Five easy mistakes to avoid in your next NOP patient

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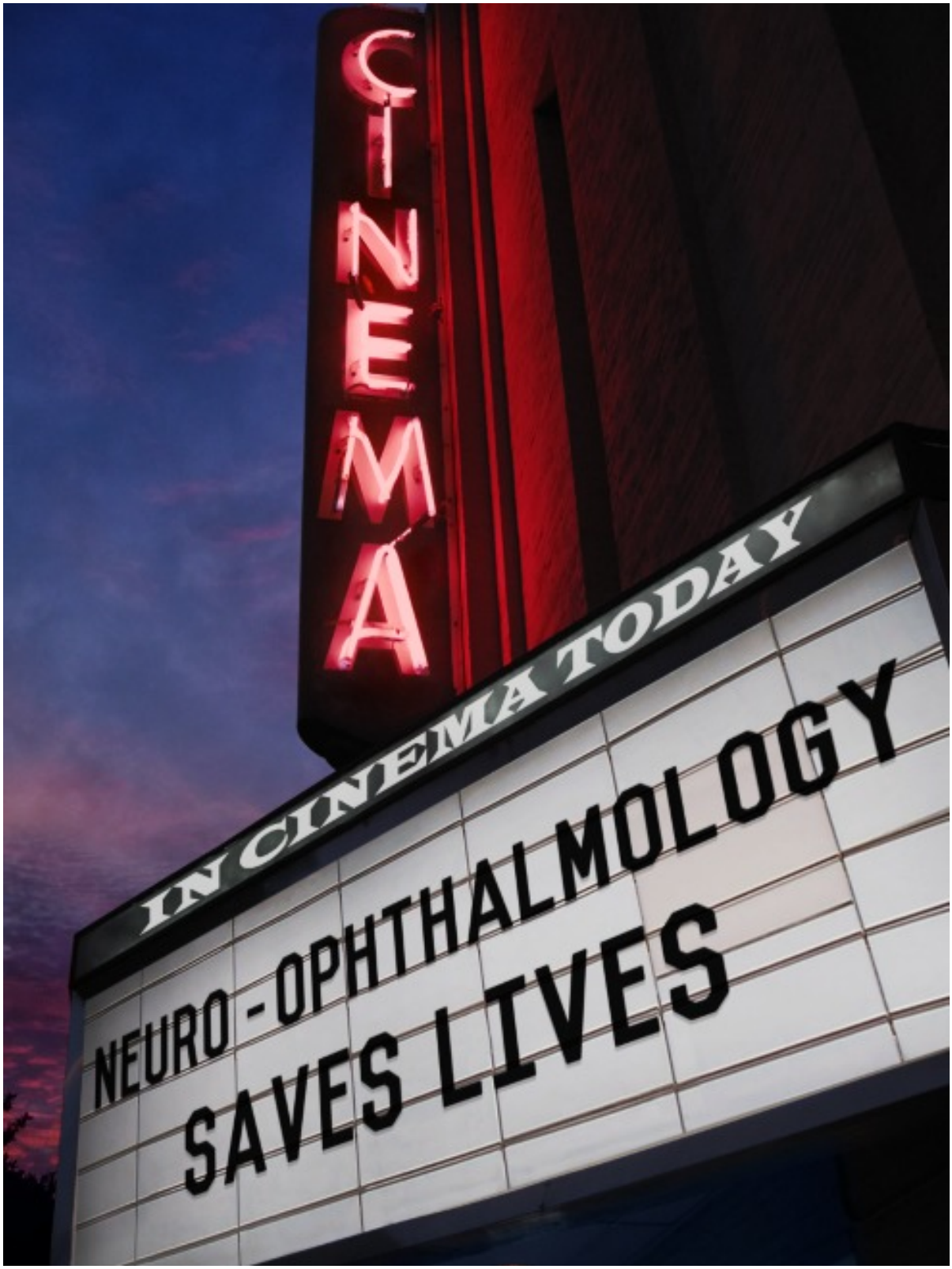
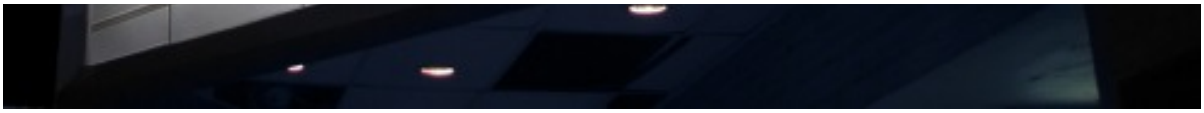
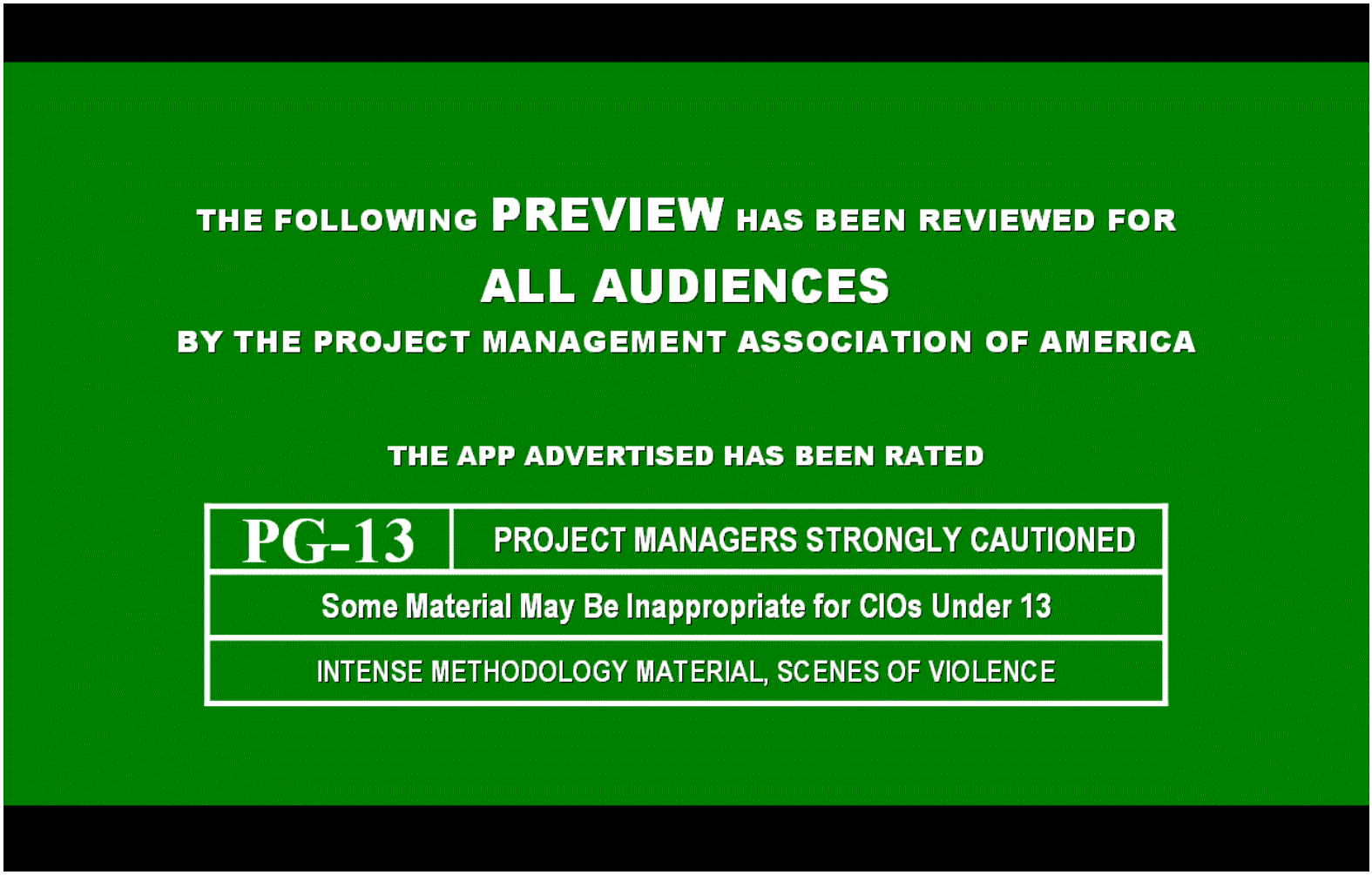
Neuro- ophth mistakes to avoid


CINEMA
IN CINEMA TODAY
NEURO-OPHTHALMOLOGY
SAVES LIVES





This talk might require a behavior change that might put you outside of your comfort zone.

I have no financial conflict of interest to disclose

I have a question for you….

Why did you go to medical school?

To be a medical doctor

Is there a doctor on this aircraft?

Hmm…Am I a doctor?....

Why am I telling you this?…Are you a real doctor?

start "I&... 7:45 PM

"I&m not a doctor. I&m an ophthalmologist" | Medical Economics - Windows Internet Explorer

http://medicaleconomics.modernmedicine.com/medical-economics/news/clinical/ophthalmology/im-not-doctor-im-ophtha

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"I&m not a doctor. I... Page Safety Tools

"I&m not a doctor. I&m an ophthalmologist"

Publish date: FEB 08, 2002

Print

By: Andrew Lee

"I'm not a doctor. I'm an ophthalmologist"

Forced to respond to an in-flight emergency, the author rediscovers his true medical identity.

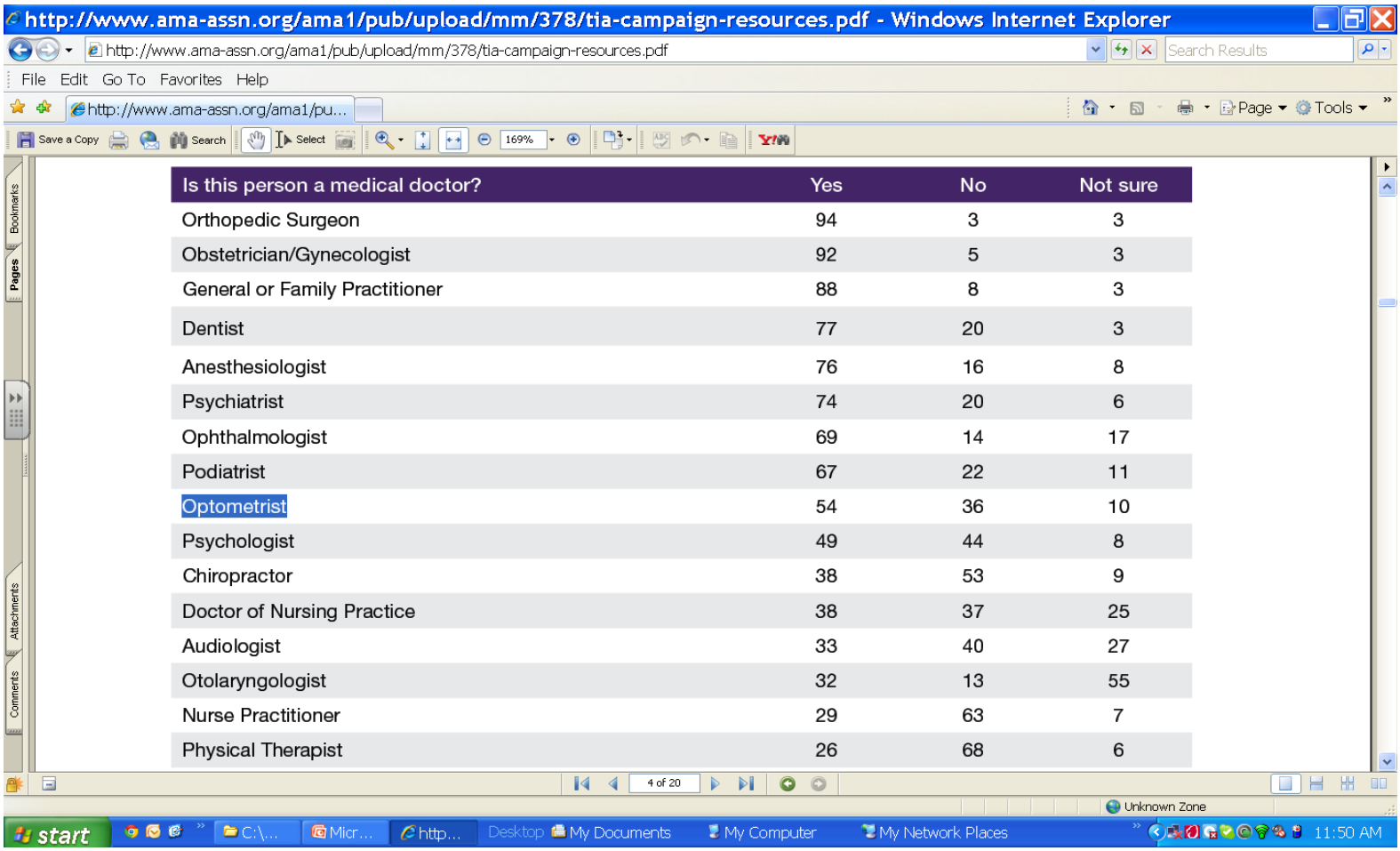
Resource Centers In-Sites

- Flu, Cold & Cough
- Erectile Dysfunction: Treatment and Diagnosis
- Immunization and vaccination
- Low Testosterone
- MORE . . .

