

Eyecare Peer Review

C-109148

Case 1



History

16yo, Female

Reason for visit: Gradual Photophobia, irritation and vision not as sharp over 1-1.5 years.
Spectacles “helps a little”

POH: Nil, No HES no prev infection, injuries or surgery. Mild dry eye - using lubricants as required

FOH: NIL

PGH: Mild hayfever Medications: AntiH as required



Examination:

Vision:

SPX – 6/12 old

RE: +0.50/-0.75x90 VA 6/12 “not clear”

LE: +0.75/-1.00x 85 VA 6/12 “not clear”

PinHole – 6/12 each eye

CT: small XOP good recovery at D&N

Pupil: PERRL No RAPD

IOP: R 14mmHg L 14mmHg

EYE CARE



Examination: Anterior Eye

Slit-lamp examination:

Lids: Normal R+L, MGD NIL

Cornea: No epithelial defects

bilateral, diffuse, fine, white crystals on the central cornea Sub-epithelial?

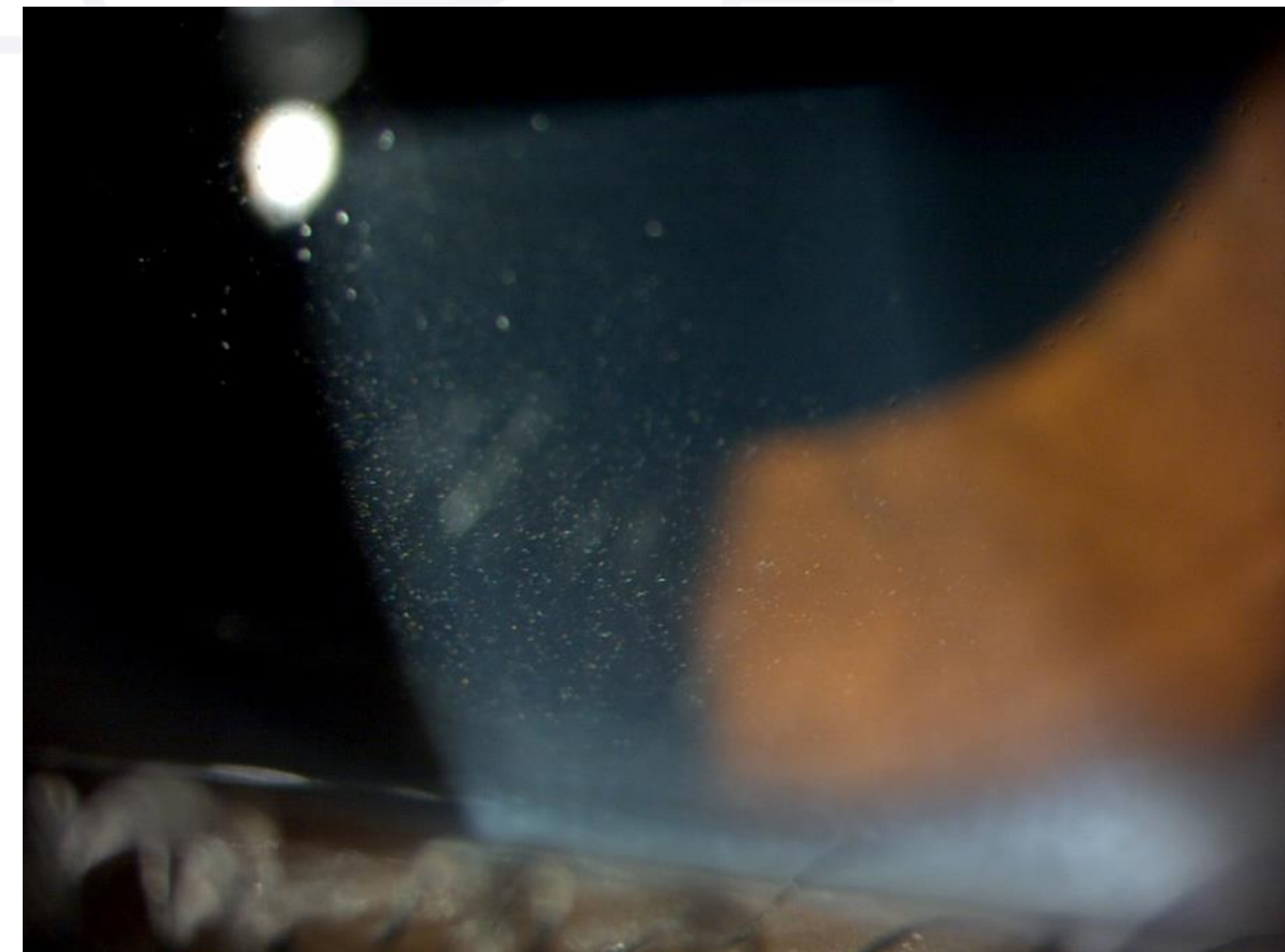
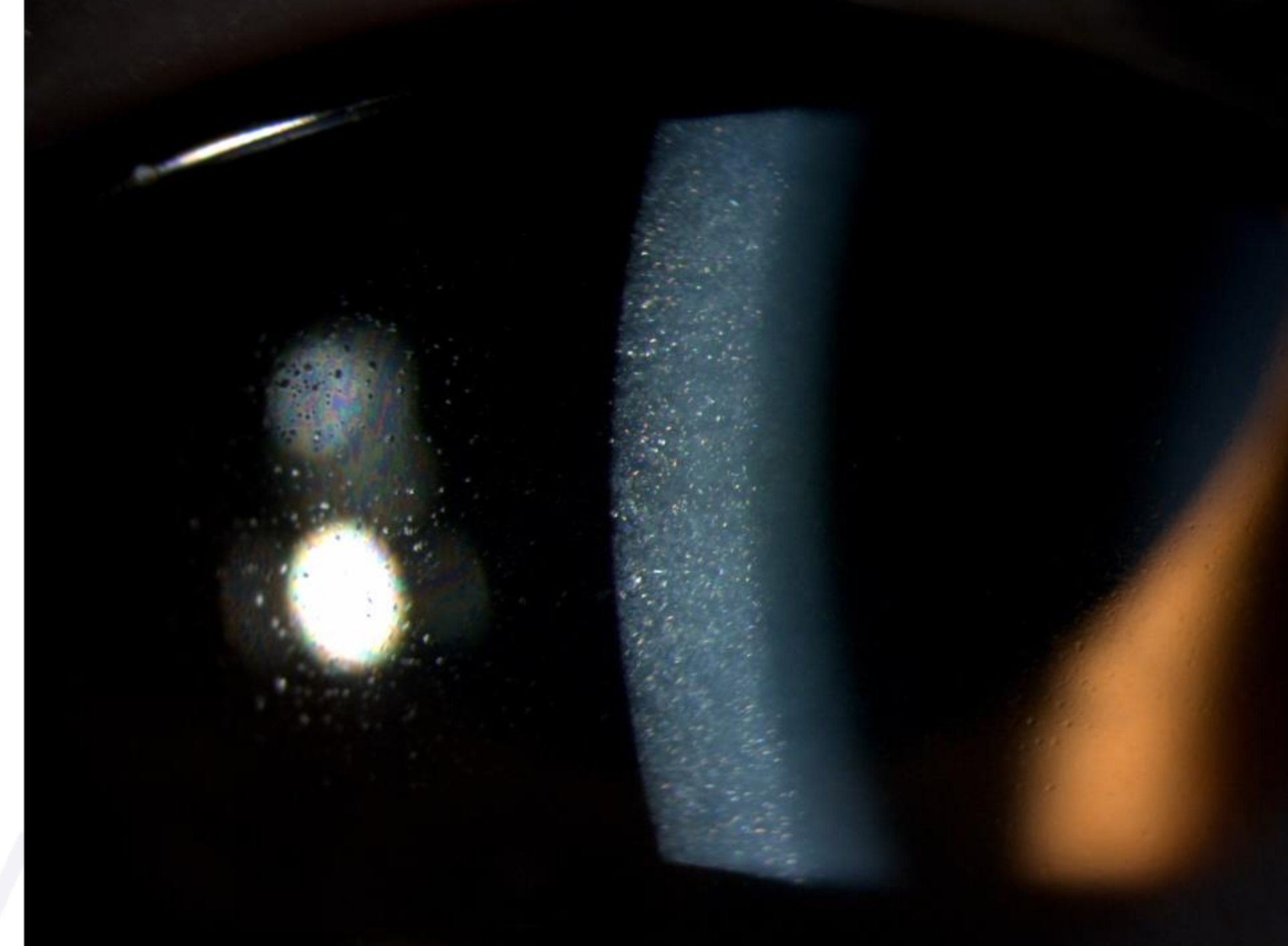
ITBUT: 7 seconds both eyes

