BEAVRS

British & Eire Association of Vitreoretinal Surgeons

Welcome

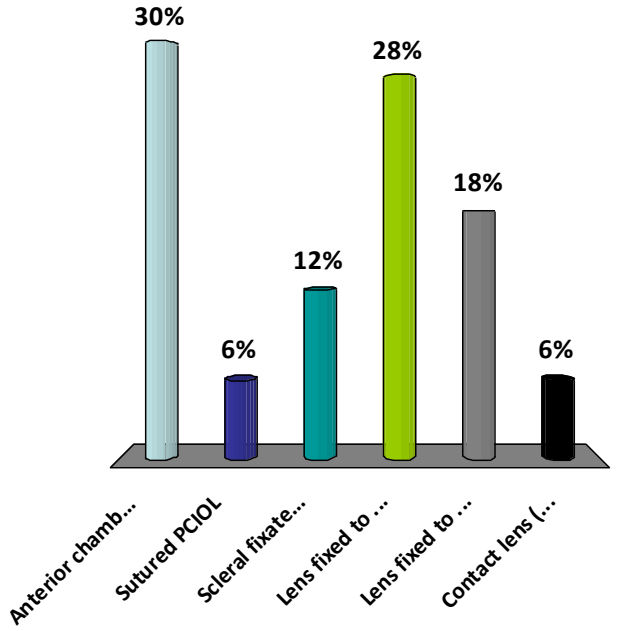
2014

Edinburgh 20-21 November

RCPE – WiFi
Password . chiron1681

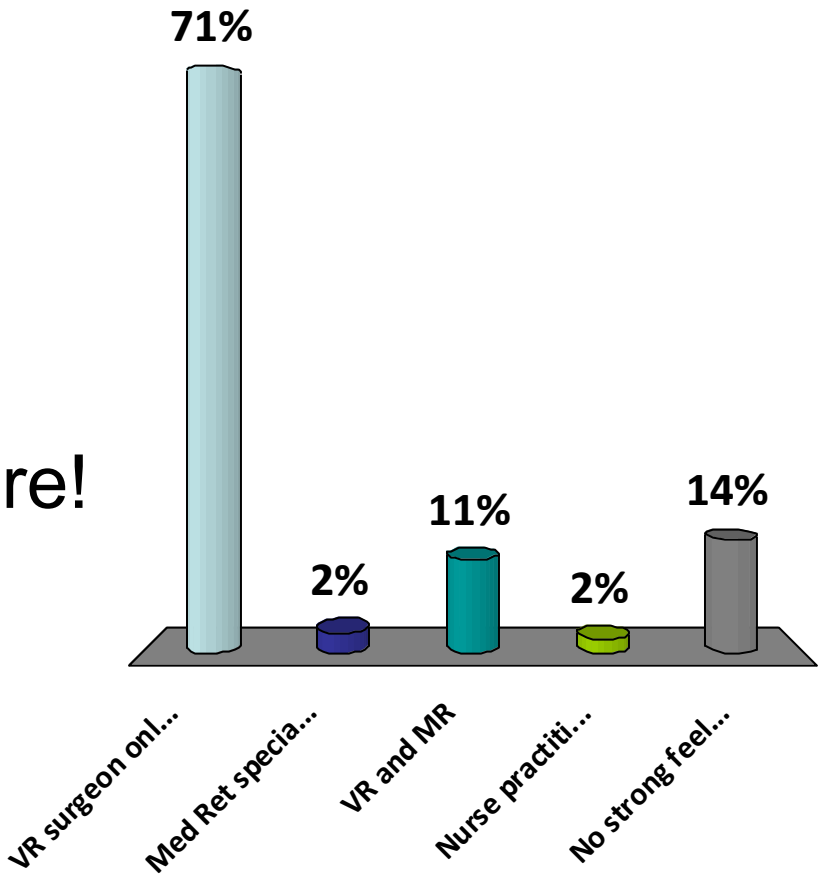
Which type of lens implant would you usually use in an aphakic eye with no capsular support?

1. Anterior chamber lens
2. Sutured PCIOL
3. Scleral fixated PCIOL - sutureless
4. Lens fixed to anterior iris
5. Lens fixed to posterior iris
6. Contact lens (no IOL)



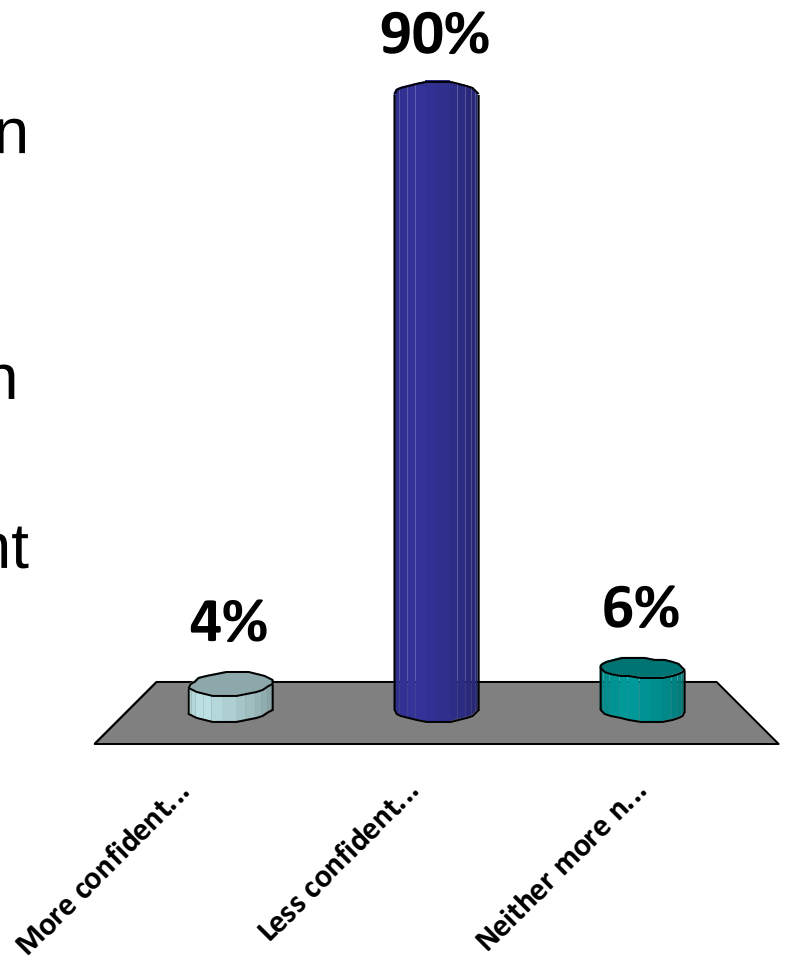
Ocriplasmin - who should inject

1. VR surgeon only
2. Med Ret specialist only
3. VR and MR
4. Nurse practitioner
5. No strong feelings/don't care!



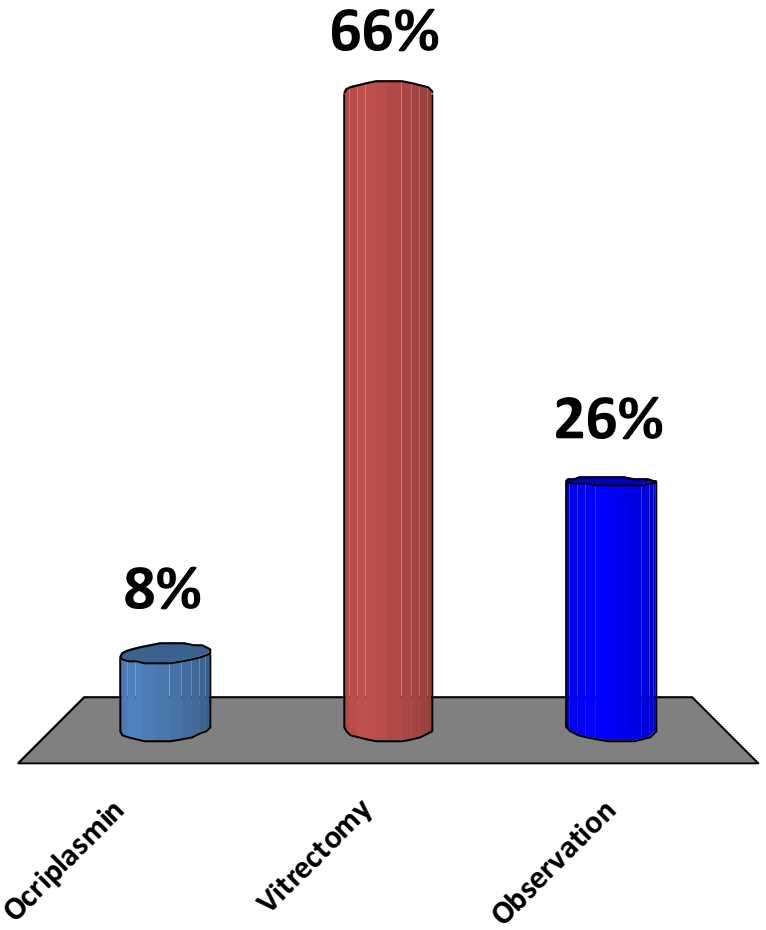
Ocriplasmin - after listening to this symposium, are you