Done Internet 100%

You don’t have to like neuro-op and You don’t have to do N-OP, you don’t have to like me…but you have to

Is this person a medical doctor? AMA survey 2008



Is this person a medical doctor?	Yes	No	Not sure
Orthopedic Surgeon	94	3	3
Obstetrician/Gynecologist	92	5	3
General or Family Practitioner	88	8	3
Dentist	77	20	3
Anesthesiologist	76	16	8
Psychiatrist	74	20	6
Ophthalmologist	69	14	17
Podiatrist	67	22	11
Optometrist	54	36	10
Psychologist	49	44	8
Chiropractor	38	53	9
Doctor of Nursing Practice	38	37	25
Audiologist	33	40	27
Otolaryngologist	32	13	55
Nurse Practitioner	29	63	7
Physical Therapist	26	68	6

You are a real doctor

Medical doctor first

Ophthalmologist second

Refractive surgeon third

The reaper is coming….

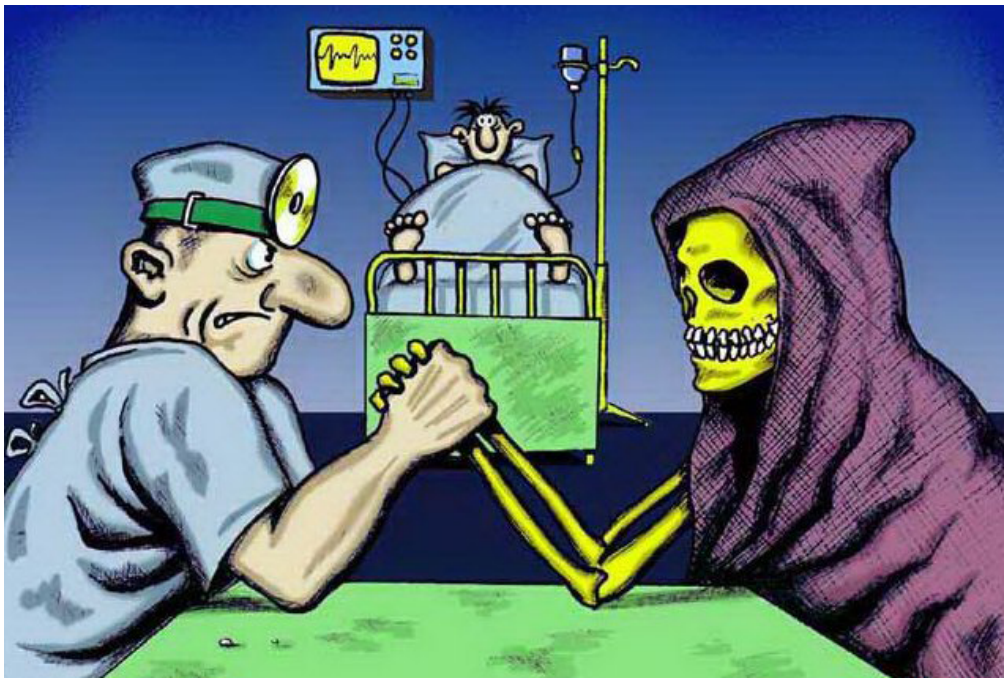
For your patient’s eyes

For your patient’s life

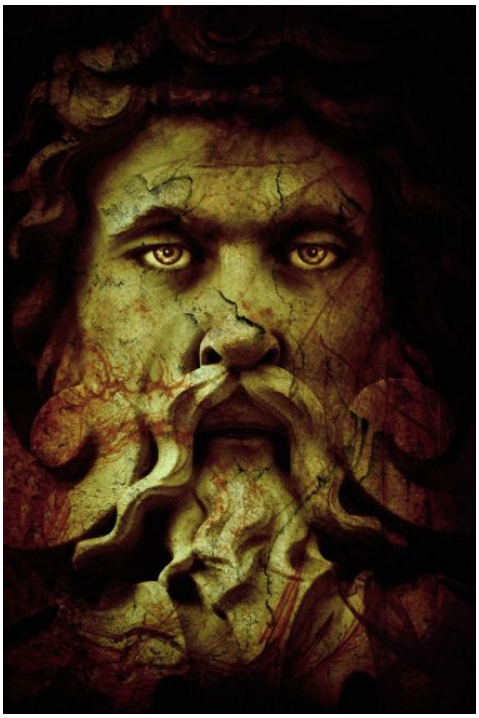
He is coming for you too…

For your very soul….

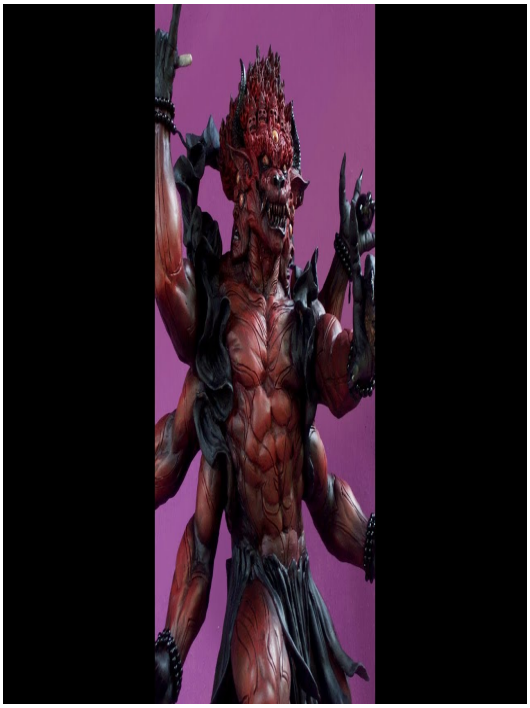
Every day we battle the reaper….your superpower is keeping him at bay



He goes by many names….

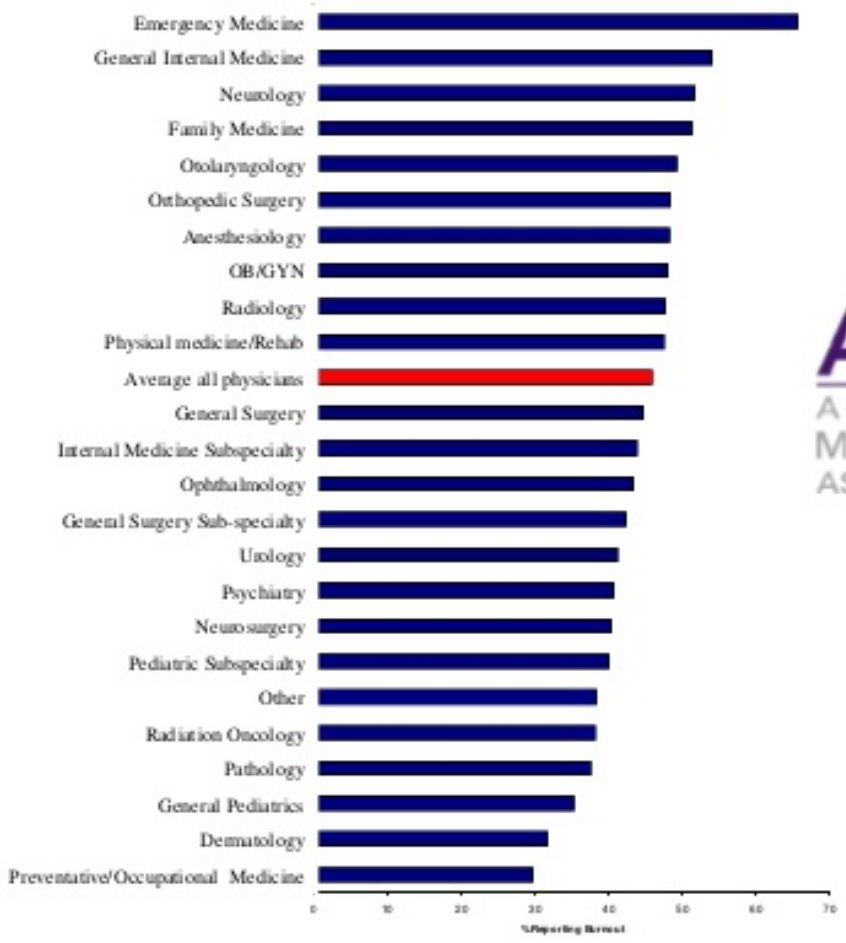


Hades



Yama

Burnout by Specialty (National)



AMA AMERICAN MEDICAL ASSOCIATION

Shanafelt *et al*.
Arch Intern Med 2012

Modern Healthcare

Maslach Burnout Inventory

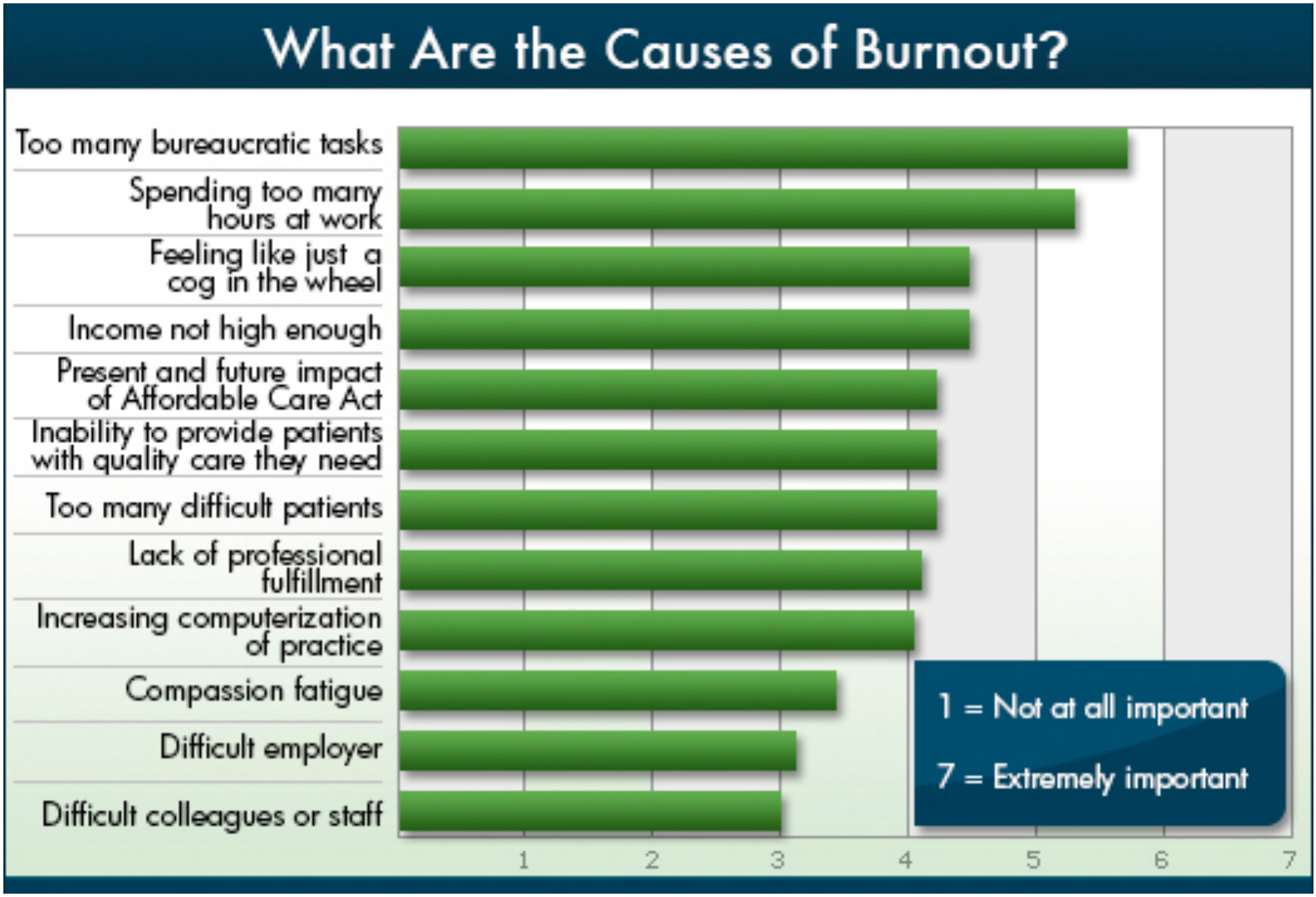
- Emotional exhaustion (EE) – feelings of being emotionally overextended by one's work; no longer able to give of themselves at a psychological level

- Depersonalization (DP) – unfeeling and impersonal response toward recipients of one's service, care, treatment, or instruction; negative, cynical attitudes and feelings about one's clients; dehumanizing perception of others that can result in viewing clients as somehow deserving of their troubles

- Personal accomplishment (PA) – feelings of competence and successful achievement in one's work with people

3

The Maslach Burnout Inventory Manual, 1997.



