OPHTHALMIC HOSPITALIST INTEREST GROUP

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OPHTHALMIC HOSPITALIST INTEREST GROUP NEWSLETTER

Donna Kim, MD | Maggie Hymowitz, MD

Announcements

Join the Community!

Meet your fellow OHIG members in the **AAO/OHIG Community**

Read about fungemia consults after new AAO guidelines, retinal artery occlusions in the ED, consult resident staffing.

Click to join: OHIG Community!

OHIG at AAO 2022

Check out "*Who's on Call? - Ophthalmic Hospitalists: A Better Way to Solve an Age Old Problem*", featuring a panel of OHIG members at the fall meeting. Date/time TBA shortly.

Welcome New Members!

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

Call for Cases

Have an interesting case or topic you'd like to share on a future newsletter? Email ohig@ohig.org

Image Source

Articles

Where are We Now with Inpatient Consultative Dermatology? Assessing the Value and Evolution of This Subspecialty Over The Past Decade, J AAD, 2019

Highlights the conception of a dermatology hospitalist and the eventual creation of a new organization, Society for Dermatology Hospitalists (SDH) in 2009.

Pediatric Hospital Medicine: A Proposed New Subspecialty, Pediatrics, 2017

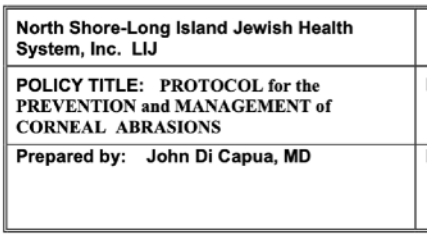
Learn about how the American Board of Pediatrics (ABP) recommended that the board of medical specialties approve pediatric hospitalist medicine as a new subspecialty.

Survey of Neurohospitalists: Subspecialty Definition and Practice Characteristics, Frontiers in Neuro, 2010

Read about neurohospitalists and the formation of a Neurohospitalist section of the American Academy of Neurology along with online survey responses about their speciality.

PEARLS

OR Corneal Abrasion Protocol



North Shore-Long Island Jewish Health System, Inc. LIJ
POLICY TITLE: PROTOCOL for the PREVENTION and MANAGEMENT of CORNEAL ABRASIONS
Prepared by: John Di Capua, MD

Are postp-op corneal abrasions a common consult for you? Check out this protocol from Northwell in NY which has reduced the incidence of post-op corneal abrasions along with diagnostic and therapeutic recs. See pages 6-7.

Nontraditional Fellowships

Quality Improvement Fellowship

Kresge Eye Institute

The Quality Improvement Fellowship at Kresge Eye Institute in Detroit is a one-year, paid, pre-residency fellowship for MDs or DOs who intend to pursue a residency position in ophthalmology. The role of the QI Fellow is to create and execute new research projects and to assist residents, fellows, and medical

Ophthalmology Research Fellowship

University of North Carolina

This is a one-year research fellowship program with Dr. David Fleischman (glaucoma) and Dr. Alice Zhang (surgical retina) at UNC. The program offers an opportunity to participate in research at the institution and to meet and be part of a great team of ophthalmologists. This program has been in place for

Have a medical student or resident looking for a unique fellowship opportunity? Check out a variety of novel options listed by geographic region.

Click here

CONSULT ROUNDS

Ophthalmic Hospitalist Academic Fellowship

Q1: What inspired you to pursue or design your own unique ophthalmic hospitalist fellowship?

A1: Throughout residency, I got so much "bucket filling" from teaching and have always been drawn to a career in academic medicine. As a senior resident, I struggled to commit to a sub-specialty. I really enjoyed the complexity of patients on the inpatient service and ED which required both breadth and depth of knowledge. I wanted to continue seeing all kinds of consults - young, old, sick, and healthy! This was my solution: a hospitalist position that would encompass them all.

Moran Eye Center has always been a unique place supportive of physicians "charting their own course." The mentorship and support of my residency program director, Jeff Petty, was critical in the genesis of my fellowship.

Q2: Where is your fellowship located and what clinical/surgical areas does it cover? What is your schedule?