1. More confident about using it in the Mx of vitreomacular adhesion cases (VMT/MH)
2. Less confident about using it in VMA
3. Neither more nor less confident



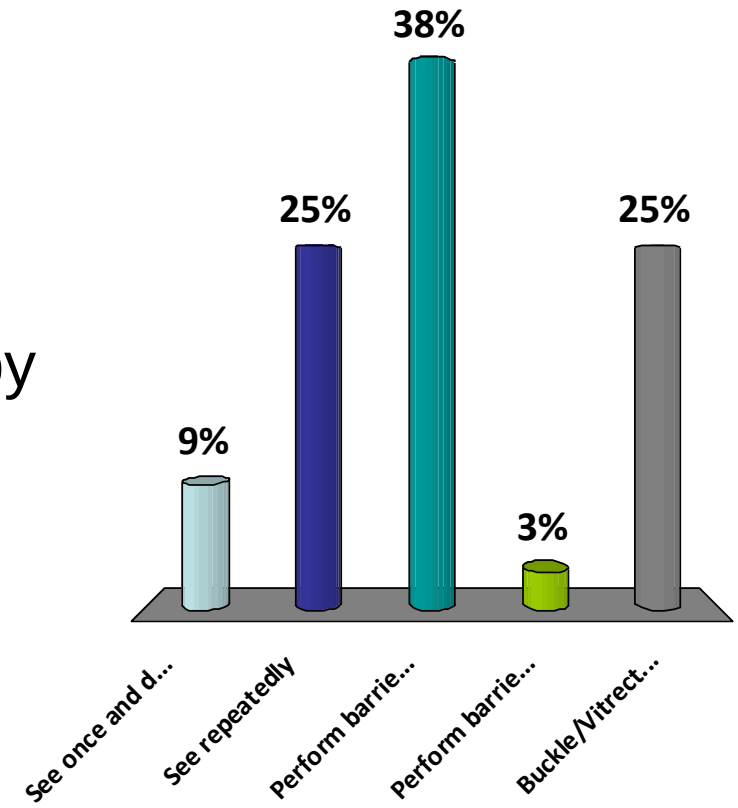
If you had a 235micron macular hole with VMT which treatment would you initially opt for ?

1. Ocriplasmin
2. Vitrectomy
3. Observation



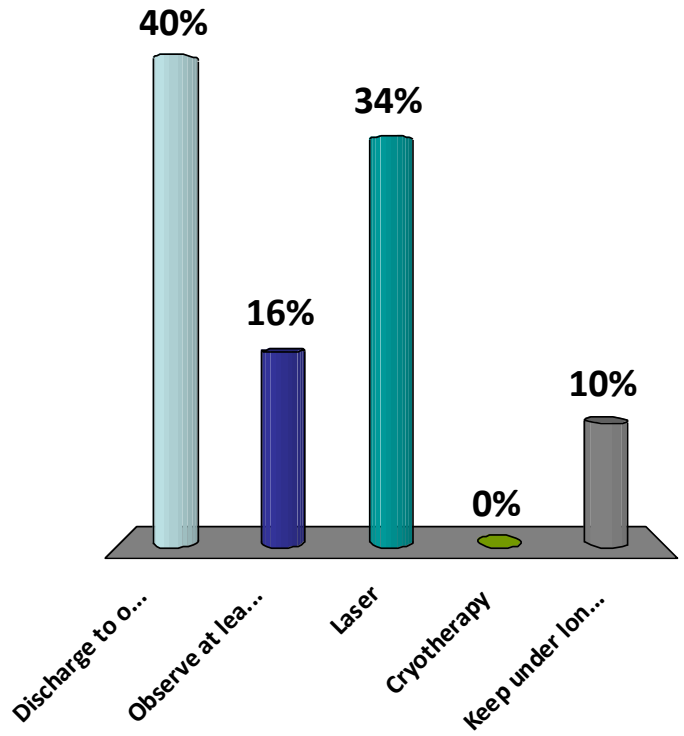
Optician referral - asymptomatic inferior RRD with incomplete/no demarcation line

1. See once and discharge with “RD” warning
2. See repeatedly
3. Perform barrier LASER
4. Perform barrier Cryotherapy
5. Buckle/Vitrectomize



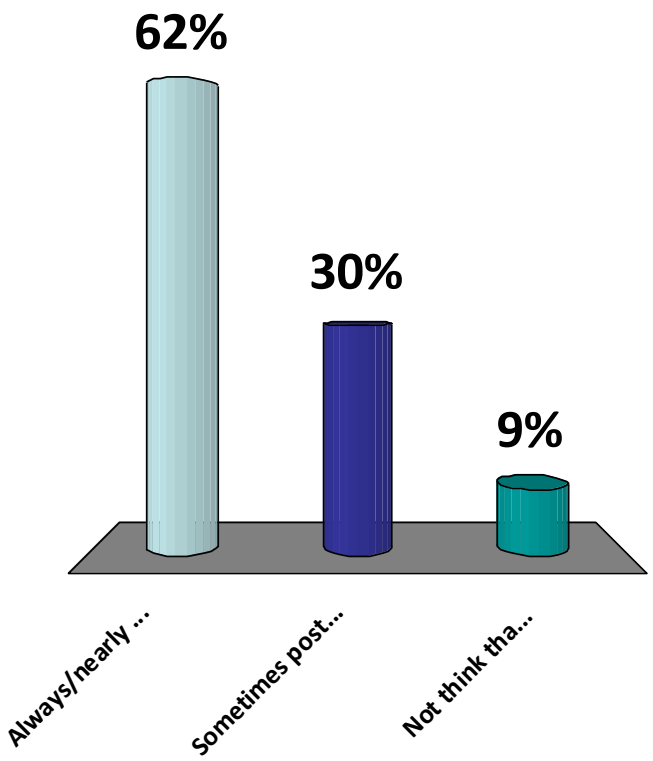
What treatment would you advocate for a young myopic patient with multiple areas of lattice degeneration and previous RD in the fellow eye?

1. Discharge to optometrist
2. Observe at least once in clinic
3. Laser
4. Cryotherapy
5. Keep under long term review



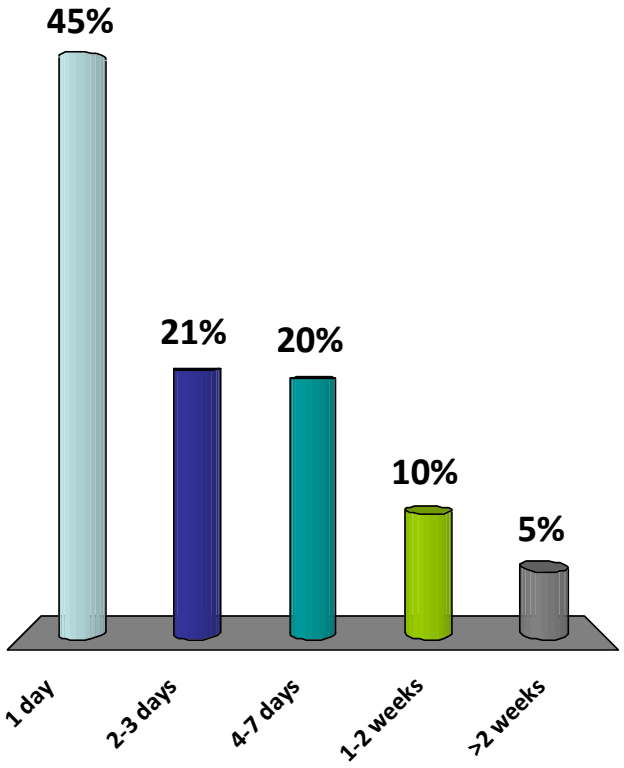
With regards to posturing the patient with a macular on RD - do you

1. Always/nearly always posture patient whilst awaiting surgery
2. Sometimes posture if RD is very bullous
3. Not think that posturing is useful



