Eye problems in general practice

Aims of this session

- Know how to approach eye problems in a systematic way
- To be able to assess safely what you can deal with and what needs referral
- To be able to make a referral that allows for rational and easy prioritisation by the eye clinic

This not absolutely dependent on making a definitive diagnosis

But

It does need a rational approach , a good history and a decent basic examination!

Remember

The eye only has one function

Vision !

so always record it!

Use a snellen chart

Remember to use a pinhole if the vision is below normal.

Ask about lazy eyes

- The Snellen chart

Expressed as a fraction

Top figure refers to chart distance

Bottom figure acuity of individual relative to that.

6/6 at 6 metres you can see what would normally be visible at 6m.

6/12 at 6m what is the norm at 12m

6/5at 6m what is the norm at 5 metres

le.

Vision

rt 6/36 . 6/12 wth corr, 6/6 ph

lt 6/36 6/36 with corr, 6/36 ph

Pinhole

The pinhole acts like a pinhole camera and reduces refractive error. If the vision comes up with it then the patient probably needs to go to an optician.

Always remember to check about “ lazy eyes”.

Amblyopia is not uncommon

Vision normal

- Conjunctivitis
- Allergy
- Episcleritis
- Subtarsal foreign body
- Ingrowing lashes
- Dry eye
- Watery eye
- Styes /chalazia
- pterygia

Vision affected

- Iritis/uveitis
- Acute glaucoma
- Retinal vein occlusion
- Temporal arteritis
- Retinal detachment
- Flashes and floaters
- Cataract
- Optic neuritis

History

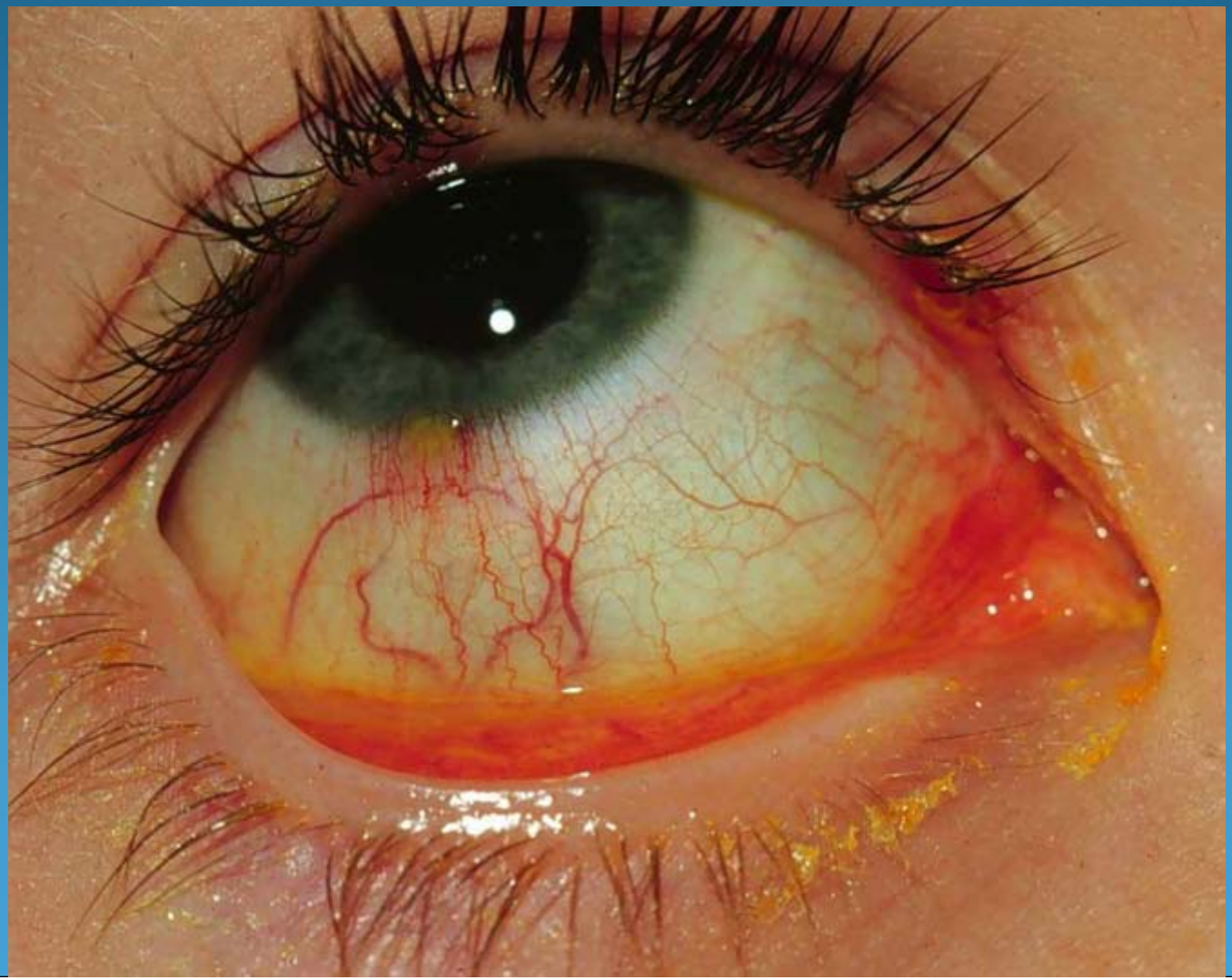
- How long?
- One or both eyes
- How does it feel, gritty ,itchy, bruised
- Have they had it before
- Past medical history/ other conditions

Examination

- VISION
- Lids…lashes , crusting, lid position, lumps and bumps
- Conjunctiva redness: general / sectoral. bright /dusky
- Cornea clear, staining or not ?if so where and what pattern
- Anterior chamber. Blood/hypopyon
- Pupil reacts or not. Big pupil, small pupil?
- Lens clear or not
- Vitreous clear or not. Blood/detachment
- Fundi disc ok? Macula ok. Near vision and amsler

