STATE BOARD OF OPTOMETRY
2450 DEL PASO ROAD, SUITE 105, SACRAMENTO, CA 95834
P (916) 575-7170 F (916) 575-7292 www.optometry .ca.gov

Continuing Education Course Approval Checklist

Title: Well That Was Unexpected! Grand Rounds Cases

Provider Name: UCSF c/o Dr. Jane Kwo

☑Completed Application
Open to all Optometrists? ☑Yes ☐No
Maintain Record Agreement? ☑Yes ☐No

☑Correct Application Fee

☑Detailed Course Summary

☑Detailed Course Outline

☑PowerPoint and/or other Presentation Materials

☐Advertising (optional)

☑CV for EACH Course Instructor

☑License Verification for Each Course Instructor
Disciplinary History? ☐Yes ☑No

CALIFORNIA STATE BOARD OF OPTOMETRY

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CONTINUING EDUCATION COURSE APPROVAL APPLICATION

$50 Mandatory Fee

FEES PAID

Pursuant to California Code of Regulations (CCR) § 1536, the Board will approve continuing education (CE) courses after receiving the applicable fee, the requested information below and it has been determined that the course meets criteria specified in CCR § 1536(g).

In addition to the information requested below, please attach a copy of the course schedule, a detailed course outline and presentation materials (e.g., PowerPoint presentation). Applications must be submitted 45 days prior to the course presentation date.

Please type or print clearly.

Course Title	**Course Presentation Date**
Well THAT Was Unexpected!: Grand Rounds cases.	02/05/2016

Course Provider Contact Information

Provider Name

Daphne (First) Chan (Last) Wai Ping (Middle)

Provider Mailing Address

Street 1339 32nd Avenue **City** San Francisco **State** CA **Zip** 94122

Dr. Jane Kuo is the provider

Jane.Kuo@ucsf.edu

Provider Email Address Daphne.Chan@ucsf.edu

Will the proposed course be open to all California licensed optometrists?	☑ YES ☐ NO
Do you agree to maintain and furnish to the Board and/or attending licensee such records of course content and attendance as the Board requires, for a period of at least three years from the date of course presentation?	☑ YES ☐ NO

Course Instructor Information

Please provide the information below and attach the curriculum vitae for each instructor or lecturer involved in the course. If there are more instructors in the course, please provide the requested information on a separate sheet of paper.

Instructor Name

Daphne (First) Chan (Last) Wai Ping (Middle)

License Number 15061 TLG	**License Type** Optometry
Phone Number (415) 615-2123 (cell)	**Email Address** Daphne.Chan@ucsf.edu

I declare under penalty of perjury under the laws of the State of California that all the information submitted on this form and on any accompanying attachments submitted is true and correct.

Daphne Chan - OD

Signature of Course Provider

01/05/2017

Date

Form CE-01, Rev. 5/16

Title: Well THAT was Unexpected!: Grand Rounds Cases

Presenter: Daphne Chan

Summary:
"Retinal swelling in a diabetic status post cataract surgery"
Optometrists play a heavy role in cataract evaluations, cataract workups, and pre- and post-op care for cataract patients. This segment of my grand rounds lecture will review the slight differences between macular edema caused by diabetes (diabetic macular edema) and compare it to macular edema caused by cataract surgery (cystoid macular edema). This is an important distinction since the treatment routes are different.

"Corneal Spots"
There are many etiologies for corneal opacities. This segment of my grand rounds lecture will discuss differentials for corneal opacities in the setting of a patient with known multiple myeloma. This is important because making the right ocular diagnosis can help lead you to a potentially serious systemic condition that requires intense treatment, and determine the type of ocular therapy needed. I will review differential diagnoses for corneal opacities, importance of careful case history, and management of both EKC and multiple myeloma.

"Retinal hemorrhages and trusting patient report of their own health condition"
As primary eye care providers, optometrists provide comprehensive eye care and routine dilated eye exams on patients both health or with blood dyscrasias. What happens when we see an isolated retinal hemorrhage in an asymptomatic patient who claims to be healthy? This segment of my grand rounds lecture explores the differentials for isolated retinal hemorrhages and the appropriate action plan for major conditions. Furthermore, I will discuss the reliability of patient report of health conditions and why sometimes it is just not sufficient to take the patient's word that he or she has normal labs.