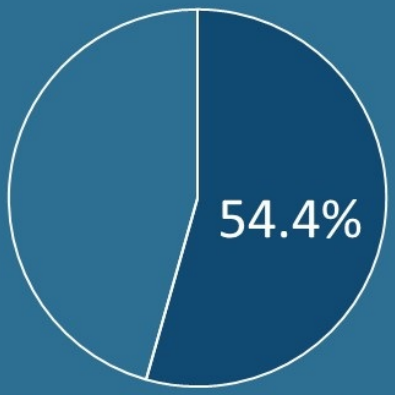
Shanafelt , et al. Burnout and satisfaction with work-life balance among US physician relative to the general US population. Arch Intern Med. 2012;172:1377-1385.

Physician Burnout: Systematic Review & Framework For Action

Causes:

- Loss of autonomy
- Subspecialty choice
- More call / work hours
- Asymmetric rewards / punitive culture
- Productivity-based compensation

Burnout Rate:



Suicide Rates: 1.5-4.5x general population

Solutions:

- Devote 20% of time to what you find meaningful
- Align personal / organizational values
- Engage w/ colleagues

Rothenberger DA et al. *Dis Colon Rectum* 2017;60(6)

DISEASES OF THE COLON & RECTUM

Do you want to help me to defeat the devil’s work and physician burnout?

I know that we can defeat burnout

You wrote about it in your personal statement

Passion about something meaningful

Enthusiasm and engagement with your colleagues

Love of ophthalmology & care of patients

Resilience in the face of adversity

The countermeasure for burnout: professional satisfaction

A word about feedback…

I care about your evaluations (PS: make them good)

I care more about you and your patients….

Come up to me at the next meeting or the reception next year and tell me…

That you made a difference

You saved someone's vision

….or someone's life….

Overview: Say this, not that… The five easy mistakes to avoid

Keep Symptoms, Signs, Diagnosis separate

Don’t let sewage in your record

Differential diagnosis is mandatory

Don’t make up your own neuro -op rules

Plan = two choices

Work it up or….

Recognize, triage, and refer

Definition: Sewage

What do you call a teaspoon of wine in a barrel full of sewage?

Sewage

What do you call a teaspoon of sewage in a barrel full of wine?

Sewage

Don’t let sewage creep into your records

Do this…not that

You must address chief complaint

Even if the eye exam is normal

CC: 75 y.o. WF with acute severe headache and scalp pain

“Imp: Normal eye exam” (don’t do this)

You did not address the chief complaint!

Do this: “Imp: 75 y/o WF with new HA and scalp pain. Plan: stat ESR and CRP, start steroids, refer”

Behavior changes

“ “Diplopia” is not a diagnosis (symptom)

“Ptosis” is NOT a diagnosis (sign)

“ Esotropia ” is NOT a diagnosis (Sign)

Normal eye exam” is NOT a diagnosis!

A special slide for retina

Not the retina” is NOT a diagnosis

“Dilated” is NOT a pupil exam

“Vision too bad for VF” is NOT a visual field exam

“Dilated OD only” is not a full eye exam

Do this, not that

Impression: “Ptosis”

Ptosis is NOT a diagnosis

No differential diagnosis

Don’t do this: “Plan: ptosis repair”

Do this: Imp: “Ptosis secondary to levator dehiscence OD, no MG, no III n. palsy, no Horner syndrome”

What I tell my residents, (One day…..

This is Dr. Lee…Beware pallid edema….

It’s Saturday night…tell that old lady to come on Monday to office…

Past medical history

Don't do this : "PMH: Lung cancer"

Do this : PMH: Stage IV small cell lung cancer s/p RUL resection last month, now on chemoRx , XRT, mets to liver and bone

Compare PMH : Incidentally found lung nodule Stage 1 adenoCA resected 1985, no chemo, no XRT, no mets , last CXR stable

In a 65 y/o WM with new optic neuropathy OD which of the above "lung cancer" patients has the metastatic disease to orbit/optic nerve?

PERRLA sucks

PERRLA: Pupils equal, round, reactive to light and accommodation

No assessment of anisocoria in the dark

No assessment of RAPD

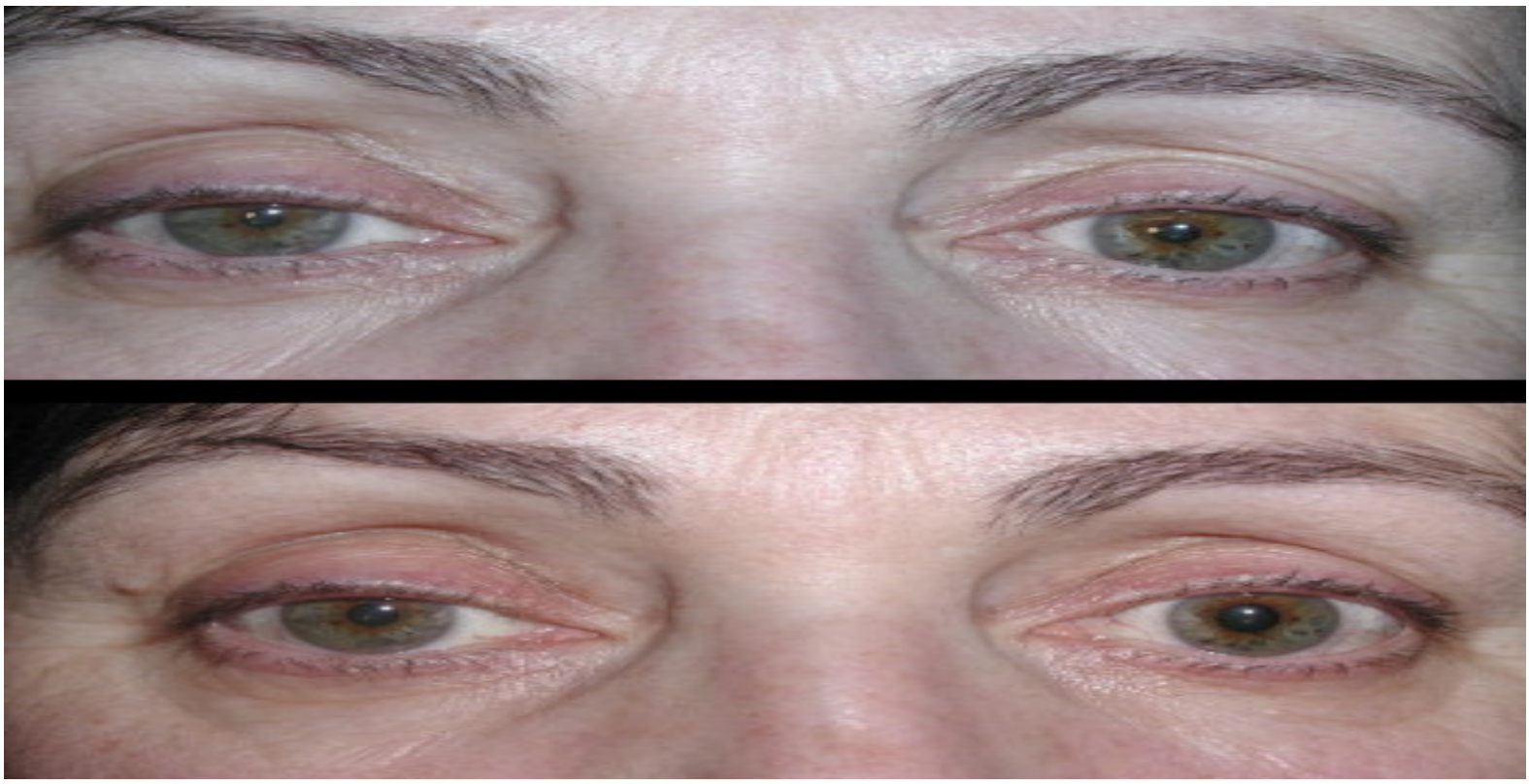
Do this: P 5 mm => 3 mm OU, No RAPD

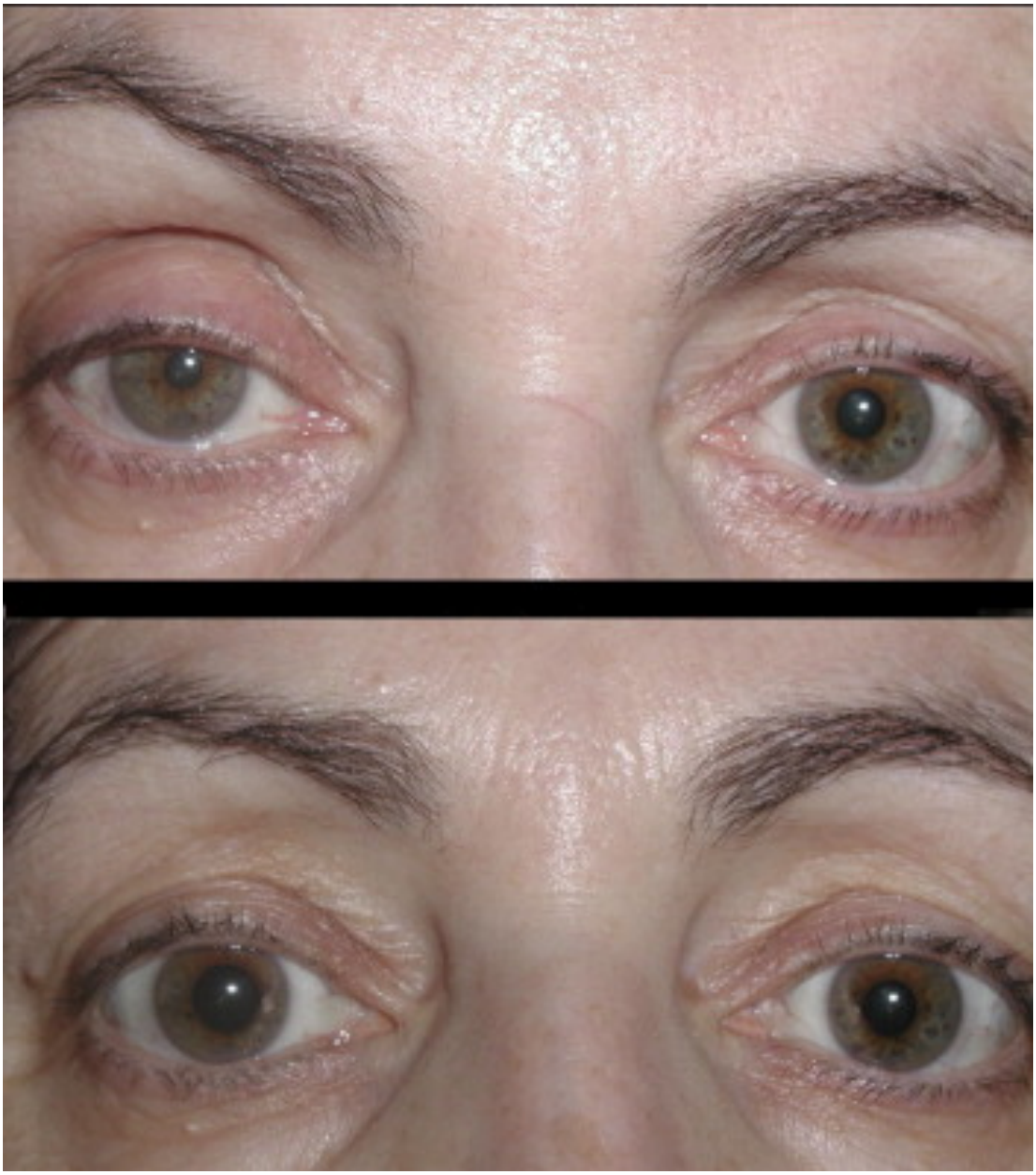
Not this: Pupils: “M & N, dilated: 245 PM”