Subconjunctival haemorrhage

conjunctivitis



conjunctivitis

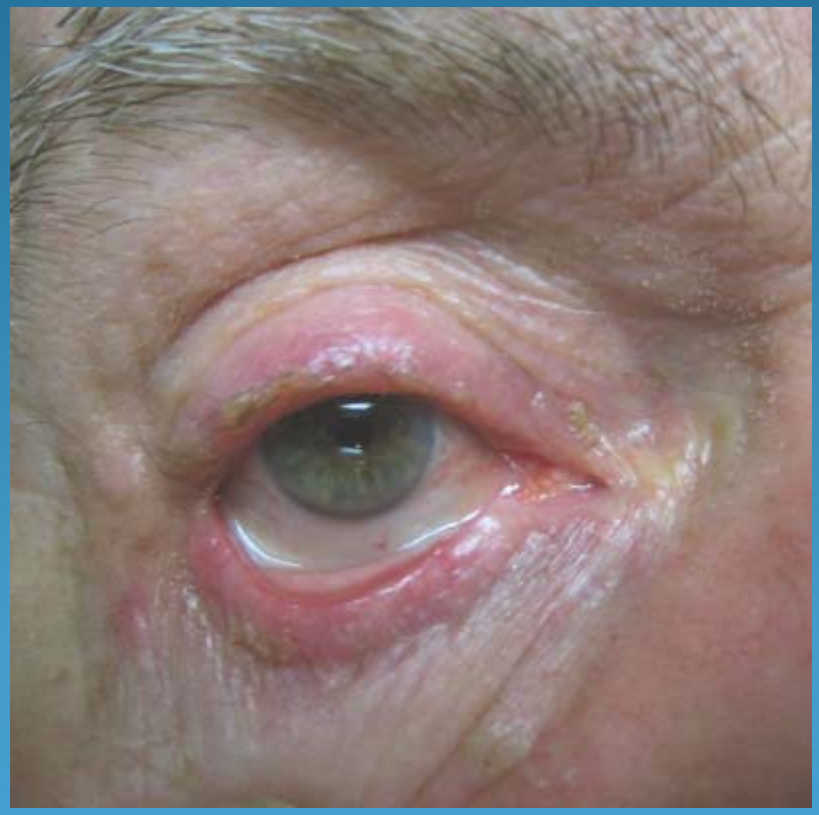
infective

- Normal vision
- Maybe bilateral
- Gritty eyes
- Often discharge
- Viral may last for weeks,is highly contagious and is sporadic. Pre auricular nodes
- a/b often not needed even if bacterial
- Beware in neonates, think of chlamydia refer if truly red eyes

allergic

- Normal vision
- Maybe bilateral
- Itchy eyes
- often chronic problem
- Start hayfever rx before symptoms start
- Always think of sensitivity to the preservatives in the drops you've been prscribing!