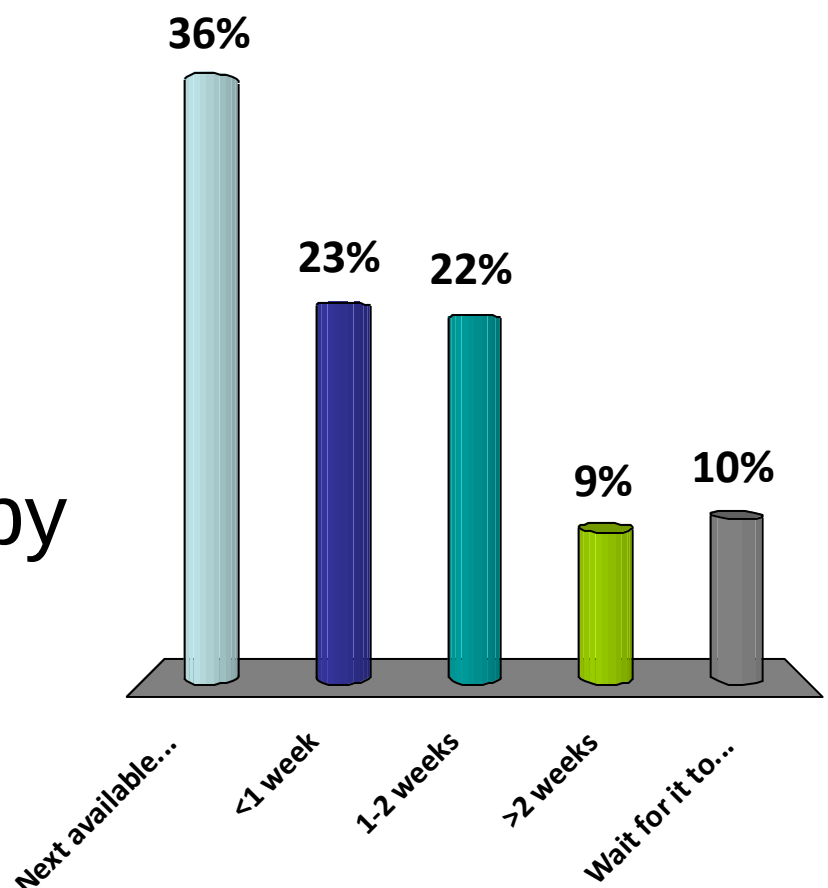
Non-diabetic, non-traumatic vitreous haemorrhage, when would you want referral to VR (B scan - No RD)

1. 1 day
2. 2-3 days
3. 4-7 days
4. 1-2 weeks
5. >2 weeks



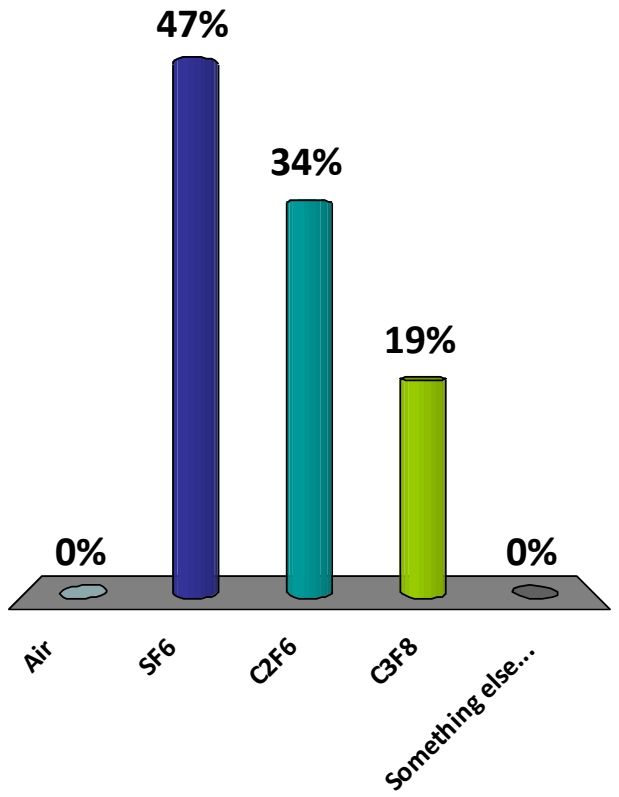
Non-diabetic, non-traumatic vitreous haemorrhage - when would you perform a vitrectomy (B scan - No RD)

1. Next available list
2. <1 week
3. 1-2 weeks
4. >2 weeks
5. Wait for it to clear by itself



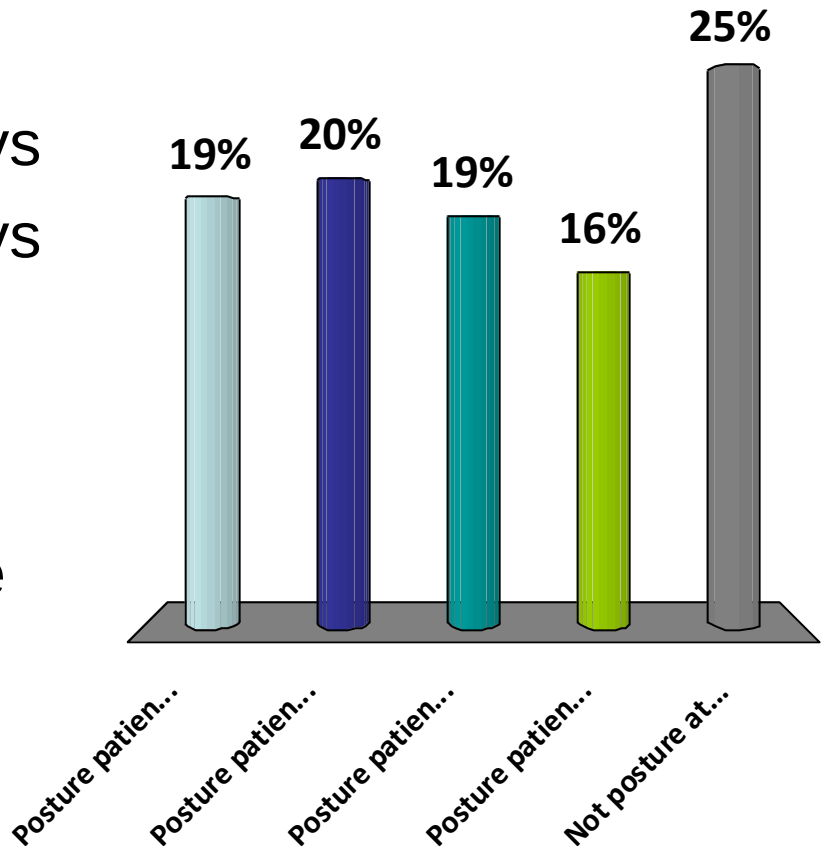
With regards to the intraocular gas in macular hole (stage II) surgery, do you use

1. Air
2. SF6
3. C2F6
4. C3F8
5. Something else??



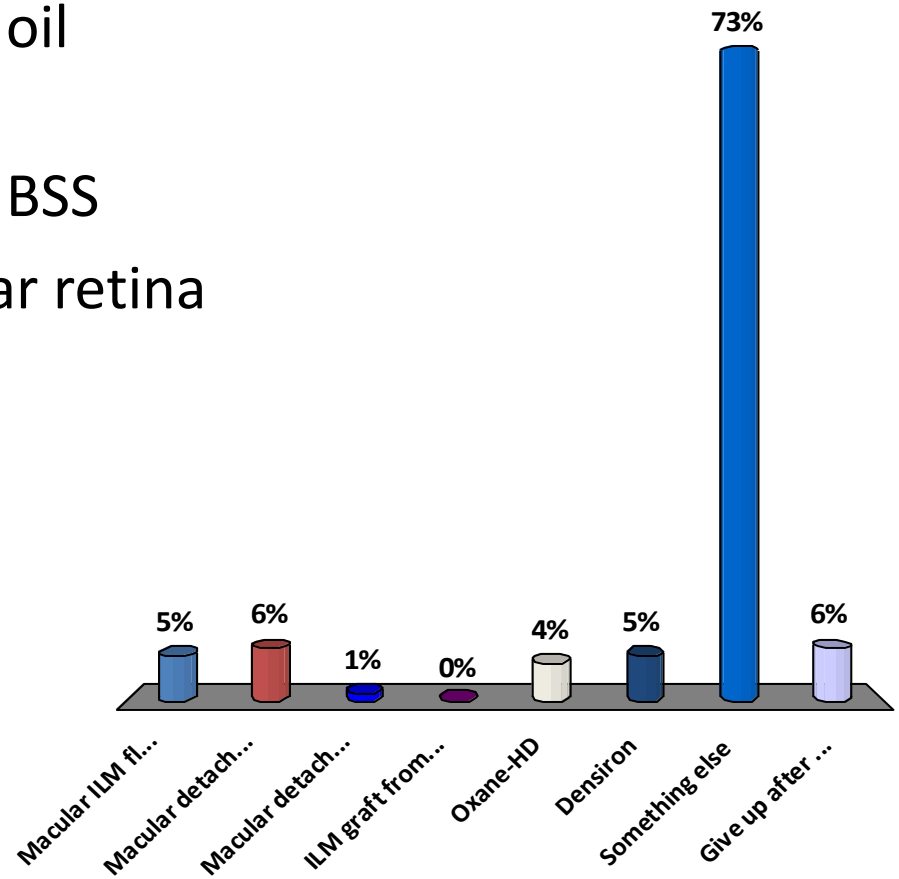
With regards to posturing following macular hole (stage II) surgery, do you

1. Posture patient for 1 week or more
2. Posture patient for 5-6 days
3. Posture patient for 2-4 days
4. Posture patient for 1 day only (includes 1st night only)
5. Not posture at all anymore



