CASE PRESENTATION

Dr. Divya Reddy

- Name : X X X X X
- Age : 60yrs
- Sex : Male
- Occupation : Farmer
- Residence : Mothkur

- **CHIEF COMPLAINTS** : -

➢ Diminision of vision in Right Eye since -- 1 yr

➢ Distortion of vision in Right Eye since --1 month

- **HISTORY OF PRESENT ILLNESS**:-

- Patient was apparently normal 1 yr back when he developed diminision of vision in right eye which is insidious in onset, gradually progressive and painless

- Diminision of vision in right eye was rapid progressive and fast deteriorating since 1month

- H/o Distortion of vision present since 1 month.

- No H/O frequent change of glasses

- No h/o Pain, Redness, Watering, Photophobia
- No h/o Trauma
- No h/o Floaters/Flashes

- **PAST HISTORY**:

➢ No h/o DM/HTN/Asthma/Drug allergy

➢ No h/o Ocular surgery

➢ 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
- Bowel and Bladder-Normal
- Appetite-Good
- Sleep-Undisturbed

Positive Findings

- Fast Progressive,Painless,Insidious vision loss since 1month

- Distortion of vision present

Differential Diagnosis ?

- Proliferative Diabetic Retinopathy
- Non proliferative Diabetic retinopathy with Clinically significant macular edema
- Central Serous Chorioretinopathy
- Wet Age related macular degeneration