Ptosis OS: Levator dehiscence, PERRLA, & motility, high crease, deep sup sulcus

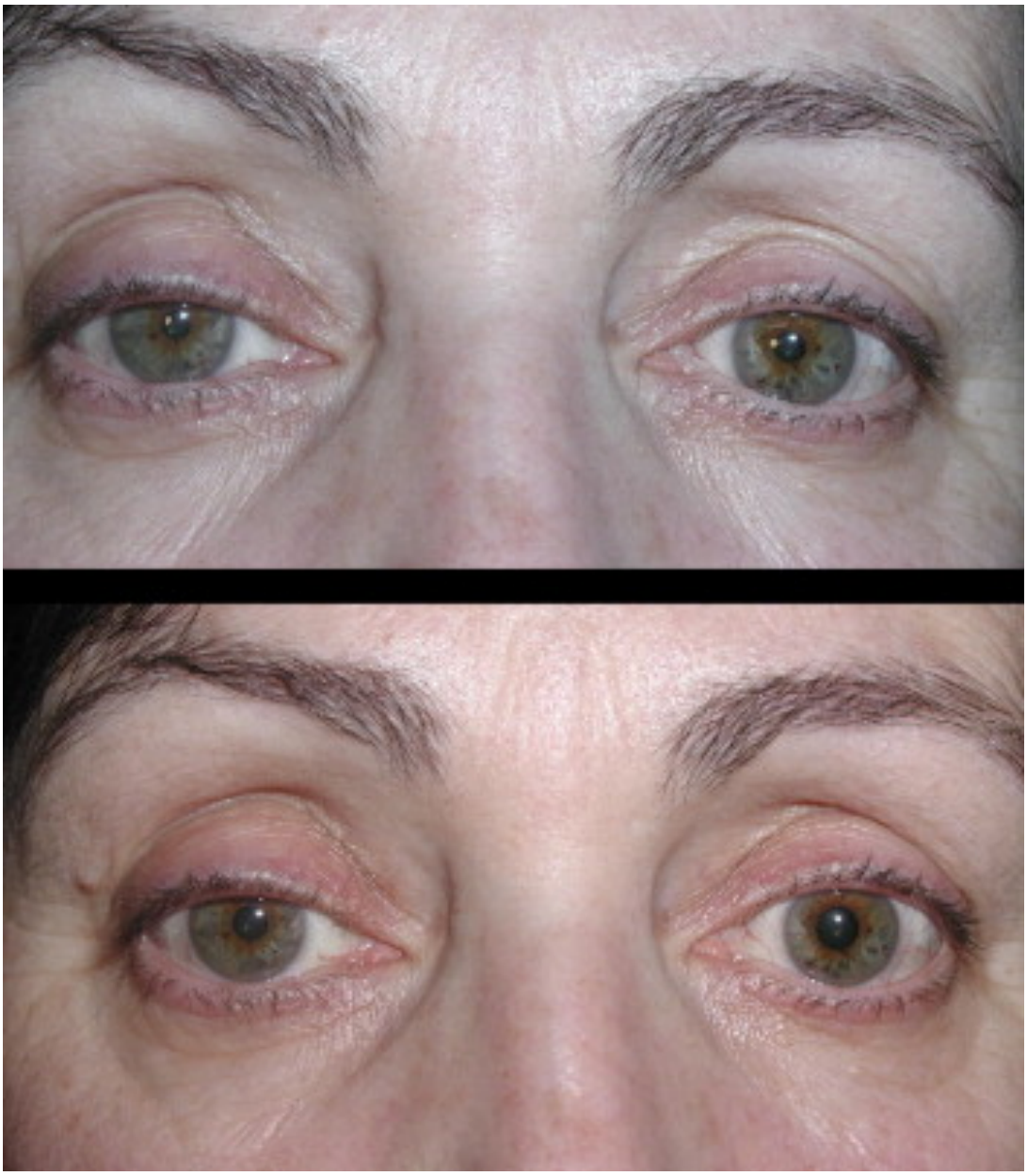

Medscape

“PERRLA” ≠ NORMAL





Apraclonidine test (inferior image) confirmed suspected diagnosis of Horner syndrome. González Martín -Moro et al. Horner Syndrome, a New Complication. J Oral Maxillofac Surg 2009.