Failed macular hole surgery. Options for second attempt

1. Macular ILM flap
2. Macular detachment with oil tamponade
3. Macular detachment with BSS
4. ILM graft from non-macular retina
5. Oxane-HD
6. Densiron
7. Something else
8. Give up after one attempt



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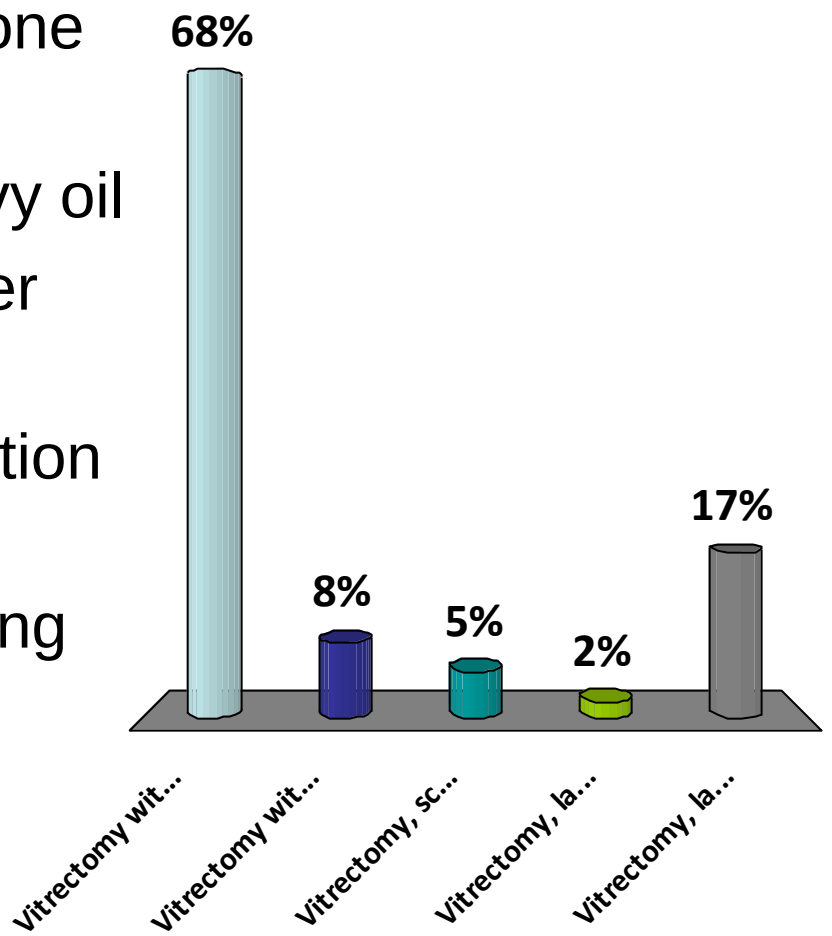
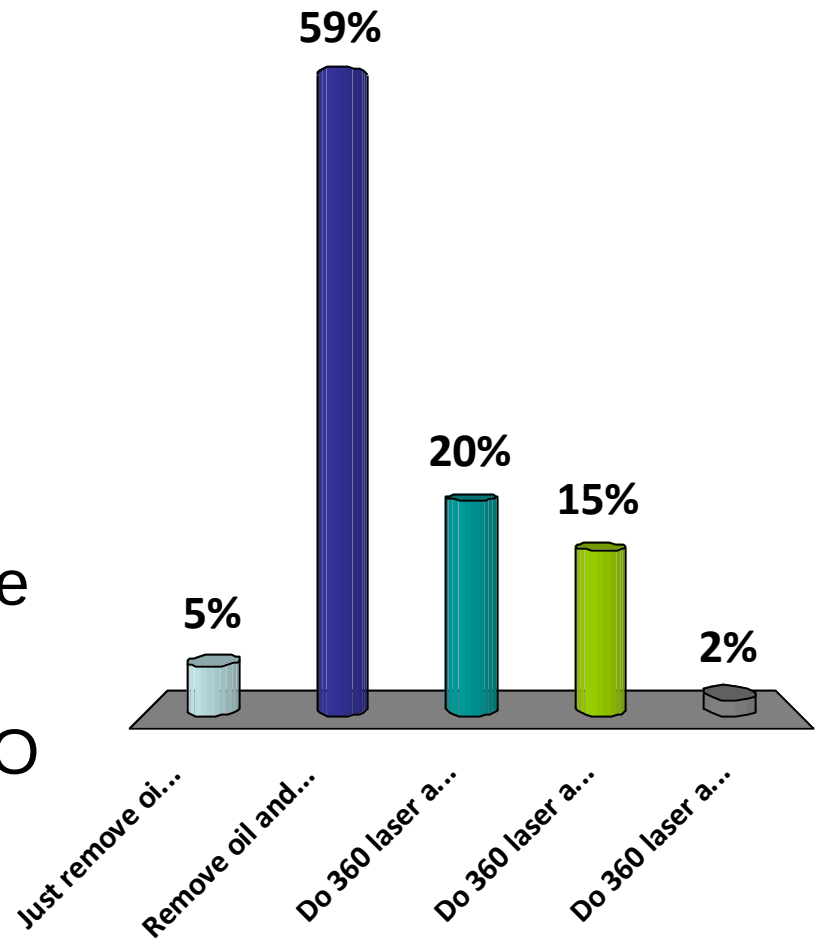
In a patient with retinal detachment and GRT extending from 1 o'clock to 6 o'clock what treatment would you advocate?

1. Vitrectomy with laser and silicone oil
2. Vitrectomy with laser and heavy oil
3. Vitrectomy, scleral buckle, laser and silicone oil
4. Vitrectomy, laser and combination of heavy and normal oil
5. Vitrectomy, laser and long acting gas



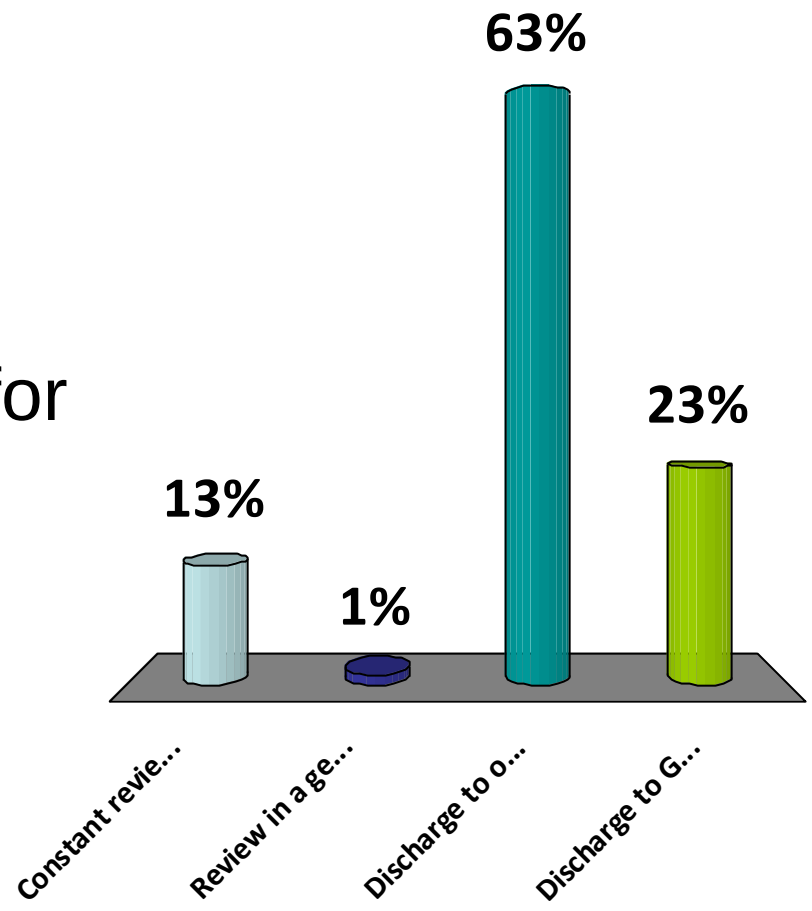
Assuming you performed the primary surgery yourself, with regards to silicone oil surgery for RD, do you

1. Just remove oil and don't look in the eye
2. Remove oil and look inside treating suspicious areas with retinopexy +/- gas
3. Do 360 laser at primary surgery
4. Do 360 laser at an interval before ROSO
5. Do 360 laser at the time of ROSO