SUMMARY:

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Optometrists play a heavy role in cataract evaluations, cataract workups, and pre- and post-op care for cataract patients. This segment of my grand rounds lecture will review the slight differences between macular edema caused by diabetes (diabetic macular edema) and compare it to macular edema caused by cataract surgery (cystoid macular edema). This is an important distinction since the treatment routes are different.

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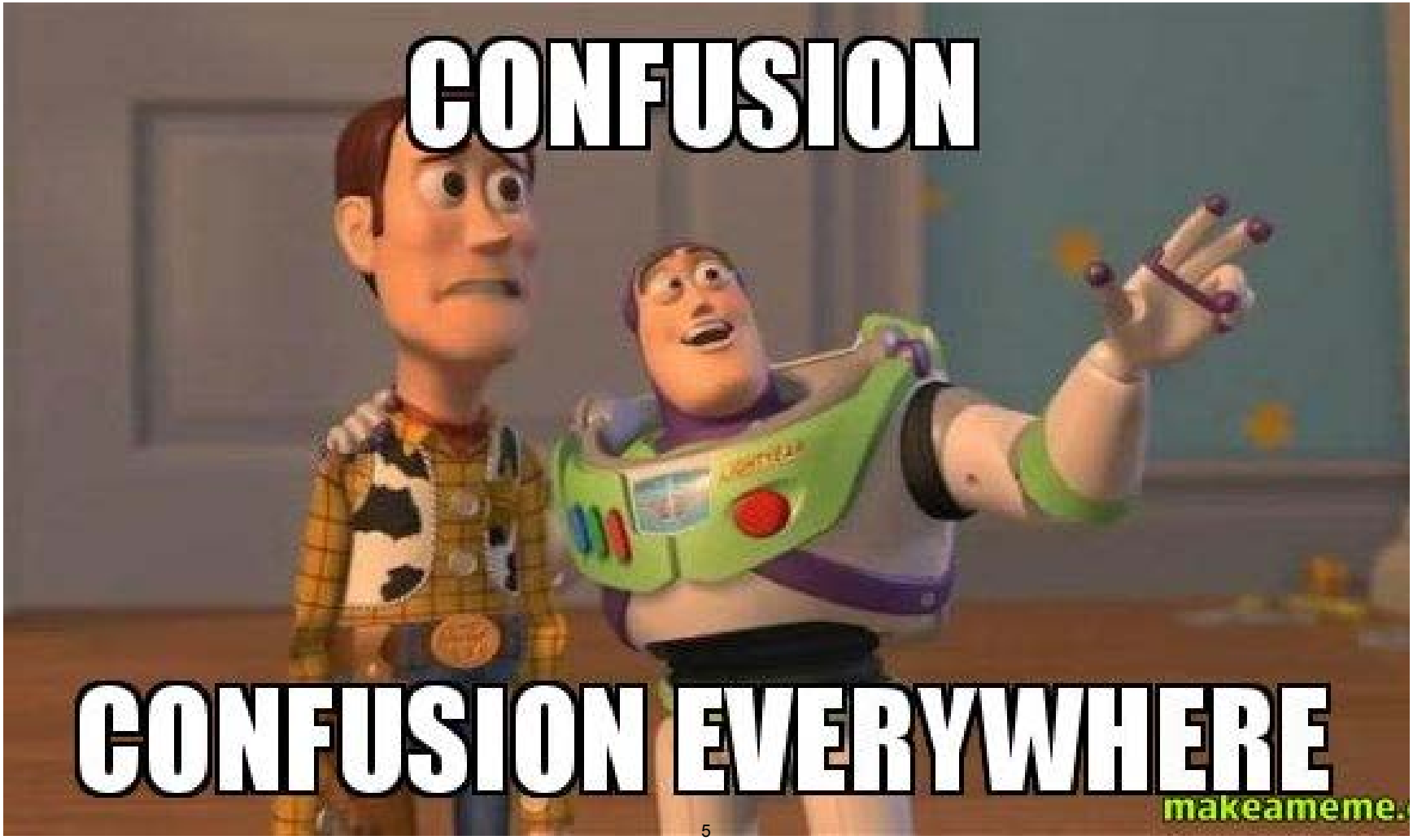
OUTLINE: Well THAT was Unexpected!: Grand Rounds Cases