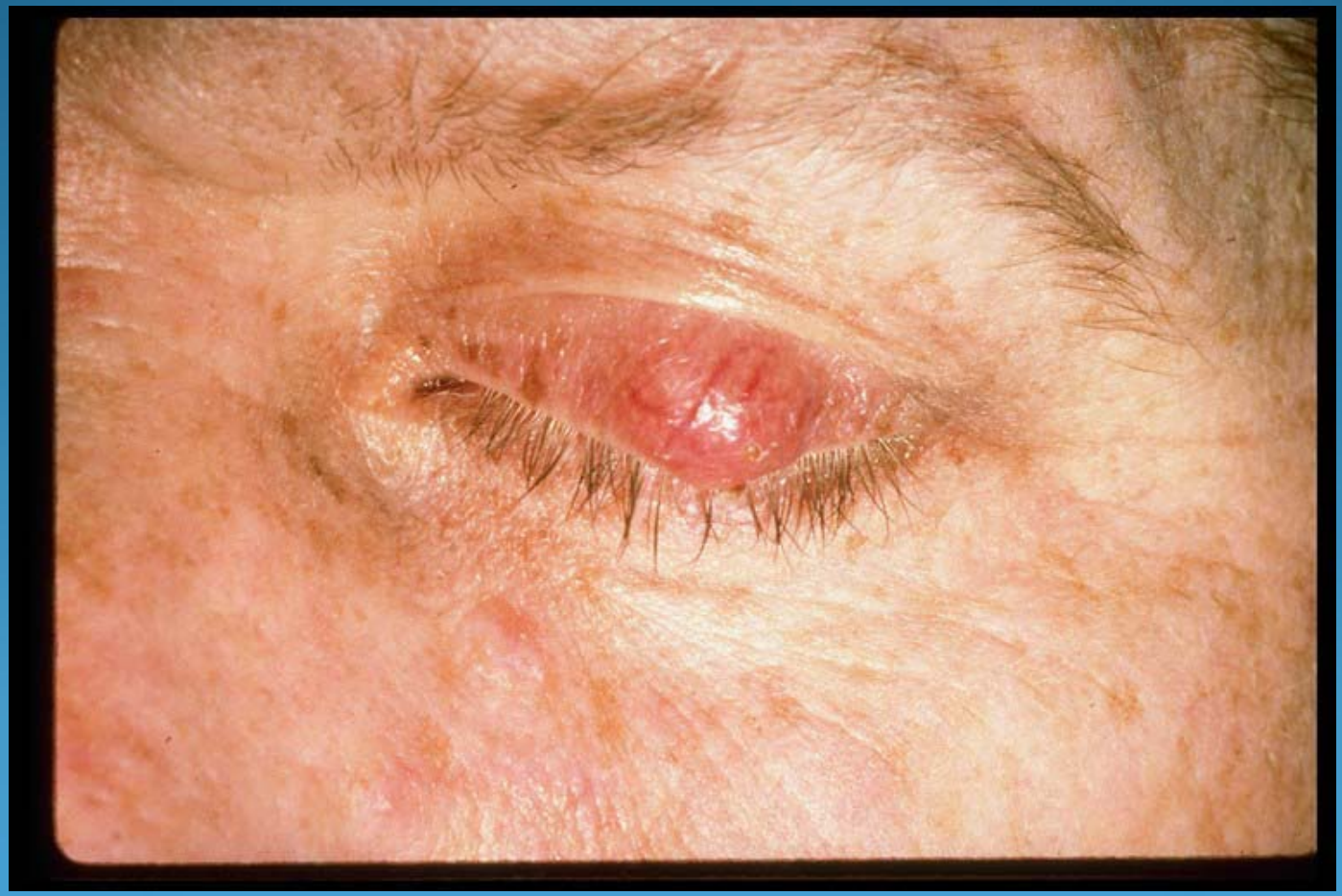
Blepharitis



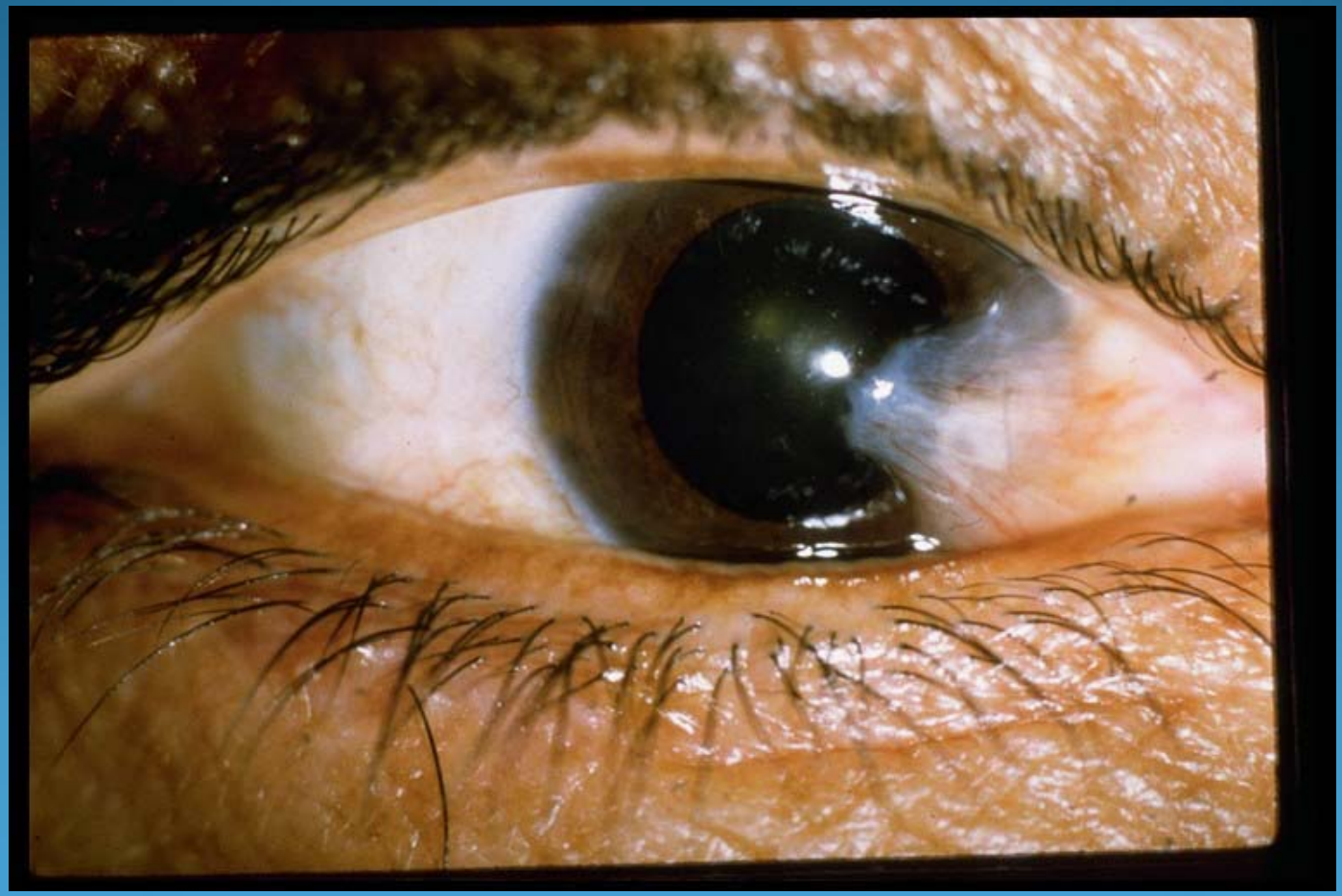
blepharitis

- Normal vision.
- Chronic mild irritation and crusting.
- May have dandruff or other skin problems
- lid hygeine is essential
- Use occ chlor at night
- Trial of oral a/b doxycycline, lymecycline for 3 months