Conj: white and healthy

AC: Deep and quiet

Lens: clear

There were no signs of inflammation or other ocular abnormalities.



Examination: Posterior Eye

Hazy view Both eyes

Retina flat and healthy – R+L

C:D 0.3 NRR healthy R+L

There were no signs of inflammation or other ocular abnormalities.



Anterior Eye deep dive

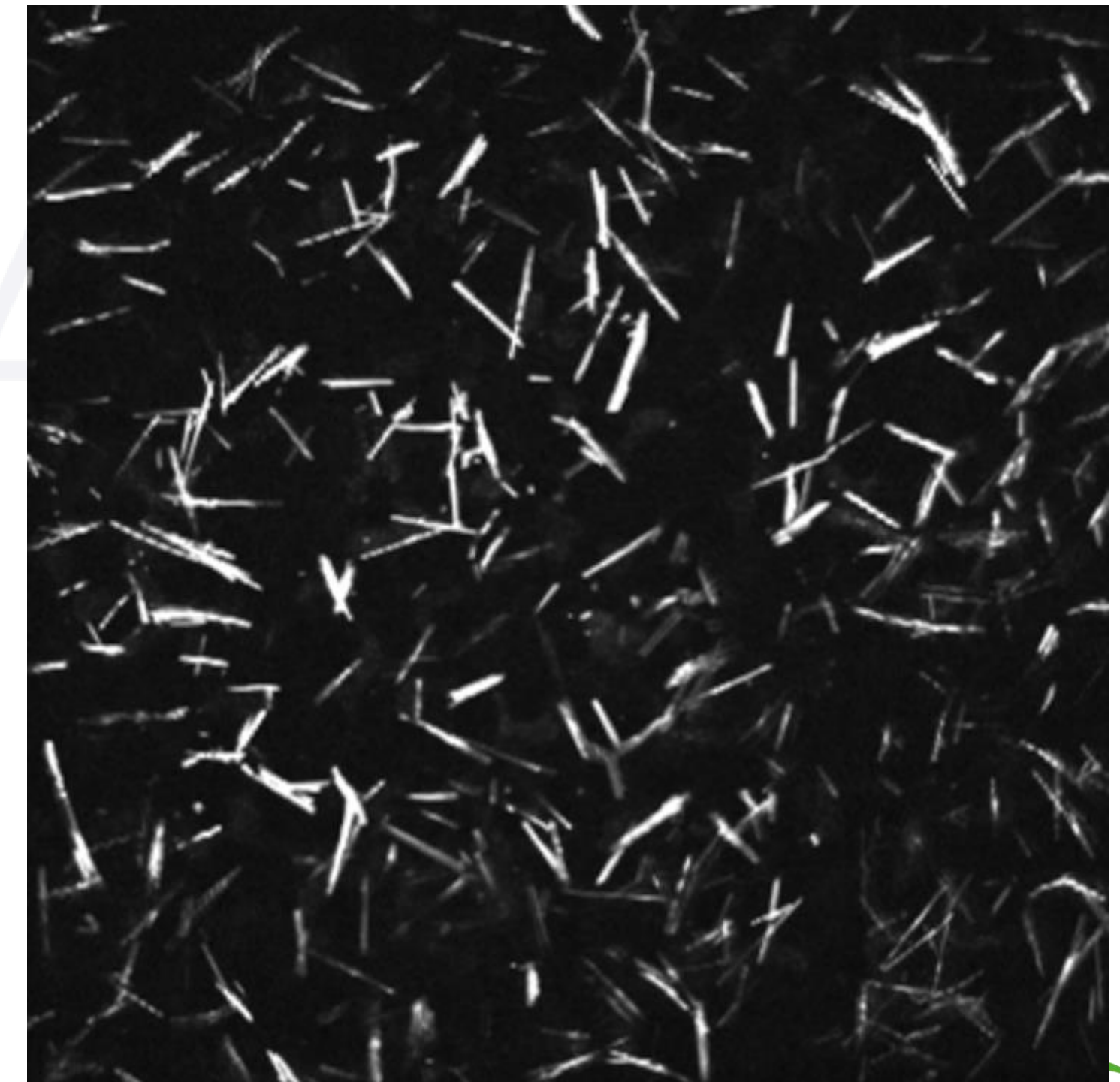
AS-OCT or Confocal microscopy

Bilateral, diffuse, fine, white crystals on the central cornea

AS-OCT or Confocal microscopy

Hyperreflective crystals - Limbus to limbus

70-120 Micron depth



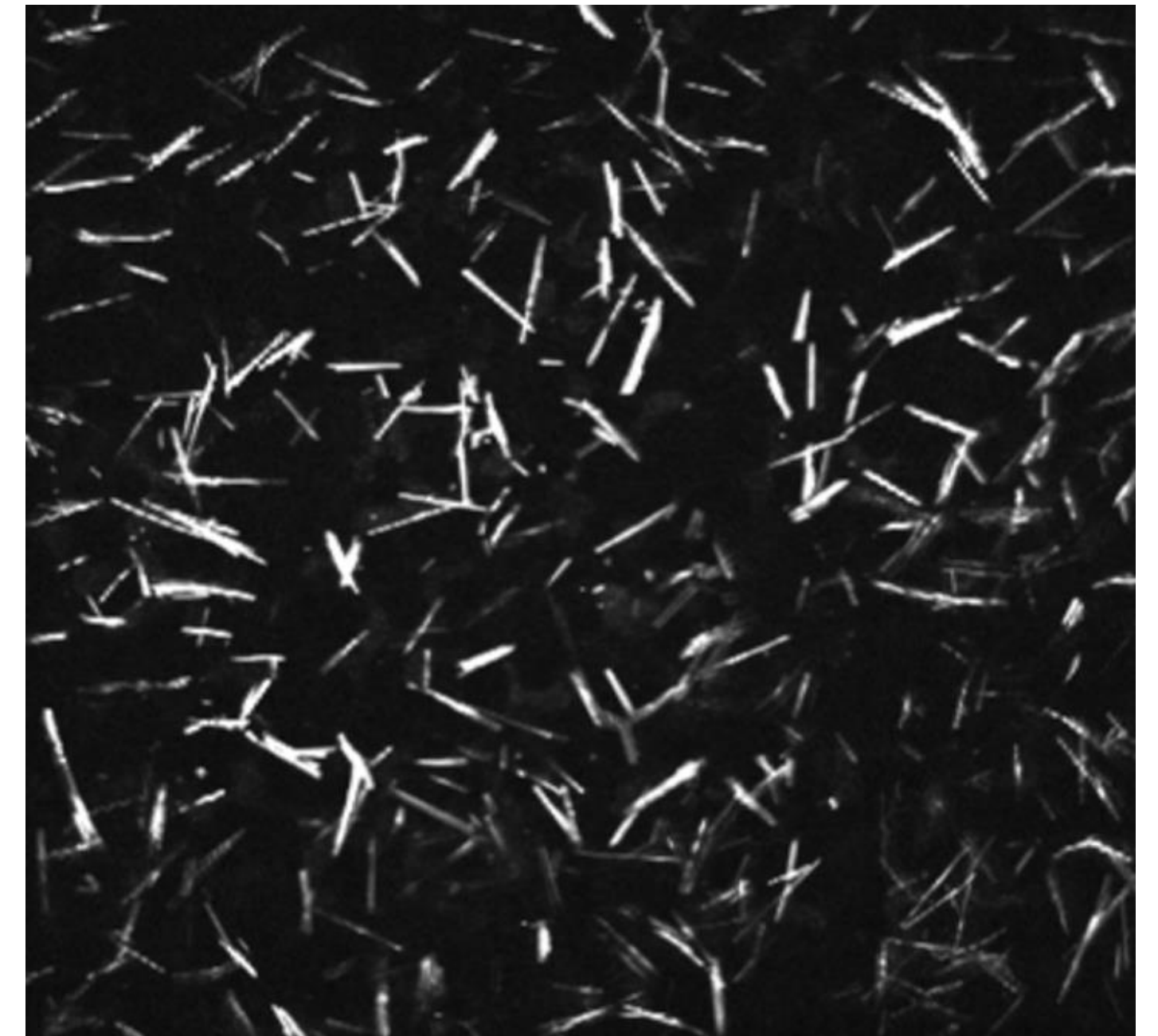
Discussion Point

Epithelium or Stromal issue?

Differential diagnosis?

Diagnosis?

Referral/ Investigation?



References

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OCT Case Review

Case 2



Patient:

Name: John Snow

Age: 58 Year Old

Gender: Male

Reason for Visit:

John Snow presents to practice with complaints of gradual worsening of his vision over the past two years. He reports difficulty reading and recognizing faces, despite wearing his prescription glasses. His vision seems particularly blurry in the center of his visual field.