I. Introduction to the importance of these Grand Rounds cases. Common theme is that each case will present one way and appear to point to a more common diagnosis, but will ultimately be an unexpected diagnosis.
II. Retinal swelling in a diabetic s/p cataract surgery
    a. Introducing the patient demographics (73yo black female), medical history, surgical history, post-op history
    b. Discuss findings of retinal edema (show images)
    c. Review journal discussing macular edema after cataract surgery in diabetic eyes evaluated by OCT (**https://www.ncbi.nlm.nih.gov/pubmed/26949615)**
    d. Review article: "In eyes with diabetic retinopathy without concurrent central-involved DME, presence of non-central-involved DME immediately prior to cataract surgery or history of DME treatment may increase the risk of developing central-involved ME 16 weeks after cataract extraction."
    e. Review dilemma of CSME vs CME and implications for treatment, follow-up, referral, etc
    f. Review the patient's outcome. It ended up being CME that was treated nicely with steroids and Ketorolac. Ultimately 20/20 acuity.
    g. Review take-home points: making sure post-op patients do not taper their drops too quickly; review different retinal layers affected by CME vs CSME
III. Corneal Spots
    a. Introduction of patient demographics: 55yo white male, works on a pharm; has history of multiple myeloma for which he is receiving radiation. Also reports recent h/o redness for

WELL, *THAT* WAS UNEXPECTED!: GRAND ROUNDS

Daphne W. Chan, OD
UCSF Department of Ophthalmology


CONFUSION
CONFUSION EVERYWHERE
makeameme.

RETINAL SWELLING IN A DIABETIC S/P CATARACT SURGERY

Case #1: D.B.

- 73yo black female

- MHx:
  - DM Type 2, A1C = 8.8 (10/25/16)
  - HTN
  - HLD
  - Coronary artery disease

- s/p CE/IOL OS 2/22/16
- s/o CE/IOL OD 3/7/16

Clinical Findings

- Insert clinical findings
- 4/15/16: rebound inflammation, AC reaction
  - 20/30 BCVA OU
  - Macula OCT- retinal edema, dx'd CME
  - Continue Pred Forte QID OU, Ketorolac TID OU
- 5/27/16: f/u
  - Resolved CME on OCT
  - Steroid response IOP (38, 46)
  - Plan: taper down PF quickly
  - Start Brimonidine BID OU and Cosopt BID OU
- F/U 1 week later:
  - 20/30 BCVA OU
  - AC reaction again
  - Macula OCT: persistent retinal edema
  - Continue PF, add Acular
  - Question of if this is DME or CME?

- **Persistent retinal edema: presumed CME, but could it have been DME?**

CME in Diabetics

- Int J Ophthalmol. 2016 Jan 18;9(1):81-5. doi: 10.18240/ijo.2016.01.14. eCollection 2016.
- **Macular edema after cataract surgery in diabetic eyes evaluated by optical coherence tomography.**
- “A statistically significant increase could be detected in the central subfield as well as perifoveal and parafoveal sectors though the increase was mild. And eyes with pre-operative DME prior to cataract surgery are at higher risk for developing central-involved ME.”

- **https://www.ncbi.nlm.nih.gov/pubmed/26949615**

CME in Diabetics

- https://www.ncbi.nlm.nih.gov/pubmed/23599174
- JAMA Ophthalmol. 2013 Jul;131(7):870-9. doi: 10.1001/jamaophthalmol.2013.2313.
- **Macular edema after cataract surgery in eyes without preoperative central-involved diabetic macular edema.**

- "In eyes with diabetic retinopathy without concurrent central-involved DME, presence of non-central-involved DME immediately prior to cataract surgery or history of DME treatment may increase the risk of developing central-involved ME 16 weeks after cataract extraction."

