us all thinking, "Wow this is amazing, how do we get a neuro-ophthalmology ophthalmic hospitalist for our institution?".*