LIGHT

DARK

AFTER APRACLONIDINE

BEFORE APRACLONIDINE

Carotid dissection

History of trauma

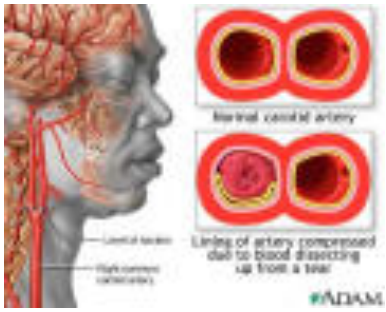
Neck pain

Ipsilateral Horner syndrome

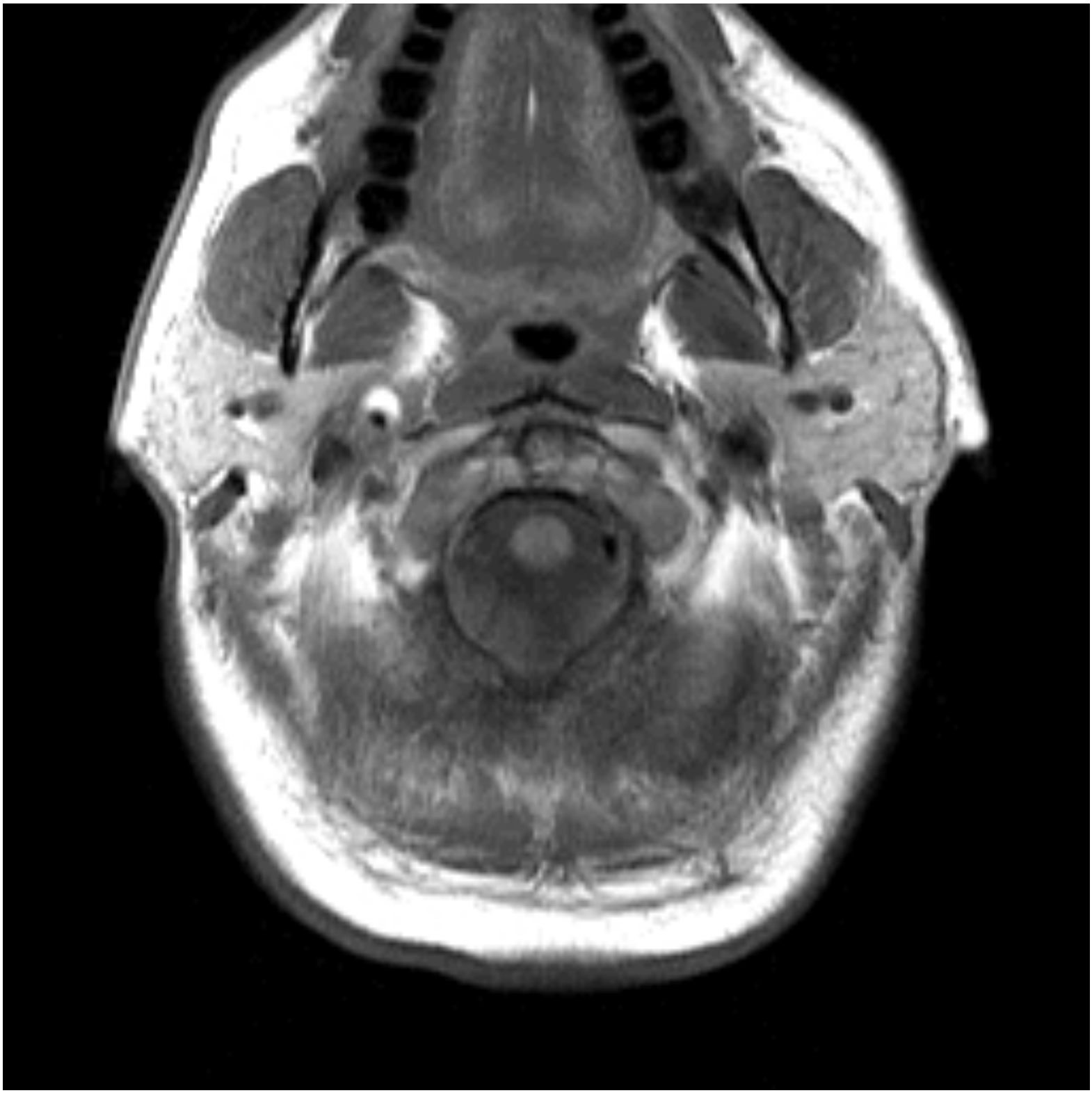
Transient visual loss

Branch or central retinal artery occlusion

Dysgeusia



www.nlm.nih.gov



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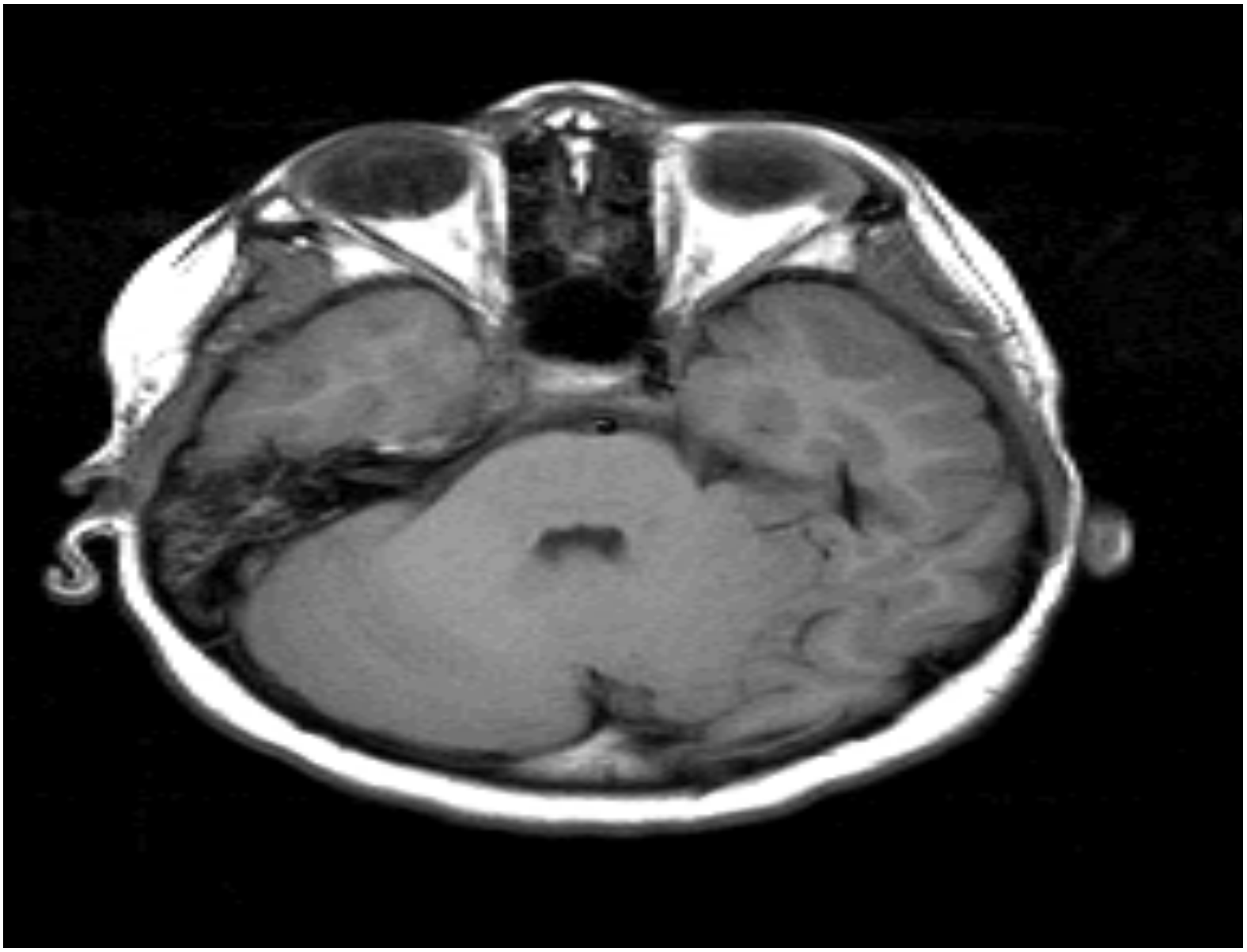
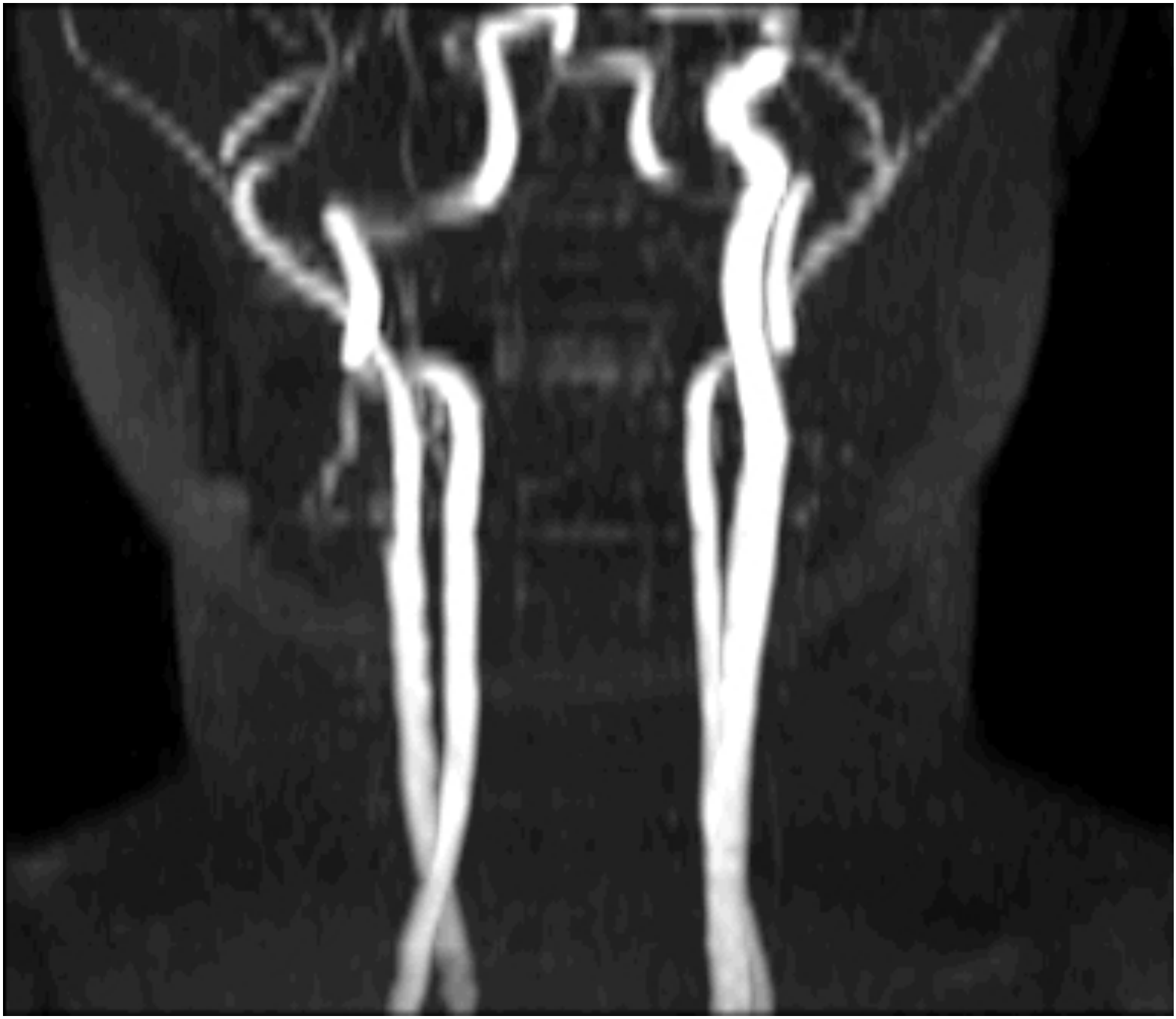




IGLE FIELD ANALYSIS — EYE: RIGHT

AME: [redacted] — ID: [redacted] — DOB: [redacted]-1947

RL 30-2 THRESHOLD TEST

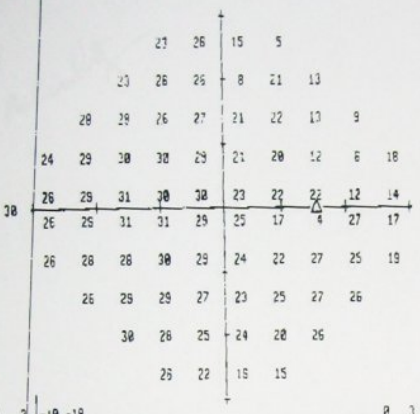
TION MONITOR: GAZE/BLINDSPOT
TION TARGET: CENTRAL
TION LOSSES: 2/13
E POS ERRORS: 3 %
E NEG ERRORS: 3 %
DURATION: 04:43

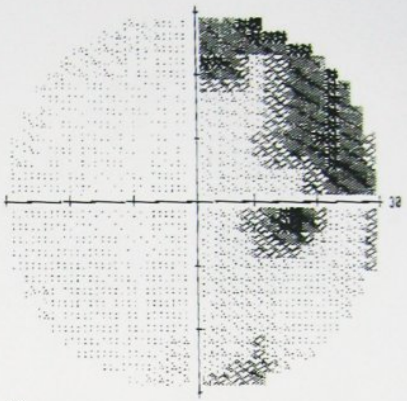
30: OFF

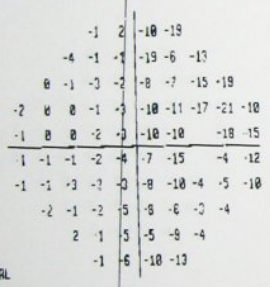
STIMULUS: III, WHITE
BACKGROUND: 31.5 ASB
STRATEGY: SITA-FAST

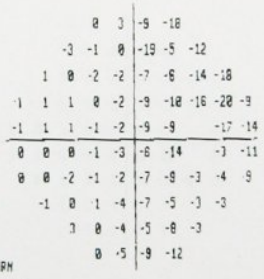
PUPIL DIAMETER:
VISUAL ACUITY:
RX: +1.25 DS OC

DATE: 06-05-2001
TIME: 9:42 AM
AGE: 54





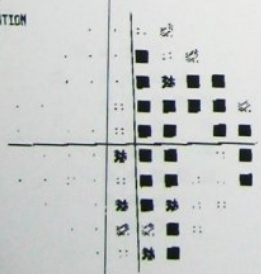




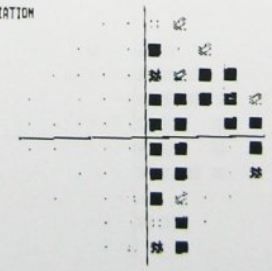
OUTSIDE NORMAL LIMITS

MD -5.46 DB P < 1%
PSD 5.98 DB P < 0.5%

TOTAL DEVIATION

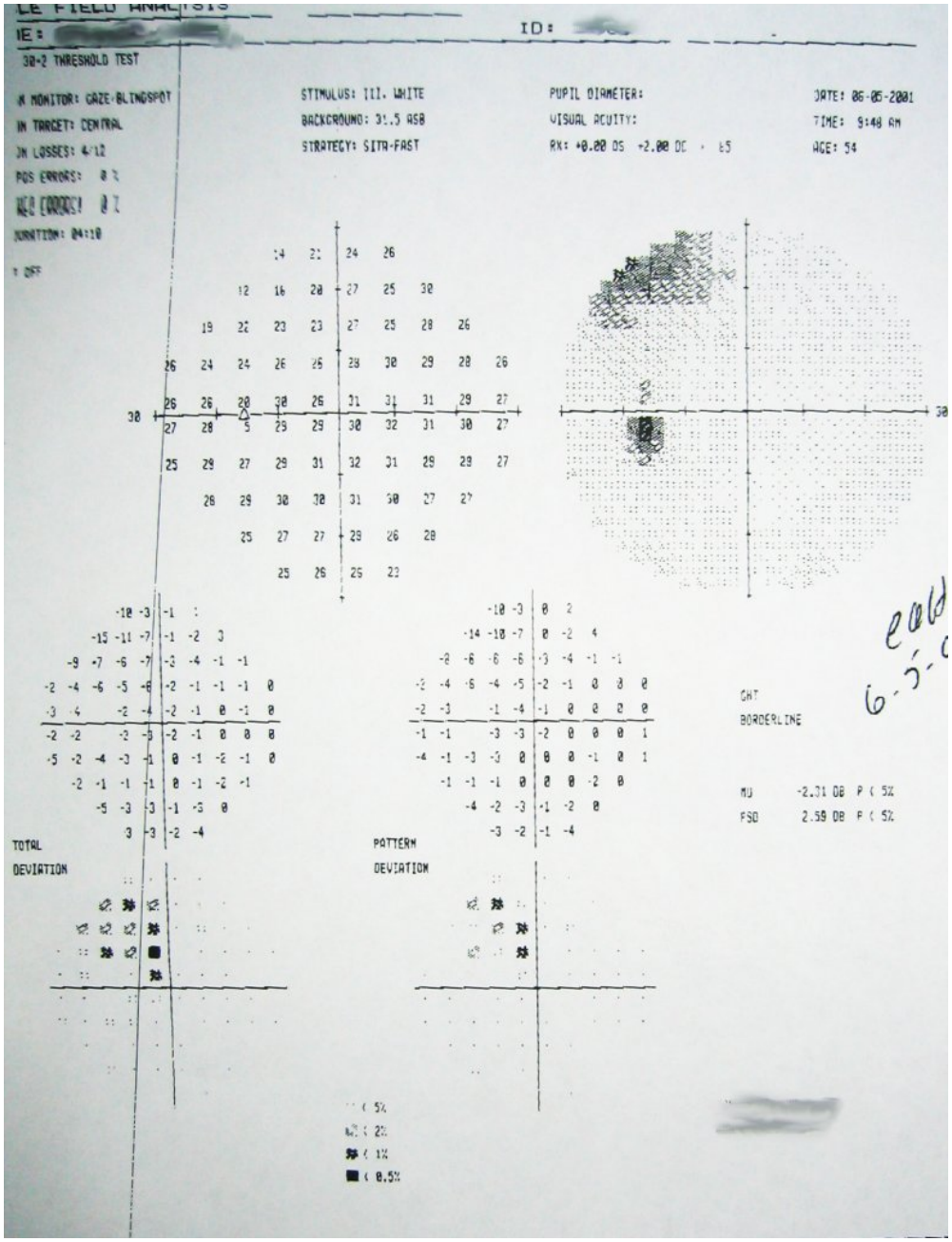


PATTERN DEVIATION



: < 5%
: < 2%
: < 1%
: < 0.5%

[redacted]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30-2 THRESHOLD TEST
STIMULUS: III, WHITE
BACKGROUND: 31.5 ASB
STRATEGY: SITA-FAST
PUPIL DIAMETER:
VISUAL ACUITY:
Rx: +0.00 DS +2.00 DC x 65
DATE: 06-05-2001
TIME: 9:48 AM
AGE: 54
FIXATION: 04:10
GHT
BORDERLINE
MD -2.31 DB P < 5%
PSD 2.59 DB P < 5%
TOTAL DEVIATION
PATTERN DEVIATION
< 5%
< 2%
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< 0.5%

