CASE PRESENTATION

DR.Sravani
1st yr PG
Dept of Ophthalmology

- Name : X X X X X
- Age : 50yrs
- Sex : male
- Occupation : Farmer
- Residence : Mothkur

- **CHIEF COMPLAINTS** : -

- Diminision of vision in Right Eye since – 3mnths

- Diminision of vision in Left eye since – 1year

- **HISTORY OF PRESENT ILLNESS**:-

- Patient was apparently asymptomatic 3mnths back , then he had blunt trauma to right eye with a ball and he had pain which was subsided on medication after 2days , following which he developed diminished vision in right eye which was sudden in onset , progressively worsened and painless

- H/O diminision of vision in left eye since 1 year insidious in onset, gradually progressive and painless

- H/O floaters in Right eye

- H/O flashes of light in Right eye

- No h/o Redness , Watering , Photophobia in right eye

- No h/o Micropsia / Macropsia / Metamorphopsia in right eye

- **PAST HISTORY** :

- H/O Right eye cataract surgery 2yr back

- No h/o DM/HTN/Asthma/Drug allergy

- No h/o Steroid usage in any form

- No h/o usage of any eye drops

- **FAMILY HISTORY :** No h/o similar complaints in the family

PERSONAL HISTORY :

Diet – mixed

Appetite – normal

Sleep – adequate

Bowel & Bladder – normal

Positive Findings

- H/o sudden , Painless, loss of vision in Right eye since 3mnths
- H/o Gradual, Painless, Progressive loss of vision in Left eye since 1 year
- H/O trauma to Right eye
- H/O floaters &Flashes in Right eye
- H/O Right eye cataract surgery 2Years back

Differential Diagnosis ?

- Retinal detachment
- Vitreous detachment
- Vitreous haemorrhage
- Degenerative retinoschisis

EXAMINATION

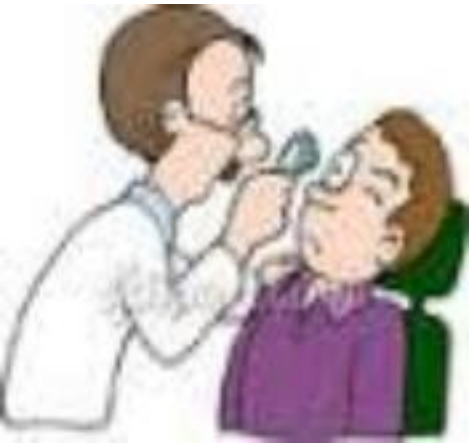
GENERAL EXAMINATION

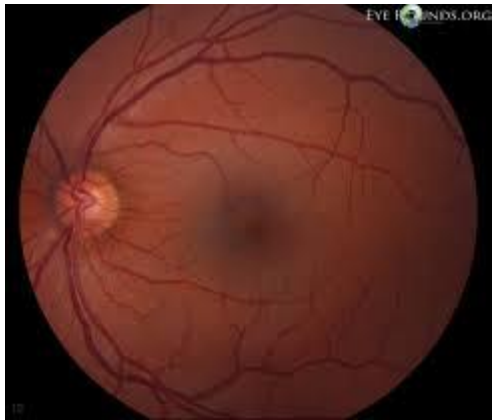
- Patient was conscious and coherent oriented to time,place and person
- Moderately built and nourished
- Vitals are normal

SYSTEMIC EXAMINATION

- CVS – Normal
- Respiratory system – Normal
- CNS – Normal
- GIT - Normal

OCULAR EXAMINATION





On the day of presentation

	OD	OS
Visual acuity	CF 3m PH NI	6/60 PH NI
Near vision	-	N12

- Head posture - Normal
- Facial symmetry – Maintained
- Ocular symmetry – Maintained
- Forehead – Normal
- Extra ocular movements – Full range in all directions