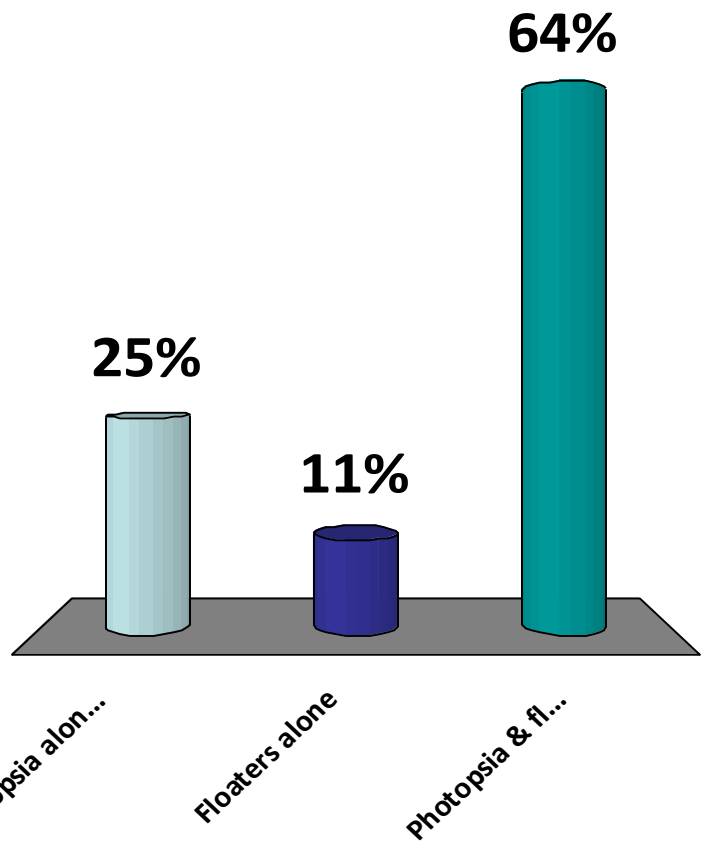
Do you manage stable adult retinoschisis by

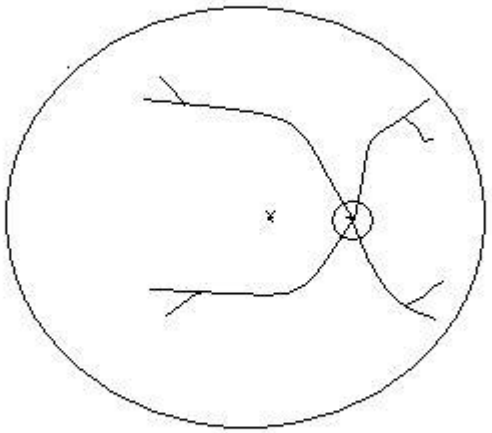
1. Constant review in VR clinic
2. Review in a general clinic by a colleague
3. Discharge to optometrist for review and RD warning given
4. Discharge to GP with RD warning



Round holes with no SRF - Do you consider the following are significant indicators for potential retinopexy

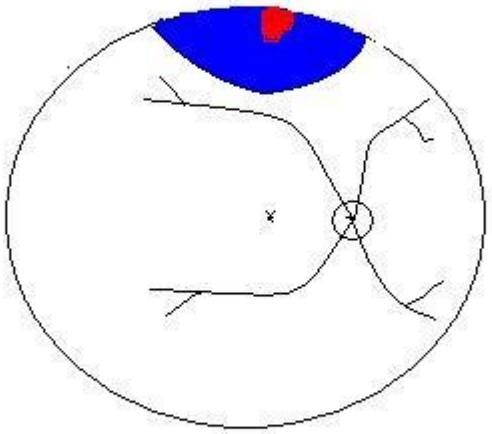
1. Photopsia alone
2. Floaters alone
3. Photopsia & floaters





Would you buckle or vitrectomize the following cases

1. Vitrectomy
2. Buckle
3. Vity + buckle
4. Pneumoretinopexy



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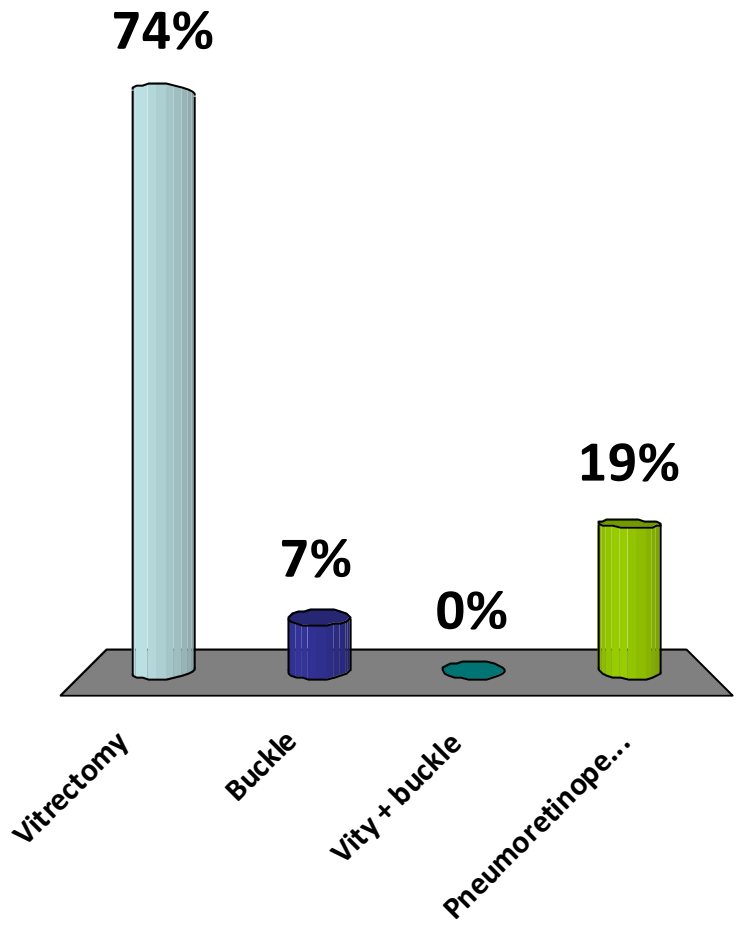

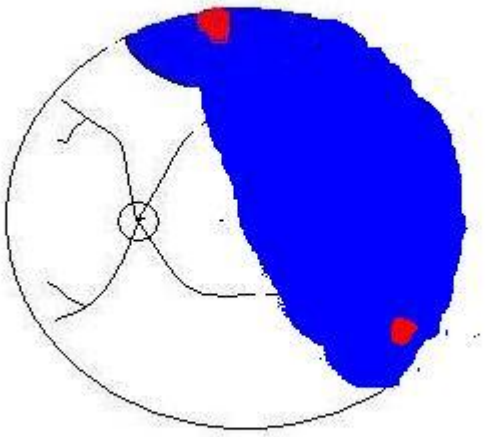

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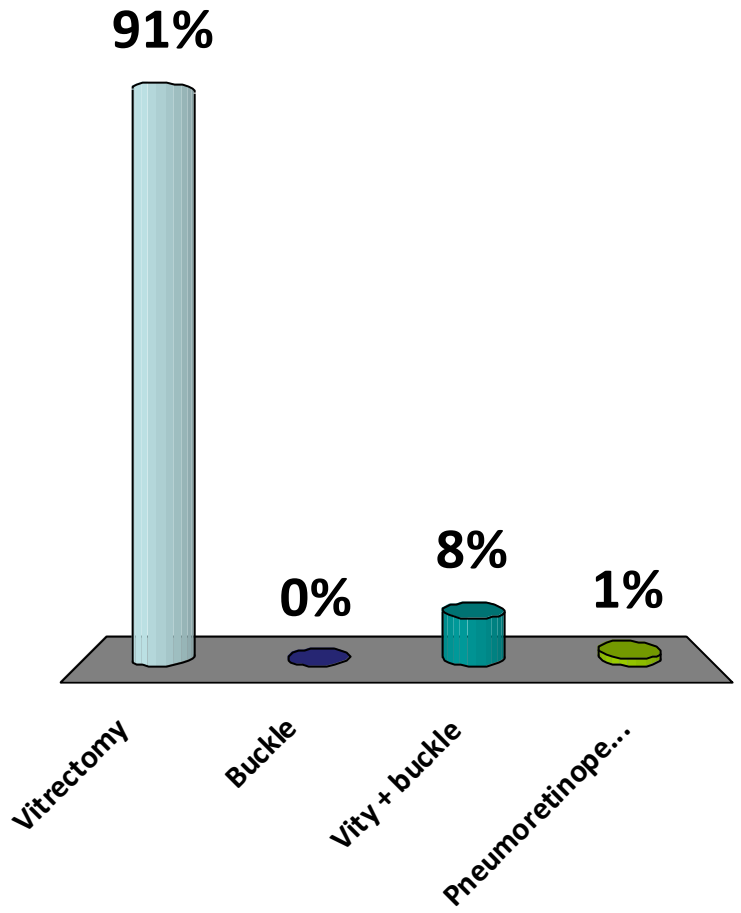

