

# Maine Medical Center Ophthalmology Guidelines

## Maine Medical Center Ophthalmology Guidelines:

The following document outlines the current process for consulting Maine Eye for Maine Medical Center/Urgent Care Plus patients. The guidelines and information provided on this document are developed by the department of emergency medicine at Maine Medical Center and Maine Eye. The information is believed, but not guaranteed to be correct. It is intended to be a reference for Maine Medical Center clinicians and is not intended to replace providers' clinical judgment or definitive consultation.

### ONLY OPHTHALMOLOGY ACCEPTS TRANSFERS FOR ISOLATED EYE CONDITIONS INCLUDING ISOLATED EYE TRAUMA

**POLYSYSTEM TRAUMA IS ADDRESSED THROUGH EXISTING TRAUMA PROTOCOLS. A 24/7 ocular emergency consultation may be delayed if other life or organ threatening injuries posing medical instability take precedence.**

### NON-URGENT CONSULTS (Also listed on AMION)

8AM – 10PM Call (207) 774-8277

10PM-8AM Call Voicemail (207) 518-5885 - will be checked first thing in AM or call office 8AM next day.

### RED-LINE (Attending to attending only, must meet REDLINE criteria)

### SEE AMION for oncall contact: (Surgical Subspecialties –Ophthalmology – REDLINE)

**MEETS REDLINE CRITERIA (call must be attending to attending or senior resident to ophthalmology attending):**

**CONDITIONS FOR WHICH OPHTHALMOLOGY CONSULTATION ARE INDICATED 24/7. SOME OF THESE PATIENTS MAY REQUIRE TRANSFER TO ANOTHER TERTIARY CARE HOSPITAL (IE. MASSACHUSETTS EYE AND EAR INFIRMARY OR TUFTS UNIVERSITY MEDICAL CENTER) AFTER CONSULTATION.**

1. Open Globe/Corneal Perforation
2. Refractory Retrobulbar hematoma
3. Dog bite/complex lid laceration/canicular if concern for concurrent open globe.
4. Non roof orbital Fx with entrapment in child

**CALL MAINE EYE CENTER IN AM OR LEAVE A VOICEMAIL MESSAGE ON URGENT (NOT 24/7 REDLINE) FOR REMAINDER – VM MESSAGES WILL BE LISTENED TO FIRST THING NEXT AM**

### **Admit to Internal Medicine/Pediatrics/Trauma with optional (unless otherwise noted) Ophthalmology Consultation:**

1. Orbital cellulitis
  2. Ophthalmia neonatorum (Newborn conjunctivitis)
  3. Endophthalmitis
  4. Acute monocular vision loss
  5. Non-roof orbital fracture (IN AN ADMITTED ADULT TRAUMA PATIENT) with entrapment or likely to be admitted for more than one week.
- \*Note, if entrapment present, ophthalmology consult is required.

**Ophthalmologic Consultation within 24 hours; CDU in off hours with Ophthalmology consult in AM/Or DC and call MEC in AM for same day appt:**

1. Severe Corneal Ulcer (vision threatening)
2. Hyphema
3. Stevens-Johnson Syndrome with ocular symptoms
4. Endophthalmitis
5. Severe hyperacute conjunctivitis and gonococcal conjunctivitis (i.e. corneal involvement)
6. Central retinal artery occlusion (monocular vision loss)
7. Severe chemical/thermal injury
8. Central retinal vein occlusion and branch retinal vein occlusion—outpatient (not inpatient)
9. Primary acute angle closure glaucoma
10. Non-Accidental Trauma Evaluations
11. Non-roof orbital fracture in an adult (not requiring hospital admission for other medical issues)
12. Eyelid laceration/ canicular laceration WITHOUT concern for concurrent globe rupture

**(+/-) Phone consultation with Ophthalmology to optimize treatment during DAYTIME HOURS, Ok to Discharge and Call Maine Eye Center Office to schedule follow-up in AM if no other concerns. If patient seen after business hours or overnight, please call at 8am the next day to review with the on call provider or leave a message on the non-urgent phone line:**