SLIT LAMP EXAMINATION

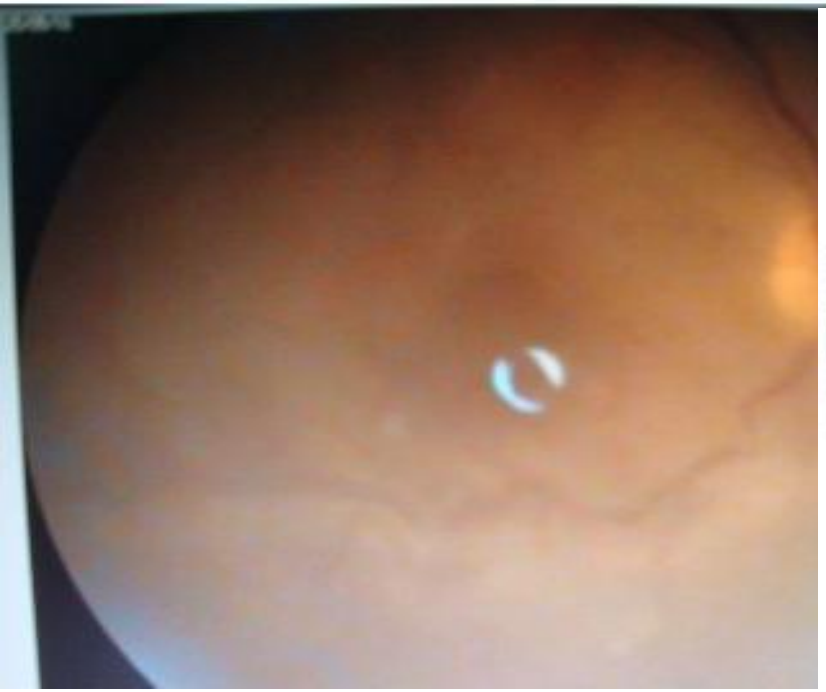
	OD	OS
EYELIDS	Normal	Normal
CONJUNCTIVA	Normal	Normal
CORNEA	Clear	Clear
ANTERIOR CHAMBER	Normal depth, clear contents	Normal depth, clear contents
IRIS	Normal pattern & colour	Normal pattern & colour
PUPIL	Relative afferent pupillary defect +	Normal size reacting to light
LENS	Pseudophakia	Greyish white opacification- immature senile cortical cataract

FUNDUS FINDINGS

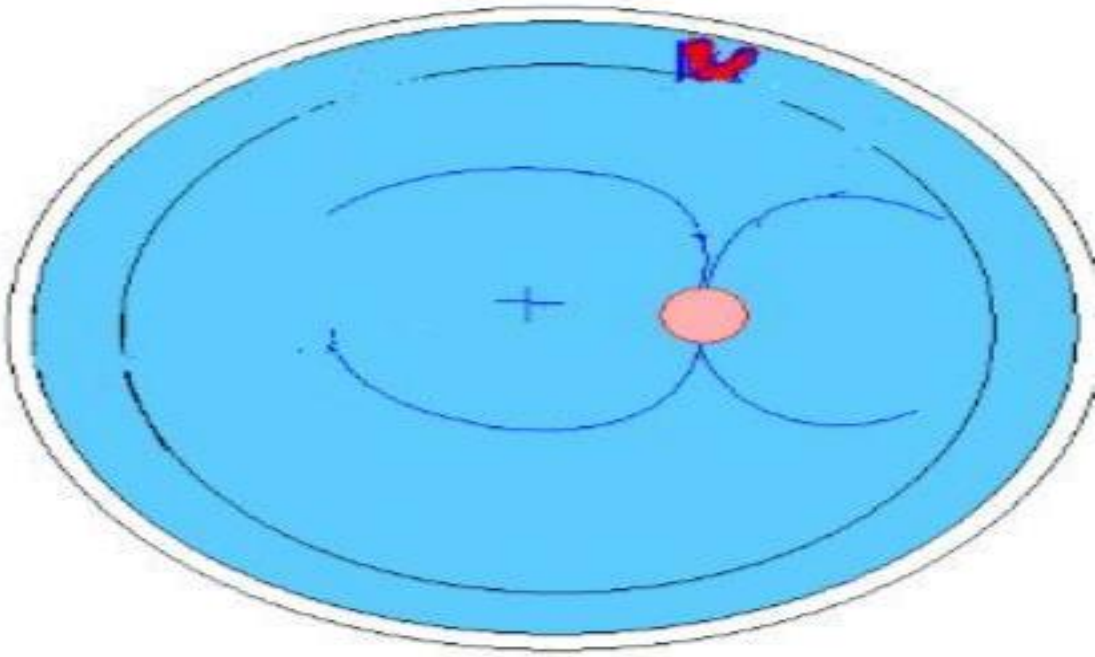
	OD	OS
Media	Clear Grey reflex seen on direct ophthalmoscopy and indirect ophthalmoscopy Few pigments in vitreous cavity	Hazy d/t Lenticular Opacity
Retina	Opaque convex,corrugated appearance of retina with loss of underlying choroidal pattern with horse-shoe tear at 12.00 clock and presence of subretinal fluid in all quadrants including macula s/o total rhegmatogenous retinal detachment including macula	Medium in size,Pink,Circular,Well defined margins Retina on in all quadrants Macula healthy