Dilemma

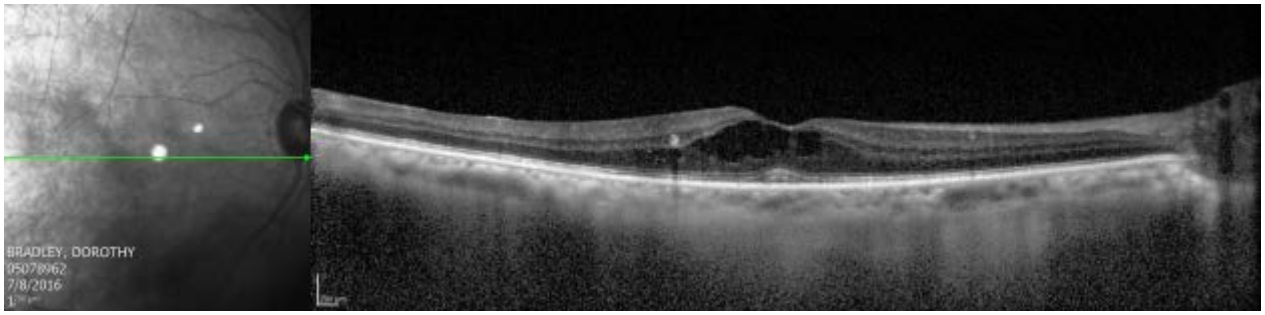
- CSME or CME?
- Different treatments
  - CSME: lucentis > avastin, triamcinolone, laser
  - CME: steroids, NSAID drops
    - The intravitreal steroid “implant is safe and effective for the treatment of recurrent CME due to IGS” https://www.ncbi.nlm.nih.gov/pubmed/27858937
    - Two successful cases of intravitreal NSAIDs https://www.ncbi.nlm.nih.gov/pubmed/26929630
    - “This review found two trials which showed that topical NSAID (0.5% ketorolac tromethamine ophthalmic solution) has a positive effect on chronic CMO. However, the effects of NSAIDs in acute CMO remains unclear and needs further investigation.” https://www.ncbi.nlm.nih.gov/pubmed/15674935
  - **WHY DO 2 ENTITIES THAT LOOK SO SIMILAR REQUIRE DIFFERENT TREATMENTS?**

DME vs Pseudophakic CME

- “That the presence of solely INL cysts seems a relevant factor to distinguish PCME from DME may be explained by the fact that PCME is caused by proinflammatory cytokine release leading to a breakdown of the blood–retina barrier.[3] As the superficial and the deep capillary plexuses are located in the GCL and INL, respectively, it seems therefore plausible that initially INL cysts appear.[31,32] Diabetic macular edema in contrast, at least when focal, will initially show ONL/HL cysts caused by microaneurysms, located more deeply in the retina, which then leak into the respective deeper retinal layers”
- “Pseudophakic cystoid-macular-edema usually presents with a central ME pattern and intraretinal cystoid fluid accumulation in the central millimeters and the inner Early Treatment Diabetic Retinopathy Study (ETDRS)-subfields. In contrast, DME typically has a higher retinal volume, diffuse or focal retinal thickening and preserved foveal depression.”
- http://iovs.arvojournals.org/article.aspx?articleid=2464687
- **Differentiation of Diabetic Macular Edema From Pseudophakic Cystoid Macular Edema by Spectral-Domain Optical Coherence Tomography**
- Marion R. Munk; Lee M. Jampol; Christian Simader; Wolfgang Huf; Tamara J. Mittermüller; Glenn J. Jaffe;Ursula Schmidt-Erfurth
- Investigative Ophthalmology & Visual Science October 2015, Vol.56, 6724-6733. doi:10.1167/iovs.15-17042

Back to our patient

- 7/7/16 OD:



- 7/27/16: Retina visit
  - Given that retinal edema was improving on PF and Ketorolac, likely CME
- Decided to continue treating with Pred Forte
- Final f/u: flat maculae, 20/20 BCVA OU
- Was likely Irvine-Gass Syndrome

Take-home points

- Making sure patients treat cataract post-ops properly with normal Pred Forte dosage, do not taper too quickly
- Be wary of steroid-induced ocular hypertension
- OK to monitor, but catch DME sooner– different treatment required than pseudophakic CME
- Different layers of the retina affected in DME vs CME due to …

CORNEAL SPOTS

Case #2: N.W.

- 55yo white male, farmer
- No vision complaints

- MHx:
- - Patient diagnosed with multiple myeloma in 2012
- - Series of different chemotherapeutic agents since 2012
- - Multiple areas of body that have been radiated.
- - Had new-onset right superotemporal orbital mass in April 2016. Relapse of multiple myeloma (lacrimal gland plasmocytoma). Was given empiric XRT to right orbit in Oculoplastics (Dr Vagefi) 5/11/16
- - Prednisone given (starting at 60mg daily) from early May to early June.
- - per previous notes, definite improvement in RUL mass following XRT and prednisone.
- - relapse of MM, with radiation of CNS end of June
- - pt denies direct radiation to left side of face

- Personal ocular hx:
  - “eye irritation,” treated with colloidal silver (home remedy), which helped

Clinical findings

- Insert photo of cornea with multiple white patchy subepithelial lesions throughout cornea OS
- OD: clear

Differentials

- Multiple myeloma?
- EKC-related SEIs? But no tearing, symptoms
- Radiation?
- Central cloudy cornea of Francois?
- Crocodile shagreen?