stye



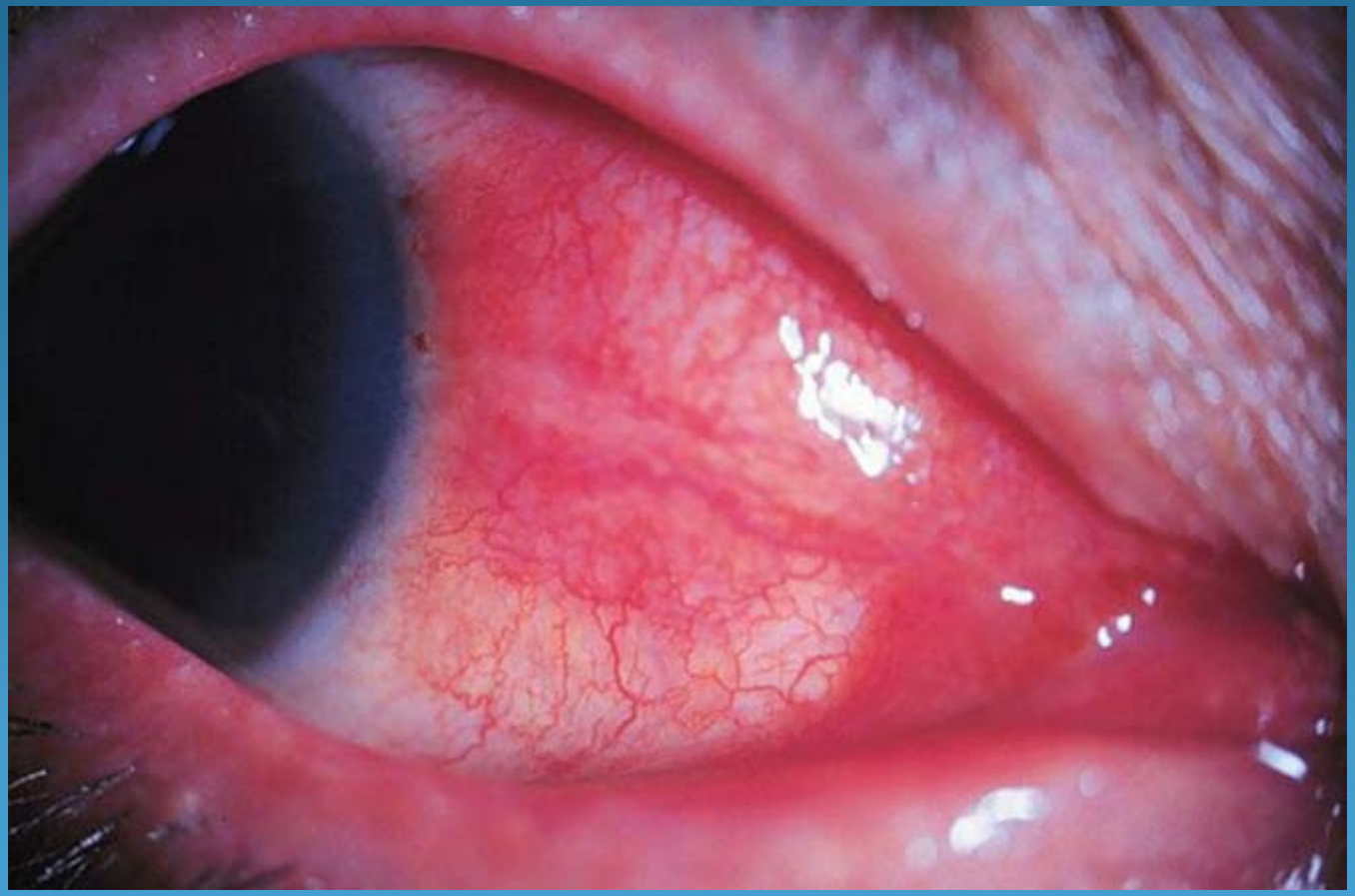
pterygium



pterygium

- Common with lot of bright sun exposure, dry arid conditions
- Benign
- Slow growing
- Usually only remove if begining to encroach on visual axis or causing problem
- May need to use tear substitute if tear film uneven

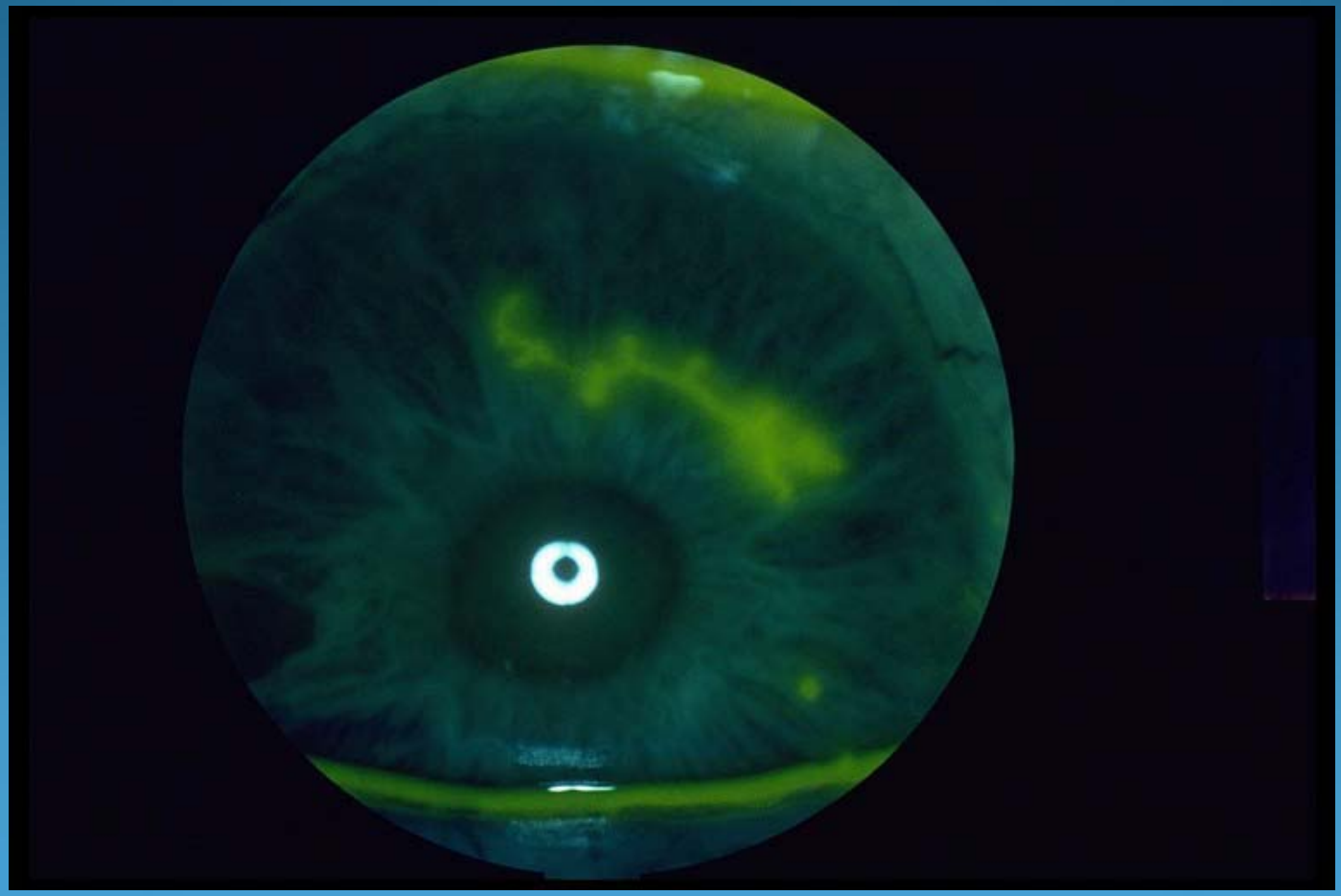
episcleritis



episcleritis

- Recurrent
- maybe relatively asymptomatic
- Sectoral inflammation
- Normal vision
- Often doesn't need rx if minor
- Topical nsaids often settle it.
- Beware of scleritis deeper dusky inflammation painful and chronic needs referral.