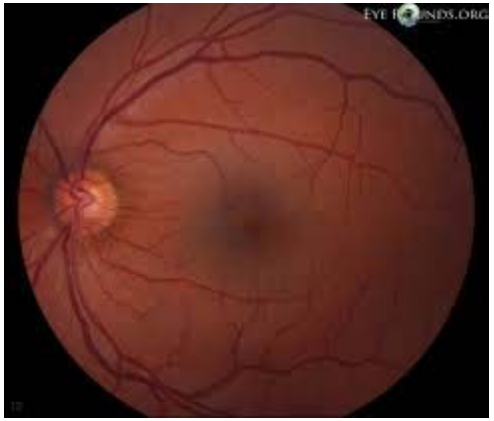
EXAMINATION

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

	OD	OS
Visual acuity	3/60 PH NI	6/12 PH NI
Near vision	N60	N10

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

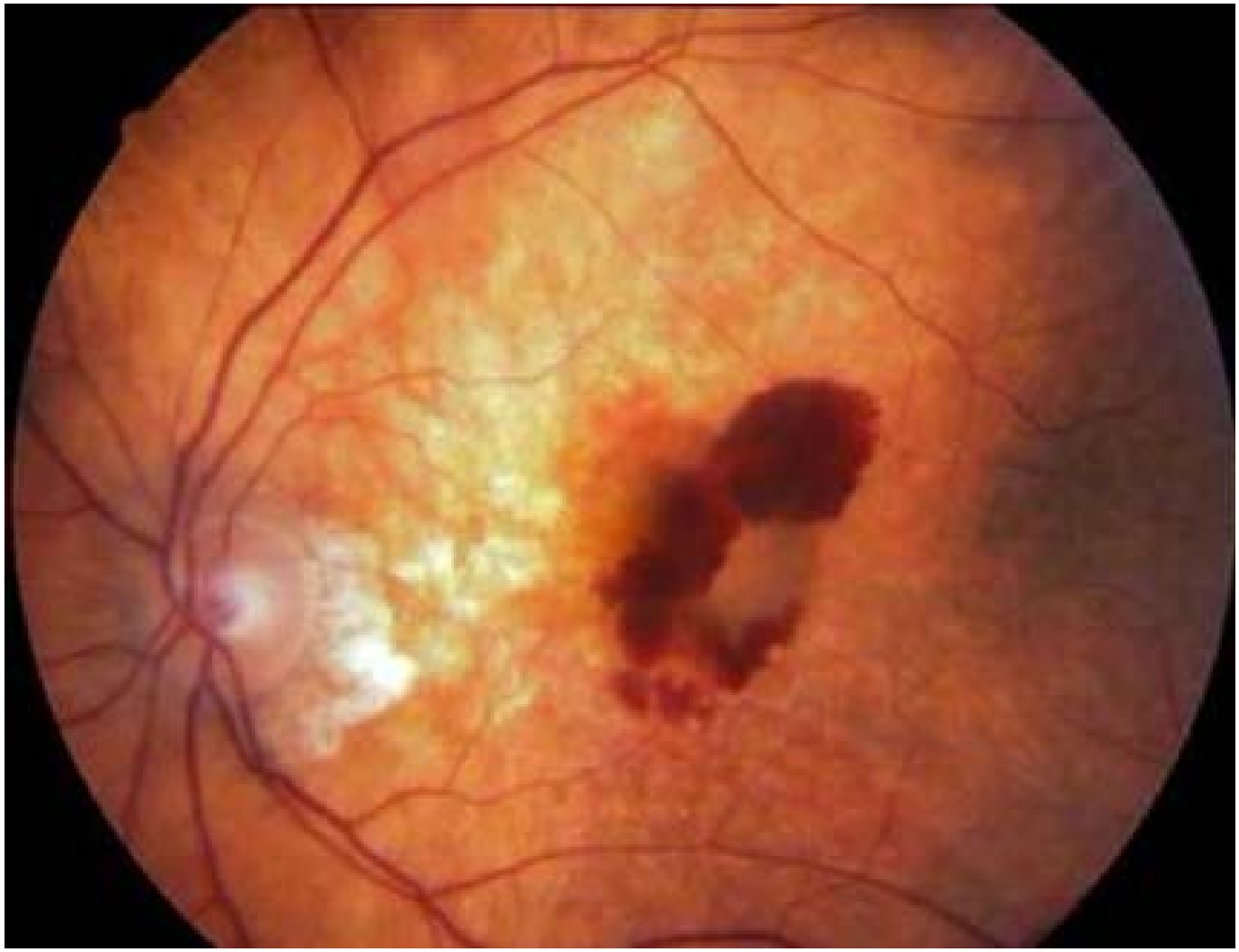
SLIT LAMP EXAMINATION

	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	**3-4mm in diameter** **Brisk reaction to direct and indirect light**	**3-4mm in diameter** **Brisk Reaction to Direct and Indirect Light**
LENS	**Greyish white opacification**	**Greyish white opacification**

FUNDUS EXAMINATION

	OD	OS
Media	**Clear**	**Clear**
Disc	**Normal in size ,circular , pink with well defined margins , CDR =0.3:1**	**Normal in size ,circular , pink with well defined margins , CDR =0.3:1**
Vessels	**Normal A:V Ratio-1:3**	**Normal A:V Ratio-2:3**
Macula	**Hypopigmented Waxy yellow, deep seated lesion suggestive of soft Drusens Dark raised irregular sub retinal Haemorrhage Plaque like Grey discrete discolouration-CNVM FR absent**	**Well defined , hypopigmented , deep seated lesion suggestive of soft Drusens FR absent**
Periphery	**Patches of chorioretinal atrophy +**	**Patches of chorioretinal atrophy +**

Fundus Photograph



INVESTIGATIONS

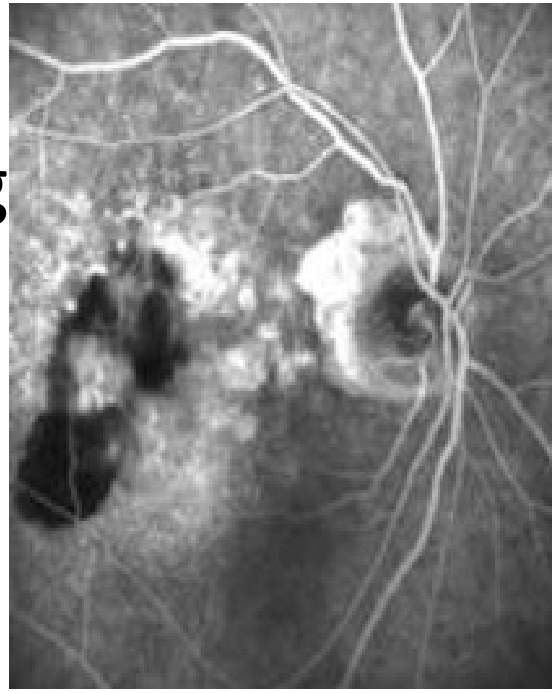
- what investigations to be done??

INVESTIGATIONS

- Amslers grid
- Direct Ophthalmoscopy
- Indirect ophthalmoscopy [+20D]
- FFA(Fundus Fluorescein Angiography)
- OCT(Optical coherence Tomography)

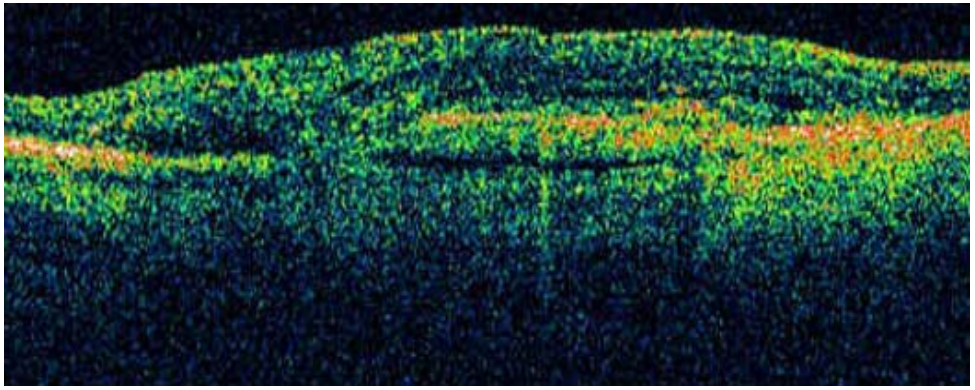
FFA

- Hypofluorescence (Blocked choroidal Fluorescence) due to sub-retinal haemorrhage
- Hyperfluorescence due to soft Drusen
- Early phase –Lacy pattern of filling
- Late phase- CNVM