- DIFFERENTIALS FOR SUBEITHEIAL LESIONS:
  - EKC (infiltrates)
  - Scars
  - Marginal keratitis– too diffusely distributed, not localized at 10/2 and 8/4

- Insert photos of each, show how they can be similar in appearance

- Tentative Tx: treat with steroids? And ATs and ung but pt opted not to treat with steroids. Referral to Cornea placed

Additional history…

- Pt revealed to Cornea MD that he had had “pink eye” before, and colloidal silver did not help
- Was presumed EKC

Referred to Cornea

- Dx’d with EKC!!
- Treated with steroids
- Waiting for pt to f/u

Take home points

- Flesh out history
- Not always the zebra but make sure to rule it out
- Urgency of f/u if there is suspected corneal involvement of multiple myeloma:

RETINAL HEMORRHAGES AND TRUSTING PATIENT REPORT OF THEIR OWN HEALTH CONDITION

Case #3: R. J.

- 66yo African American male
- 6/11/16: new comprehensive eye exam
  - Single flame-shaped hemorrhage near macula OS
  - A1C 1/22/14: 5.7
  - BG 129/77 on 5/20/16
  - Not consistent with NPDR– f/u 3 months for resolution

Exam findings continued

- 9/9/16:
  - OD: blot heme superior to ONH; CWS superior to ONH; blot heme nasal to ONH
  - OS: CWS sup-temporal to ONH
  - Dx: DM Type 2 with mild NPDR OU, no DME OU
  - Pt last obtained labs at Kaiser on 4/21/15 (A1C 6.9)
  - Diet-controlled only
  - No BP updated on file but blood pressure is “fine”

DDx for retinal hemorrhages

- DM
- HTN
- Trauma
- Anemia
- HIV
- Interferon retinopathy
- Valsalva
- Vein occlusions
- The list goes on and on and on

Dx for our patient

- DM, controlled only on meds with elevated A1C
- Pt denied other issues

- Plan: return 1 year since it smells more like mild NPDR

… *or does it?*

Meanwhile…

- Visit with PCP 10/8/16:
  - “Reports new onset numbness and tingling of the left side of the face, L hand and arm, and left side of the torso x 2 weeks. States it came on suddenly while on a walk, has been constant, and is interfering with his ability to write as he is L handed. Reports prior history of neck injury due to MVA 2 yrs ago but no recent trauma. Denies neck pain, dysarthria, HA, muscle weakness, syncope, f/s/c, or other neurologic changes. Denies CP, SOB, or palpitations. Denies new medications. Was seen for this at Golden Gate Urgent care within the past week and states he had a negative w/u, records are not currently available. Has DM II but states this has been under good control, HA1c on 9/29/15 was 6.6. Denies other acute sx or concerns today.”
  - Next available appt is 11/20/16

- PCP visit 11/6/16:
- **Assessment and Plan**
-
- **1. Paresthesia of left arm**
- -Stable since last visit. The MRI does not fully explain the facial symptoms in V2 and V3.
- - Ambulatory Referral to Orthopedic Surgery; Future
-
- **2. Cervical stenosis of spine**
- - May be responsible for the extremity numbness and paresthesias.
- - Ambulatory Referral to Orthopedic Surgery; Future
-
- **3. Chest pain, exertional**
- - Likely stable angina
- - Patient with extensive cardiac history, last f/u with Kasier cardiology in 2012.
- - Recommend management by cardiology.
- - Ambulatory Referral to Cardiology; Future