Dendritic ulcer



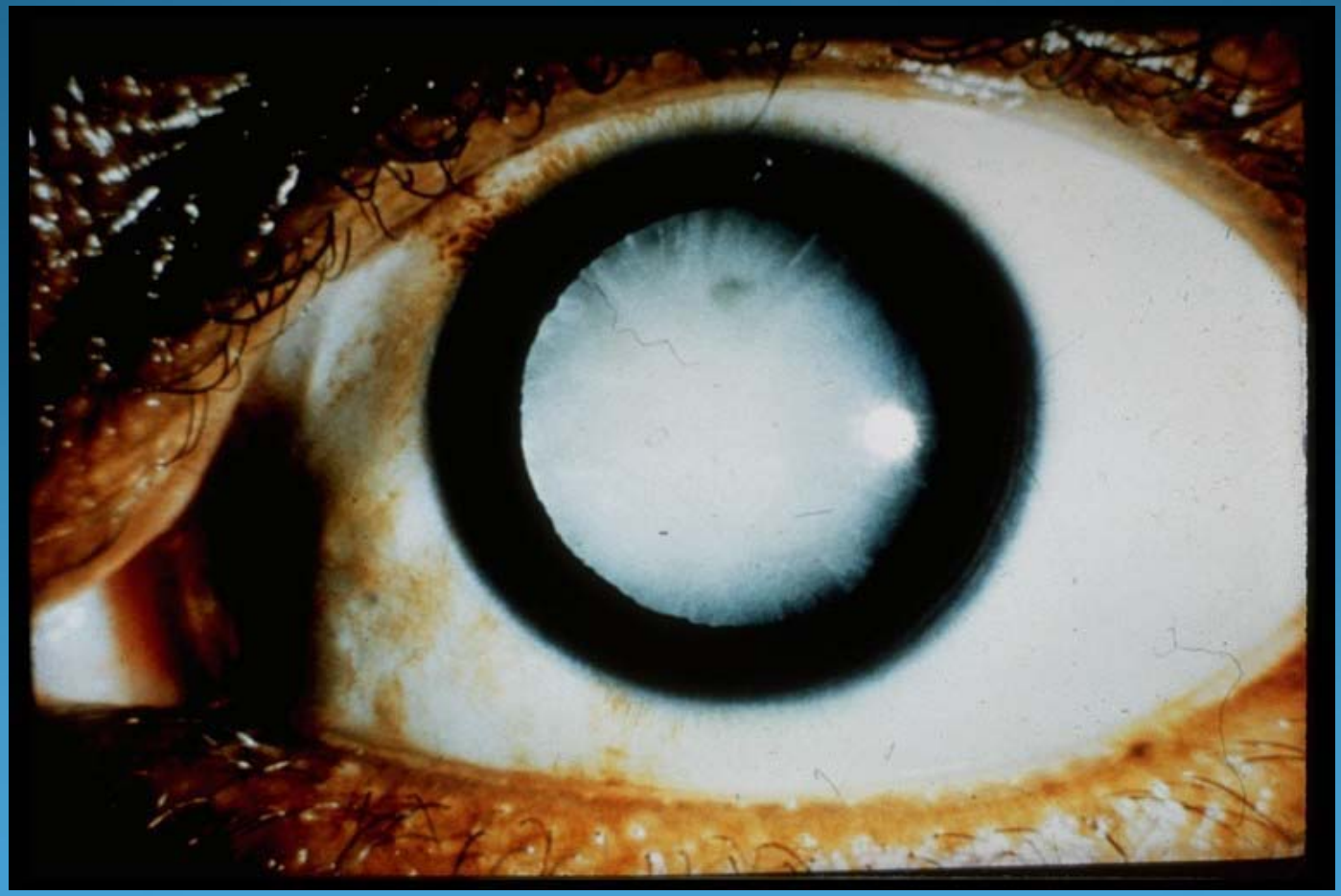
Dendritic ulcer

- Vision often not affected depends on position
- Usually painful
- Usually obvious with fluorescein
- Treatment with antiviral drops.

Dendritic ulcer

- NEVER !NEVER! USE STEROID EYE DROPS IN GENERAL PRACTICE.
- IT is indefensible to put steroids onto a dendritic ulcer
- They rapidly become geographic and indolent and are extremely difficult to ever get them to heal again.