History and Symptoms

Reason for Visit:

John first noticed a slight blurring of his central vision about two years ago, which he initially attributed to aging. However, the blurring has progressively worsened, and he now finds it challenging to perform tasks such as reading small print or working on his computer. He denies experiencing any pain, redness, or sudden changes in vision. He does not see floaters or flashes of light. There is no history of trauma to the eyes.

GH: Type 2 DM diagnosed 2009, Hypertension, Hyperlipidemia

Medication: Metformin, Lisinopril, Atorvastatin, Aspirin

OH: No HES besides DRS, no prev infection, injuries or surgery

FH: No relevant FH

Occupation: Accountant

Driver: Yes

Lifestyle: Skiing, Fencing



Examination:

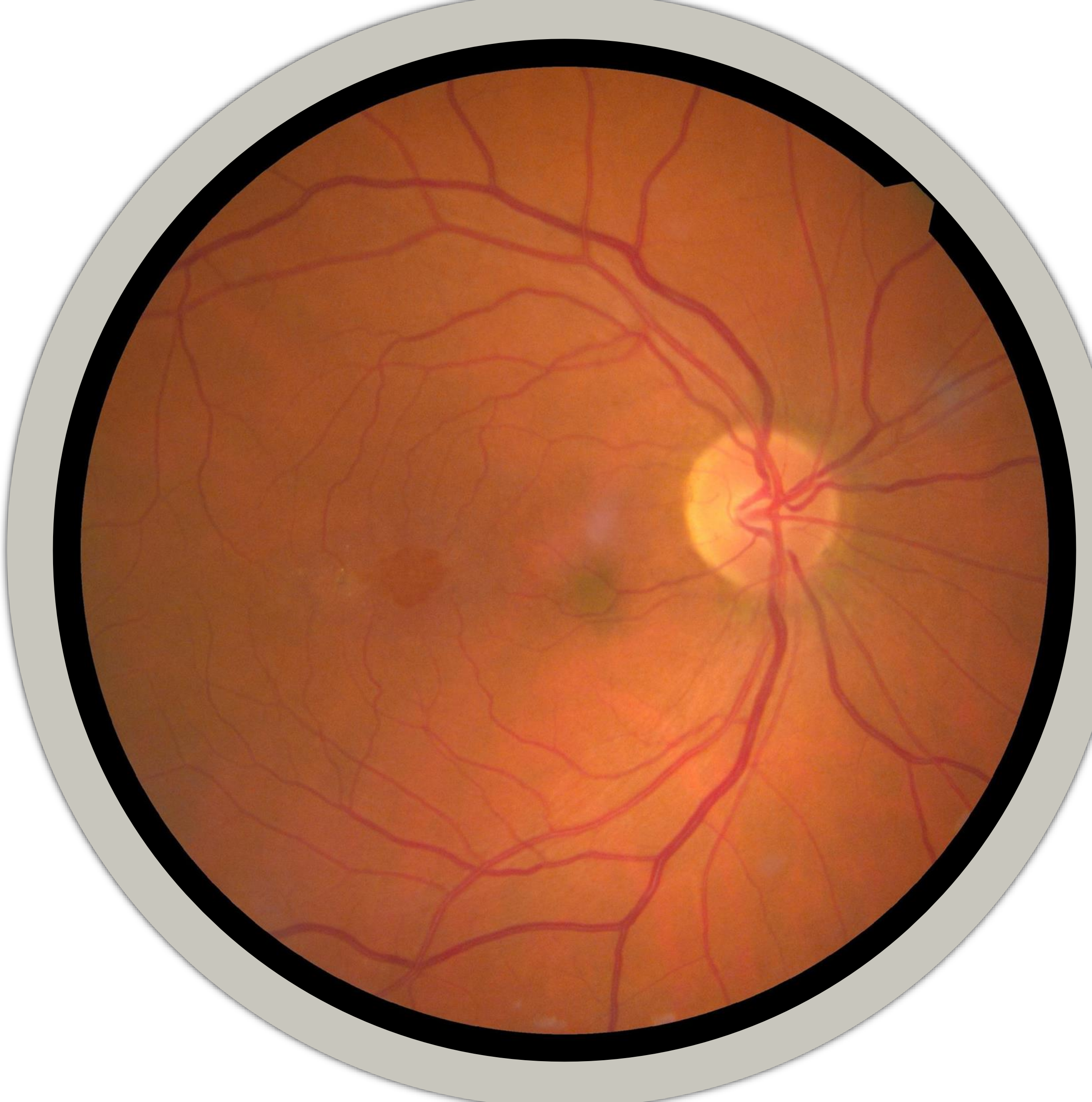
VA: R 6/12-2 L 6/12-3 BE: 6/12
CT: small XOP good recovery at D&N
Pupil: PERRL No RAPD
IOP: R 15mmHg L 13mmHg