IGLE FIELD ANALYSIS — EYE: RIGHT

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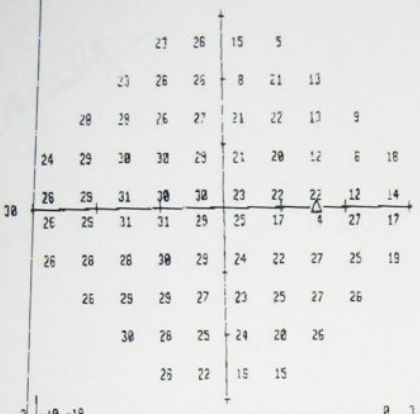
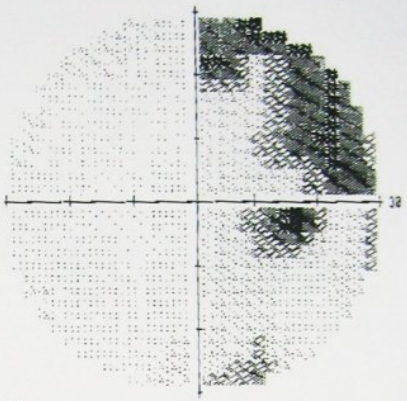
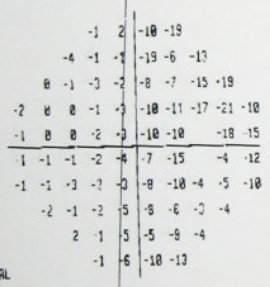
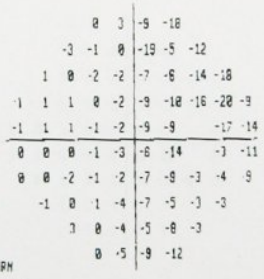
PUPIL DIAMETER:
VISUAL ACUITY:
RX: +1.25 DS OC

DATE: 06-05-2001
TIME: 9:42 AM
AGE: 54









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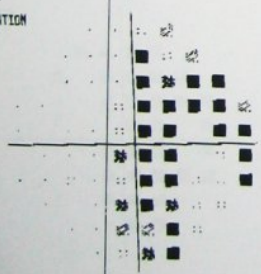
TOTAL DEVIATION



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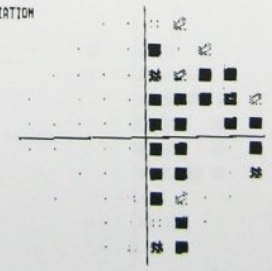
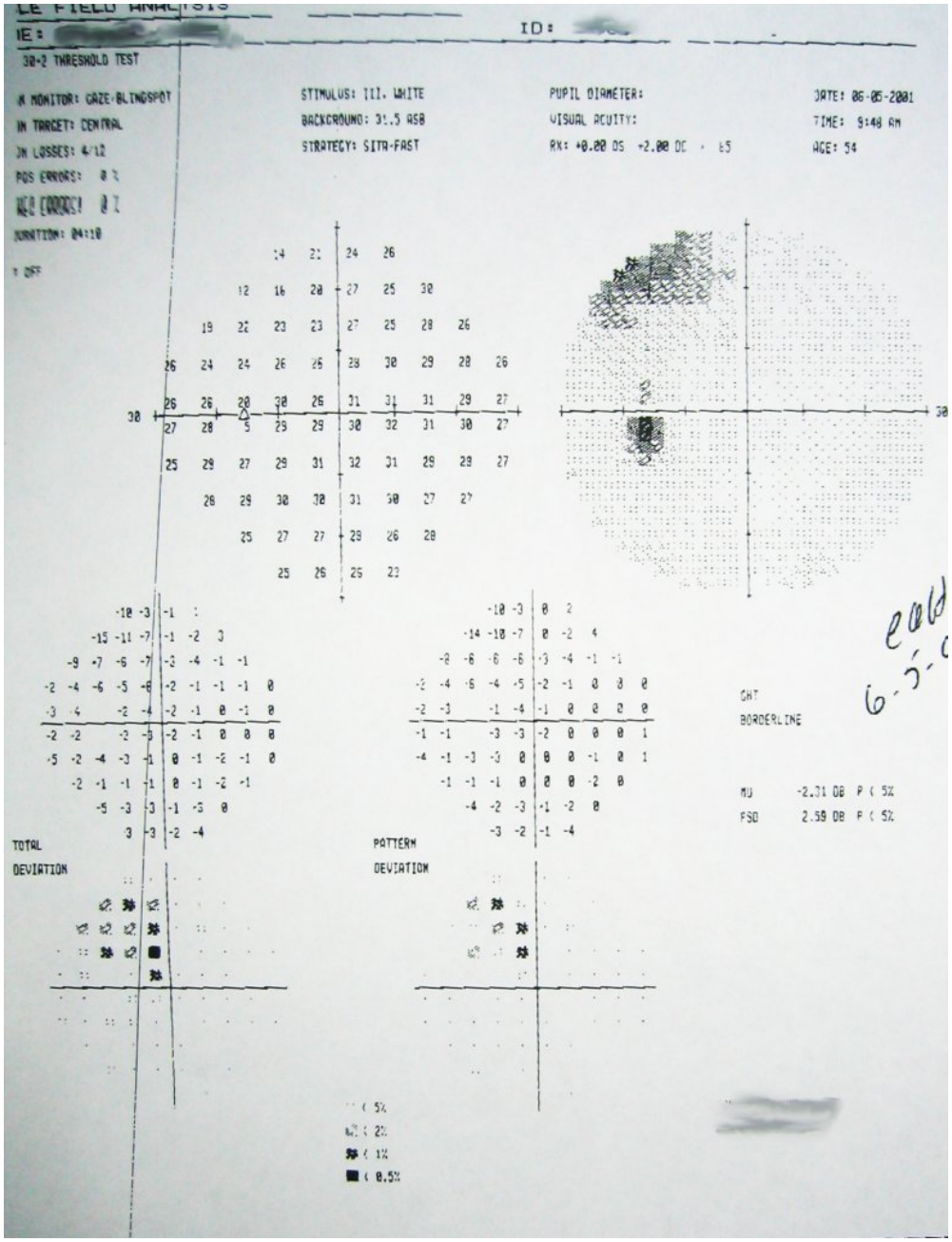


: < 5%
: < 2%
: < 1%
: < 0.5%

[redacted]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30-2 THRESHOLD TEST
STIMULUS: III, WHITE
BACKGROUND: 31.5 ASB
STRATEGY: SITA-FAST
PUPIL DIAMETER:
VISUAL ACUITY:
Rx: +0.00 DS +2.00 DC x 65
DATE: 06-05-2001
TIME: 9:48 AM
AGE: 54
FIXATION: 04:10
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BORDERLINE
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PSD 2.59 DB P < 5%
TOTAL DEVIATION
PATTERN DEVIATION
< 5%
< 2%
< 1%
< 0.5%

NGLE FIELD ANALYSIS — EYE: RIGHT

AME: [redacted] — ID: — DOB: [redacted]-1947

SSL 24-2 THRESHOLD TEST

TION MONITOR: GAZE BLINDSPOT — STIMULUS: III, WHITE — PUPIL DIAMETER: — DATE: 07-23-2003

TION TARGET: CENTRAL — BACKGROUND: 31.5 ASB — VISUAL ACUITY: — TIME: 10:29 AM

TION LOSSES: 0/11 — STRATEGY: SITA-FAST — RX: +0.00 DS DC X — AGE: 56

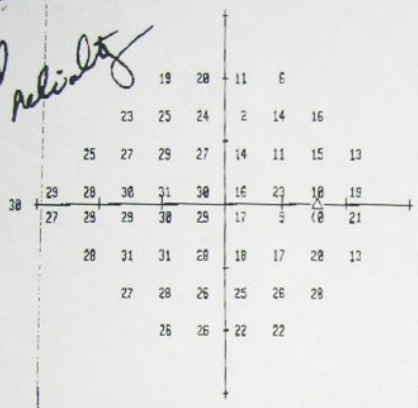
E POS ERRORS: 0 %

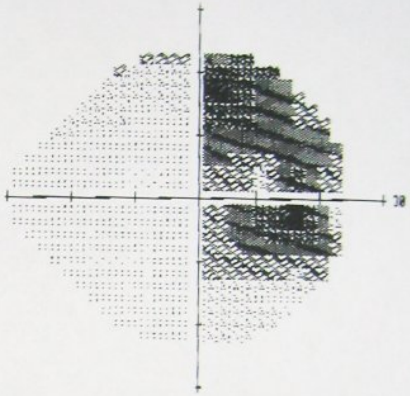
E NEG ERRORS: 2 %

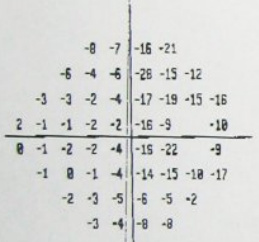
DURATION: 03:50

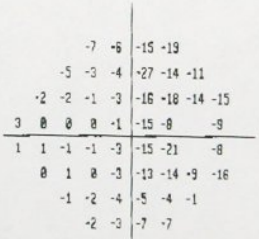
A: OFF

good reliability







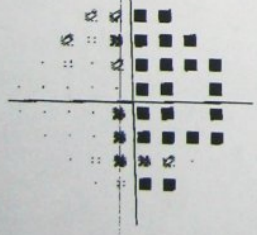


OUTSIDE NORMAL LIMITS

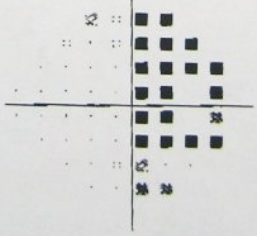
MD -7.12 DB P < 0.5%

PSD 7.05 DB P < 0.5%

TOTAL DEVIATION



PATTERN DEVIATION



:: < 5%

% < 2%

%% < 1%

■ < 0.5%

No significant glaucoma

NGLE FIELD ANALYSIS

EYE: LEFT

AME: [redacted] ID: DOB: [redacted]-194

RAL 24-2 THRESHOLD TEST

STIMULUS: III, WHITE
BACKGROUND: 31.5 ASB
STRATEGY: SITA-FAST

PUPIL DIAMETER:
VISUAL ACUITY:
RX: +2.50 DS -2.00 DC x 180

DATE: 07-23-2003
TIME: 10:35 AM
AGE: 56

ATION MONITOR: BLINDSPOT
ATION TARGET: CENTRAL
ATION LOSSES: 1/12
SE POS ERRORS: 6 %
SE NEG ERRORS: 6 %
T DURATION: 04:06

ER: OFF

? Not Sig

GHT
OUTSIDE NORMAL LIMITS

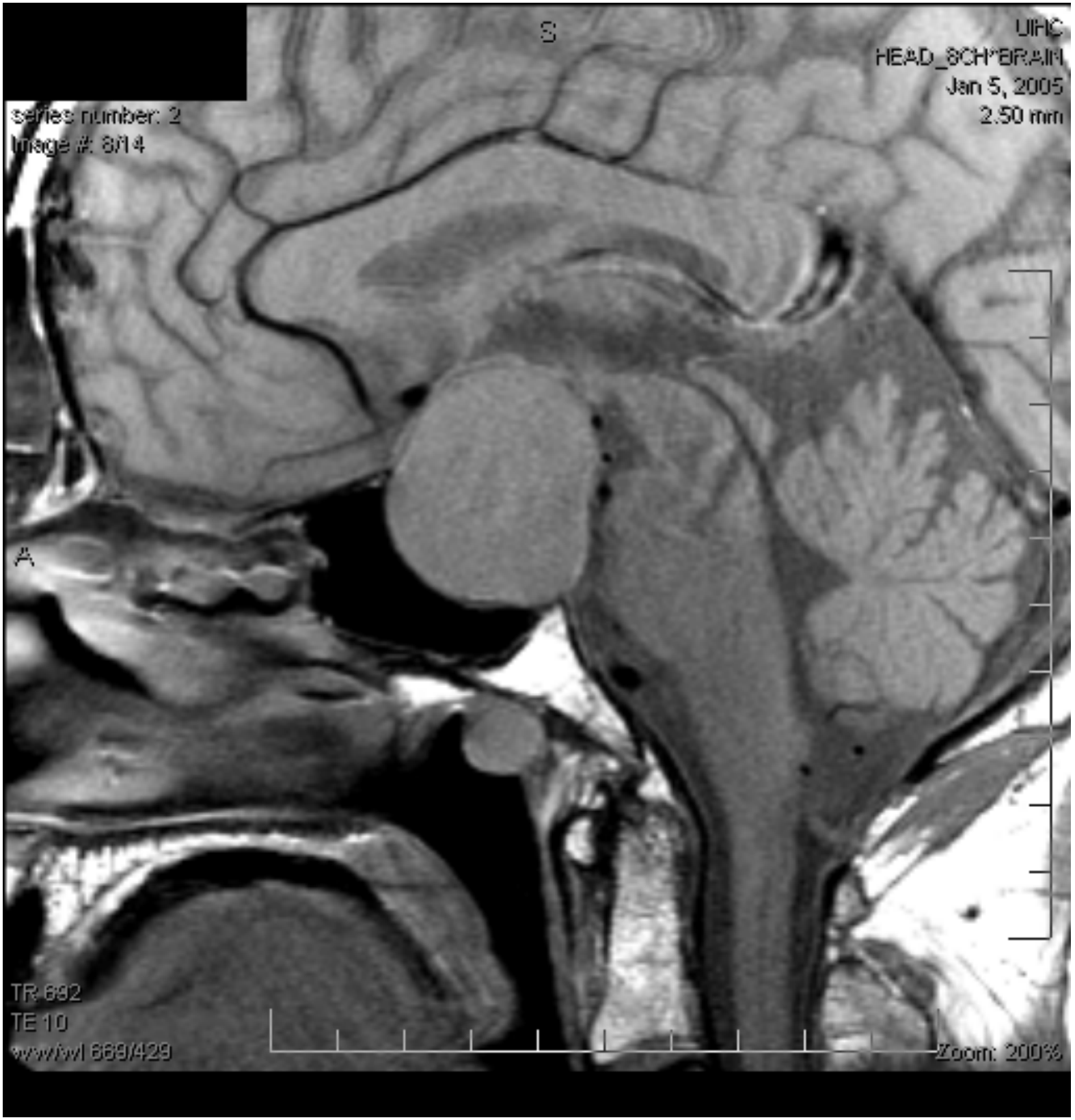
MD -7.84 DB P < 0.5%
PSD 5.83 DB P < 1%

TOTAL DEVIATION

PATTERN DEVIATION

:: < 5%
< 2%
< 1%
< 0.5%

MT. VERNON EYE CLINIC P.L.C.
DRS. SKOTOWSKI AND SINDT
202 GLENN ST.
MT. VERNON, IA 52314
319 895-6888 1-800-476-2312


S
UIHC
HEAD_SCH^BRAIN
Jan 5, 2005
2.50 mm
series number: 2
Image #: 8/14
A
TR 692
TE 10
Zoom: 200%

Do this

Always look at visual field with this question in mind….