- 11/10/15… pt presents to ED with chest pain
  - 219/121 mmHg,
  - Unstable angina vs NSTEMI (non-ST-segment myocardial infarction)
  - Given nitroglycerin
- 12/10/15: Neuro Clinic
  - “Blood pressure is 200/115 supine and 196/110 standing”
  - “Almost certainly he had a lacunar infarction, probably in the thalamus, due to his hypertension.”
- 12/14/15: Primary Care
  - “Atenolol and Lasix were d/c'ed, and pt was started on Norvasc 10 mg qd, Spironolactone 50 mg qd, and HCTZ 25 mg qd. Pt was treated with potassium supplementation for hypokalemia, potassium 3.0. Clonidine and losartan were continued. Since d/c reports CP with exertion and BP control have improved”
  - BP 138/86
- 4/11/16: Cardiology
  - BP: 116/56
  - Adjusted meds, goal for systolic BP to be <120, keep BP diary

Annual eye exam 8/17/16

- VA 20/20 OD, OS
- Diabetes without retinopathy
- Pt casually mentioned he had had a stroke a few months ago!

DM vs HTN retinopathy

- In retrospect, was the retinal presentation more hypertensive or diabetic in nature?
- HTN:
  - More CWS
  - “drier” look
- NPDR:
  - More hemorrhages
  - Some CWS

- How often do we ask patients how their blood pressure is?
- How often do we check BP in office?
- Could I have caught his uncontrolled HTN before he actually developed tingling of his left side and his stroke?

- Article: accuracy of patient report of blood pressure and how much we can actually rely on patient self-reports

Take home points

- If it smells like hypertensive retinopathy, it’s probably not DR
- Check BP in office
- Refer to PCP as appropriate

- Thank you for your attention!

- Daphne.Chan@ucsf.edu

which colloidal silver drops have not been helping. Currently asymptomatic. Presents for refraction only.

b. Review clinical findings, show corneal photos
c. Review corneal presentation of multiple myeloma, treatment, how it can be confused for EKC
d. Review differential diagnoses for corneal infiltrates, review similarities and differences, and different treatments of each
e. Referred patient to Cornea clinic, where it was elucidated that the patient likely had had an episode of EKC and now has residual corneal infiltrates
f. Treatment: topically with steroids.
g. Review take-home points: flesh out case history! Treating a patient for corneal infiltrates is very different than making an unnecessary referral to ocular oncology for evaluation of ocular involvement of multiple myeloma

IV. Retinal hemorrhages and trusting patient report of their own health conditions

a. Review patient demographics: 66yo African American male presenting for routine eye exam 8/17/16. All findings normal, 20/20 vision, normal IOPs, normal posterior segment.
b. Congratulated the patient on his improved ocular health since he had had an isolated retinal hemorrhage on 6/11/15. We see these all the time. Given that A1C and BP were normal, I had the patient return for f/u DFE in 3 months
c. Sept 2015: resolved hemorrhage but now cotton wool spots in both eyes. Was diagnosed with mild NPDR OU since the patient has DM. Labs were done at outside facility. Pt stated BP was "fine." Return 1 year since it was likely NPDR.
d. Review differential diagnoses of retinal hemorrhages
e. Upon review of improvement in findings, the patient casually mentioned that he had had a stroke in November 2015! This prompted further review of his chart—the patient had presented to the ED with left arm numbness and exertional chest pain (stable angina). BP in neuro clinic on 12/10/15 was 200/115 supine and 196/110 standing. Diagnosed with lacunar infarction due to hypertension
f. Review differentials between DM and HTN retinopathy
g. Review how reliable patient reports of their health history is: (http://eurpub.oxfordjournals.org/content/24/6/941)
h. Take home points: consider checking BP in office for all patients. This could potentially have helped the patient manage his HTN better and prevented the stroke.

DAPHNE W. P. CHAN, O.D.

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EDUCATION

Salt Lake City Veterans Affairs Health Care System *Salt Lake City, UT*
Resident, Primary Eye Care and Specialty Contact Lenses July 2013- June 2014

- Compassionate optometrist with strong diagnostic, co-management, leadership, teamwork, and interpersonal skills
- Worked with Harald E. Olafsson, OD, at the University of Utah Moran Eye Center fitting specialty contact lenses
- Presented poster "Mucomyst and Other Treatment for Severe Dry Eye Secondary to Graft Versus Host Disease" at Academy Meeting (*Seattle, WA, October 2013)*
- Award: Allergan Disease Resident Travel Fellowship *(Sept 2013)*

University of California, Berkeley, School of Optometry *Berkeley, CA*
Doctor of Optometry August 2009- May 2013