1. Corneal ulcer (small, peripheral ulcer)
2. Mild hyperacute/gonococcal conjunctivitis (severe cases require IV antibiotics)
3. Retinal detachment
4. Corneal foreign body

5. Corneal abrasion
6. Corneal laceration (minor, not full thickness)
7. Minor chemical/thermal injury
8. Small, uncomplicated hyphema
9. Herpetic Keratitis or eye changes WITH zoster rash in cranial nerve 5 distribution
10. Vitreous hemorrhage
11. Posterior vitreous detachment
12. Keratitis
13. New onset BINOCULAR double vision
14. Stevens-Johnson Syndrome without ocular findings/concerns

**Delayed Referral to Maine Eye Center (within one week):**

1. Orbital Wall fractures (no entrapment or roof fracture) without vision changes or ocular complaints
2. Traumatic Iritis
3. Scleritis

**Follow up Maine Eye Center prn:**

1. Corneal Abrasion
2. Conjunctivitis

**Consult Maine Eye Center during 8a-10p, leave message on Maine Eye Center Voicemail or Call Redline if meets Redline criteria.**

Diagnosis	Presentation/Considerations/Treatment	Consultation
Open globe	<ul style="list-style-type: none"> <li>- Surgical exploration and repair</li> <li>- CT of brain and orbits to rule out intraocular foreign body in most cases</li> <li>- NPO, antiemetic agents, tetanus, elevate HOB, eye shield</li> <li>- Systemic antibiotics within 6 hours of injury</li> </ul>	<p><b>Office Hours 8a-10p</b> Consult Ophthalmologist on call for Maine Eye Center</p> <p><b>Off Hours 10p – 8a</b> Options include immediate transfer <b>if obvious rupture vs call REDLINE if likely rupture but need confirmation</b></p>
Retrobulbar hematoma (Isolated trauma only and trauma surgery chooses not to admit)	<ul style="list-style-type: none"> <li>- Pain, decreased vision, inability to open eyelids due to severe swelling</li> <li>- Proptosis with resistance to retropulsion, tense eyelids</li> <li>- A lateral canthotomy/cantholysis should be done by the emergency physician as a temporizing measure before definitive decompression.</li> <li>- Treatment of increased intraocular pressure includes oral carbonic anhydrase inhibitor, topical beta-blocker, and Diamox (500 mg IV).</li> <li>- Re-evaluate eye pressures after treatment and monitor for improvement</li> </ul>	<p><b>Office Hours 8a-10p</b> Consult Ophthalmologist on call for Maine Eye Center</p> <p><b>Off Hours 10p – 8a</b> <b>If IOP not able to be controlled s/p canthotomy/cantholysis and IOP lowering topical and po/IV agents, call REDLINE.</b></p>
Primary acute angle closure glaucoma	<ul style="list-style-type: none"> <li>- Pain, blurred vision, colored halos around lights, frontal headache/brow ache, N/V, conjunctival injection; fixed, mid-dilated pupil</li> <li>- Emergent ophthalmologic consultation IF IOP cannot be adequately lowered</li> <li>- Intraocular pressures less than 40 mm Hg can be managed without IV medications</li> <li>- Topical therapy with timolol 0.5%, brimonidine, and dorzolamide 2% should be initiated immediately. In urgent cases, three rounds of these medications may be given, with each round being separated by 15 minutes</li> <li>- Topical steroid (prednisolone acetate 1% every 15 minutes for four doses) should be given.</li> <li>- Recheck the IOP and visual acuity in one hour. If IOP does not decrease and vision does not improve, repeat topical medications and give oral acetazolamide 500mg and recheck IOP in 45 minutes. If IOP does not decrease and vision does not improve, give mannitol 1-2 g/kg IV over 45 minutes</li> </ul>	<p><b>Office Hours 8a-10p</b> Consult Ophthalmologist on call for Maine Eye Center</p> <p><b>Off Hours 10p – 8a</b> Options include CDU for AM evaluation and definitive management vs AM MEC office visit vs Redline for refractory IOPs &gt;50.</p> <ul style="list-style-type: none"> <li>• Pressures improved post management appropriate for AM follow up</li> <li>• Call Redline if pressures remain &gt;50mm Hg after 3 hours of treatment</li> </ul>