Is it bitemporal ? Or homonymous?

Respect of vertical midline

SINGLE FIELD ANALYSIS

EYE: RIGHT

NAME: [redacted] ID: [redacted] DOB: [redacted] 1947

CENTRAL 30-2 THRESHOLD TEST

FIXATION MONITOR: GAZE/BLINDSPOT
FIXATION TARGET: CENTRAL
FIXATION LOSSES: 1/12
FALSE POS ERRORS: 1 %
FALSE NEG ERRORS: 4 %
TEST DURATION: 04:25

FOVEA: OFF

STIMULUS: III, WHITE
BACKGROUND: 31.5 ASB
STRATEGY: SITA-FAST

PUPIL DIAMETER:
VISUAL ACUITY:
RX: +1.50 DS OC X

DATE: 12-14-1999
TIME: 11:01 AM
AGE: 52

GHT
BORDERLINE

MD -3.28 DB P < 1%
PSD 2.99 DB P < 5%

TOTAL DEVIATION

PATTERN DEVIATION

: < 5%
: < 2%
: < 1%
: < 0.5%

12-14-99

[redacted]

[redacted]

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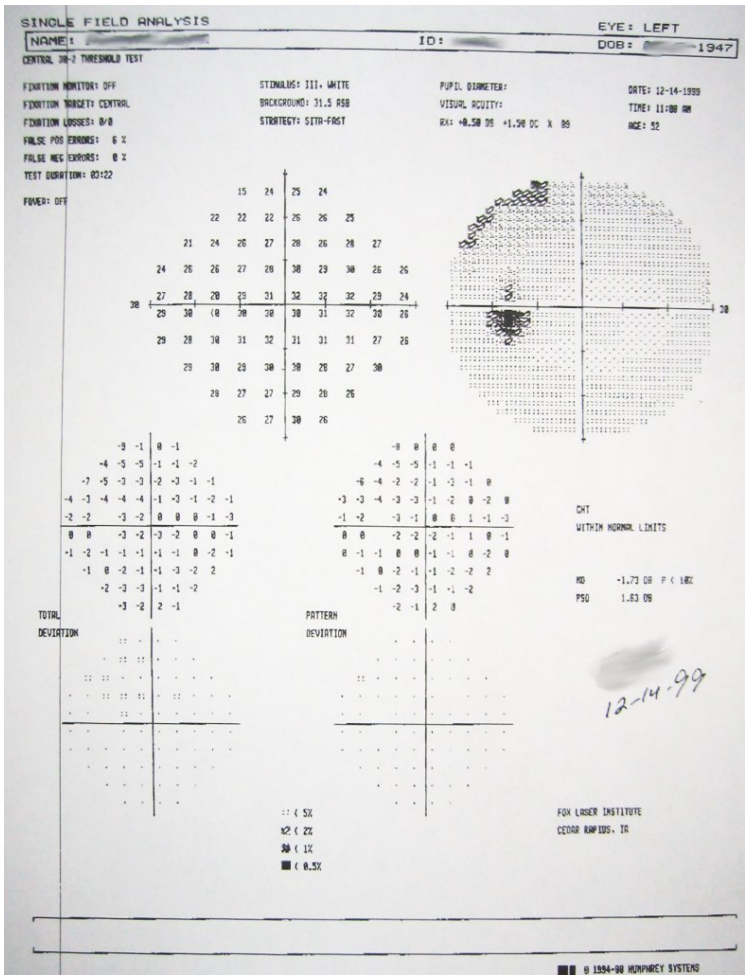
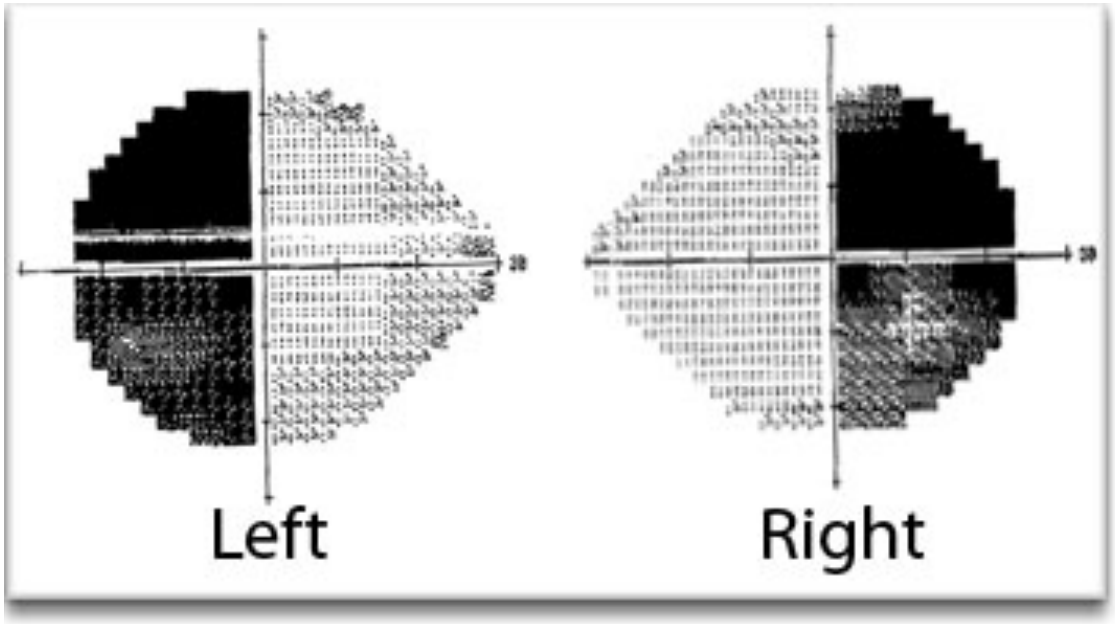

SINGLE FIELD ANALYSIS
EYE: LEFT
NAME:
ID:
DOB: 1947
CENTRAL 30-2 THRESHOLD TEST
FIXATION MONITOR: OFF
FIXATION TARGET: CENTRAL
FIXATION LOSSES: 0/0
FALSE POS ERRORS: 6 %
FALSE NEG ERRORS: 0 %
TEST DURATION: 03:22
FOVEA: OFF
STIMULUS: III, WHITE
BACKGROUND: 31.5 ASB
STRATEGY: SITA-FAST
PUPIL DIAMETER:
VISUAL ACUITY:
RX: +0.50 DS +1.50 DC X 89
DATE: 12-14-1999
TIME: 11:08 AM
AGE: 52
GHT
WITHIN NORMAL LIMITS
MD -1.73 DB P < 1%
PSD 1.83 DB
TOTAL DEVIATION
PATTERN DEVIATION
12-14-99
FOX LASER INSTITUTE
CEDAR RAPIDS, IA
< 5%
< 2%
< 1%
< 0.5%
© 1994-98 HUMPHREY SYSTEMS


Left
Right

Book bitemporal

Real world bitemporal

Ischemic optic neuropathy

Do NOT write ischemic optic neuropathy unless it is…

ION is NOT an etiologic diagnosis

AION is NOT an etiologic diagnosis

Two forms of AION: Nonarteritic (NAION) & Arteritic (A-AION)

Dangerous to write “ION” or even “AION” without excluding GCA!

PS: No such thing as “ischemic optic neuritis”

Beware “optic neuritis” in elderly….likely GCA

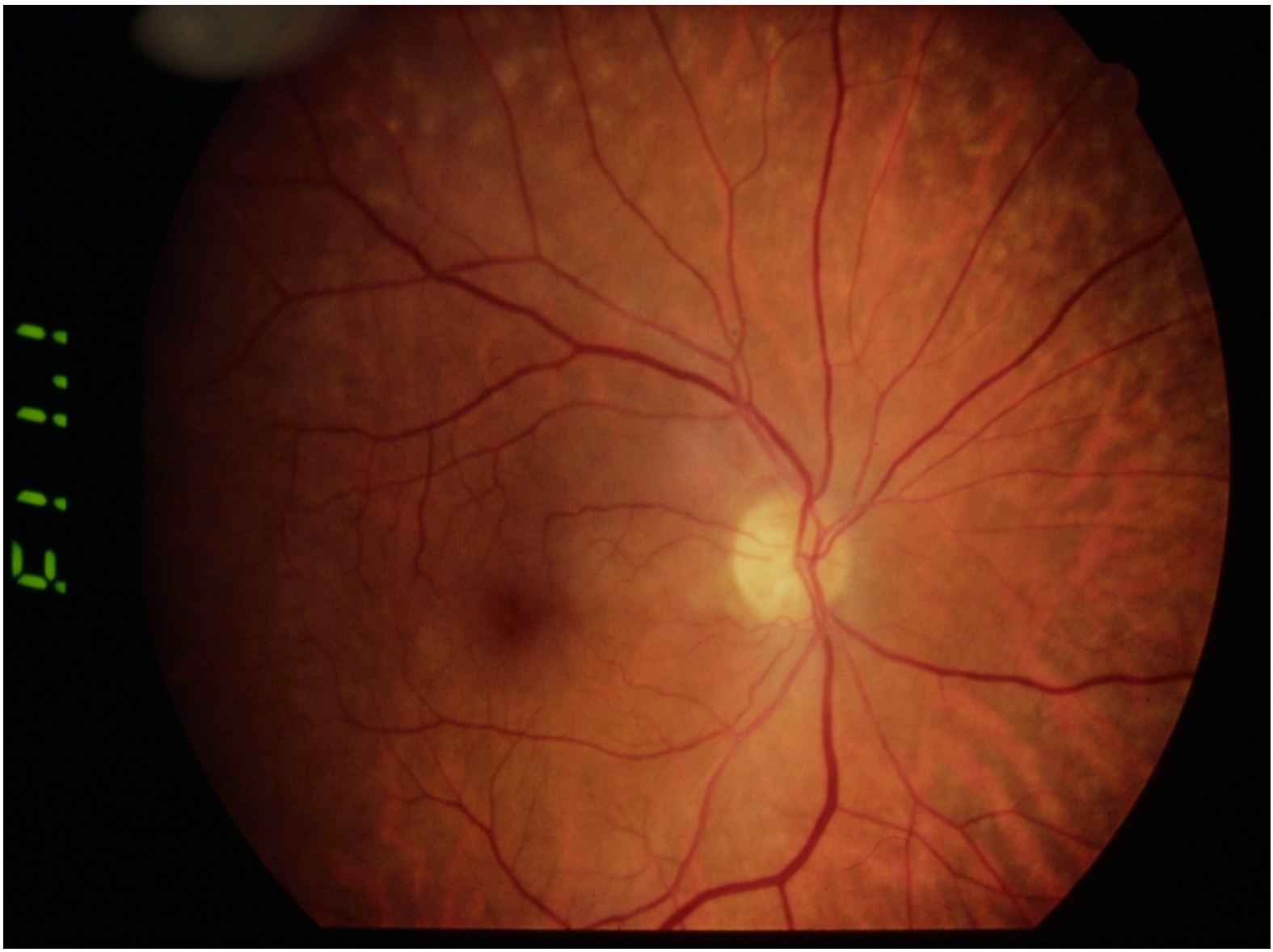
Wicked good pearl: retrobulbar optic neuritis in elderly might be PION due to GCA….Pallid edema sometimes looks like no edema (dead nerve cant swell)

It also can be NMO or MOG!