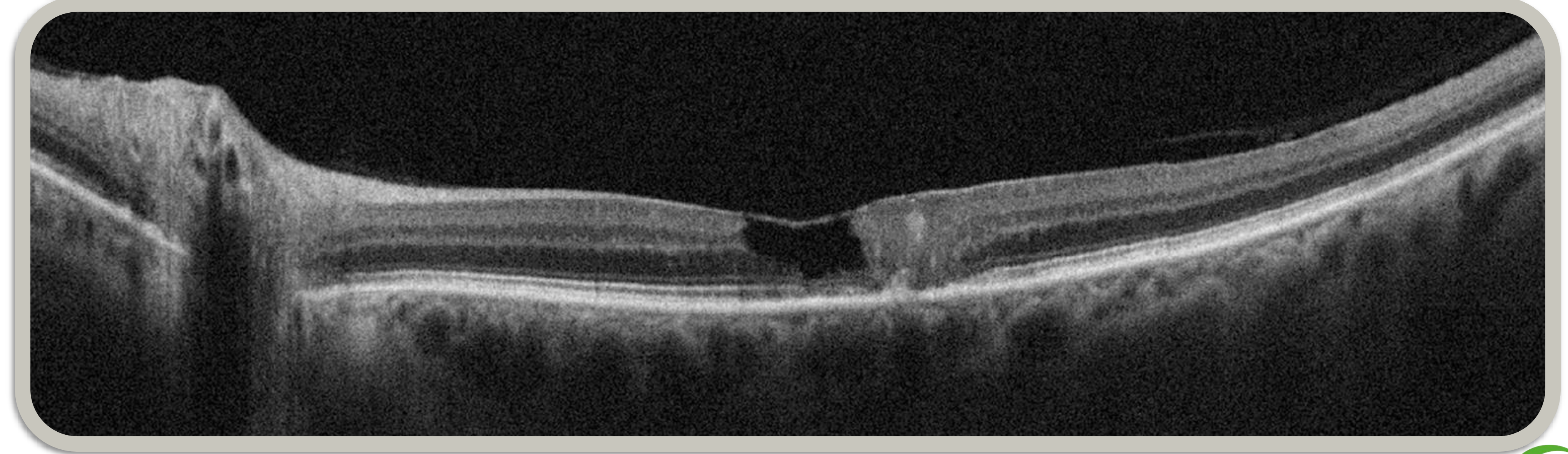
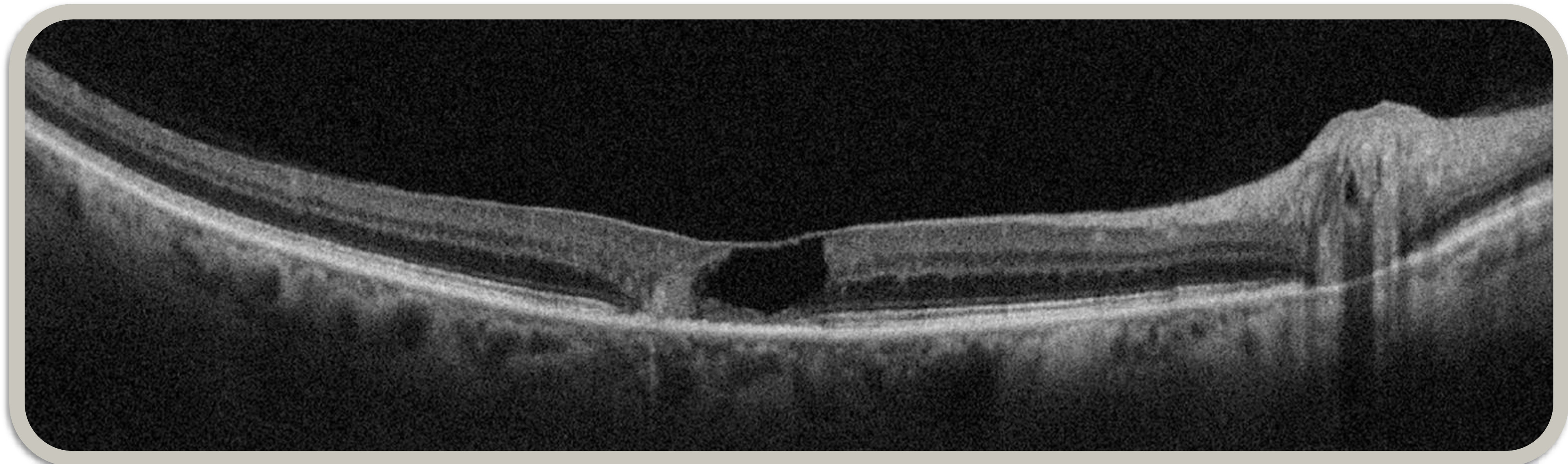
Anterior Segment: Unremarkable

