There are very few ocular emergencies that you will have to deal with in practice, but it is imperative that you be able to identify these immediately to ensure proper treatment is given immediately.

We will discuss the ocular emergencies and how you should respond to patients calling or dropping in the office with complaints typical of the condition. We will also discuss ocular urgencies, which are conditions that need to be seen as soon as possible, but usually do not have as serious vision threatening outcomes as emergencies.

**Chemical Burn**

- Patient calls in and reports that they have splashed a chemical in their eye
  - Ask if they have rinsed the eyes, if not they should be instructed to do so immediately
  - After rinsing the patient needs to get to the office as soon as possible
  - Advise the patient to bring the substance bottle with them

- Notify the doctor that the patient will be arriving
- Get exam room ready. Will need sterile solution for rinsing, morgan lens if available, and pH paper
- When patient arrives they will be immediately seen - Forms, questions, etc. LATER!!
The Morgan Lens®
The World’s Leading Method of Ocular Irrigation

- Effective, easy to use ocular irrigation
- Frees medical personnel to treat other injuries
- Developed by a practicing ophthalmologist
- Used in 95% of U.S. emergency departments

CENTRAL RETINAL ARTERY OCCLUSION

- Patient may report sudden vision loss/blurriness
- Patient must get treatment within first hour for best outcome. After 4 hours vision loss may be permanent.
- Usually from an embolus blocking the main artery that supplies the retina
- Notify doctor the patient will be arriving

VITREOUS HEMORRHAGE

- Patient may complain of dim vision, may see pink or red, and will be blurry
- Patient needs to be worked into the schedule as soon as possible
- Patient will need to see a retinal specialist for evaluation and management of underlying cause

FOREIGN BODY IN EYE

- Patient may report foreign body sensation, pain, redness, sensitivity to light
- The patient needs to be worked into the schedule so that the foreign body may be removed
- Any rust ring will need to be removed
- The patient may need to be patched overnight and will likely need to be examined the next day
FOREIGN BODY REMOVAL

- Patient may report flashes, floaters, or a curtain over their vision. Some patients describe “cobwebs” in their vision.
- Patients need to be worked into the schedule as soon as possible for dilation.
- Sometimes it may be a vitreous detachment, but needs to be evaluated as with a possible retinal detachment.

RETINAL DETACHMENT

- Patient may report flashes, floaters, or a curtain over their vision. Some patients describe “cobwebs” in their vision.
- Patients need to be worked into the schedule as soon as possible for dilation.
- Sometimes it may be a vitreous detachment, but needs to be evaluated as with a possible retinal detachment.

HORDEOLUM OR CHALAZION

- Patient will report bump on lid.
- May or may not be painful.
- May drain.
- May or may not be red and swollen.
- Usually been there at least a week.
- Treatment usually with antibiotic and hot compress/massage.

SWOLLEN LIDS

- Patient may report lid hurts, is red, had a bump and just got worse over time.
- Could be cellulitis - infection of the lid and surrounding tissue.
- Infection can come from untreated hordeolum or a puncture wound/scratch.
- Can be serious if not treated quickly and correctly with oral antibiotics.

SWOLLEN LIDS

- Patient may report lids became swollen very quickly and have severe itching.
- May have been working outside or with chemicals to which they were allergic.
- Lids may swell shut very quickly due to the allergic reaction.
- Treatment with cool compresses, may need steroid treatment, and antihistamines.
TRAUMA

Any patient reporting any trauma to the eye should be worked into the schedule as soon as possible.
- Blow out fracture of the orbit
- Corneal abrasion
- Eyelid laceration
- Penetrating ocular trauma

RED EYE

- Could be a variety of things.
- Most should be worked into the schedule the same day to ensure timely treatment given.
- Some etiologies:
  - Hemorrhage
  - Infection
  - Foreign Body
  - Allergies
  - Angle Closure
  - Uveitis

Acute Onset of Pain

- Possible Etiologies:
  - Trauma
  - Increased IOP
  - Uveitis
  - Corneal Compromise
  - Sinus infection
  - Hordeolum
  - Temporal Artery Pain
  - Optic neuritis
- Patients reporting with acute onset of pain should be worked into the schedule same day for evaluation.
Uveitis
- Peri-limbal injection
- Can cause increased pressure due to inflammatory cells and mediators clogging aqueous drainage
- Patient usually complains about photophobia
- Treated with topical, sometimes oral steroid
- Must evaluate patient for possible systemic cause (TB, RA other systemic cause)

Corneal Compromise
- Abrasion/laceration
- Herpes simplex (No Steroid!)
- Herpes zoster
- Recurrent corneal erosion
- Bacterial keratitis (ulcer) - (No Patch and No Steroid!)
- Severe dry eye

Herpes Simplex Keratitis

ACANTHAMOEBA

?????
Sinus Infection
- Dull ache behind eyes (referred pain)
- Typical symptoms of sinus infection
- Ethmoid infection can cause preseptal cellulitis, orbital cellulitis (proptosis)

Temporal Artery Pain
- Patients usually over 60
- Needs immediate ESR
- If high will need immediate oral steroids
- Schedule Temporal Artery Biopsy
- All must be done quickly because other eye can be affected in days

Optic Neuritis
- Pain around/behind eye
- Pain on eye movement
- Vision decreased
- Color vision desaturated
- APD
- Normal ONH appearance

THANK YOU