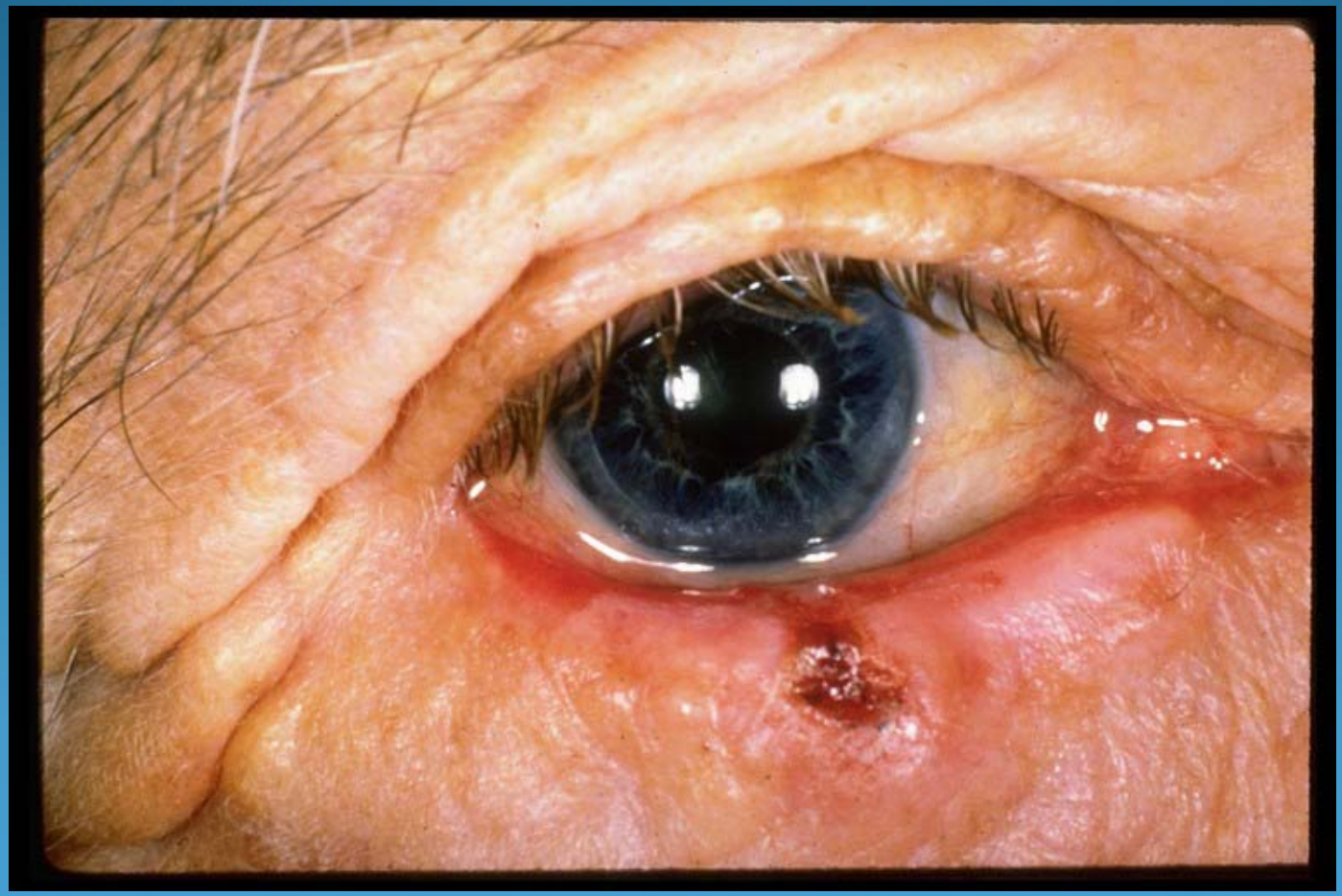
cataract



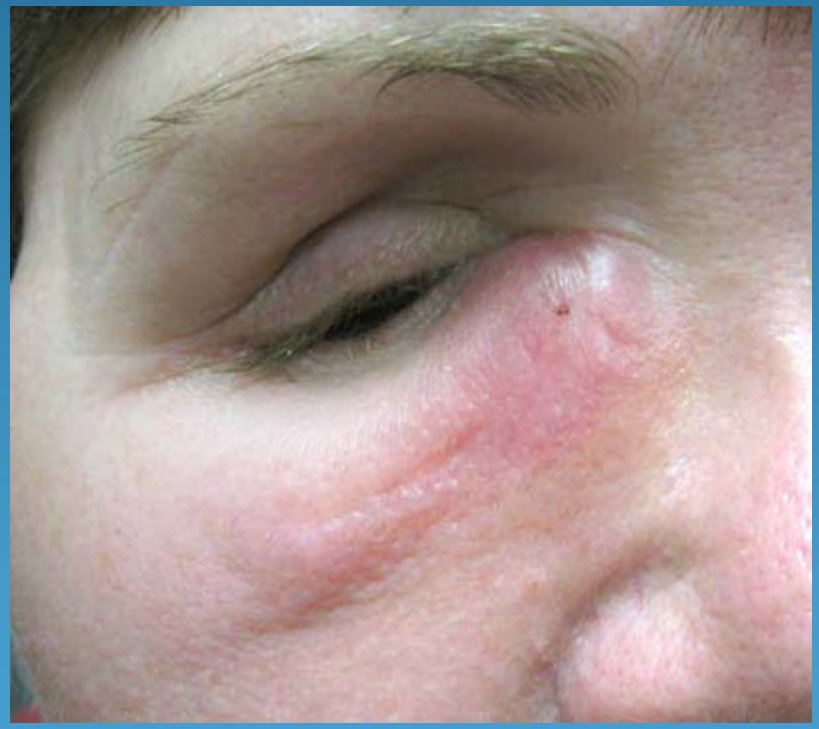
Cataract

- Slow deterioration in vision
- May be cause of dazzle with headlights etc
- There is no right time to do surgery, it depends on the patient and how much it bothers them. Always check how bothered they are before you refer
- If they drive however its better to do it before they get near the legal limit