PREOP FUNDUS

Retinal detachment with macula off



Horseshoe tear at 12.0clock position



INVESTIGATIONS

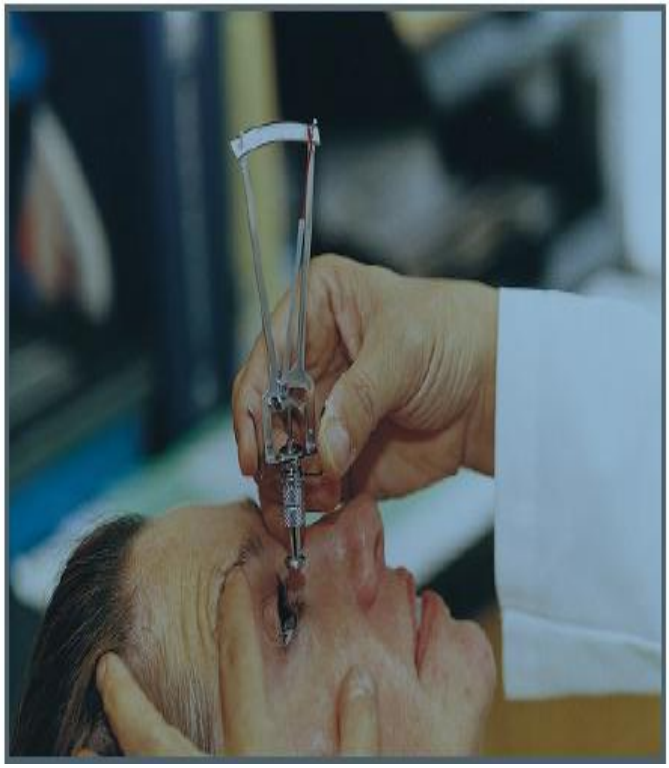
- what investigations to be done??

OCULAR INVESTIGATIONS

- Intraocular pressure
- Sac syringing
- A-scan
- Visual field charting
- Indirect ophthalmoscopy
- Optical coherence tomography(OCT)
- Ultrasonography