## Admit to Internal Medicine/Family Medicine/Pediatrics with Optional Ophthalmology Consultation:

Diagnosis	Presentation/Considerations/Treatment	Consultation
Orbital cellulitis	<ul style="list-style-type: none"> <li>-Red eye, pain, blurred vision, double vision, proptosis, pain with extraocular movements</li> <li>- CT orbits, broad spectrum IV antibiotics to cover Gram-positive, gram – negative and anaerobic organisms</li> <li>-Consider inpatient ophthalmology consult</li> <li>- Early surgical drainage of paranasal sinuses by ENT specialist if sinusitis/ subperiosteal abscess present</li> </ul>	<b>Office Hours 8a-10p</b> If ophthalmology consultation desired, consult Ophthalmologist on call for Maine Eye Center
		<b>Off Hours 10p – 8a</b> Rarely requires transfer – Options include admission vs CDU for AM evaluation and definitive management.
Orbital Fracture	<ul style="list-style-type: none"> <li>- Roof fracture requires neurosurgery consult</li> <li>-Floor/medial wall/lateral wall fractures:</li> <li>- Check vision (attempt to open eye and check if lid swollen), check IOP, check EOM range of motion, check for signs of globe rupture clinically or on CT, look for sign of hyphema</li> <li>- Entrapment can be seen on CT and patient should have difficulty moving the eye past the midline (vertically for floor fractures, horizontally for lat/med wall fractures).</li> <li>-If fracture involves infected sinus, treatment consists of nasal decongestants, and broad spectrum antibiotics and sinus precautions.</li> <li>-If entrapment present, surgical repair preferable within first 72 hours. If no entrapment, surgery can be delayed.</li> </ul>	Consult Ophthalmology on-call at Maine Eye Center if concern for entrapment or concomitant globe injury.
		Options include: <ul style="list-style-type: none"> <li>- CDU and leave message on Maine Eye Center urgent phone line if significant (but non-ruptured) globe trauma suspected and otherwise does not meet requirements for admission.</li> <li>- Admission if polytrauma with AM consult to ophthalmology if concern for entrapment or globe trauma or if patient expected to be in hospital greater than 1 week.</li> <li>- Discharge with call to Maine Eye Center for follow-up if vision unaffected and no significant signs of globe trauma</li> <li>-</li> </ul>
Ophthalmia neonatorum (Newborn conjunctivitis)	<ul style="list-style-type: none"> <li>- Purulent, mucopurulent, or mucoid discharge from one or both eyes in the first month of life with diffuse conjunctival injection</li> <li>- Etiologies include Neisseria gonorrhea, Chlamydia trachomatis, Staphylococci (including MRSA), streptococci, and Gram-negative species, herpes simplex virus</li> <li>- Perform gram stain and culture</li> <li>- Treatment based on suspected organism</li> <li>- Admit for antibiotics or consider AM office follow up with Maine Eye Center</li> <li>- Consider CDU</li> </ul>	<b>Office Hours 8a-10p</b> If ophthalmology consultation desired, consult Ophthalmologist on call for Maine Eye Center
		<b>Off Hours 10p – 8a</b> Options include admission, CDU or AM office visit