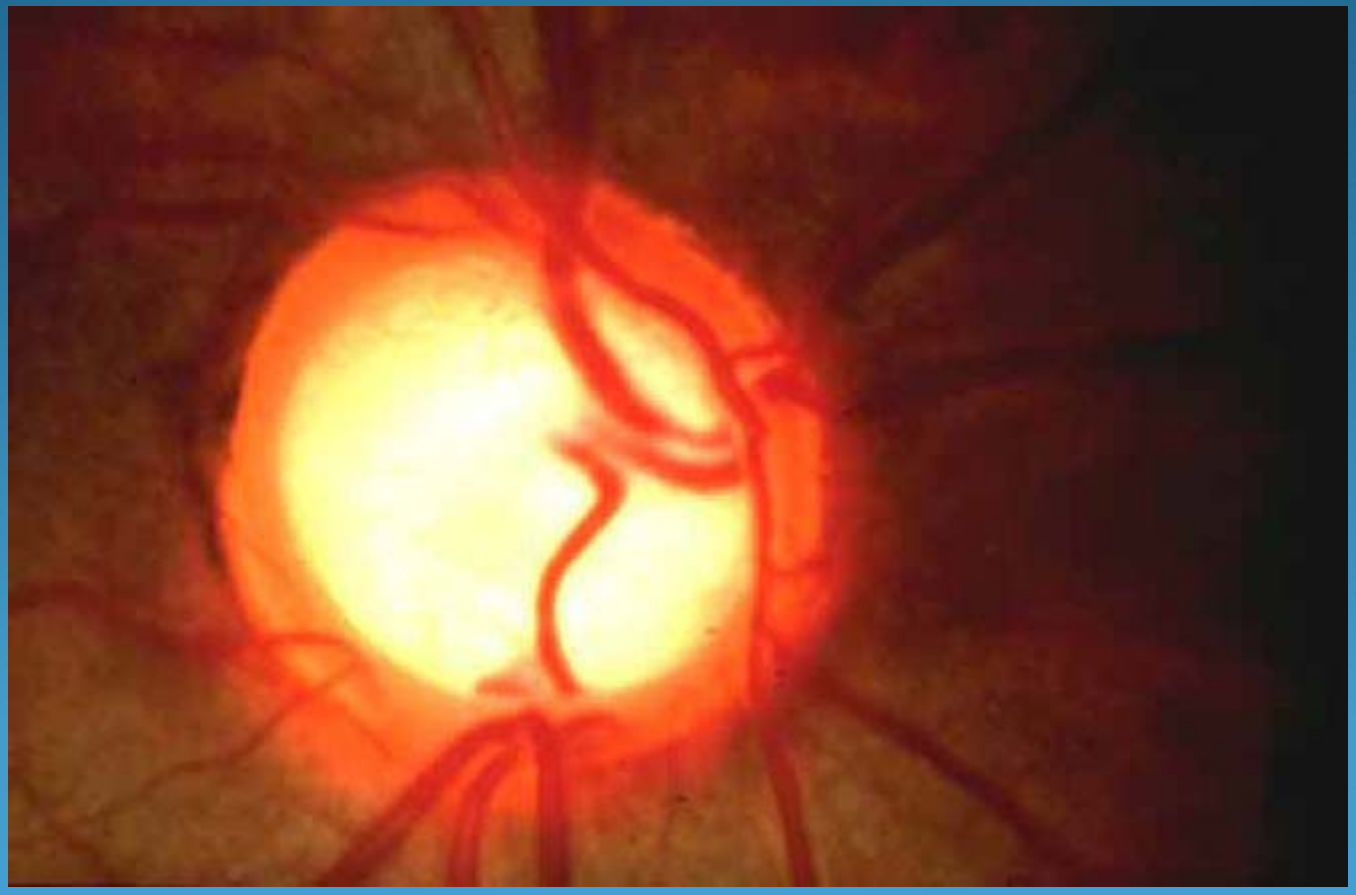
Basal cell carcinoma



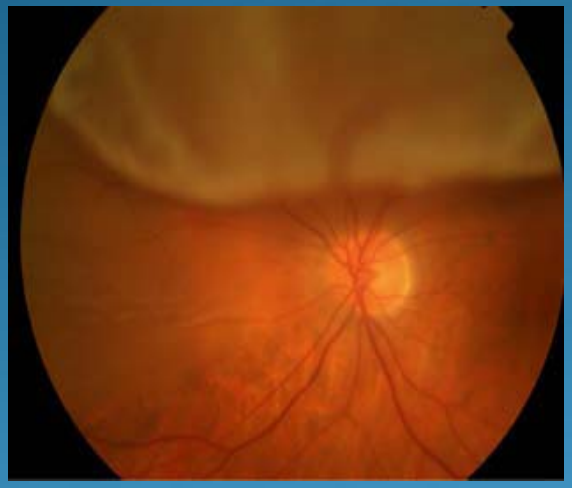
dacrocystitis

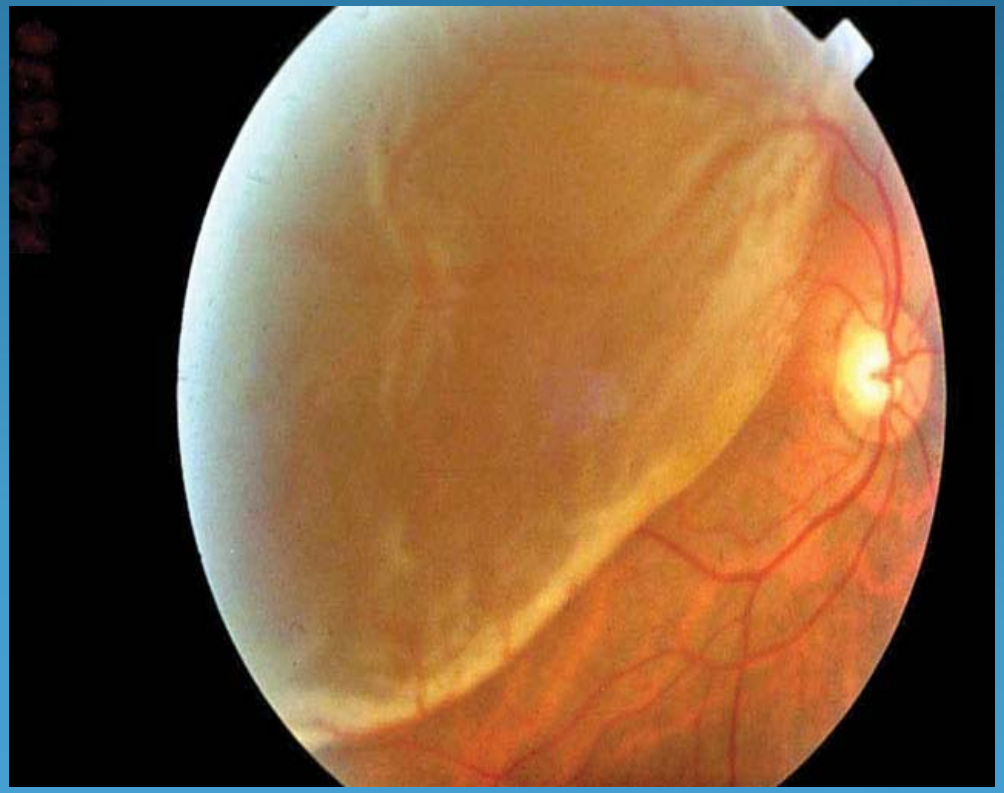


Glaucomatous cupping

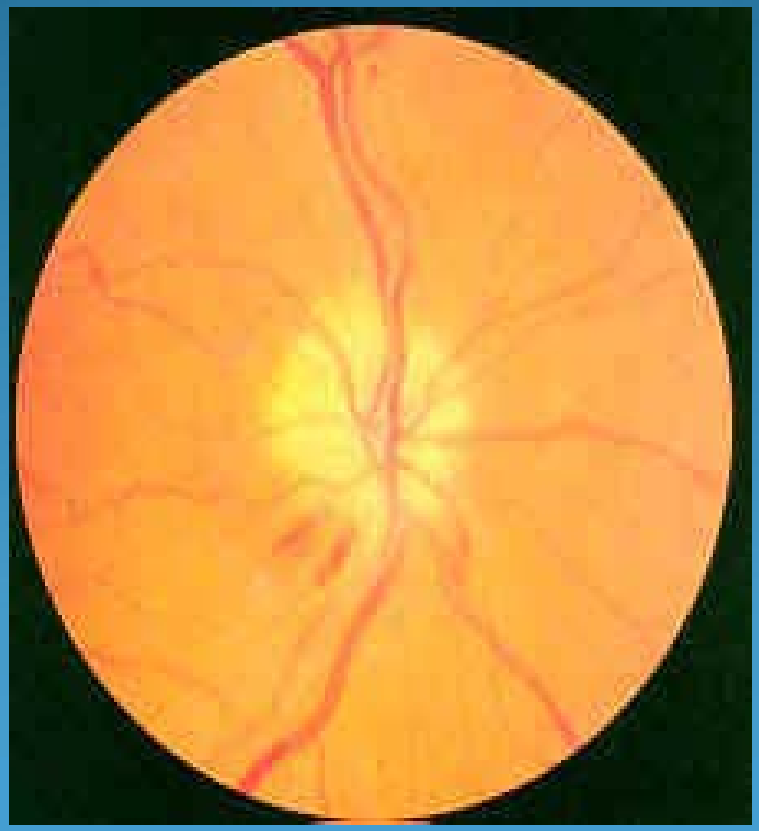


Retinal detachment





temporal arteritis



Your patient comes in complaining that over the last week they have become aware of some tadpoles moving around in their right visual field and that when they go into a dark room they can see flashes of light at the periphery of their vision. Their vision is normal and there s nothing obvious on examination

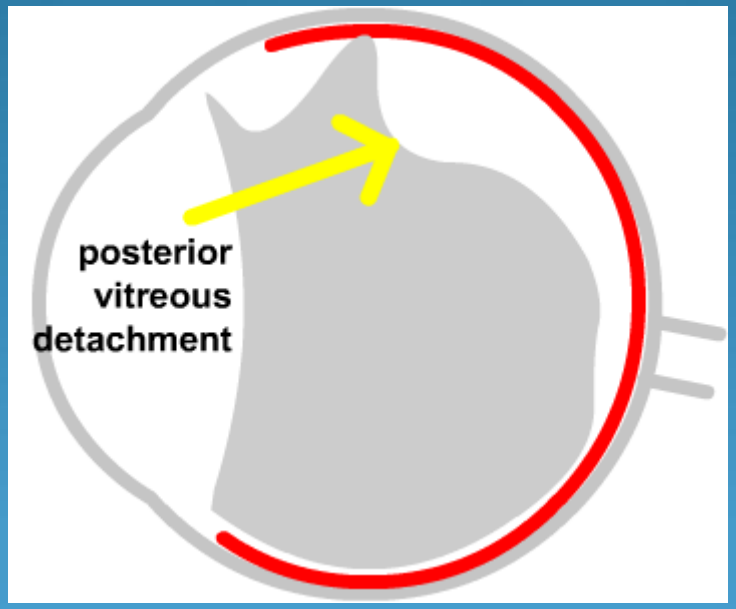
What is the diagnosis?

What are you going to do and say to the patient?

flashes and floaters

- chronic floaters are common especially in myopes
- New onset flashes usually obvious in the evening r in dark situations and/or new onset floaters are signs of posterior vitreous detachment
- The risk is of a tear in the peripheral retina which will eventually lead to detachment and they need urgent/same day referral. If not immediate then they need clear warning of red flags..sudden increase in symptoms or any kind of veil coming down

Flashes and floaters



Dave is an engineer. He was hammering and felt a bit of something go in his eye and its been mildly irritable. His vision is normal and apart from some minor redness you can't see anything.

What are you going to do ?

You get a phone call from the local nursing home .Annie has dementia and has suddenly started to vomit during the night and been restless. The staff also mention that she has a bit of conjunctivitis.

How urgent is this call?
What is your working diagnosis?
What do you expect to find on examination?

John is in his mid seventies he comes in to tell you that he's noticed that he's having difficulty reading small print and that when he closed his right eye to check thing he noticed that the straight lines looked wavy in his left eye.