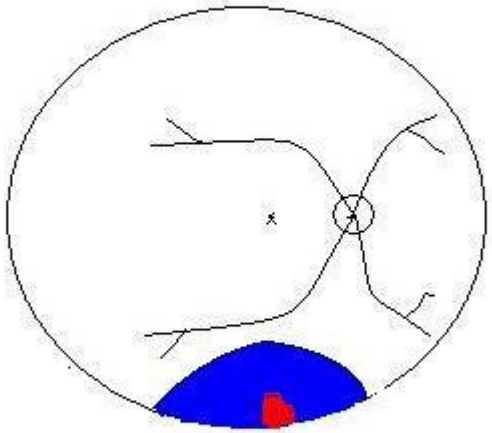

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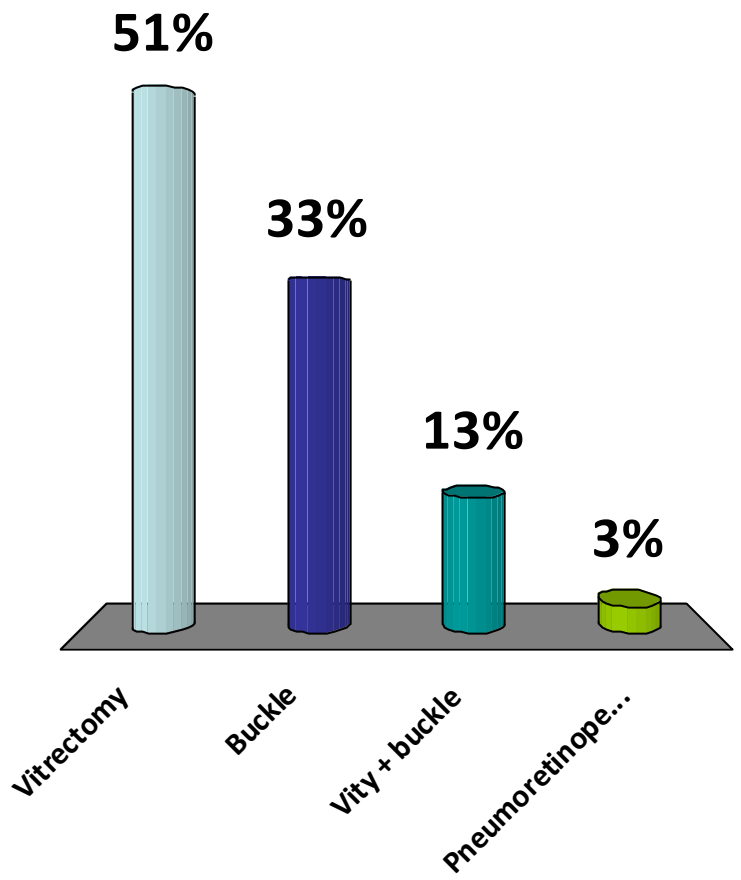

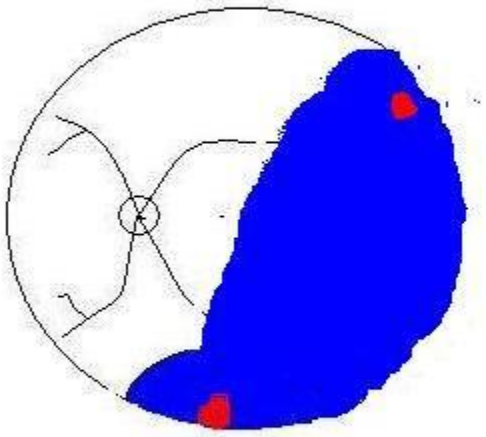

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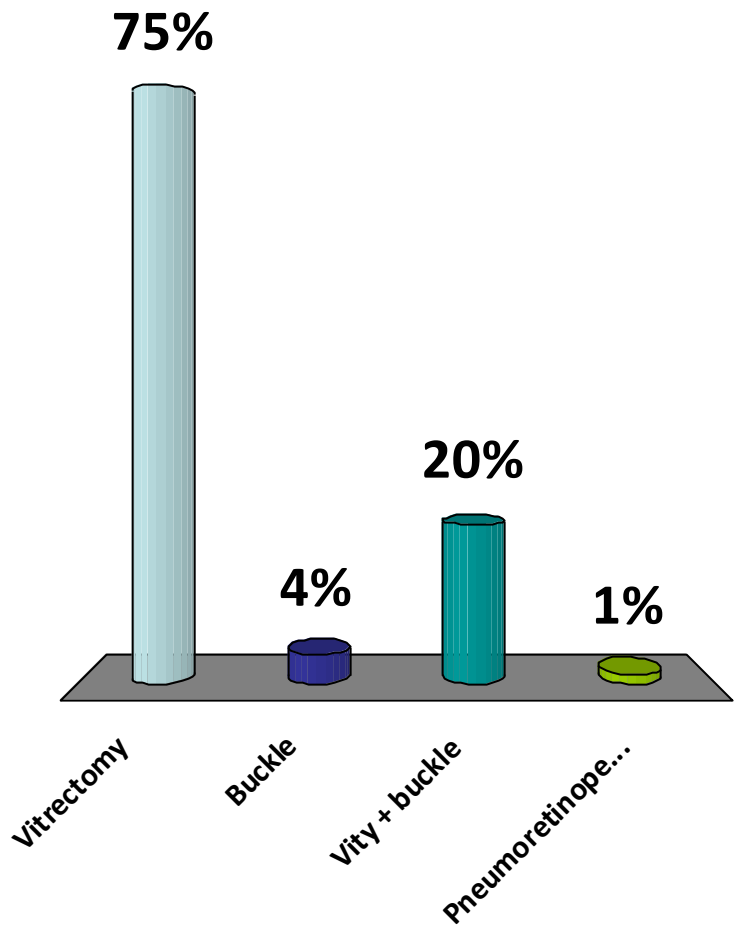
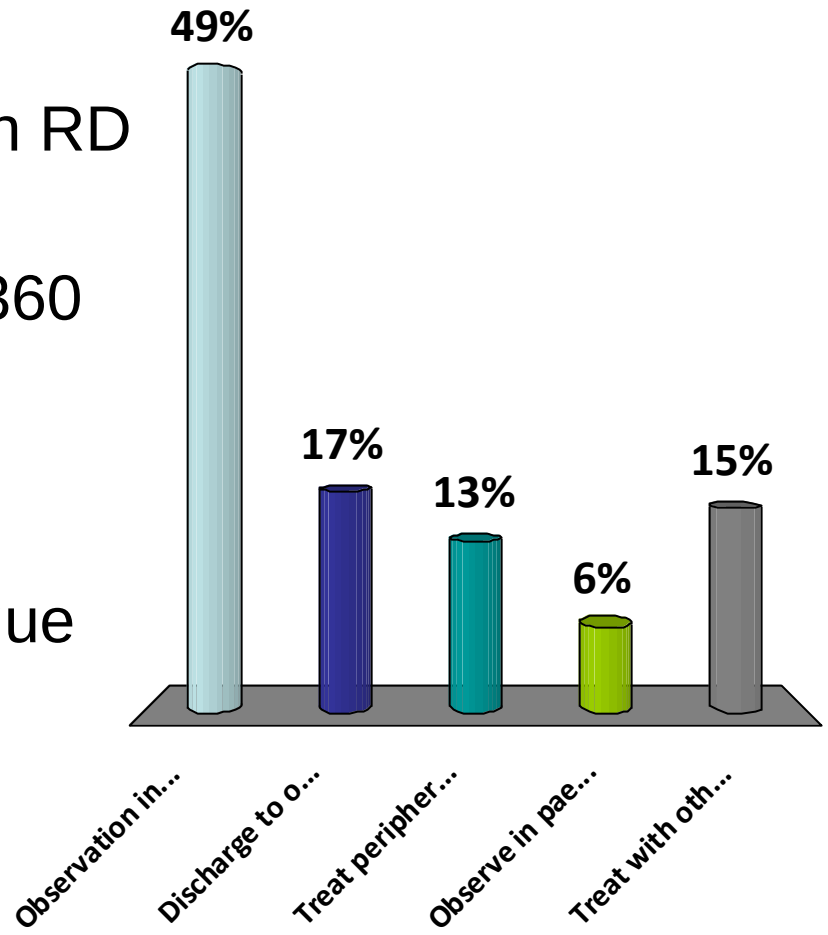