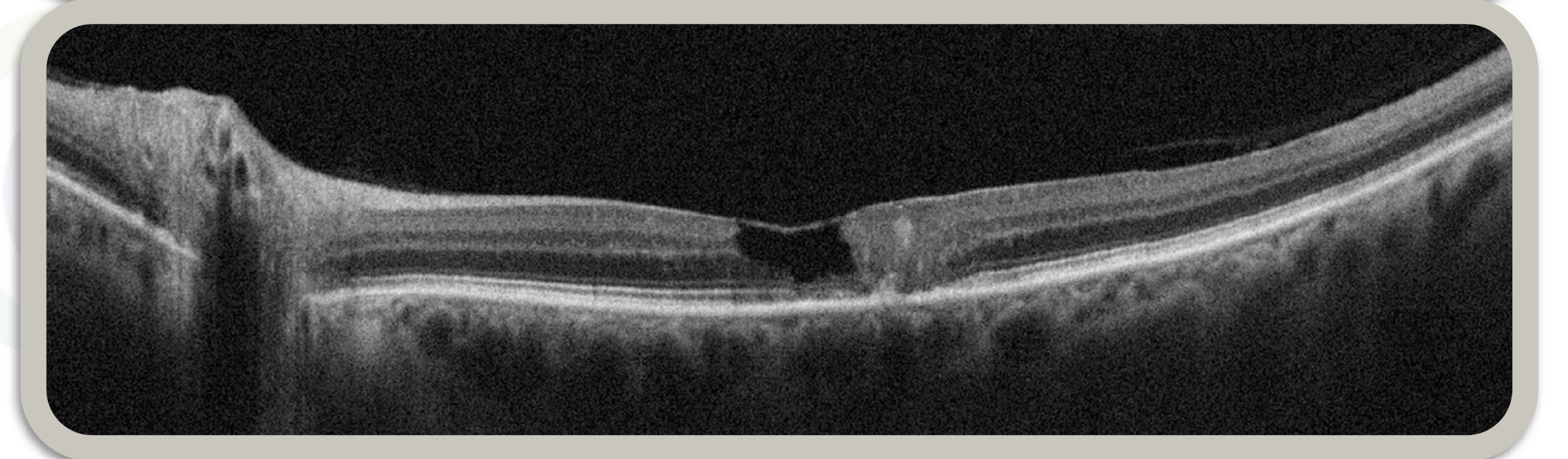
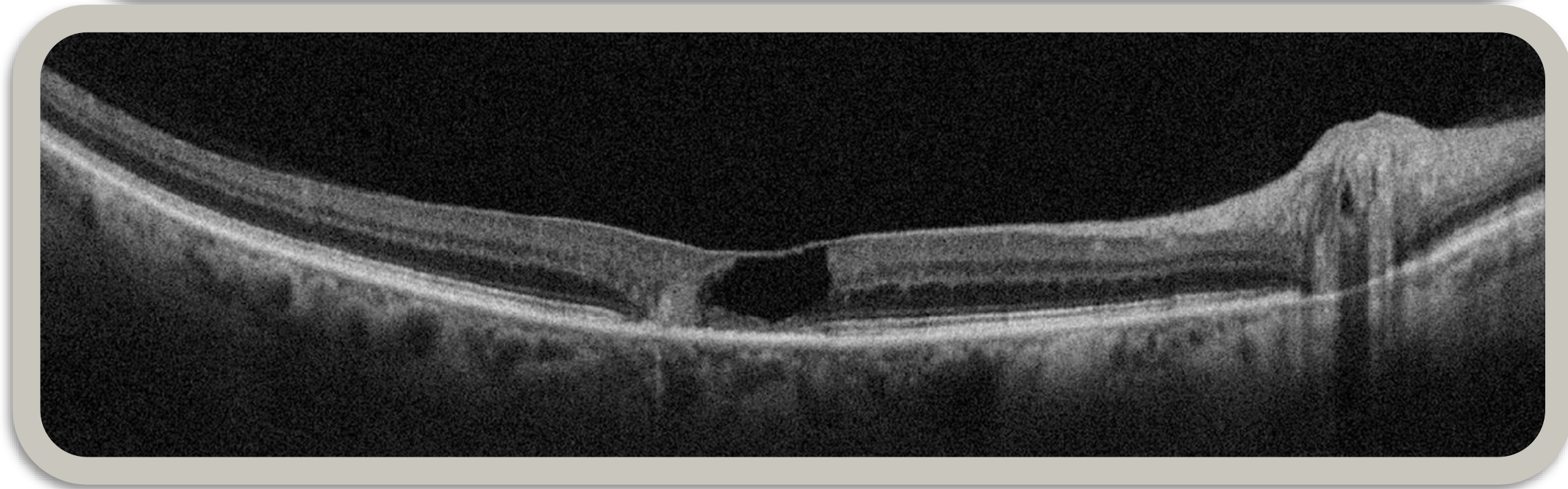
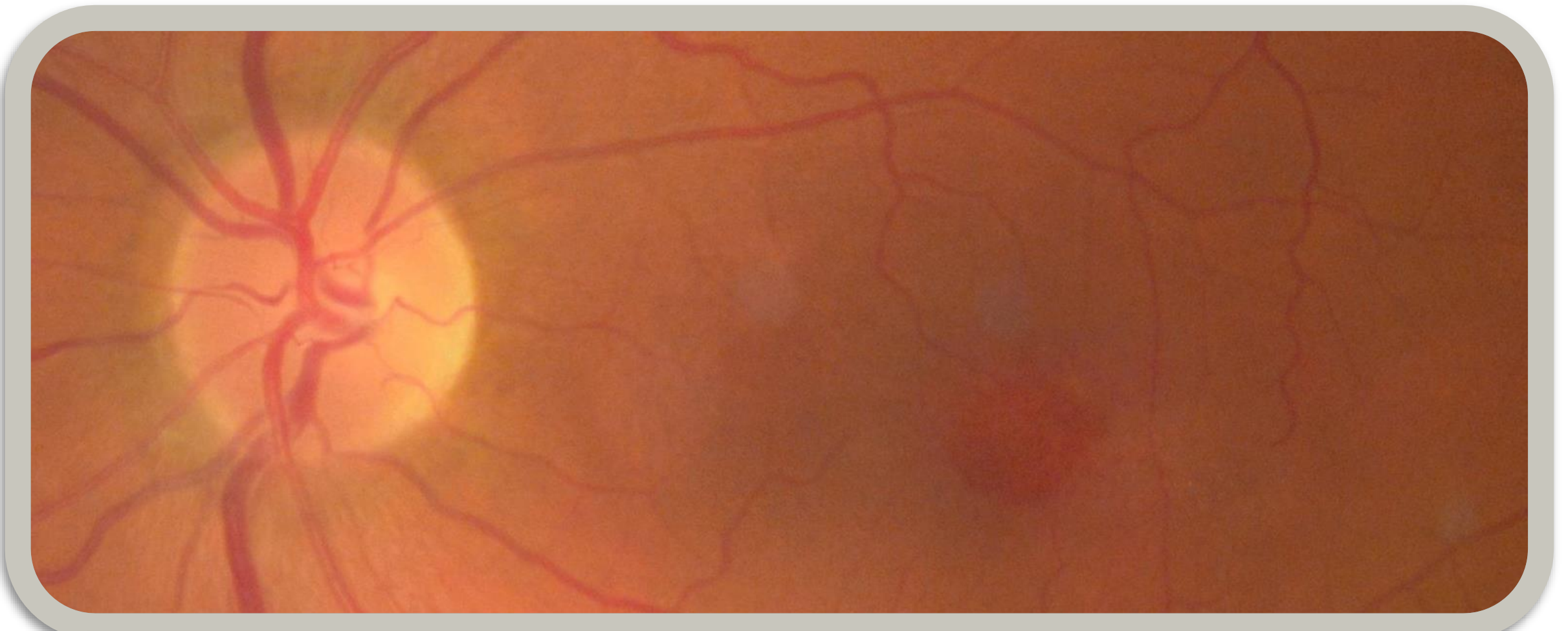
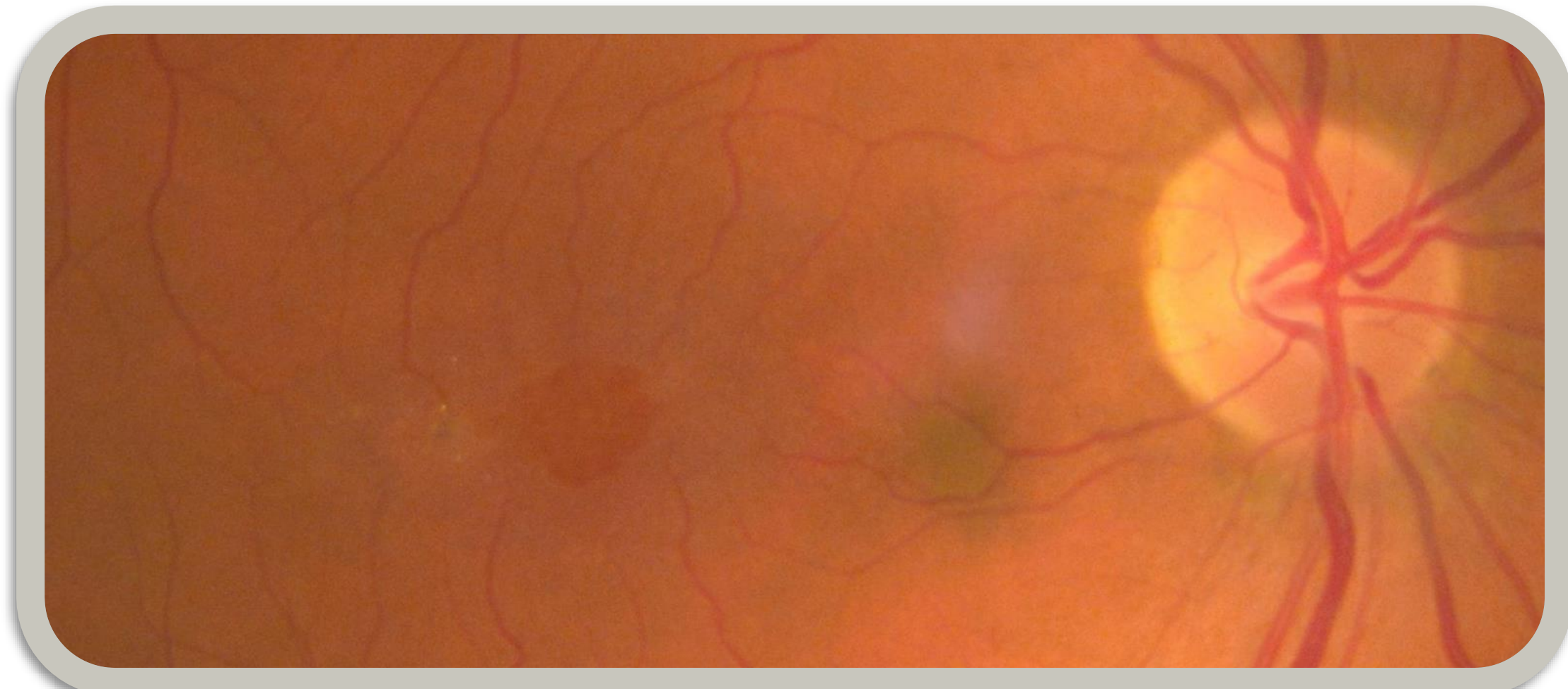
Fundus: See Images

OCT: See Images









Discussion Points

From the history and symptoms give a differential diagnosis?

