

Response Report

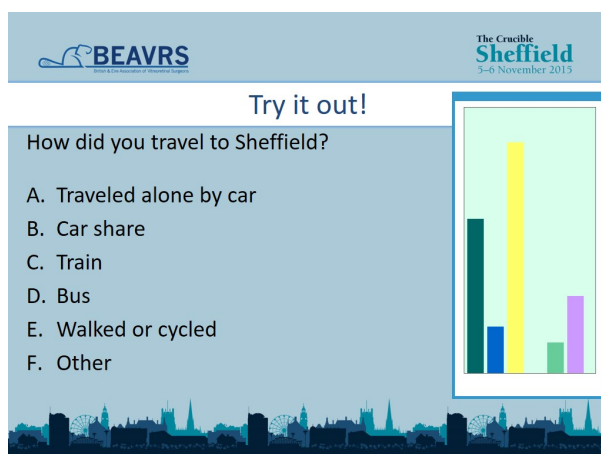
Session: BEAVRS 2015 Survey Questions Live Voting.pptx

Class: Default Class

Date/Time: 06/11/2015 - 12:27 Profile: BARRY LEWIS

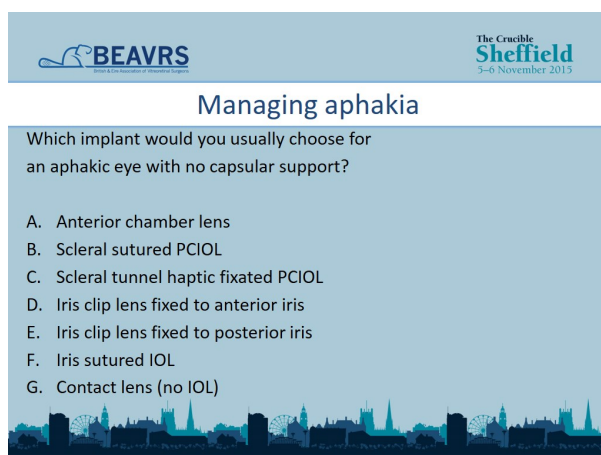
*Includes only students who were part of the assessment

1 Slide :2



	Response %	Answers
A	29% (10)	
B	8% (3)	
C	43% (15)	
D	0% (0)	
E	6% (2)	
F	14% (5)	



2 Slide :3



	Response %	Answers
A	37% (40)	

- B 7% (8)**
- C 8% (9)**
- D 28% (30)**
- E 17% (19)**
- F 0% (0)**
- G 3% (3)**


3 Slide :5





Small macular hole with VMT



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

- A. Ocriplasmin
- B. Vitrectomy
- C. Observation



	Response %	Answers
A	11% (13)	
 B	71% (82)	
C	18% (21)	


4 Slide :7

Asymptomatic inferior RRD

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


- A. See once & discharge with RDW
- B. Serial follow up
- C. Perform barrier retinopexy
- D. Surgery: buckle
- E. Surgery: vitrectomy



	Response %	Answers
A	5% (6)	
B	19% (22)	

- C 53% (61)**
D 16% (18)
E 7% (8)

5 Slide :9



Fellow eye lattice

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

- A. Discharge to optometrist
- B. Observe at least once in clinic
- C. Laser
- D. Cryotherapy
- E. Keep under long term review

	Response %	Answers
A	53% (60)	
B	15% (17)	
C	25% (29)	
D	0% (0)	
E	7% (8)	


6 Slide :11






Pre-op posturing for mac on RD

With regards to pre-op posturing in patients with a macular on RD, do you?

- A. Always/nearly always posture patient whilst awaiting surgery
- B. Sometimes posture if RD is very bullous
- C. Not think that posturing is useful


	Response %	Answers
 A	58% (65)	
B	32% (36)	
C	10% (11)	

7 Slide :13





Vitreous haemorrhage referral

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

- A. 1 day
- B. 2-3 days
- C. 4-7 days
- D. 1-2 weeks
- E. >2 weeks




	Response %	Answers
A	36% (41)	
B	26% (30)	
C	23% (26)	
D	11% (12)	
E	4% (5)	

8 Slide :15



Vitreous haemorrhage time to PPV?



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

- A. Next available list
- B. <1 week
- C. 1-2 weeks
- D. >2 weeks
- E. Wait for it to clear by itself



	Response %	Answers
A	46% (57)	
B	24% (29)	
C	15% (18)	
D	8% (11)	
E	7% (8)	


9 Slide :17

Stage II macular hole surgery – which gas?



With regards to gas tamponade in stage II macular hole surgery, do you use:

- A. Air
- B. SF6
- C. C2F6
- D. C3F8
- E. Something else??



	Response %	Answers
A	0% (0)	
B	49% (53)	
C	36% (40)	
D	15% (16)	
E	0% (0)	


10 Slide :19

Posturing after macular hole surgery



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

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



	Response %	Answers
A	15% (18)	
B	19% (24)	
C	26% (33)	
D	20% (24)	
E	20% (25)	


11 Slide :22

Redo macular hole surgery?



Failed macular hole surgery. Options for 2nd surgery:

- A. Macular ILM flap
- B. Macular detachment with oil tamponade
- C. Macular detachment with BSS
- D. ILM graft from non-macular retina
- E. Oxane-HD
- F. Densiron
- G. Something else
- H. Give up after one attempt



	Response %	Answers
A	13% (16)	
B	7% (8)	
C	1% (2)	
D	16% (19)	
E	3% (4)	
F	5% (6)	
G	50% (62)	
H	5% (6)	


12 Slide :24

GRT management

In a patient with RD & GRT extending from 1 to 6 o'clock what treatment would you advocate?

- A. Vitrectomy with laser and silicone oil
- B. Vitrectomy with laser and heavy oil
- C. Vitrectomy, buckle, laser, silicone oil
- D. Vitrectomy, laser, combination of heavy & normal oil
- E. Vitrectomy, laser & long-acting gas



	Response %	Answers
A	63% (69)	
B	5% (5)	
C	13% (14)	
D	5% (6)	
E	14% (15)	


13 Slide :26





Removal of silicone oil

Assuming you performed the primary surgery yourself, with regards silicone oil removal, do you:

- A. Just remove oil & don't look in the eye
- B. Remove oil & look inside treating suspicious areas with retinopexy +/- gas
- C. Do 360 laser at primary surgery
- D. Do 360 laser at an interval before ROSO
- E. Do 360 laser at the time of ROSO




	Response %	Answers
A	14% (16)	
B	52% (58)	
C	15% (17)	
D	19% (21)	
E	0% (0)	

14 Slide :28



Stable retinoschisis



Do you manage stable adult retinoschisis by:

- A. Regular review in VR clinic
- B. Review in a general clinic by a colleague
- C. Discharge to optician for review
- D. Discharge to GP with RD warning



	Response %	Answers
A	7% (8)	
B	6% (7)	
C	60% (68)	
D	27% (30)	


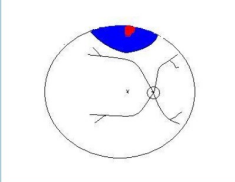
15 Slide :30

Buckle or Vity?

Would you buckle or vitrectomize the following cases:

- A. Vitrectomy
- B. Buckle
- C. Vity + buckle
- D. Pneumoretinopexy



	Response %	Answers
A	70% (30)	
B	16% (7)	
C	0% (0)	
D	14% (6)	

End of Report.