OPHTHALMIC HOSPITALIST INTEREST GROUP

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OPHTHALMIC HOSPITALIST INTEREST GROUP NEWSLETTER

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Announcements

AAO/OHIG Online Community

What are OHIG members saying about medication eye exams in the hospital, COVID findings in newborns, and upcoming fall meeting content for consults?

Join the conversation on the AAO OHIG Community! It has 68 members and growing!

OHIG Think Tank Meeting Now Virtual

Due to COVID related uncertainties, we have opted to a make this meeting virtual and will reschedule for a future date. More details coming!

Welcome New Members!

Excited to have you join OHIG! Please verify your information on the OHIG website. Thank you!

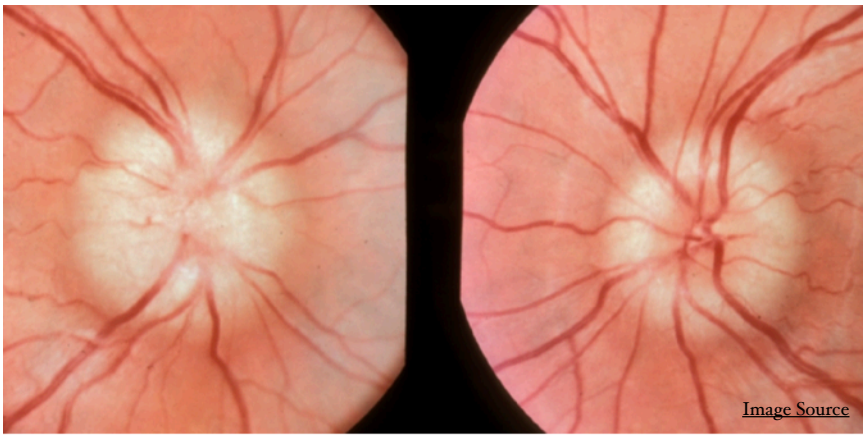


Image Source

Articles

Characteristics and Incidence of Inpatient Ophthalmology Consultations to Screen for Papilledema, JAO, 2019

A helpful study evaluating papilledema consults at a major referral hospital authored by OHIG members Dr. Matt Gorski and Dr. Jules Winokur from Northwell.

Sensitivity of Papilledema as Sign of Shunt Failure in Children, Journal of JAPPOS, 2008

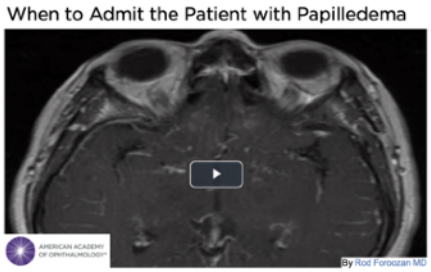
An article showing how papilledema is not a sensitive sign of shunt failure even among children with severe ICP elevation from shunt malfunction.

Artificial Intelligence to Detect Papilledema from Ocular Fundus Photographs, NEJM, 2020

An exciting look into technological innovations where AI can be used to screen for papilledema or other optic nerve abnormalities.

PEARLS

Papilledema Video



A presentation sponsored by the AAO and NANOS featuring Dr. Rod Foroozan on papilledema recommendation and work up.

Click here

Neuro-ophthalmology Cases

UPFRONT

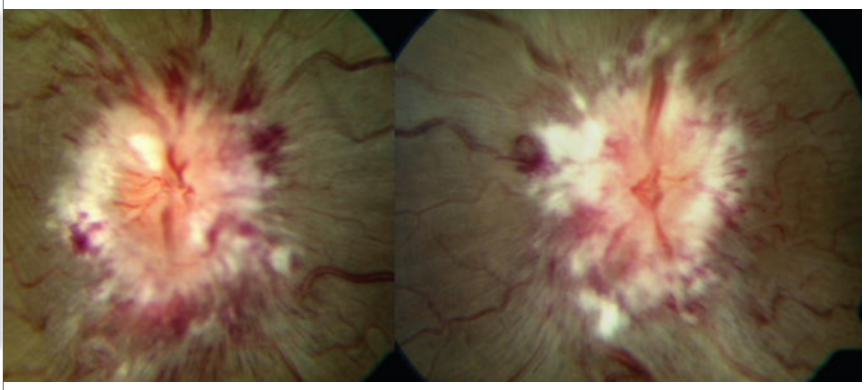
UNKNOWN PATIENTS FOR RESIDENTS IN OPHTHALMOLOGY OR NEUROLOGY TRAINING

New free case series from NANOS known as "**U**nknown **P**atients **F**or **R**esidents in **O**phthalmology and **N**eurology **Tr**aining" = UPFRONT available as narrated powerpoints on the Journal of Neuro-Ophthalmology.

Cases can be found in the right lower corner of the webpage. Check out "Double Vision and Headache".

Click here

CONSULT ROUNDS



You receive a page from the ER regarding a 27 year old female who complains of bilateral vision loss, severe headache, pulsatile tinnitus, and vomiting which has rapidly worsened over past 12 days. At baseline she has normal vision.

When you arrive to the ER, the patient in crying, holding her head in her hands while rolled up into a fetal position in her bed.

On exam she is 20/400 OD and HM OS with a left APD. She has significant peripheral field constriction OU. She is ET with bilateral abduction deficits c/w CN VI palsies. Her anterior segment is otherwise wnl. Dilated funduscopic exam is notable for severe Grade V bilateral optic disc edema with multiple flame shaped hemorrhages, cotton wool spots, and vessel tortuosity.

MRI and MRV imaging of the brain is negative for acute intracranial pathology or venous sinus thrombosis. Opening pressure on LP is highly elevated at 55. CSF studies are wnl.

The patient is felt to have a fulminant presentation of idiopathic intracranial hypertension (IIH) and placed on high dose IV Diamox and followed closely. Her vision and symptoms do not improve and after further discussion with multiple services including Neuro-ophthalmology, Oculoplastics, and Neurosurgery, the decision is made to place a lumbar drain while the patient waits for urgent optic nerve sheath fenestration.

After bilateral ONSF, the patient's vision improves to 20/70 OD and 20/80 OS with persistent generalized field constriction OU. The lumbar drain is removed but severe headaches return despite

continued use of Diamox. The patient eventually underwent a shunt procedure with neurosurgery which finally resolved her systemic symptoms.

She was closely followed in neuro-ophthalmology clinic after discharge. Her visual acuity and fields have remained largely stable. She now has mild optic disc pallor in each eye.

Case Comments:
"Fulminant" IIH is defined as intracranial hypertension with no secondary cause, severe vision loss within 4 weeks of symptom onset, and progressive vision loss over days. While this represents a small subset of IIH patients (the majority of whom do not have rapid vision loss and often respond well to medical therapy alone) it is important for on-call providers to rapidly recognize this diagnosis. Timely medical and surgical interventions are critical for preventing irreversible vision loss.

How are cases of fulminant IIH typically managed at your institution? Click all that apply.

A) Oral Diamox
B) IV Diamox
C) IV Steroid
D) Serial Lumbar Puncture
E) Lumbar Drain
F) Optic Nerve Sheath Fenestration (ONSF)
G) Venous Sinus Stenting (VSS)
H) VP Shunt (VPS)

Share your answer and see what others have to say on the AAO/OHIG Community! Click here

Relevant Articles:
Fulminant Idiopathic Intracranial Hypertension, Neuro-ophthalmology, March 2020 Click here
Fulminant Idiopathic Intracranial Hypertension, Neurology, Jan 2007 Click here

Representative Case Image Source: Click here