Describe the fundus picture?

Describe the OCT?

What is your diagnosis?

What is your management?



References

https://eyewiki.aao.org/Macular_Telangiectasia

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2. Wu L, Evans T, Arevalo JF. Idiopathic macular telangiectasia type 2 (idiopathic juxtafoveolar retinal telangiectasis type 2A, Mac Tel 2). *Surv Ophthalmol.* 2013 Nov-Dec;58(6):536-59.
3. Charbel Issa P, Gillies MC, Chew EY, Bird AC, Heeren TF, Peto T, Holz FG, Scholl HP. Macular telangiectasia type 2. *Prog Retin Eye Res.* 2013 May;34:49-77.
4. Kedarisetti KC, Narayanan R, Stewart MW, Reddy Gurram N, Khanani AM. Macular Telangiectasia Type 2: A Comprehensive Review. *Clin Ophthalmol.* 2022 Oct 10;16:3297-3309.
5. Heeren TFC, Chew EY, Clemons T, Fruttiger M, Balaskas K, Schwartz R, Egan CA, Charbel Issa P; MacTel Study Group. Macular Telangiectasia Type 2: Visual Acuity, Disease End Stage, and the MacTel Area: MacTel Project Report Number 8. *Ophthalmology.* 2020 Nov;127(11):1539-1548.

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KC or Not KC - That's the Question

Case 3

Dr Keyur Patel



Presentation

MW 15 yo WF was initially referred for an Ophthalmology consultation by her optometrist as a suspect KC. -

‘they were concerned about changing prescription and potentially decreased BCVA’

Having been seen and reassured that there was no KC, they presented to us for a CL re-fit.



At CL refit appointment, they reported;

Currently wearing Proclear XR Toric - not happy visually. Vision get worse the older the lens.'

Currently studying for GCSEs

Hobbies: Horse Riding, Hockey, Netball

FOH: M - Hyperopic Astigmat, MGF - Strab, MGM - sudden loss of vision (CRAO)

Meds: Lamotrigine, Lymecline

NKDA



Currently Wearing;

Cooper Vision, Proclear XR Toric

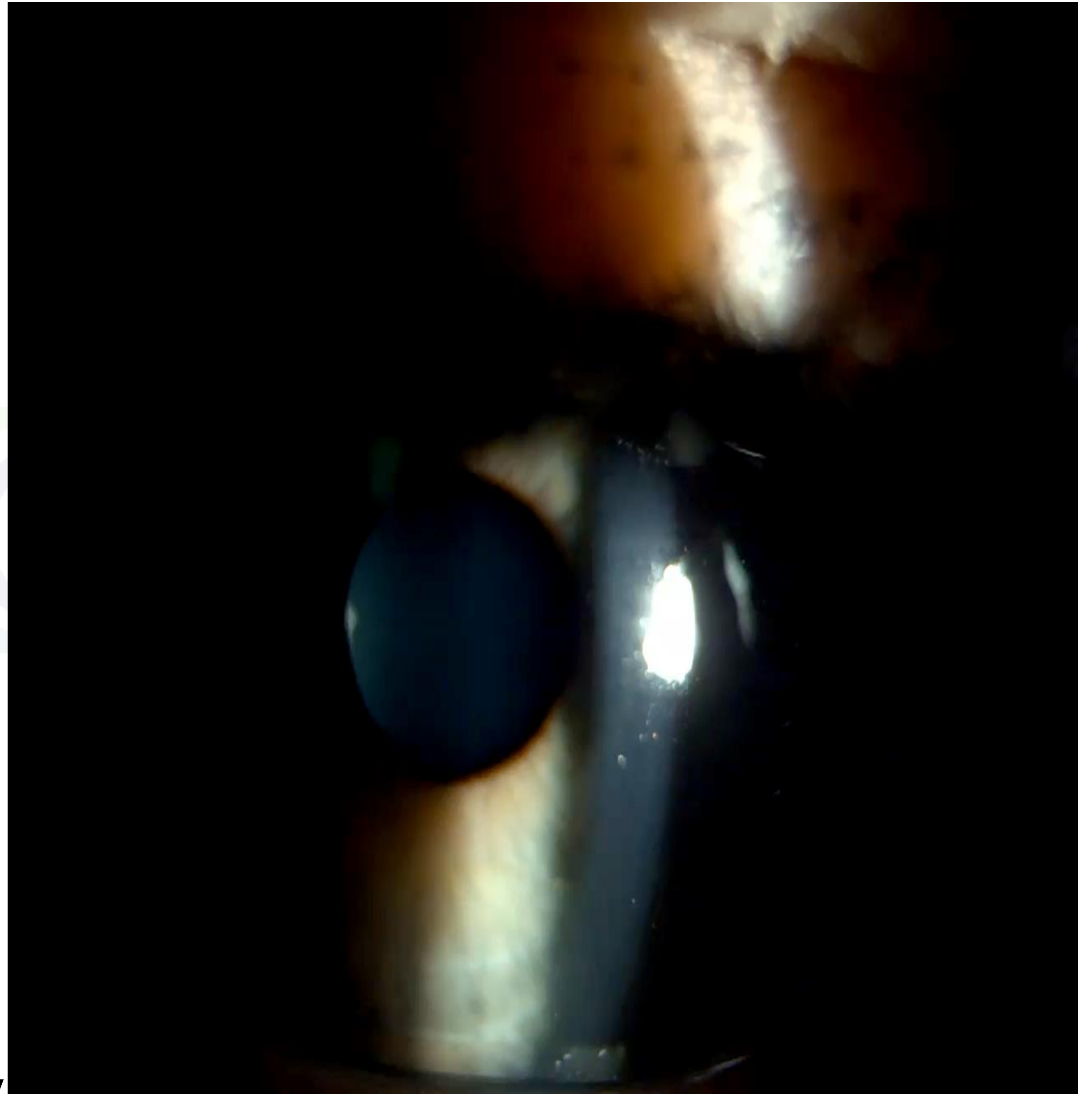
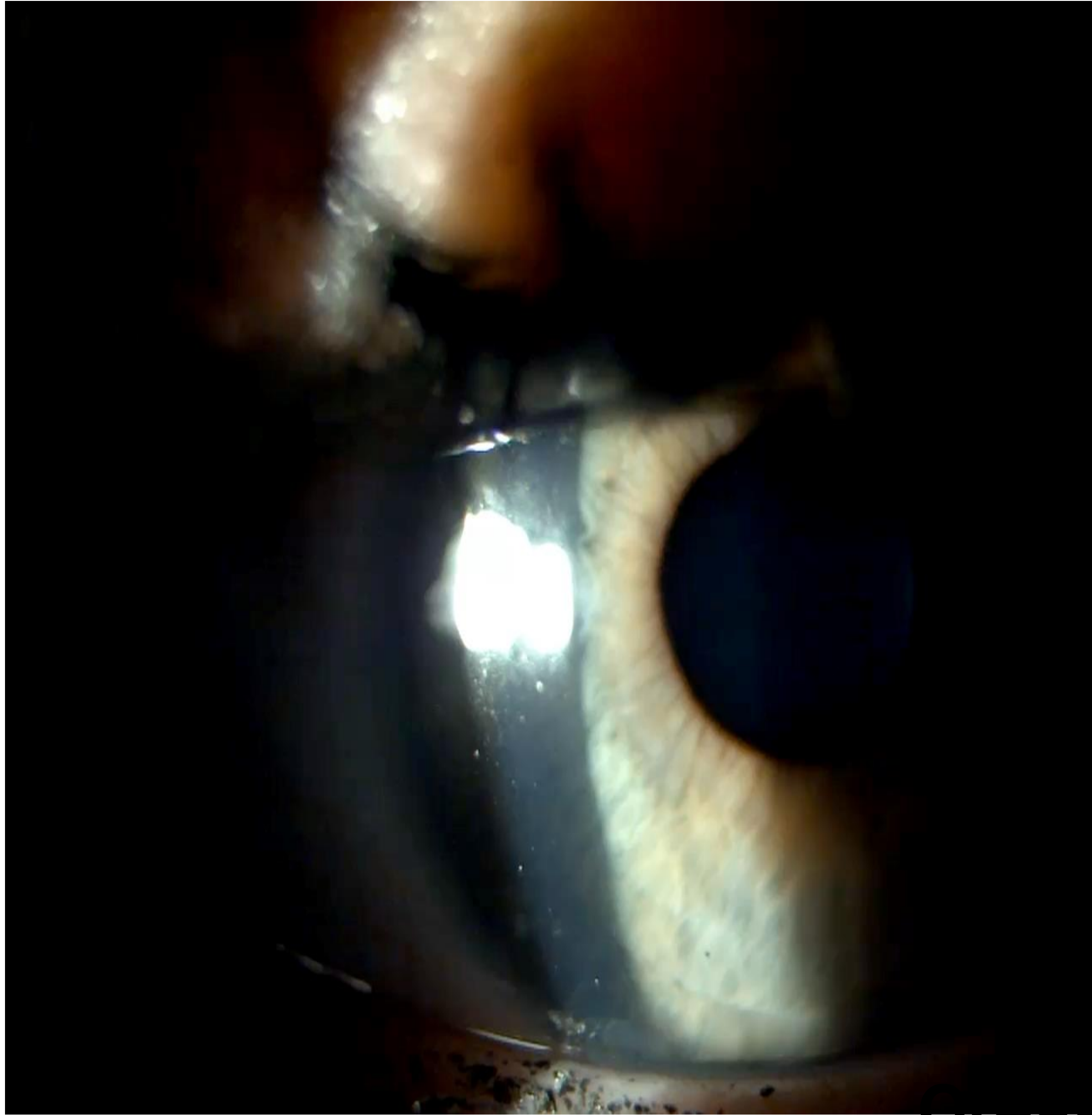
R +5.00/-5.75x10