## Immediate Ophthalmologic Consultation; CDU in off hours with Ophthalmology consult in AM:

Diagnosis	Presentation/Considerations/Treatment	Consultation
<b>Corneal ulcer</b>	<ul style="list-style-type: none"> <li>- Large, vision threatening ulcers (&gt; 1.5 mm in diameter and central ulcers should be referred to ophthalmologist urgently</li> <li>- Consider CDU admission if patient unable to self-administer antibiotics, high likelihood of noncompliance or large corneal ulcer</li> <li>-Initiate broad spectrum topical ex. Vigamox Q1h</li> </ul>	<b>Office Hours 8 – 10 p</b> Consult Ophthalmologist on call for Maine Eye Center
		<b>Off Hours 10p – 8a</b> Consider CDU or AM office visit
<b>Complicated hyphema</b> <ul style="list-style-type: none"> <li>- Hyphema grade III or IV</li> <li>- IOP &gt; 30</li> <li>- Lens subluxation</li> <li>- Vitreous hemorrhage</li> <li>- Unable to visualize fundus</li> <li>- Higher level of concern with IOP &gt; 40</li> <li>- Monocular patient</li> </ul>	<ul style="list-style-type: none"> <li>-Consider hospitalization for noncompliant patients, patients with bleeding diathesis or blood dyscrasia, patients with other severe ocular or orbital injuries and patients with concomitant significant IOP elevation and sickle cell</li> <li>- Elevate head of bed, place eye shield, atropine 1% solution b.i.d. to t.i.d. or scopolamine 0.25% b.i.d. to t.i.d. Bedrest with bathroom privileges.</li> <li>- Use topical steroids (eg. prednisolone acetate 1% q.i.d. to q1h) if any suggestion of iritis (eg. photophobia, deep ache, ciliary flush)</li> <li>- Refer to definitive text/consultation for treatment of increased IOP</li> </ul>	<b>Office Hours 8 – 10 p</b> Contact On Call Maine Eye Center
		<b>Off Hours 10p – 8a</b> Consider CDU or AM office visit
<b>Corneal perforation</b>	<ul style="list-style-type: none"> <li>- Most often 2<sup>nd</sup> to infectious breakdown (other causes include trauma, inflammatory conditions, environmental exposures)</li> <li>- NPO, antiemetic agents PRN, eye shield</li> <li>- Treatment is surgical (or tissue adhesives for non-operative patients)</li> </ul>	<b>Office Hours 8 – 10 p</b> Consult Ophthalmologist on call for Maine Eye Center
		<b>Off Hours 10p – 8a</b> Consider CDU or AM office visit. High likelihood of requiring transfer to Tufts/MEEI.
<b>Endophthalmitis</b>	<ul style="list-style-type: none"> <li>- Patients most at risk are those with recent ocular surgery or intravitreal injection. Other risk factors are severe bacterial keratitis or ulceration or bacteremia/fungemia/IVDU.</li> <li>-Likely present with red swollen, painful red eye and possibly floaters and decreased vision.</li> <li>-Usually present with hypopyon (yellow hyphema)</li> <li>-Immediate ophthalmology consultation unless endogenous (ie IVDU, bacteremia- can wait until am)</li> </ul>	<b>Office Hours 8 – 10 p</b> Consult Ophthalmologist on call for Maine Eye Center
		<b>Off Hours 10p – 8a</b> Consider CDU or AM office visit. <b>IF MEC patient and in immediate POST OP PERIOD CALL REDLINE.</b> High likelihood of transfer to Tufts/MEEI.
<b>Severe hyperacute conjunctivitis and gonococcal conjunctivitis (i.e. corneal involvement)</b>	<ul style="list-style-type: none"> <li>- Excessively purulent appearing eye</li> <li>- Emergent referral to ophthalmology for moderate/severe cases</li> <li>- Ceftriaxone 1 g IM as single dose</li> <li>- Swab culture with gram stain</li> <li>- Outpt treatment after Rocephin IM includes topical antibiotics, saline solution for conjunctival irrigation</li> <li>- Consider testing or treating presumptively for concomitant Chlamydia trachomatis infection with oral doxycycline, tetracycline, or erythromycin or single dose of 1 g of azithromycin</li> </ul>	<b>Office Hours 8 – 10 p</b> Consult Ophthalmologist on call for Maine Eye Center
		<b>Off Hours 10p – 8a</b> Consider CDU or AM office visit
		<b>Office Hours 8 – 10 p</b>

