**When To Call Ophthalmology**

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| **Clinical Scenario - ER** | | **Pearls** | | **Typical disposition/communication** |
| **Corneal foreign body** | | get the bulk out, don't fuss about all the deeper rust ring | | topical antibiotic, 1-2 day f/u |
| **Peripheral and small corneal infiltrates** | |  | | topical antibiotic, 1-2 day f/u |
| **Central or large corneal infiltrates** | | may benefit from culture | | Call |
| **Hyphema** | | consider open globe, know the eye pressure | | call or start drops (pred 1%qid, atropine 1% bid), antibiotic if also abrasion, 1 day f/u |
| **Corneal abrasions** | |  | | topical antibiotic, variable f/u |
| **Herpetic eye disease, simplex or zoster** | |  | | oral acyclovir, 1-2 day f/u |
| **Cannulicular/lid margin laceration** | | Only a minority of our on-call staff repair these | | No immediate management issues, call within 12 hours for either treatment or to initiate the planning for repair. |
| **Flashes and floaters** | | Consider migraine aura, retinal detachment | | Call or 1 day f/u |
| **Double vision** | | Evaluate for 3rd nerve palsy, consider neurology consultation, imaging | | Call vs f/u few days, varies |
| **Orbit fracture** | | Consider open globe, orbital compartment syndrome. Consider the child with "white-eyed" blow out/green stick/trap door type fracture that infarcts the entrapped muscle (limited upgaze, possible bradycardia from oculocardiac reflex) - Urgent repair needed. | | Varies. If outpatient and uncomplicated f/u few days. If inpatient and undergoing urgent repair: Ophtho should be contacted within 12 hours. |
| **Orbital compartment syndrome** | | Clinical evidence of "tight orbit" - tense lids (from hemorrhage or soft tissue swelling), +/- proptosis, resistence to retropulsion of globe, + "orbit signs", +/- retro bulbar hemorrhage on CT | | Call, but timely treatment supercedes waiting for ophthalmology. |
| **Cellulitis** | | Evaluate "orbit signs" - vision, pupils, bulbar redness, motility, "tightness" of orbit, CT orbits scan often helpful, subperiosteal abscess on CT with clinical "orbit signs" may need urgent operative drainage | | Call if + "orbit signs" |
| **Chemical exposure** | | Topical anesthetic aids in irrigation, examine/sweep fornices for retained material, check pH at several time points | | Call, but immediate treatment supercedes communication with ophthalmology |
| **Clinical Scenario - ER** | **Pearls** | | **Typical disposition/communication** | |
| **Suspected angle closure** | Repeat pressure measurement, smaller sluggish pupil, most will also have decreased vision, inquire if on Topamax/Topiramate | | Call | |
| **Suspected iritis** |  | | Call vs cycloplegic with 1 day f/u | |
| **Suspected open globe** | Seidel test if corneal, peaked pupil, purple uvea hidden under conjunctival hemorrhage, CT can be helpful. Eye pressure can be normal or low | | Obvious Open globe: CT scan, NPO, shield over the eye, tetanus shot, avoid manipulation - no pressure check etc once confident it's ruptured | |
| **Unilateral painless vision loss** | How much better is the "pinhole" vision? There there a relative afferrent pupil defect? Do they have symptoms of possible temporal arteritis? | | Discuss with ophthalmology (DDx includes - vascular occlusions, ischemic optic neuropathy, vitreous hemorrhage, retinal detachment, migraine, and others) | |
| **Unexplained eye pain/redness** | Upper lid eversion, orbit process, viral history, contact lens complications | | Call or topical antibiotic/cycloplegic 1 day f/u | |
| **Unequal pupils - Anisocoria** | Consider 3rd nerve palsy, Horner's, unintended pharmacologic effect | | Varies | |
| **General Trauma** |  | |  | |
| **General peri-ocular trauma** | If no sign of open globe or orbital compartment syndrome, evaluate to the extent possible for afferent pupillary defect (swinging light test) and vision. Many trauma patients have miotic pupils from narcotic pain control and this is difficult | | Varies, typically call within 12-24 hours. See orbit fracture section above | |
| **Orbital compartment syndrome** | Clinical evidence of "tight orbit" - tense lids (from hemorrhage or soft tissue swelling), +/- apparent proptosis, resistence to retropulsion of globe, + "orbit signs", +/- retro bulbar hemorrhage on CT. This is an underappreciated emergency. | | Call, but immediate treatment supercedes waiting for ophthalmology. Treatment is emergent canthotomy and cantholysis. | |
| **Cannulicular/lid margin laceration** | A minority of ophthalmologists repair these | | No immediate management issues, call within 12 hours for either treatment or to initiate the planning for repair. Topical antibiotic drop or ointment | |