A2: My schedule, which was self-designed, has been in constant flux throughout the year as I work to perfect it. I have time for clinics and OR in the mornings and time to staff consults with the resident in the afternoons. I take 3 weeks of faculty call and 6 weeks of trauma/globe call staffing open globes with the residents. I staff inpatient and ED consults at our University Hospital and the adjacent children's hospital and cancer center. I also spend time working in the Triage clinic at the Moran Eye Center to learn from undifferentiated patients. I supervise a

comprehensive clinic at the VA with the residents and have my own comprehensive clinic a few times a month. I also participate in comprehensive clinics and OR with two comprehensive attendings. Our Neuro-Ophthalmology service also always welcomes me to their daily morning case conference to discuss consult patients as needed. And, I volunteer once a month down on the Navajo reservation or in community outreach clinics and have gone to Tanzania for 2 weeks with our Outreach Division. I find that volunteering in our austere environments gives me a unique perspective on hospital ophthalmic medicine. (Yes, it's been a busy year!)

Q3: Which faculty areas are involved with your training?

A3: Comprehensive ophthalmology, neuro-ophthalmology, oculoplastics, and subspecialty fellows to an extent as cases arise.

Q4: How is your fellowship funded?

A4: My fellowship was funded through the Moran Eye Center in Utah.

Q5: What have been the best features of your fellowship?

A5: The best feature of my fellowship have been mentoring the PGY-2 residents and watching them grow in skill, knowledge, and confidence throughout the year. I enjoy using my creative side to make improvements in their educational curriculums and streamlining system processes in our residency program.

Q6: What advice would you give to others who are interested in setting up a similar type of hospitalist fellowship at their institution?

A7:
1) Get critical faculty buy in (this will most likely be from the residency program directors)
2) Prioritize your goals early and make them clear. Get faculty support for areas you want to learn
3) Be a self-directed learner
4) Don't be afraid to ask for changes. If something is not working, figure out how to fix it!
5) Don't bite off more than you chew (advice from a chronic over-committer)

Theresa Long, MD
Academic/Anterior Segment Fellow
University of Utah - Moran Eye Center
Department of Ophthalmology

Ophthalmic Trauma Fellowship

Q1: What inspired you and members of the ASOT to design a unique ophthalmic trauma fellowship?

A1: Ophthalmic trauma is a bit unique, in that patients often have multiple issues that ultimately require different subspecialists to provide definitive treatment. These specialists may not be readily available, therefore it is important to have an individual with the ability to acutely diagnose, stabilize, and either definitively treat or triage patients appropriately. Additionally, for the first time the majority of ophthalmologists surveyed reported their practice structure as "employed." In the past, the vast majority of employed ophthalmologists would be in a University setting. However, we are now seeing more employed ophthalmologists in private health systems or regional centers, with a significant increase in ophthalmic hospitalists. These individuals are expected to acutely manage all inpatient and Emergency Department consults, which often involve patients who have sustained ophthalmic trauma. Providers in settings with high volumes of trauma would benefit from additional exposure and training in dealing with these complex cases.

Q2: Where is your fellowship located and what clinical/surgical areas does it cover? What is its schedule?

A2: The Ophthalmic Trauma and Emergency Care Fellowship. I am Program Director. It is located in Columbus, Ohio at OhioHealth Grant Medical Center. Grant is a Level I Trauma Center that is number one in Ohio and in the top 10 nationally for patient volume according to the American College of Surgeons. Dr. Johnstone Kim, a retina specialist, is the Assistant Program Director, and is also faculty for the MidWest Retina Fellowship program. All other ophthalmology subspecialties are represented in the extended faculty that are available on a consultation basis when required. As the focus of the fellowship is

acute care, once patients are stabilized, they will receive any further required treatment in the outpatient setting. The Fellow will typically be based at the hospital Monday through Friday from 8am to 5pm. During that time they will either see consults, perform procedures, participate in subspecialty clinics, attend didactics, or work on research projects. They will cover evening call every other week and weekend. There will always be an attending on call should the Fellow need support.

Q3: How is your fellowship funded?

A3: The fellowship is funded through the Trauma Department at Grant. Fellows are compensated at the PGY-5 level with all the typical benefits associated with PGY training. Further details are available here: https://www.ohiohealth.com/medical-education/benefits

Q4: What are best features of your fellowship?

A4: I think the best features of the fellowship involve the variety and volume or cases, the flexibility of the curriculum, and the ability to participate in prospective, ophthalmic trauma associated research.

Q5: How can others find out more about your fellowship and its application process?