<b>Central retinal artery occlusion</b>	<p>Severe painless vision loss that occurs rapidly, typically over a minute: markedly reduced visual acuity with prominent afferent pupillary defect; on acute fundoscopic exam, retina appears edematous with pale-grey appearance, may possibly see a foveal "cherry red spot"</p> <ul style="list-style-type: none"> <li>- Consider ocular massage</li> <li>-Consider Timoptic</li> <li>-Work up includes STAT ESR, CRP and Carotid US or neck angiography/ MRI/A brain (need CVA w/u)</li> <li>-NOTE: Treatment and disposition are time dependent, symptoms present longer than 90min are unlikely to respond to interventions</li> </ul>	<p>Consult Ophthalmologist on call for Maine Eye Center</p> <p><b>Off Hours 10p – 8a</b></p> <p>Options include CVATIA workup in CDU plus AM evaluation and definitive management for eye.</p>
<b>Severe chemical/thermal injury</b>	<ul style="list-style-type: none"> <li>- Based on degree of chemosis, corneal cloudiness and conjunctival blanching</li> <li>- Check pH prior to instilling any drops/flushing</li> <li>- Thorough irrigation with Morgan Lens for chemical burns</li> <li>- Confirm neutral ph for chemical burns after adequate irrigation</li> <li>- Severe chemical injury requires urgent ophthalmologic follow up (based on degree of corneal cloudiness and sclera whitening)</li> <li>- Mild thermal injuries can be left unpatched with antibiotic ointment and seen in 1-2 days</li> <li>- Cyloplegic drop for ciliary body spasms and pain</li> <li>- Oral analgesics, tetanus</li> </ul>	<p><b>Office Hours 8 – 10 p</b></p> <p>Consult Ophthalmologist on call for Maine Eye Center</p> <p><b>Off Hours 10p – 8a</b></p> <p>AM office visit at Maine Eye Center</p>
<b>Central retinal vein occlusion and branch retinal vein occlusion</b>	<ul style="list-style-type: none"> <li>- Painless vision loss with hemorrhage of retinal vessels in a pt with co-morbidities (DM, HTN)</li> <li>- No effective treatment in ED</li> <li>- Check pressure and refer for AM follow up</li> <li>- Urgent follow up (within 24 hours, not emergent)</li> </ul>	<p><b>Office Hours 8 – 10 p</b></p> <p>Consult Ophthalmologist on call for Maine Eye Center</p> <p><b>Off Hours 10p – 8a</b></p> <p>AM office visit</p>
<b>Eyelid laceration</b>	<p>Refer to ophthalmology/plastic surgery to repair if:</p> <ol style="list-style-type: none"> <li>1. Lacerations involving lid margins</li> <li>2. Lacerations involving the canalicular system. Injury to the canalicular system should be suspected in any laceration involving the medial lower eyelid area</li> <li>3. Lacerations involving the levator or canthal tendons.</li> <li>4. Laceration through the orbital septum. Orbital fat protrudes through septal lacerations into the wound.</li> <li>5. Lacerations with tissue loss.</li> </ol> <p>The Emergency Physician can repair:</p>	<p><b>Office Hours 8 – 10 p</b></p> <p>Consult Ophthalmologist on call for Maine Eye Center</p> <p><b>Off Hours 10p – 8a</b></p> <p><b>IF CONCERN FOR CONCURRENT OPEN GLOBE, call REDLINE. Will likely need transfer. If no concern for globe injury, advise CDU/AM visit and discussion with ophtho re definitive management. May require transfer to Tufts/MEEI.</b></p>

	Simple or partial thickness horizontal, vertical or oblique lacerations not meeting above criteria*NOTE: 6-0 nylon or express gut or 5-0 fast gut work well for eyelid tissues with recommended follow up in 1-2 weeks	
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**(+/-) Phone consultation with Ophthalmology to Optimize Treatment, Follow Up in at Maine Eye Center Office in AM:**