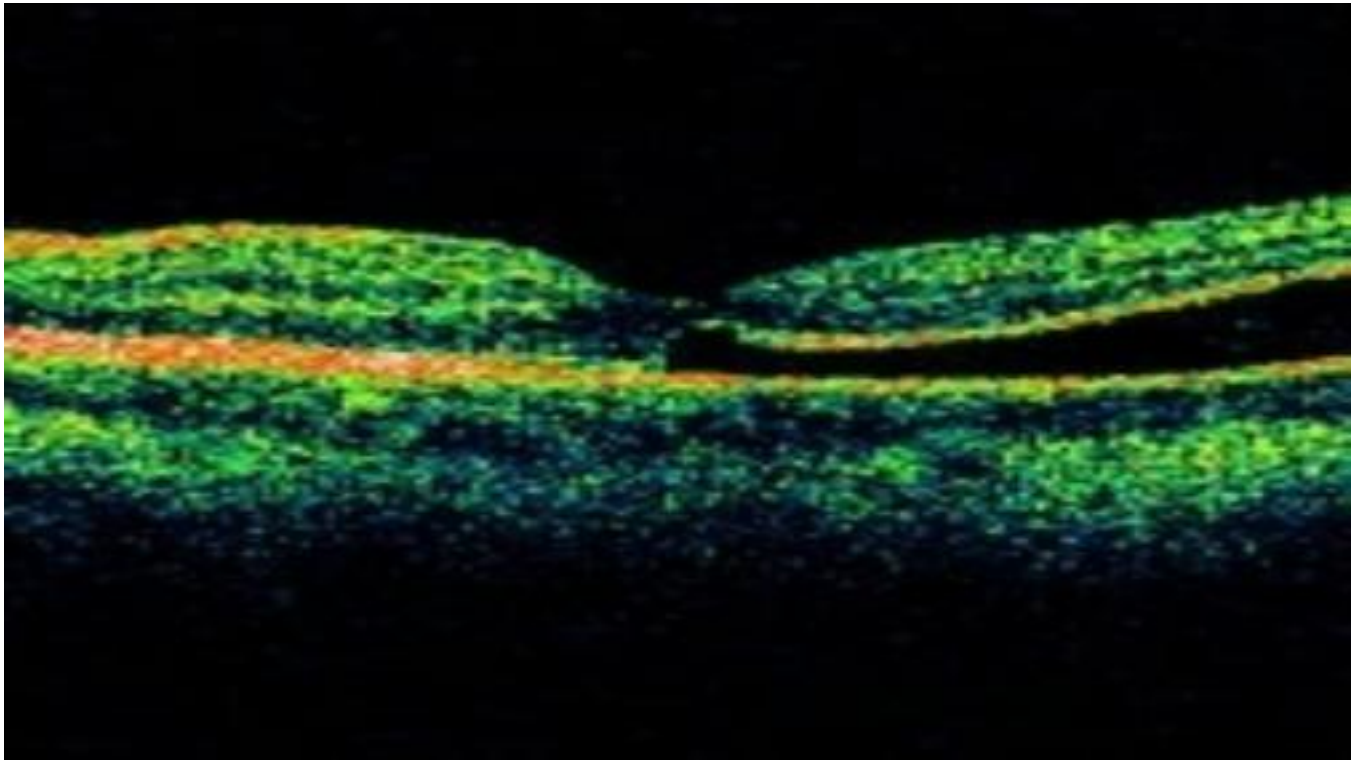
INTRAOCULAR PRESSURE – Schiotz tonometer by using 5.5 gmwt

