

Patient A. Bilateral Papilledema: Patient B. Amelanotic Melanoma

G Robert Gosnell*

Optometrist at Primary Eye Care, Kansas City, Missouri Area Hospital and Health Care, USA

***Corresponding Author:** G Robert Gosnell, Optometrist at Primary Eye Care, Kansas City, Missouri Area Hospital and Health Care, USA.

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Patient A presented as a four year old Caucasian male with migraine headaches including vomiting. Mom was concerned with the fact that he would state things like "my brain hurts".

We were fortunate enough to get great cooperation during direct ophthalmoscopy, then enough cooperative efforts with mothers help for excellent non-mydriatic fundus photography. The optic nerves had the obvious appearance of swollen disc margins, in the order of moderate swelling.

We made an immediate referral to the Children's Mercy hospital, after having the mother also calling the primary care physician to keep her in the loop. The ophthalmology clinic at the facility spent 6 hours evaluating and finally deciding to diagnose optic disc drusen.

We were concerned with this as was the mother, since she had copies of our 21 mega-pixel digital photos in hand at that evaluation. Nevertheless, mother calls our office with this confusion and trepidation of what to do, and where to go from where they were in the referral experience.

Knowing that the elevated C.S.F. was the culprit, and the need for the four year old to have a lumbar puncture for pressure measure, then culture for virus or bacteria as well as a protein assay, all necessary to make a definitive diagnosis, we proceeded to recommend the emergency room next and hopefully involving neurological evaluation and concurrent treatment.

The E.R. physician immediately recognized the bilateral papilledema and involved a neurologist. Scheduled for an immediate L.P. & unsuccessful, rescheduled for a few days later. Finally with the right personnel and with radiography the L.P. revealed pressures of mm.Hg. and negative culture and no protein. Now, no cause but treatment initiated such as C.S.F. release and carbonic anhydrase inhibitors, to halt over production of C.S.F. * (Would like to reference this article in a separate editorial regarding either a seamless transition from Optometry to Ophthalmology via referral process, or Optometric referrals can save time and should command some credibility).

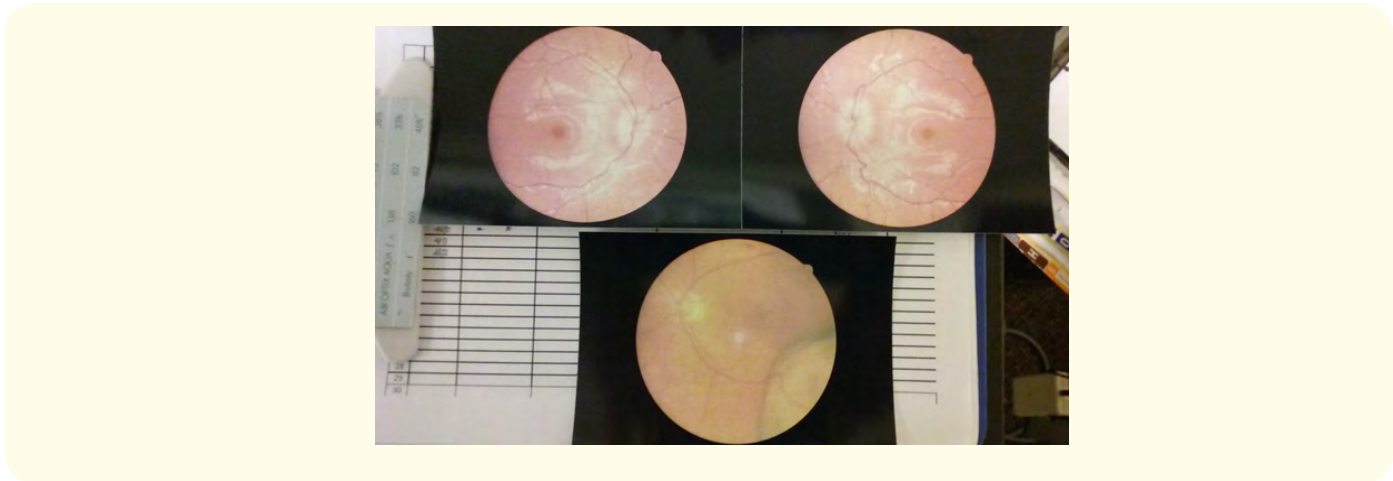
Patient B presented as a routine annual visit (68 yr Caucasian female) the need for a spare set of rigid gas permeable trifocal contact lenses and fitting. Having seen this patient numerous times over 27 years of practice, and her inability to find an eye care practitioner able to fulfill this need in her hometown more than 500 miles away, she sees us when home to visit family.

We observed this moderately sized mid-peripheral mass, which was an obvious new development. We proceeded to take non-mydriatic fundus photography with our digital full frame 21 mega-pixel resolution camera, and this is what we documented for the immediate referral to our retinal specialist of choice, knowing that an oncologist would be eminent. Our diagnosis was an Amelanotic Melanoma the question was treatment here or in her home state?

Both patients required follow up, and many reports. But more importantly good rapport between the referring and the referred to physicians.

Thank you for considering these cases for publication, and possible editorial for a progressive change for the better! With experience and youthful eyes, large pupils (undilated) and non-mydratic fundus photography, and the tenacity to insist on all of the necessary tests for a comprehensive evaluation for the established contact lens patient. All shows that we must be vigilant and thorough as well as cooperative to insure proper follow through on treatment. We must improve optometric and ophthalmology relationships.

L.P. opening pressure was 50 cm H₂O, (>28 cm H₂O is alarming) removed 12cc's.



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