<b>Diagnosis</b>	<b>Presentation/Considerations/Treatment</b>	<b>Consultation</b>
<b>Corneal ulcer (Small peripheral ulcers)</b>	<ul style="list-style-type: none"> <li>- Pain, photophobia, tearing, red eye</li> <li>- An ulcer exists if there is a stromal infiltrate with an overlying epithelial defect that stains with fluorescein</li> <li>- Broad spectrum topical antibiotics (ex- Moxifloxacin 6x/day)</li> <li>- If contact lens wearer, d/c CL wear</li> <li>- Next day follow up</li> </ul>	<b>Office Hours 8 – 10 p</b> Consult Ophthalmologist on call for Maine Eye Center
		<b>Off Hours 10p – 8a</b> Options include CDU for AM evaluation or AM office visit
<b>Retinal detachment</b>	<ul style="list-style-type: none"> <li>- Floaters and flashers</li> <li>- Potential field loss</li> <li>- Use ultrasound/fundoscopy exam to diagnose</li> <li>- Visual acuity can help determine if macula is threatened, ie 20/40 vision or better suggests macula on.</li> <li>- Keep NPO until otherwise directed by ophthalmology.</li> </ul>	<b>Office Hours 8 – 10 p</b> Consult Ophthalmologist on call for Maine Eye Center
		<b>Off Hours 10p – 8a</b> For macula threatening detachments, options include <b>DISCHARGE WITH RECOMMENDATION TO GO TO MEEI</b> or CDU/early am consult for definitive plan. Pt may still be advised to go to MEEI ER (esp on weekends).
<b>Corneal foreign body</b>	<ul style="list-style-type: none"> <li>- Attempt to first remove with moistened cotton swab, then tip of 25 gauge needle (anesthetize eye first!)</li> <li>- Antibiotic ointment or drops</li> <li>- Cycloplegic agent prn for ocular discomfort if significant photophobia</li> <li>- Emergent referral if any corneal laceration, positive seidel test, evidence of corneal ulcer or infiltrate, deeply embedded foreign body, hypopyon or significant anterior chamber reaction</li> <li>- Referral if not removed or residual rust ring</li> <li>- 24-48 hour referral for all other retained FB's not removed</li> <li>- Simple foreign bodies successfully removed in ED may not need ophthalmology referral</li> </ul>	<b>Office Hours 8 – 10 p</b> Consult Ophthalmologist on call for Maine Eye Center
		<b>Off Hours 10p – 8a</b> Consider AM office visit
<b>Corneal abrasion</b>	<ul style="list-style-type: none"> <li>- Large abrasions in visual axis should be examined the next day</li> <li>- Small peripheral abrasions can be followed up 2-5 days prn</li> <li>- Start prophylactic topical antibiotic</li> </ul>	<b>Office Hours 8 – 10 p</b> Consult Ophthalmologist on call for Maine Eye Center