	OD	OS
On the day of presentation at 11.00am	8 mm Hg	12 mm Hg



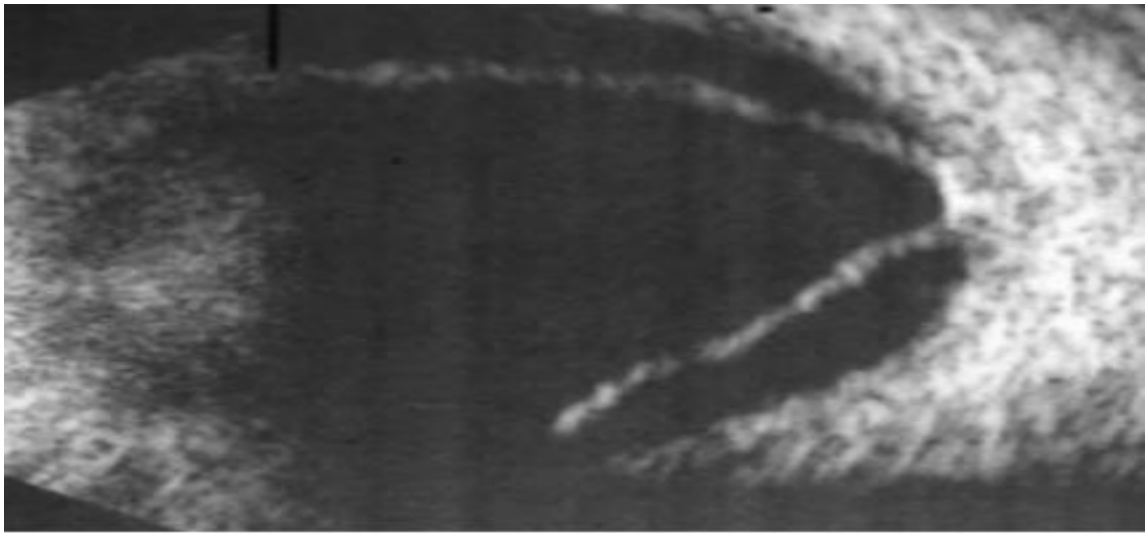
Optical coherence tomography

reveals subfoveal fluid

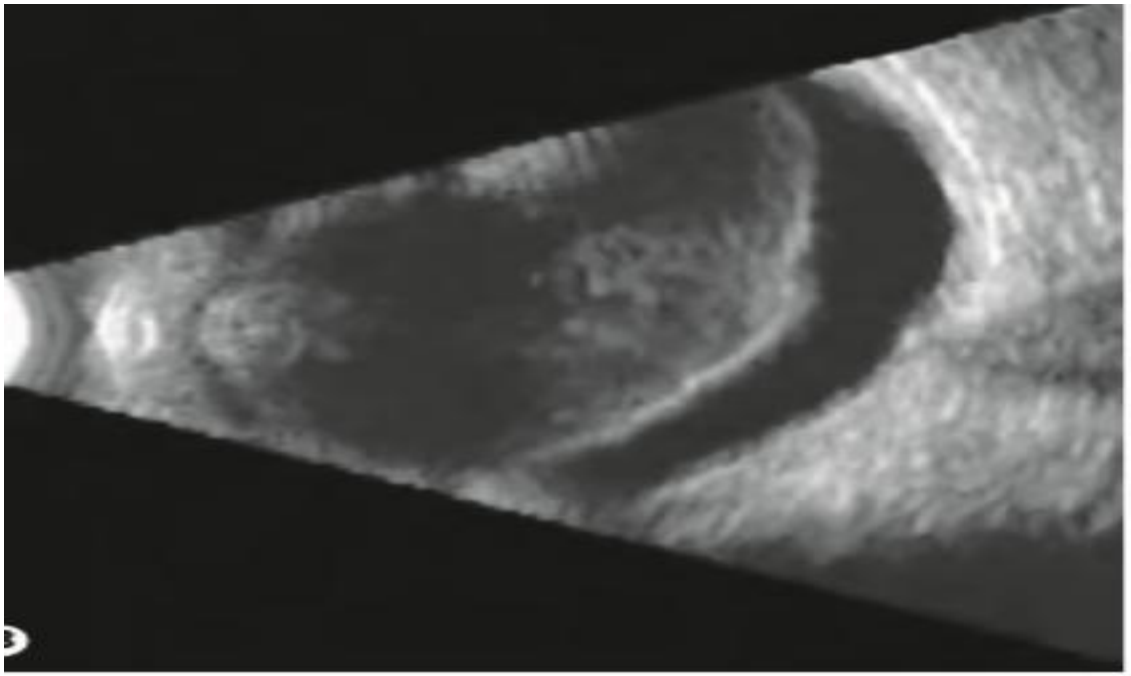


Ultrasound

Retinal detachment and proliferative vitreoretinopathy



Posterior vitreous detachment



SYSTEMIC INVESTIGATIONS

- Random blood sugar level
- Complete urine examination
- Electrocardiogram
- Physician fitness for surgery

DIAGNOSIS

What is the probable diagnosis?

- RE-- Total Rhegmatogenous retinal detachment with macula-off with proliferative vitreoretinopathy Grade-B with posterior vitreous detachment with horshoe tear at 12.00 clock in pseudophakic eye

- LE– Immature senile cortical cataract

TREATMENT

PREOP MEDICATION

TOPICAL –

- Eyedrops MOXIFLOX 0.5% 6times per day

CONSENT

INFORMED WRITTEN consent was taken from patient and his attendant (son)

SURGICAL TREATMENT

- **SCLERAL BUCKLING + PARS PLANA VITRECTOMY + ENDOLASER + SILICON OIL TAMPONADE UNDER LOCAL ANESTHESIA**

POSTOP MEDICATION

TOPICAL : RIGHT EYE

- Eyedrops PREDNISOLONE ACETATE 1% hourly
- Eyedrops TIMOLOL MALEATE 0.5% twice a day
- Eyedrops MOXIFLOX 0.5% 6times per day

SYSTEMIC:

- Tab DIAMOX (Acetazolamide) 250mg twice a day for 3days
- Tab CIFRAN 500mg twice a day for 5days
- Tab FLEXAN twice a day for 5 days
- Tab RANTAC 150mg twice a day for 5days