L +4.25/-5.25 x175

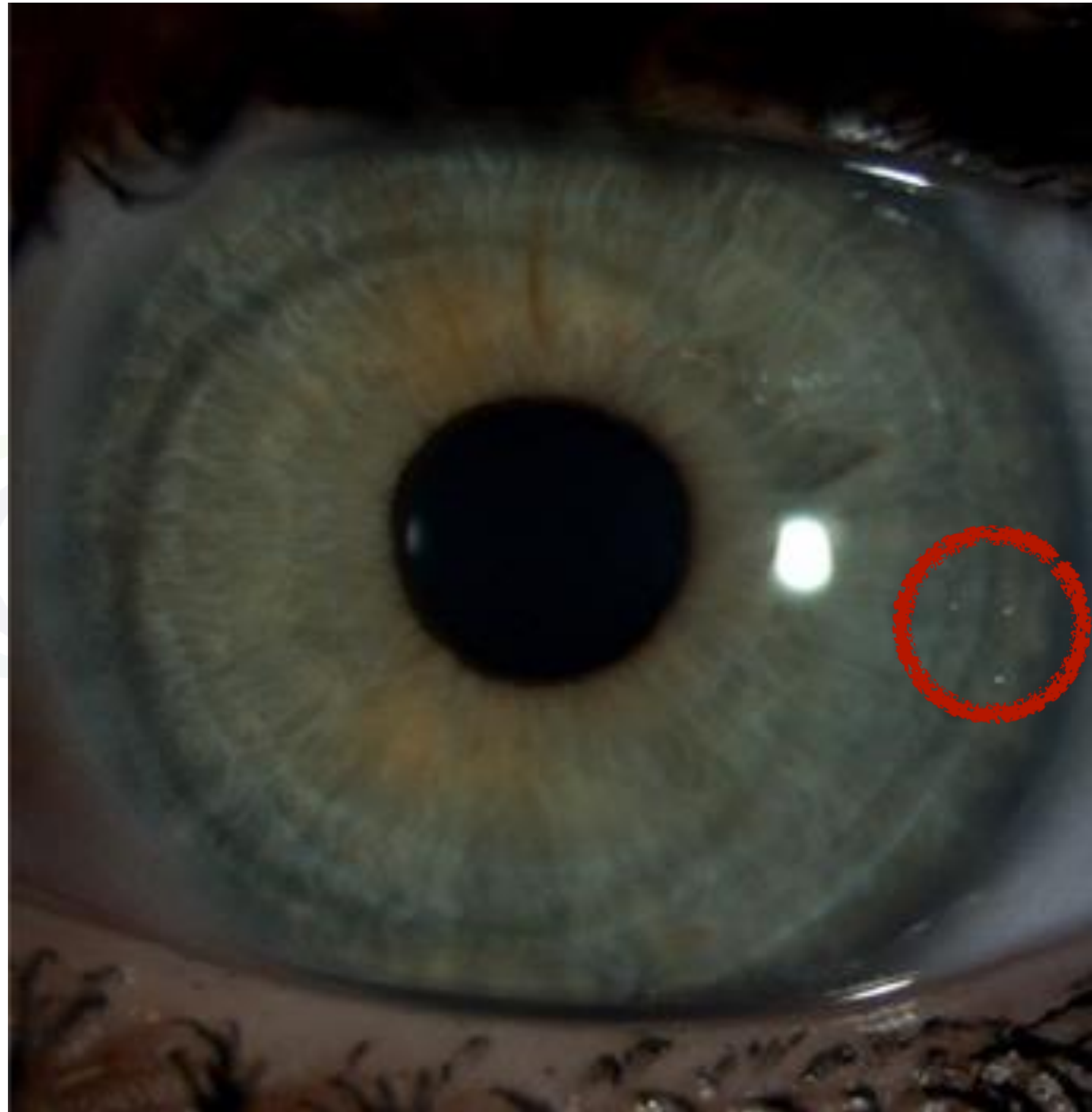
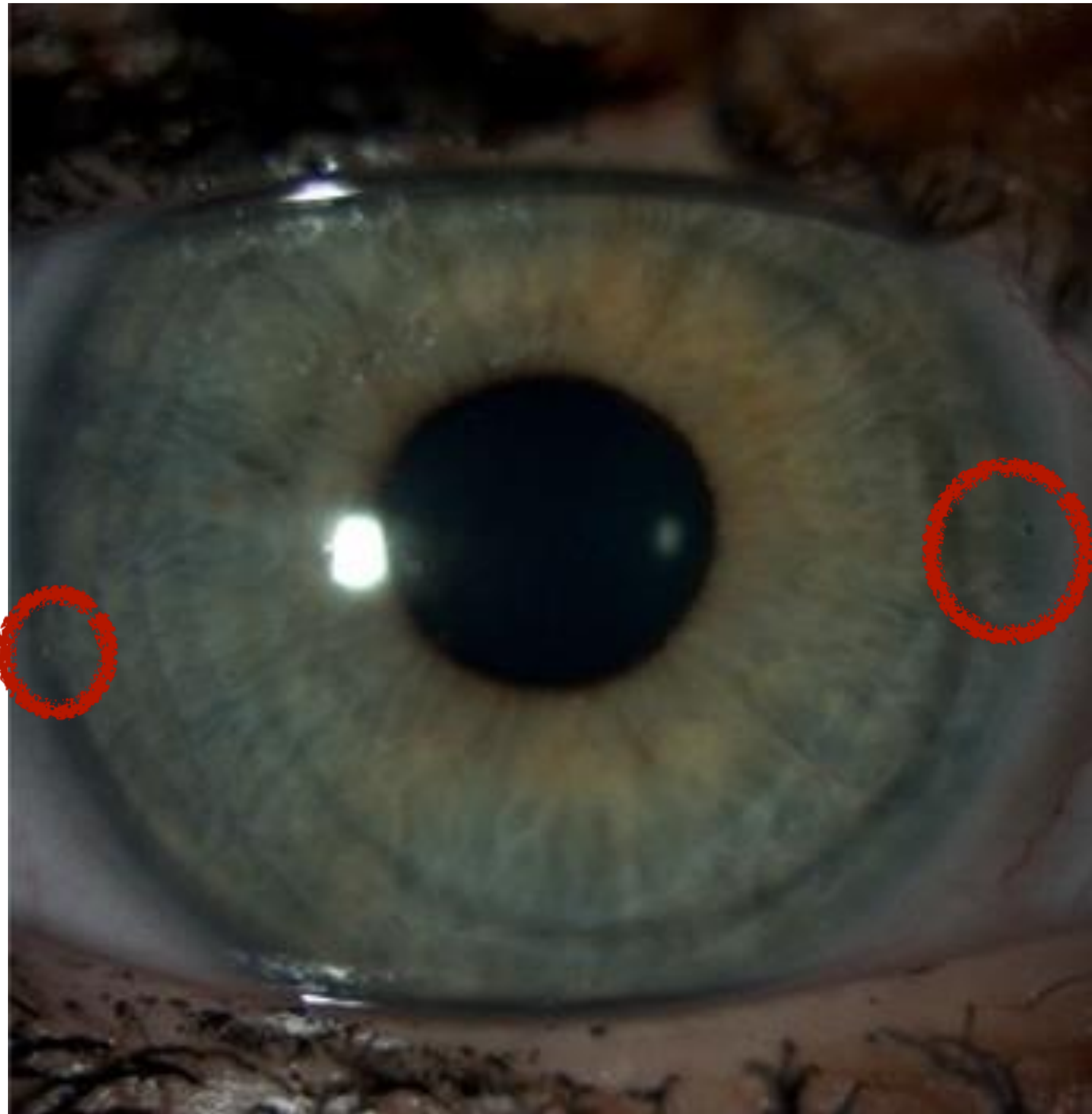
Current lenses about 3/52