		<b>Off Hours 10p – 8a</b> Consider AM office visit
<b>Corneal laceration</b>	<ul style="list-style-type: none"> <li>- R/o perforated globe</li> <li>- Ophthalmologic consultation within 24 hrs for partial thickness</li> <li>- Place eye shield</li> <li>- Partial thickness lacerations treat with cycloplegic agents, topical antibiotics, tetanus</li> <li>- NPO after midnight, may need transfer</li> </ul>	<b>Office Hours 8 – 10 p</b> Consult Ophthalmologist on call for Maine Eye Center
		<b>Off Hours 10p – 8a</b> Consider AM office visit at Maine Eye Center
<b>Minor chemical/thermal Injury</b>	<ul style="list-style-type: none"> <li>- Thorough irrigation with Morgan Lens for chemical burns</li> <li>- Confirm neutral pH for chemical burns after adequate irrigation</li> <li>- Severe chemical injury requires urgent ophthalmologic follow up</li> <li>- Mild thermal injuries can be left unpatched with antibiotic ointment and seen in 1-2 days</li> <li>- Cycloplegic drop for ciliary body spasms and pain</li> <li>- Oral analgesics, tetanus</li> </ul>	<b>Office Hours 8 – 10 p</b> Consult Ophthalmologist on call for Maine Eye Center
		<b>Off Hours 10p – 8a</b> Consider CDU or AM office visit at Maine Eye Center
<b>Small, uncomplicated hyphema</b>	<ul style="list-style-type: none"> <li>- If traumatic, screen for other significant signs of trauma (corneal laceration/abrasion, perforated globe)</li> <li>- Cycloplegic to help minimize pain and discomfort</li> <li>- Prednisolone acetate 1% QID if symptoms of concomitant iritis (photophobia, ache, ciliary flush)</li> <li>- Protective eye shield, elevate HOB, no NSAIDs/ASA, bedrest with bathroom privileges</li> </ul>	<b>Office Hours 8 – 10 p</b> Consult Ophthalmologist on call for Maine Eye Center
		<b>Off Hours 10p – 8a</b> Consider AM office visit
<b>HSV Herpetic Keratitis (dendrites) OR Zoster rash on cranial nerve V distribution with eye changes</b>	<ul style="list-style-type: none"> <li>- Dermatomal pain, paresthesias, skin rash or discomfort</li> <li>- May be preceded by headache, fever, malaise, blurred vision, eye pain and red eye</li> <li>- Initiate oral antiviral: Oral valacyclovir 500mg (HSV) or 1g (Zoster) PO TID or acyclovir 400mg (HSV) or 800mg (zoster) PO 5 times/day</li> <li>- 24 hour follow up with ophthalmologist</li> <li>- Severe cases may require admission for IV antiviral therapy</li> <li>- Follow up Maine Eye Center in AM</li> </ul>	<b>Office Hours 8 – 10 p</b> Consult Ophthalmologist on call for Maine Eye Center or refer for follow up
		<b>Off Hours 10p-8a</b> Consider CDU or AM office visit
<b>Vitreous hemorrhage</b>	<ul style="list-style-type: none"> <li>- Sudden, painless loss of vision or sudden appearance of black spots, cobwebs or haze in vision</li> <li>- Partial to complete obstructed view to fundus</li> <li>- Screen for retinal detachment with ultrasound</li> <li>- No emergent treatment</li> <li>-</li> </ul>	<b>Office Hours 8 – 10 p</b> Contact Ophthalmologist on Call for Maine Eye Center or refer for follow up
		<b>Off Hours 10p – 8a</b> Consider CDU or AM office visit
<b>Posterior vitreous detachment</b>	<ul style="list-style-type: none"> <li>- May present as “Flashers/floaters”</li> <li>- Use ultrasound/fundoscopic exam to r/o retinal detachment</li> </ul> <p>Patients with a new posterior vitreous detachment should have prompt evaluation (24-48 hours) by an ophthalmologist to rule out these surgically amenable complications.</p>	<b>Office Hours 8 – 10 p</b> Contact Ophthalmologist on Call for Maine Eye Center or refer for follow up
		<b>Off Hours 10p – 8a</b> AM office visit

	<ul style="list-style-type: none"> <li>- No specific treatment is indicated for posterior vitreous detachment unless it is accompanied by a retinal break, vitreous hemorrhage, or retinal detachment.</li> </ul>	
<b>Keratitis</b>	<ul style="list-style-type: none"> <li>- If patient wears contact lens, instruct the patient to remove and temporarily discontinue wearing</li> <li>- If infectious etiology suspected, thorough exam by ophthalmologist to r/o corneal ulcer</li> <li>- Consider topical antibiotics if contact lens wearer</li> <li>- Next day follow-up with patient's established eye care provider or ophthalmology follow up</li> </ul>	<b>Office Hours 8 – 10 p</b> Contact Ophthalmologist on Call for Maine Eye Center or refer for follow up
		<b>Off Hours 10p – 8a</b> Consider CDU or AM office visit

