

Refer or Relax: Macula

2 hours

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Description:

This course discusses macula cases encountered in the primary care ODs office and asks if this is something that we can monitor ourselves (relax) or require referral to a retinal specialist for further treatment. Cases include Central Serous Retinopathy, macular holes, Vitreo-macular traction, and more. Clinical pearls regarding follow up and appropriate referral criteria will be presented.

Learning Objectives:

- Understand those macula conditions that can be followed by the primary care OD vs. those that should be referred to a retinal specialist
- Recognize additional testing to help differentiate and manage common macula disorders
- Review best practice referrals and timelines for macular conditions
- Become knowledgeable as to treatment options for common macular diseases
- Become more proficient treating patients with macular disease
- Increase communications between primary care optometrists and retinal specialists

Outline:

- I. Introduction and Disclosures
- II. Macular hole cases
 - a. Case demographics
 - b. Clinical characteristics
 - i. Circular depression of varying degrees in avascular area of macula
 1. Most common cause is idiopathic

- a. Most likely due to VMT
- 2. Highest incidence 7th decade of life
- 3. Women 2x as much as men
- ii. FTMH (full thickness macular holes)
 - 1. VA 20/80 to 20/100
 - 2. Size
 - a. Small: <250 um
 - b. Medium: 250um to 400 um
 - c. Large: >400 um
 - i. ½ of all holes are larger at time of Diagnosis
 - 3. Treatment
 - a. Refer to retinal specialist to consider surgery
 - b. Respond well to surgery
 - c. Pharmacologic agents fell out of favor
 - d. Face down positioning not as important as previously thought
- iii. LMH (lamellar macular hole)
 - 1. Also called partial thickness
 - 2. Mild metamorphopsia
 - 3. Limited acuity loss
 - a. Typically 20/40 ish
 - 4. Treatment
 - a. Surgery is controversial
 - i. 25% to 75% improved VA
 - b. Monitoring often reasonable

III. VMT (Vitreomacular traction)

a. Case demographics

b. Clinical characteristics

i. Posterior Vitreous detachment with persistent adherence to macula

1. Can lead to CME, ERM or macular hole

ii. VAST study

1. VMA IN 31% of eyes

2. Peak age 50-59

iii. Aphakia/pseudophakia are protective

iv. Symptoms include decreased VA, metamorphopsia and photopsia

c. Treatment

i. 10% will have resolution in 30 days

ii. More if wait longer (maybe 25%?)

iii. Monitoring reasonable

iv. Surgical Treatment is PPV if pt symptomatic

a. 75% success rate

b. Jetrea out of favor

IV. ERM (epi retinal membrane)

a. Case demographics

b. Clinical characteristics

i. Aka macular pucker, cellophane maculopathy

ii. Typically idiopathic, but can be secondary

iii. VA 20/20 to 20/200

1. <5% have worse than 20/220

2. Symptoms include mild vision loss and metamorphopsia

3. Increases with age

a. 9.3% after age 80

c. Treatment

i. Vitrectomy with membrane peel if symptomatic

ii. Very technical surgery: good surgeon matters

V. CSR (central serous retinopathy)

a. Case demographics

b. Clinical characteristics

i. Serous detachment of neurosensory retina

ii. Age: 20-45

iii. Male to female: 10:1

iv. VA typically 20/30-20/70

v. Unilateral in 70% of cases

vi. Smoke stack on FA vs ink-blot

c. Risk factors

i. Male vs female

ii. Age

iii. Type a personality/stress

iv. Pregnancy

v. Steroid use

vi. Others

1. Thick choroid

2. Sleep apnea

3. Viagra?

d. Treatment

i. Observation

1. 80-90% resolve in 1-6 mos
2. Rare to have VA worse than 20/40
3. 40% recurrence

ii. Refer if

1. Does not resolve in 6 mos
2. Pt desires quicker resolution
3. Oct/FA/Demographics not consistent

iii. Options

1. PDT
2. Anti-Vegf
3. Eplerenone
4. Others

VI. Conclusions/questions and answers