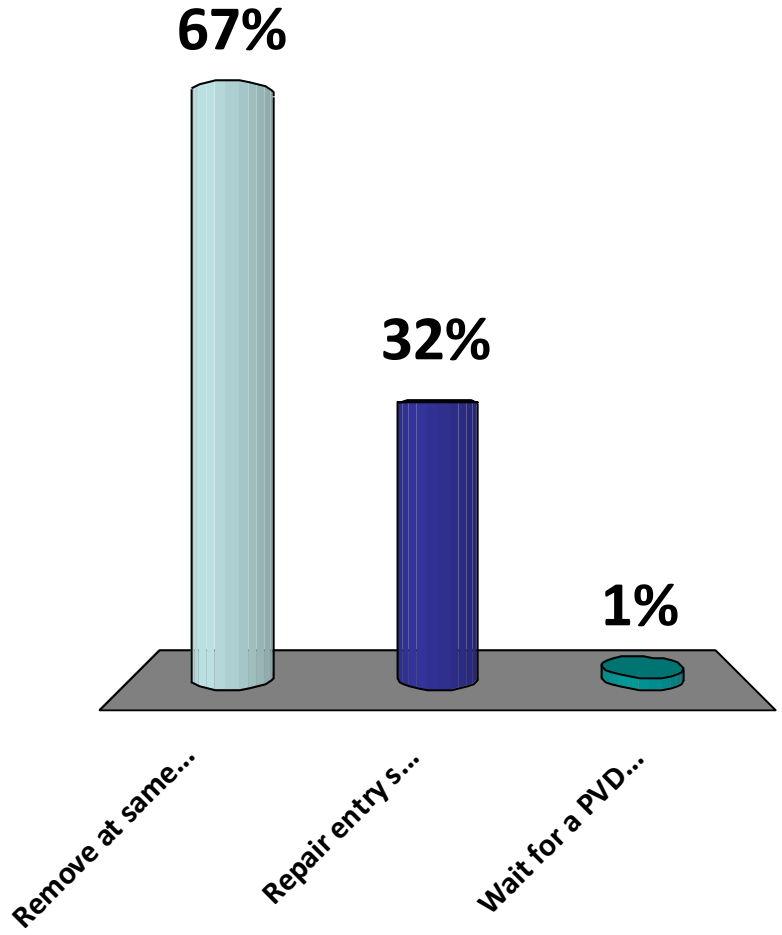
Do you manage Sticklers cases with

1. Observation in VR clinic
2. Discharge to optometrist with RD warning
3. Treat peripheral retina with 360 cryo as per Cambridge recommendations
4. Observe in paeds clinic by consultant paediatric colleague
5. Treat with other form of prophylaxis eg laser, buckle



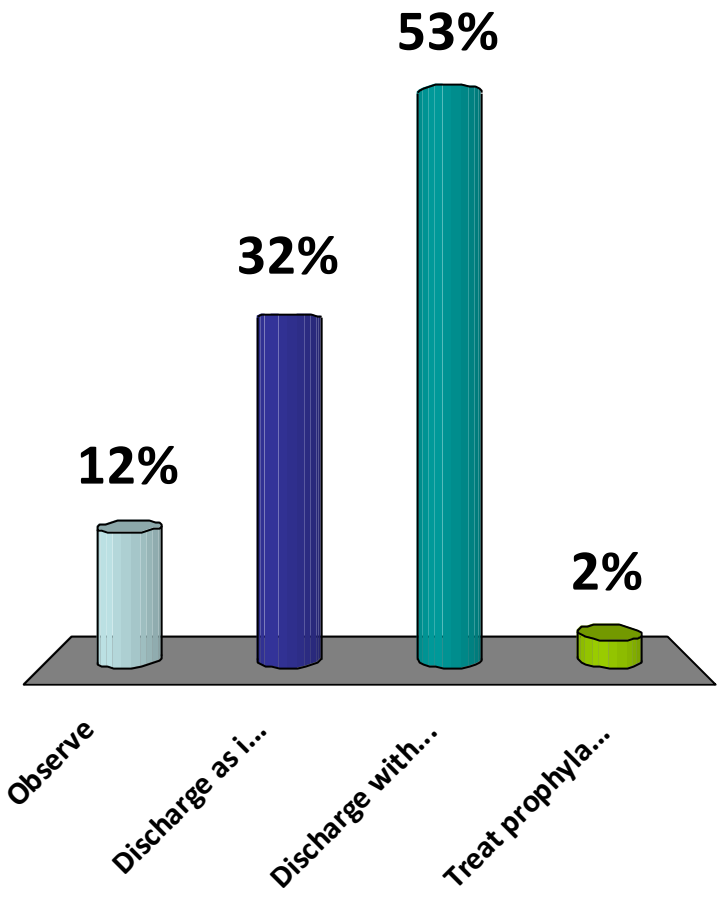
Management of metallic IOFB which appears to be impacted in the retina-do you

1. Remove at same time of primary entry site repair
2. Repair entry site & wait 24-72 hours before removal with intravitreal antibiotic cover
3. Wait for a PVD to occur



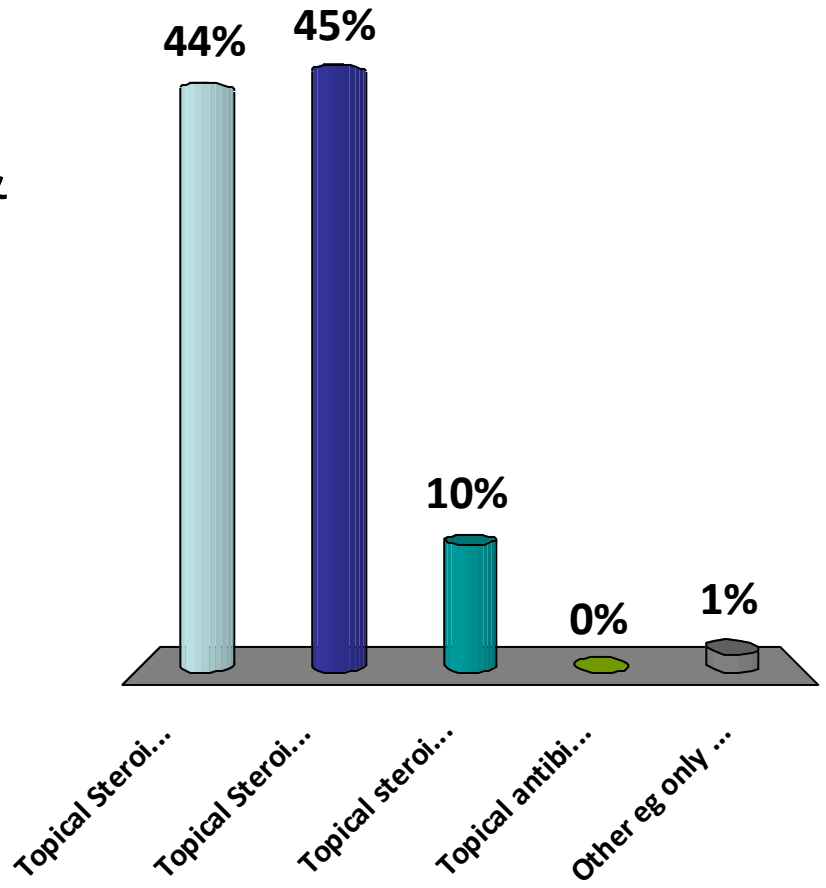
White with or without pressure - do you

1. Observe
2. Discharge as it is not significant
3. Discharge with RD warning
4. Treat prophylactically with either laser, cryo, buckling



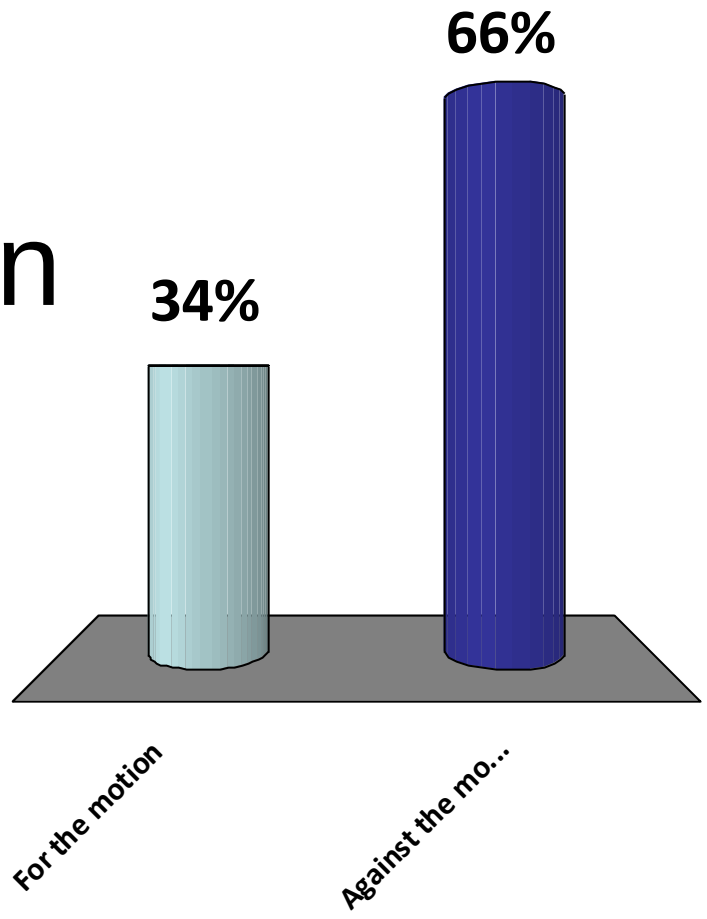
Post-op drops - do you use

1. Topical Steroid/ant-inflammatory & Antibiotic
2. Topical Steroid/anti-inflammatory, Antibiotic & cyclopegic
3. Topical steroid/anti-inflammatory only
4. Topical antibiotic only
5. Other eg only cycloplegic