How will you check this out?
What will be the most useful test you can do?
What is the likely diagnosis and where should you refer

Paul has ankylosing spondylitis. He saw your colleague a week ago and was given chloramphenicol for conjunctivitis but things are no better.

What are your first thoughts about diagnosis?

What qustions would you ask?

What would you expect to see on examination?

Tom comes in complaining of feeling a bit below par. He says that he been aware of some discomfort brushing his hair and that his jaw aches especially when he's eating. His vision has been ok and his eye doesn't hurt

What would opthalmic cause would you consider?

What examination would you do ? How urgent is this?

Mum brings in her 6 month old baby. She is frustrated that the child has a sticky eye again and nursery don't want to have. She complains that this is the third time this year and the eye is always runny and sticky. She's forever using the drops and needs some more.

What's the problem?

What are you going to do?

Chris is in his 80s diabetic and hypertensive He comes in to tell you that last night the vision in his left eye suddenly went blurred. His vision is 6/24.The eye is white and quiet

What is your working diagnosis?
What do you expect to see on examination?
How urgent is the problem and what are the possible complications ?

Mary comes in complaining that for the last three months frequently when she wakes in the morning her eye is sore and irritable and mildly red. The vision is ok and as the day goes on it improves and by evening is ok

What past history might she well have ?

What's the likely problem?

How can you treat it?

Terry is in his 60 and while mowing the lawn suddenly lost the vision in his left eye.
He had no warning and there is no pain. His vision is down to hand movements

You check his pupils what do you expect to find?

What will the fundus look like?