OCT

- Thickening and fragmentation of RPE-High reflective band
- Retinal thickening(CMT=402 microns)
- Sub retinal fluid accumulation



DIAGNOSIS

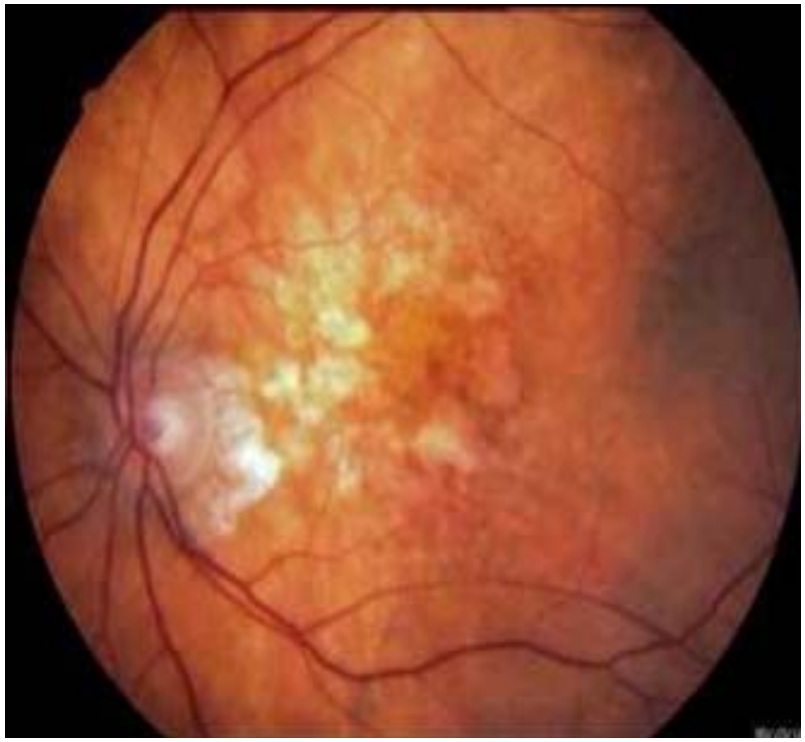
- RE - Wet Age Related Macular Degeneration

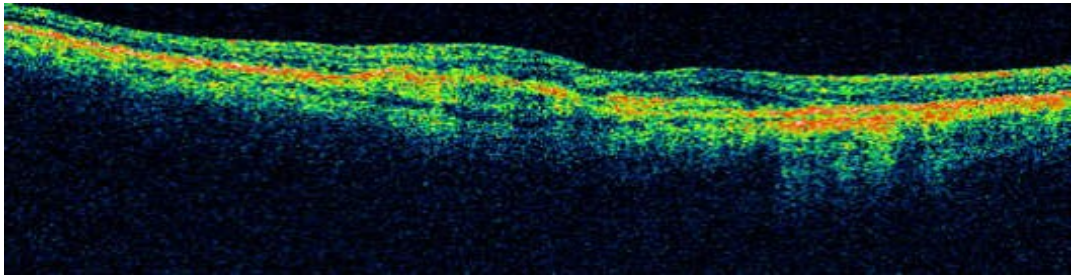
TREATMENT

TREATMENT

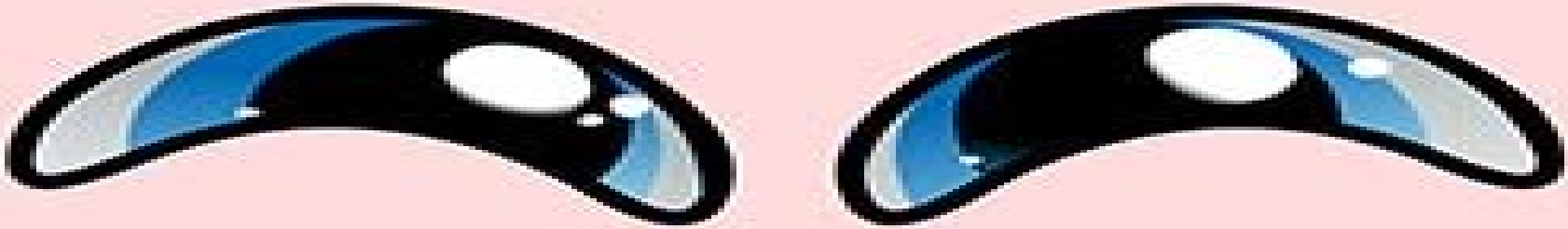
- ANTI VEGFS –INTRAVITREAL Ranibizumab [Lucentis] 0.5mg/0.05ml every monthly for 3 months and Followed with OCT and Best corrected visual acuity.

Fundus Photograph and OCT
POST-TREATMENT





- Visual Acuity Post treatment- 6/24
- CMT=257 microns



Thank you!