**Delayed Referral to Maine Eye Center (within one week):**

<b>Diagnosis</b>	<b>Presentation/Considerations/Treatment</b>	<b>Consultation</b>
<b>Orbital Wall fractures (no entrapment or roof fracture)</b>	<ul style="list-style-type: none"> <li>- Consult neurosurgery if roof fracture present or fracture extends into optic canal</li> <li>- Needs non-urgent ophtho exam to assess for accessory ocular</li> <li>- If fracture involves infected sinus, treatment consists of nasal decongestants, broad-spectrum oral antibiotics</li> <li>- Patients with orbital floor and medial orbital wall fractures should follow strict sinus precautions to include avoidance of nose blowing, Valsalva maneuver, lifting &gt; 10 lb, and strenuous activity to limit the extent of orbital emphysema. Need non-urgent ophtho exam to assess for double vision or enophthalmos along with clinical evaluation for concurrent intraocular damage</li> <li>- Surgical repair may eventually be warranted for pts with diplopia or clinically significant enophthalmos. Surgery is non-urgent and is best performed once acute orbital swelling has subsided.</li> </ul>	<b>Office Hours 8a-10p</b> If ophthalmology consultation desired, consult Ophthalmologist on call for Maine Eye Center
		<b>Off Hours 10p – 8a</b> Delayed referral to Maine Eye Center <ul style="list-style-type: none"> <li>• If significant vision loss or concern for significant (non-rupture) globe injury, CDU or AM office visit for non-admitted patients, or AM ophthalmology consult if admitted patient.</li> <li>• 1-2 weeks referral if no significant decrease in vision and no concern for significant globe injury.</li> </ul>
<b>Traumatic Iritis</b>	<ul style="list-style-type: none"> <li>- Photophobia, redness, history of trauma</li> <li>- Conjunctival injection, perilimbal flush</li> <li>- Anterior chamber cell and flare</li> <li>- Long-acting cycloplegic agent for pain (ex atropine)</li> <li>- Topical steroid (e.g. Prednisolone 1%) for inflammation</li> </ul>	<b>Office Hours 8a-10p</b> If ophthalmology consultation desired, consult Ophthalmologist on call for Maine Eye Center Delayed referral to Maine Eye Center
		<b>Off Hours 10p – 8a</b> Consider delayed referral to Maine Eye Center
<b>Scleritis</b>	<ul style="list-style-type: none"> <li>- Severe and boring eye pain (most prominent eye feature), which may radiate to the forehead, brow, or jaw, and may awaken the patient at night</li> <li>- Refer for outpatient workup</li> <li>- Oral NSAID</li> </ul>	<b>Office Hours 8a-10p</b> If ophthalmology consultation desired, consult Ophthalmologist on call for Maine Eye Center Delayed referral to Maine Eye Center
		<b>Off Hours 10p – 8a</b> Delayed referral to Maine Eye Center

## Follow up prn with Maine Eye Center:

Diagnosis	Presentation/Considerations/Treatment	Consultation
<b>Corneal abrasion</b>	<ul style="list-style-type: none"><li>- Topical antibiotics, cycloplegia for severe discomfort; +/- topical NSAID</li><li>- Contact lens wearers should get anti-pseudomonal coverage, avoid contact wearing</li><li>- No patch, <b>no topical anesthetics</b></li><li>- Small abrasions do not require follow up, larger abrasions f/u with ophthalmology prn</li></ul>	<b>Office Hours 8a-10p</b> If ophthalmology consultation desired, consult Ophthalmologist on call for Maine Eye Center Follow up prn with Maine Eye Center
		<b>Off Hours 10p – 8a</b> Follow up prn with Maine Eye Center
<b>Conjunctivitis</b>	<ul style="list-style-type: none"><li>- Red eye, discharge, eyelids sticking or crusting, foreign body sensation</li><li>- Consider topical antibiotics if purulent white-yellow discharge of mild to moderate degree</li><li>-</li></ul>	<b>Office Hours 8a-10p</b> If ophthalmology consultation desired, consult Ophthalmologist on call for Maine Eye Center Follow up prn with Maine Eye Center
		<b>Off Hours 10p – 8a</b> Follow up prn with Maine Eye Center
<b>Episcleritis</b>	<ul style="list-style-type: none"><li>- Almost always benign, resolves spontaneously 1-2 weeks, 20% reoccur</li><li>- Often no therapy required, but may respond to oral or topical anti-inflammatory meds</li></ul>	<b>Office Hours 8a-10p</b> If ophthalmology consultation desired, consult Ophthalmologist on call for Maine Eye Center Follow up prn with Maine Eye Center
		<b>Off Hours 10p – 8a</b> Follow up prn with Maine Eye Center

### References

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