POSTOP INSTRUCTIONS

Patient was advised to lie in prone position

POD – 1

On slit lamp examination of RE

cornea – clear

lens – pseudophakia

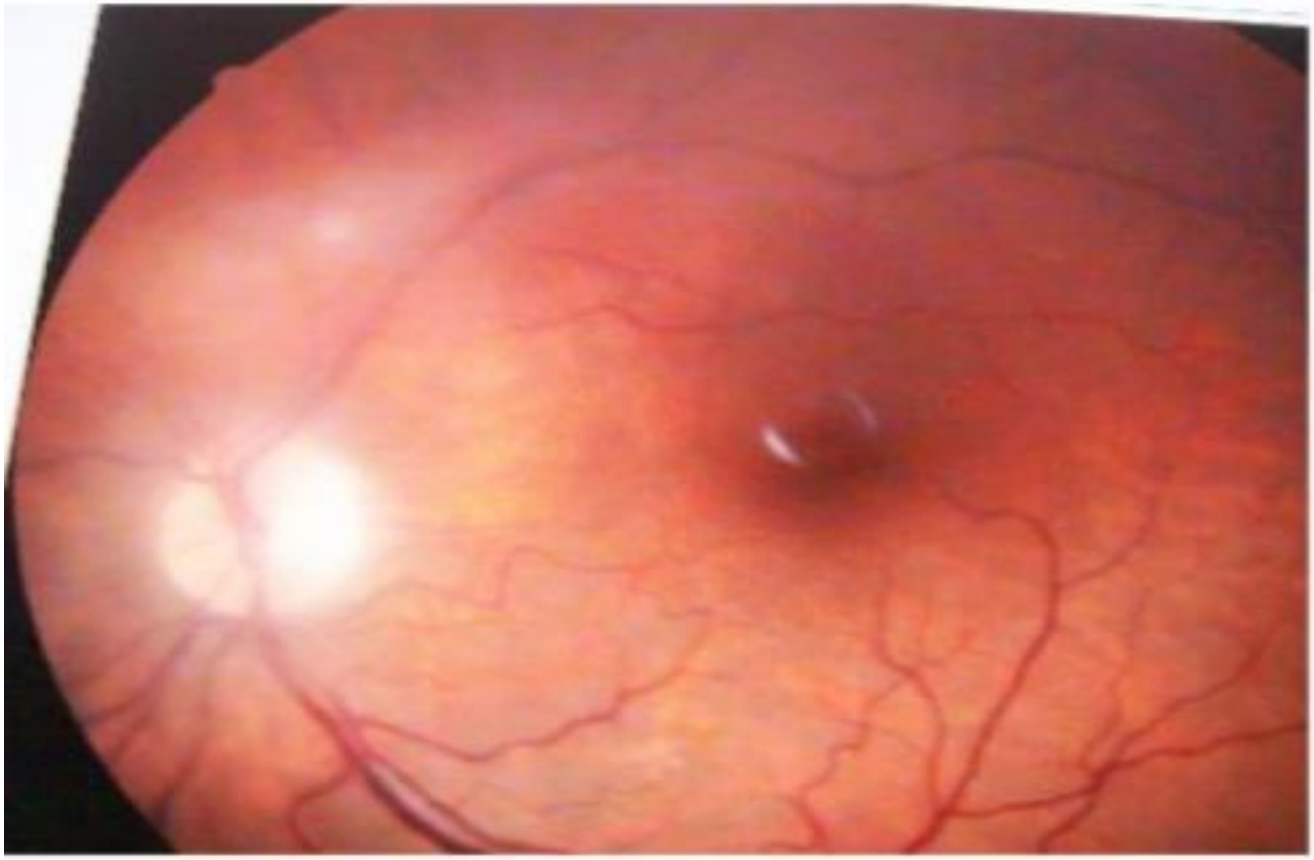
INTRAOCULAR PRESSURE – using schiotz tonometer with 5.5gm wt

	OD	OS
POD-1 at 11.00am	14 mm Hg	12 mm Hg

INDIRECT OPHTHALMOSCOPY OF RIGHTEYE

- Media - clear
- Retina – on with silicon oil insitu
- Endolaser marks seen
- Retina Break- flat

Post-operative fundus RE: retina flat with macula on



- POD – 3

	OD	OS
Visual acuity	CF 5m PH 6/36	6/60 PH NI
Near vision	N 36	N12

Patient was discharged on POD 5 with medications

TOPICAL- RIGHT EYE

- Eyedrops PREDNISOLONE ACETATE 1% with tapering dose
- Eyedrops TIMOLOL MALEATE 0.5% twice a day
- Eyedrops MOXIFLOX 0.5% 6times per day

Patient was advised to review every week

THANK YOU