OPHTHALMIC HOSPITALIST INTEREST GROUP

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OPHTHALMIC HOSPITALIST INTEREST GROUP NEWSLETTER

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Announcements

Join the AAO/OHIG Online Community!

Read about flashes and floaters protocols, open hospitalist positions, Monkeypox updates and more! Click here to join!

OHIG at AAO 2022

It was great to see many of you at the OHIG Meet and Greet and panel presentation! See page 4-5 for photos.

Papilledema Study

We are in the process of an IRB approved multi center study reviewing papilledema consults. During the AAO meeting, some of you expressed interested in joining. For further info, please email ohig@ohig.org

Welcome New Members!

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

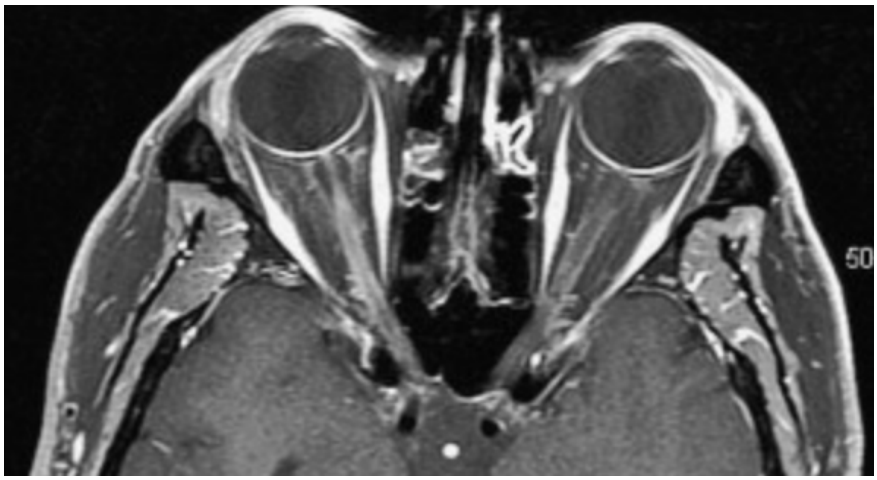


Image Source

Articles

Treatment of Optic Neuritis by Plasma Exchange (Add-On) in Neuromyelitis Optica, JAMA Ophthalmology, July 2012

A helpful study showing improved benefit of sequential treatment with IV steroid with plasma exchange compared to standard steroid therapy only for cases of optic neuritis related NMO.

MRI Characteristics of NMO, MOG, and MS Related Optic Neuritis, Seminars in Ophthalmology, Jan 2021

A review of optic nerve imaging in major demyelinating disorders with clinically relevant differences and prognostic indicators.

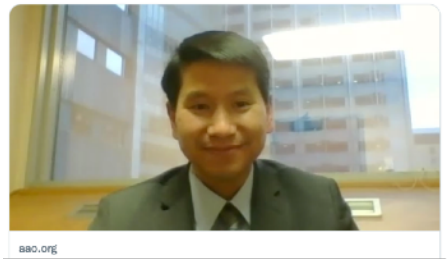
The Pediatric Optic Neuritis Prospective Outcomes Study, Two Year Results, Ophthalmology, March 2022

Results of an observational study looking at visual acuity outcomes for optic neuritis in the pediatric population.

PEARLS

What the Comprehensive Ophthalmologist Needs to Know About Optic Neuritis

Learn the different etiologies for demyelinating optic neuritis from Dr. John Chen:



A Twitter posting from the AAO featuring Dr. John Chen who discusses how NMO and MOG differ from MS.

Click here

MEMBER SPOTLIGHT

Meet OHIG member **Amanda Redfern, MD** who shares perspectives about neuro-op involvement on consults, see page 3

CONSULT ROUNDS

Image Source

You are paged by the ER regarding a 61 yo Caucasian female with h/o HTN and CVA who presents with acute left eye vision changes x 1 day.

The patient awoke with a diffuse gray fog in her left eye along with pain with eye movement. She reports having had a similar episode 4 months prior involving her right eye.

Her visual acuity is 20/20 OD and CF OS. Pupils are reactive with a left APD. Visual fields are notable for a dense superior visual field defect in the left eye. She has pain on upgaze. Anterior segment is wnl. Dilated funduscopic exam is unremarkable with sharp, pink optic nerves.

There is clinical suspicion for retrobulbar optic neuritis. MRI brain and orbital imaging confirm left optic nerve T2 hyperintensity with contrast enhancement, there are no lesions in the brain or spinal cord. The patient underwent LP for CSF studies.

She is treated with 3 days of IV solumedrol and her vision did not improve. CSF study results came back positive for NMO IgG/anti-aquaporin-4 and she was started on 5 sessions of PLEX and eventually transitioned to oral steroids.