Using Multipurpose cleaning solution from previous provider

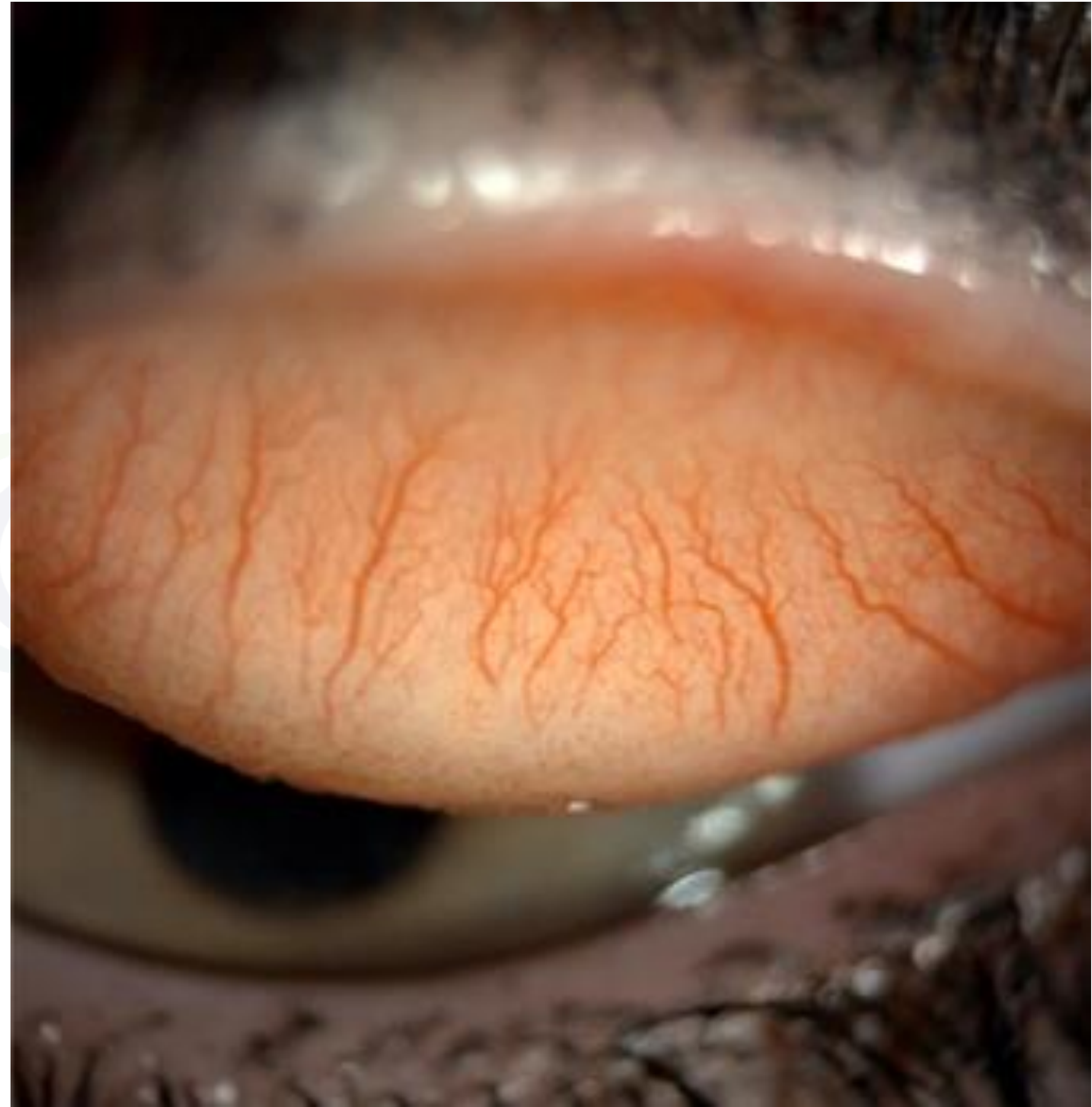




**Greasy
Tears**



Lens Deposits



Papilliae – grading scales – 1-2 Efron R+L

Management by Me

1) Re-order Proclear Toric, and order Bioinfinity Toric

When lenses arrive, then can send to Px and then needs to wear in preferred option

2) Switch make-up to EATS, Peroxide Care Solution and advised Hycosan Dual



Review Appointment

Preferred Proclear Toric vs Bioinfinity

Vision not ideal though

RE 6/15; O/R +1.75/-2.00 x145; VA 6/7.6-

LE 6/9.5+; O/R +1.25/-1.50x27; VA 6/7.6-

Order New Trials with O/R incorporated



Review Appointment 2

RE 6/9.5; O/R +0.75; VA 6/7.6-

LE 6/9.5; O/R +0.75; VA 6/7.6-

Advised to report and if happy with new Rx
can order

Anti-Fatigue plano Add +1.50 for conc
tasks.



Discussion Point

What signs would you look for in KC?
What additional tests would/could you perform?
What is Lamotrigine?
What is Lymecycline?
Causes and DDX?
Management Options?



References

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- * <https://eyewiki.aao.org/Keratoconus>
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- * <https://bnf.nice.org.uk/drugs/lymecycline/#indications-and-dose>