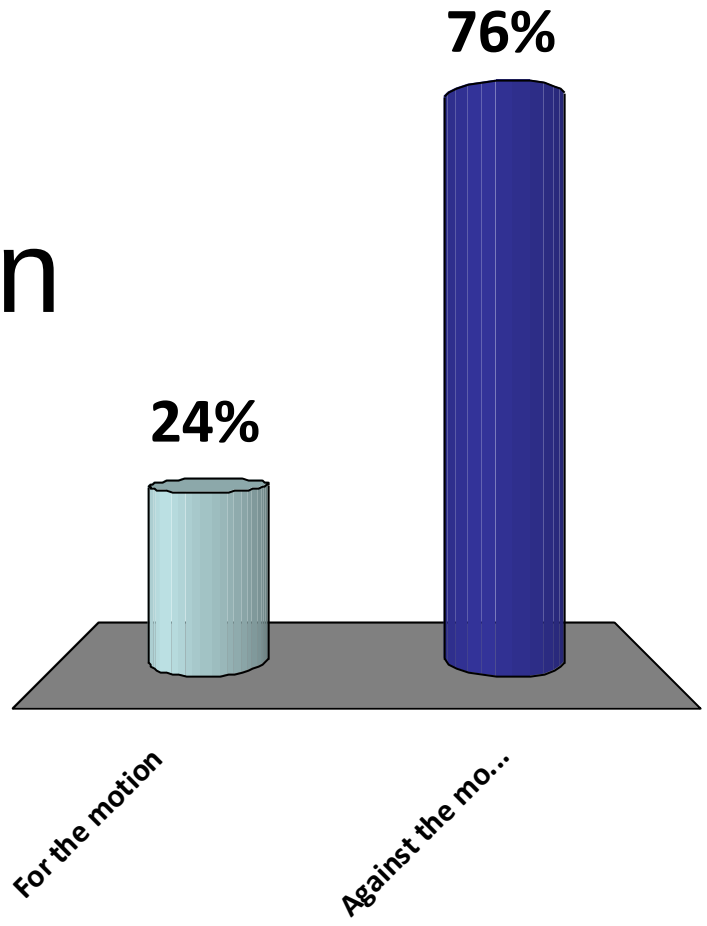
The Great Debate
Post-op Endophthalmitis

1. For the motion
2. Against the motion



What do you want the outcome to be !

1. For the motion
2. Against the motion



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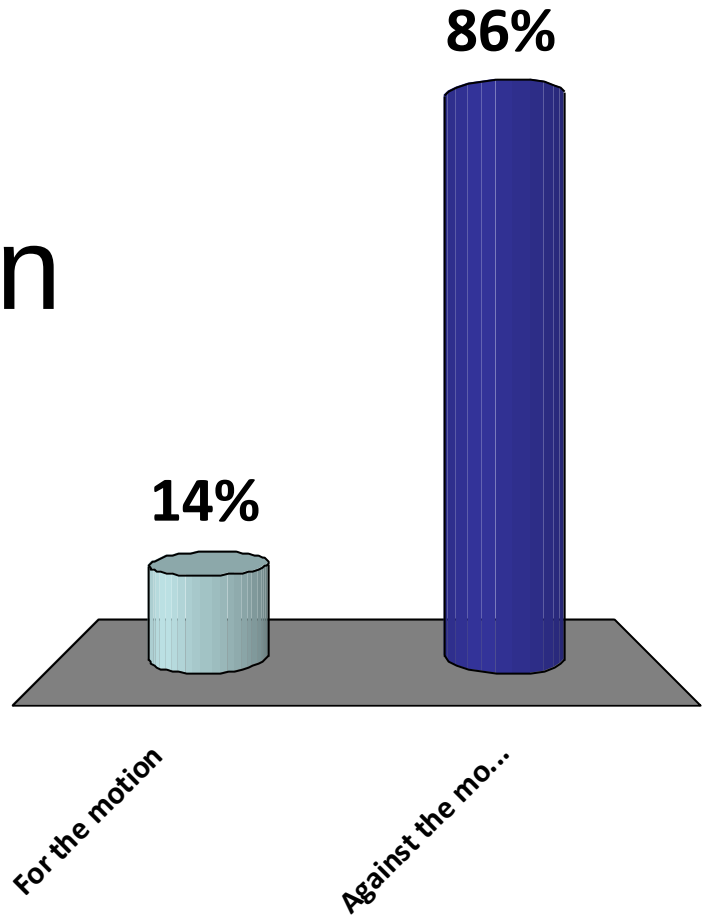
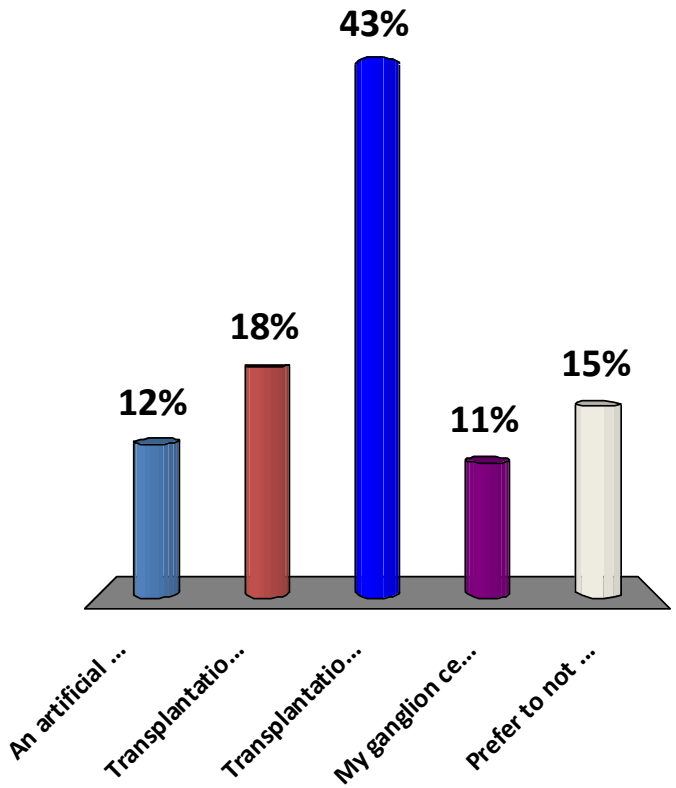


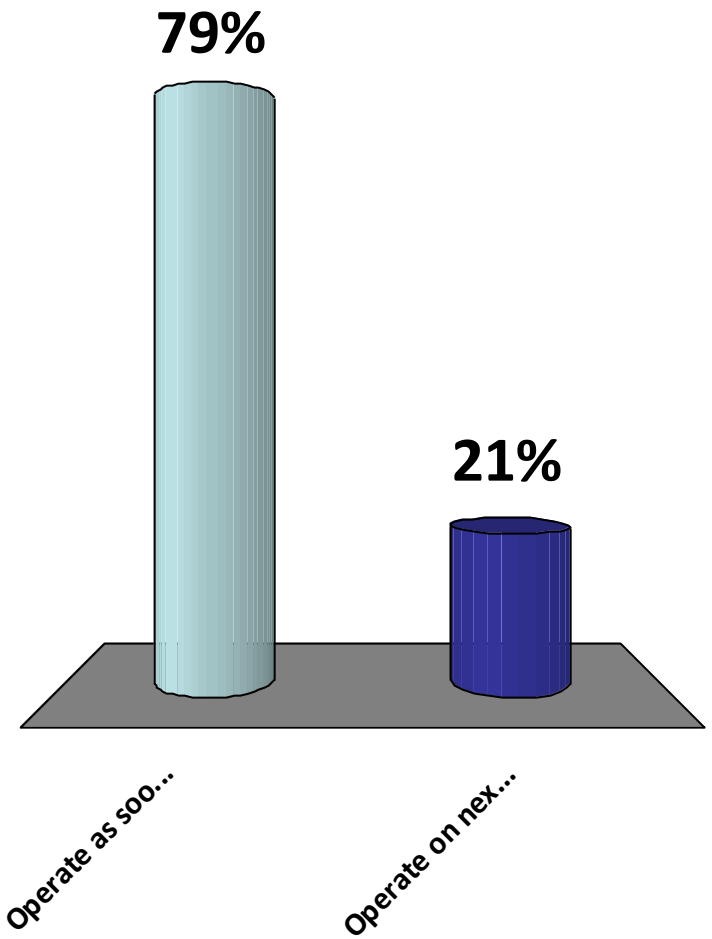
You become blind from outer retinal disease -all things being equal – which would you prefer ?

1. An artificial retinal prosthesis implanted
2. Transplantation of new retinal cells from ESC
3. Transplantation of new retinal cells from iPSC
4. My ganglion cell layer made light sensitive
5. Prefer to not see



Patient with acute bullous STQ macular on RD presents at 5pm Friday evening - do you

1. Operate as soon as is feasible that evening/over the weekend
2. Operate on next available weekday list



Patient with acute bullous STQ macular off 1/7 RD presents at 5pm Friday evening - do you

1. Operate as soon as is feasible that evening/over the weekend
2. Operate on next available weekday list
3. Do electively on routine list because timing of mac off RD surgery doesn't matter