- Clinical Rotations:
  - VA Medical Center (*San Francisco, CA*)
  - Bascom Palmer Eye Institute, Pediatrics (*Miami, FL*)
  - Eastmont Wellness Center (*Alameda, CA*)
  - Castle Family Health Center (*Atwater, CA*)
  - Meredith Morgan Eye Center (*Berkeley, CA)*
  - Cal State University (*Hayward, CA*)
- American Optometric Student Association (AOSA): Trustee-Elect, Trustee, and Delegate *2010-2012*
- Select Awards: Berkeley Optometry Departmental Award *(2009- 2012)*; Berkeley Optometry Service Award *(2010)*
- Beta Sigma Kappa Optometric Honor Society

University of California, Berkeley *Berkeley, CA*
Bachelor of Arts, Public Health; Minor, Education August 2005- May 2009

JOB EXPERIENCE

- **Optometrist, UC San Francisco.** San Francisco, CA *(April 2015- present)*
  - Perform comprehensive eye exams on patients as young as 4, fit a variety of specialty contact lenses, design bandage lenses over complex K-Pros, support cataract and refractive surgery pre- and post-op, diagnose and manage glaucoma
  - Pioneer the training of five ophthalmology interns (PGY-1) in eye exam components, clinical thinking skills, instrument technique, ocular pathology, refractive analysis, and optics
  - Evaluate ocular health of participants of ENDEAVOUR trial studying Revusiran in patients with Transthyretin Mediated Familial Amyloidotic Cardiomyopathy (FAC)
- **Clinical Instructor, UC Berkeley School of Optometry.** Berkeley, CA. *(July 2014- May 2015)*
  - Preceptor at Southeast Health Clinic (San Francisco); Eastmont Wellness Center (Oakland); UC Eye Center (Berkeley)
  - Mentor, Glaucoma Grand Rounds *(August 2014)*
- **Per Diem Optometrist, Target.** Sandy and Salt Lake City locations, UT *(December 2013- February 2014)*
- **Per Diem Optometrist, Swain Vision Care.** South Jordan, UT *(September 2013- May 2014)*
- **Advanced Procedures Teaching Assistant, UC Berkeley School of Optometry**. Berkeley, CA *(August - Oct 2012)*
- **Optometric Assistant, Berkeley Optometric Group.** Berkeley, CA *(October 2008 - August 2009)*

ARTICLES REVIEWED

- Invited to review articles for *Optometry and Vision Science* (OVS), the journal of the American Academy of Optometry (AAO)
- 2015: 1 article
- 2016: 2 articles

OPTOMETRIC SKILLS

- **Specialty Contact Lenses**
  - Experienced with keratoconus, grafted eyes, post-refractive ectasia, aphakia, traumatic eyes, and irregular corneas
  - Attended Blanchard's "Beyond the Limbus" scleral lens fitting workshop *(Las Vegas, NV, March 2014)*
  - Attended The Vision Care Institute Specialty Contact Lens Training Seminar *(Jacksonville, FL, March 2012)*
- **Primary Care:** TLG certified; skilled in managing glaucoma
- **Pediatrics:** Comfortable examining and fitting contact lenses in babies younger than one year old
- **Imaging & Auxiliary Skills:** Heidelberg SD-OCT, Zeiss Cirrus HD-OCT, Zeiss Fundus Camera, Topcon TRC 50EX fundus camera, Topcon Anterior Segment Camera, and Humphrey Visual Field Analyzer
  - Past experience with intravenous injections and obtaining fluorescein angiograms
- **Languages:** Proficient in medical Spanish, Cantonese, Toisan. Fluent in conversational Cantonese. Proficient in Mandarin.

OPTOMETRIC AFFILIATIONS

- American Academy of Optometry (Fellowship in process)
- American Optometric Association
- California Optometric Association
- National Association of VA Optometrists
- Contact Lens and Cornea Society

COMMUNITY & PERSONAL

- Regular volunteer at homeless vision screenings in Salt Lake City (Sept 2013- June 2014) and the San Francisco Bay Area (2009-2011); VOSH Peru (2010)
- Buddha's Universal Church: Youth Group Leader & annual bilingual performance volunteer; main point-person for 2016-2017 production *(San Francisco, CA, 2005-present)*
- Black belt in Taekwondo through UC Martial Arts Program *(Berkeley, CA, August 2010)*
- Talented at planning events, birthdays, welcome-back celebrations, going-away parties, etc.