A5: Further information about the program, requirements, application process, and the sponsoring institution can be found here: https://www.ohiohealth.com/medical-education/fellowships/eye-trauma-fellowship-grant-medical-center. I can be contacted for any questions regarding the program at dsp4000@aol.com

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Professor of Ophthalmology
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Section Chief, Oculofacial Plastics & Reconstructive Surgery
Ohio University / OhioHealth Doctors Hospital

Ophthalmic Trauma Fellowship Director
Grant Medical Center

Case Comments:
Many thanks to Dr. Theresa Long and Dr. Craig Czyz for sharing their expertise about these innovate fellowships! Very inspiring.

Northwell Protocol For Post-Operative Corneal Abrasions

North Shore-Long Island Jewish Health System, Inc. LIJ	ANESTHESIA POLICY AND PROCEDURE		
POLICY TITLE: PROTOCOL for the PREVENTION and MANAGEMENT of CORNEAL ABRASIONS	POLICY	DEPARTMENT: Anesthesia	
Prepared by: John Di Capua, MD	Effective Date: 10/2009	Last Revised/Reviewed: 01/2011 1/8/2019 05/2013	Pages: 2

Objectives:

- To identify patients at risk for corneal abrasions.
- To prevent the occurrence of corneal abrasions to patients rendered unconscious during the peri-anesthesia period
- To describe the management of corneal abrasions that occur during the peri-anesthesia period.

Procedure:

A. Preventing corneal abrasions

1. Patients will be screened through PST for ophthalmology risk factors. They will be asked if they have any factors which increase the risks of corneal abrasion (e.g.; prior corneal abrasions, Sjogrens syndrome, or recurrent erosion) PST will notify Anesthesia via First Class of patients at risk.
2. In the event a patient has not been previously screened, the Attending Anesthesiologist will assess the patient for risk factors prior to surgery.
3. All patients having general anesthesia and deep sedation (unless contraindicated) will have 1-2 drops of artificial tears administered to each eye in the OR prior to intubation.
4. For patients having general Anesthesia, both eyes will be taped immediately after induction and prior to intubation, if possible. Area should be dry prior to taping. Tape should be placed from the upper lid to the lower lid, with the lids opposed, using 3M Transpore plastic tape. The best way to verify the lids are fully opposed is to look at the eyes from mid chest. The use of tape for patients having deep or lesser forms of sedation is up to the practitioner.
5. For patients with a high risk of pressure trauma during surgery (e.g. surgery on face, head or neck; existing ophthalmology risk factors) an eye shield should be utilized after placing drops and taping the eyes.
6. Avoid placing pulse oximeter on index finger. Cover oximeter with finger cot to eliminate sharp edges.

B. In the event a patient complains of post operative eye pain:

1. A Licensed Practitioner from the Department of Anesthesia will evaluate the patient.
2. If there is evidence of ocular trauma, complaint of visual loss, or the patient is a pediatric patient, request Ophthalmology consult immediately.

3. If a corneal abrasion is suspected, a Licensed Practitioner from the Department of Anesthesia will order and administer Tetracaine ophthalmic solution 0.5% one drop, times one to the affected eye. Tetracaine will be used as a diagnostic tool only.
    a. If pain relief is not achieved, request an Ophthalmology consult immediately.
    b. If pain relief is achieved, the Licensed Practitioner from the Department of Anesthesia will order Tobramycin ophthalmic solution, one drop every four hours, times three doses to the affected eye. The first dose will be administered in the PACU. If the patient has an allergy to Tobramycin, a fluroquinolone antibiotic, available as per current formulary, may be ordered (eg: Ocuflox, Vigamox).

        i. If the patient is to be discharged home, they will be given written instructions regarding corneal abrasions.
            a. The pain may return after the local anesthesia wears off which can be as early as 20 minutes.
            b. The patient will be provided with a prescription for Tobramycin Ophthalmic solution to use for 24 hours unless he/she can go home with the solution provided by the hospital.
            c. If pain persists beyond 24 hours, the patient should contact a private Ophthalmologist or call the out- patient clinic (LIJ 516 470-2030; NSUH 516 465-8500).

        ii. If the patient is to be admitted, a Licensed Practitioner from the Department of Anesthesia will assess the patient prior to discharge from the PACU.
            a. The pain may return after the local anesthesia wears off which can be as early as 20 minutes.
            b. Post operative orders will be written for ophthalmic medications.
            c. The patient will be re-evaluated during the post operative visit the following day.
            d. If there is persistent pain 24 hours after surgery, an Ophthalmology consult must be called.
            e. If the patient is transferred directly from the OR to a critical care unit, corneal abrasions will be managed by the critical care team.