Upon discharge the patient reported subjective visual improvement and her visual acuity was noted to be 20/400 with a

full CVF and resolution of pain on eye movement. She was eventually started on Uplizna, a CD19-directed cytolytic antibody indicated for the treatment of Neuromyelitis Optica Spectrum Disorder (NMOSD) in adult patients who are anti-aquaporin-4 (AQP4) antibody positive. The patient is due for her follow up with neuro-ophthalmology in a few weeks.

Case Comments: Consults to evaluate for optic neuritis can be fairly common. Atypical features can include severe vision loss, bilateral involvement, optic disc edema, longitudinally extensive degree of optic nerve or chiasmal enhancement on MRI, etc. For these cases, a full work up including dilated exam, MRI imaging, LP, and blood work up including NMO ab, MOG ab, and oligoclonal bands can be warranted to evaluate for infectious, inflammatory/demyelinating causes.

It is important to consult with neurology when treating these patients in the hospital. Systemic inflammatory disorders such as NMO and MOG may specifically benefit from additional treatments such as plasmapheresis or intravenous immunoglobulin in addition to IV steroid to preserve/improve their vision. Long-term immunosuppression may also necessary to help prevent recurrence.

OHIG MEMBER SPOTLIGHT

Amanda Redfern, MD
Assistant Professor
Associate Residency Program Director
Casey Eye Institute, Neuro-ophthalmology Division
Oregon Health and Science University

Q1: What is your clinical background?
I did my medical school at OHSU, ophthalmology residency at Yale, and neuro-ophthalmology fellowship at the Moran Eye Center. I currently practice half-time neuro-ophthalmology and half-time comprehensive ophthalmology.

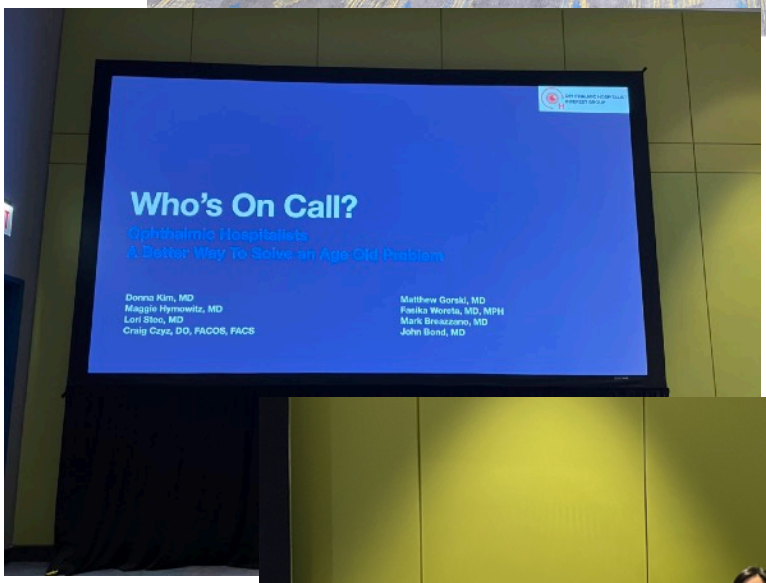
Q2. How are you involved on inpatient/ER consults?
Because of the nature of neuro-ophthalmology I'm often on unofficial call for our ophthalmology residents when they have questions about a neuro case. I also cover as the inpatient consult attending, staffing residents as they evaluate inpatients and sometimes ED patients as well.

Q3: What advice do you have for other neuro-ophthalmologists who might be considering ways to become more involved on consults?
I think neuro-ophthalmology and consults go very well together because a lot of the challenging consults are really interesting neuro-ophthalmology cases. It can be intimidating to see complex cases that fall under other subspecialties, but I treat them the same way I would with any complex neuro case that I'm

not sure what to do with – literature search, discuss with a colleague, etc. To start getting involved, let the residents or your colleagues know that you are available (by phone/email/Epic) to discuss neuro cases. This has the additional benefit of providing some degree of continuity when these patients are referred to your outpatient clinic. If you would like to become more involved, there are different models that you can try exploring with your department, such as staffing consults one (or more days) per week with residents or covering consults for a week at a time as they do in the neurology world when they close clinic for a week to cover the inpatient neurology service. The latter probably won't work for private practice, but nearby academic institutions often have opportunities for community attendings to be get involved or help cover on off hours.

Q5: Anything else you'd like to share about your consult experience or aspirations?
For those who enjoy teaching, consults is a great way to be involved with residents. As someone who trained at a program with a neuro-ophthalmologist/consult attending, I can honestly say that I learned a lot and had a much more positive experience than my senior residents who did their consult rotation before Dr. Anita Kohli joined the faculty. I hope to pay it forward as I join our consult service at OHSU.

OHIG at AAO 2022!



Many thanks to our OHIG panelists (left to right):
John Bond, Mark Breazzano, Fasika Woreta, Donna Kim, Matt Gorski, Maggie Hymowitz, Craig Czyz, Lori Stec