Don’t make up your own NOP rules

The artery on the side of my head hurts

I have GCA



33

Optic neuritis

Optic neuritis is demyelinating or idiopathic, it is a disorder of YOUNG patients

80 y.o. with optic neuritis is not likely

PION is more likely & PION is usually GCA

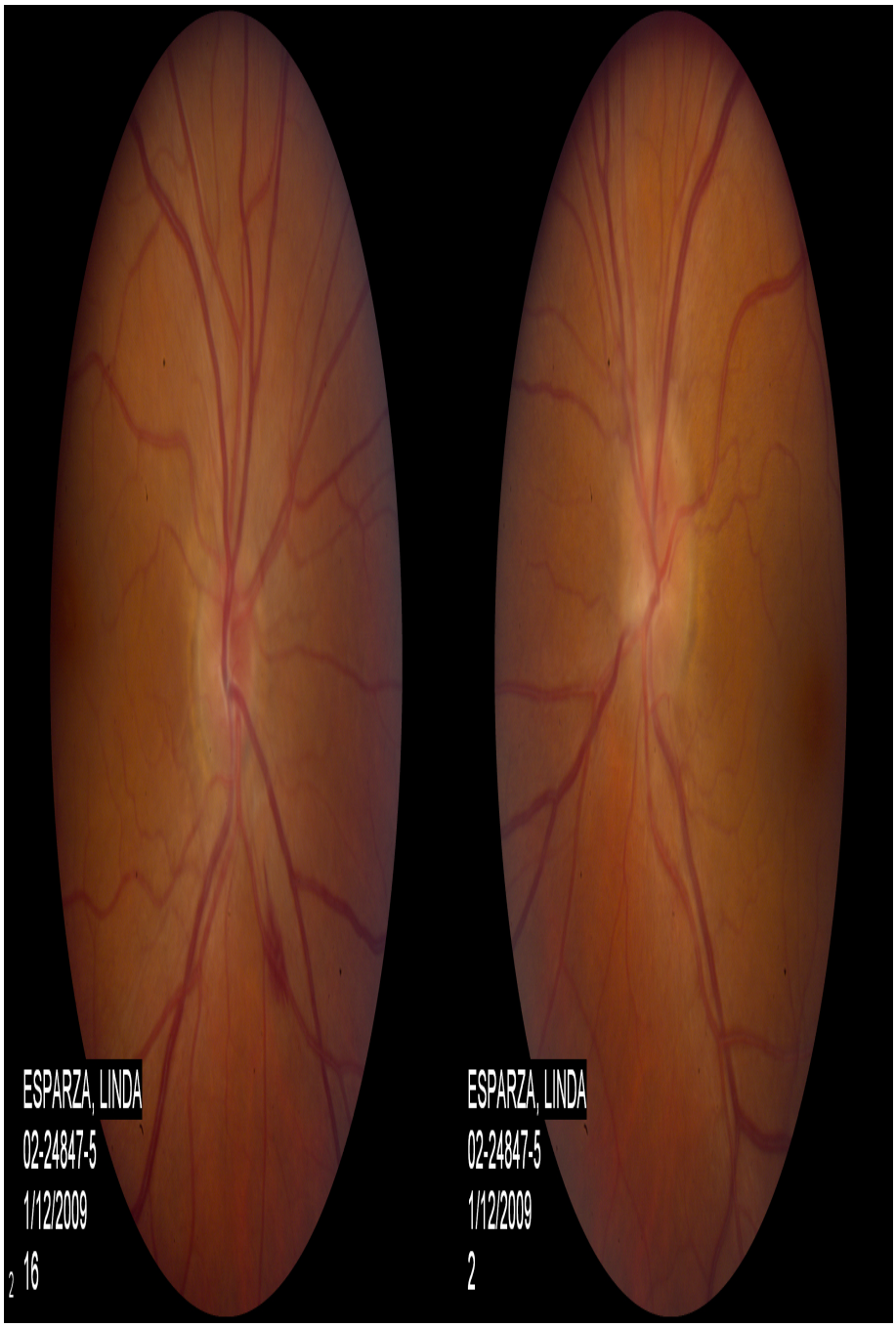
Don’t write: 80 y.o. with optic neuritis

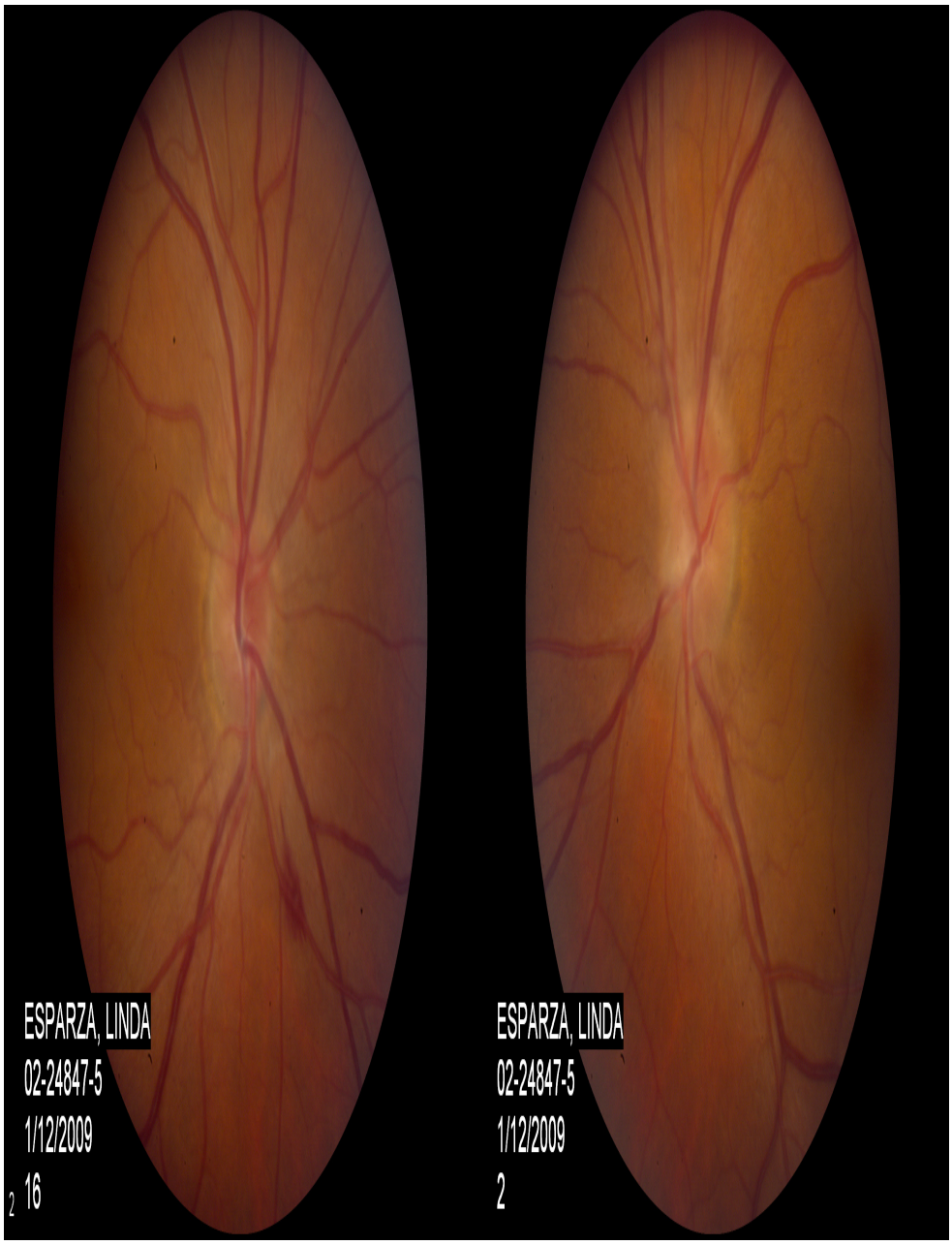
Think GCA in retrobulbar optic neuropathy of elderly

Definitely don’t write: “Ischemic optic neuritis”….there is NO SUCH THING

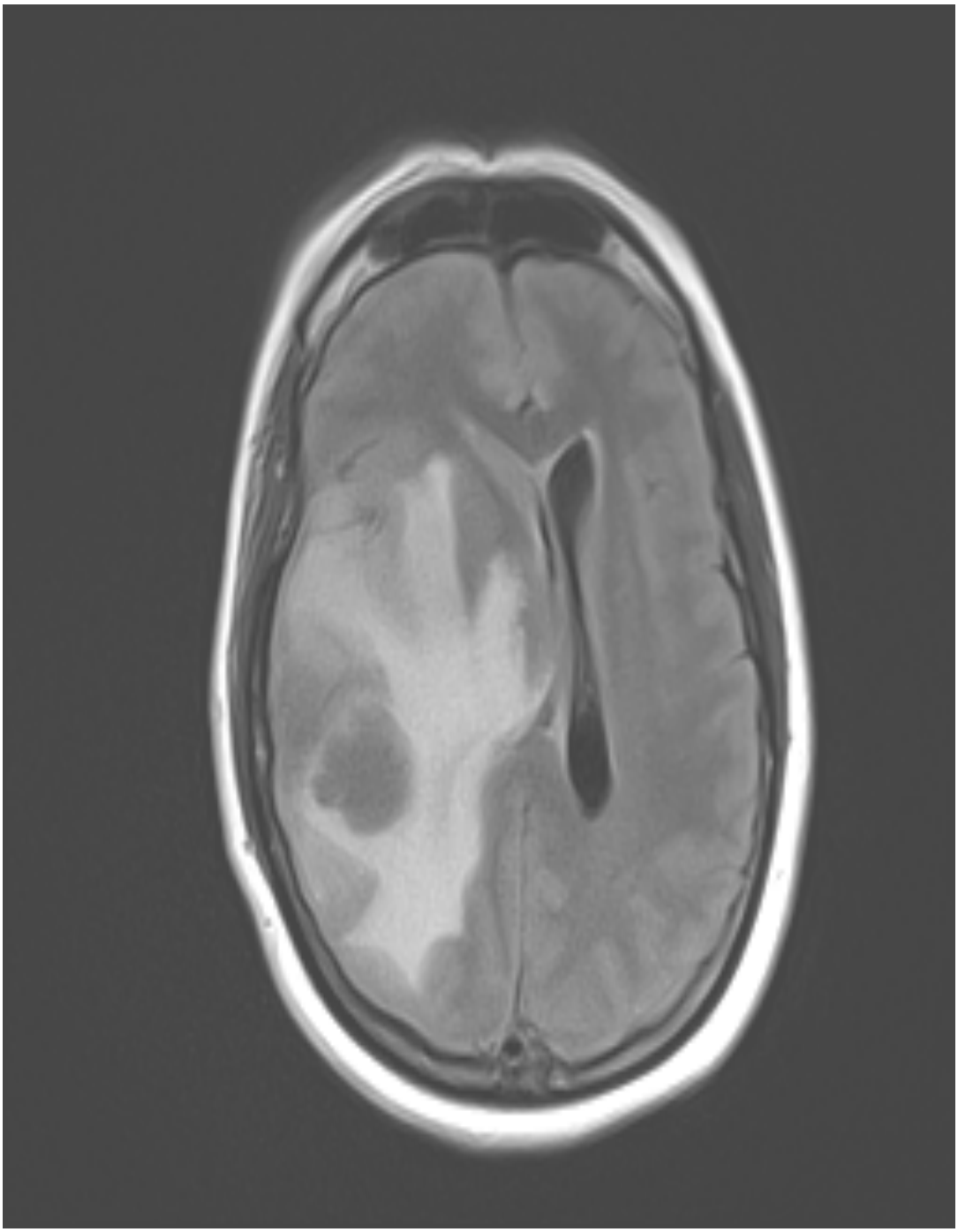
Size does not matter…in neuro -op

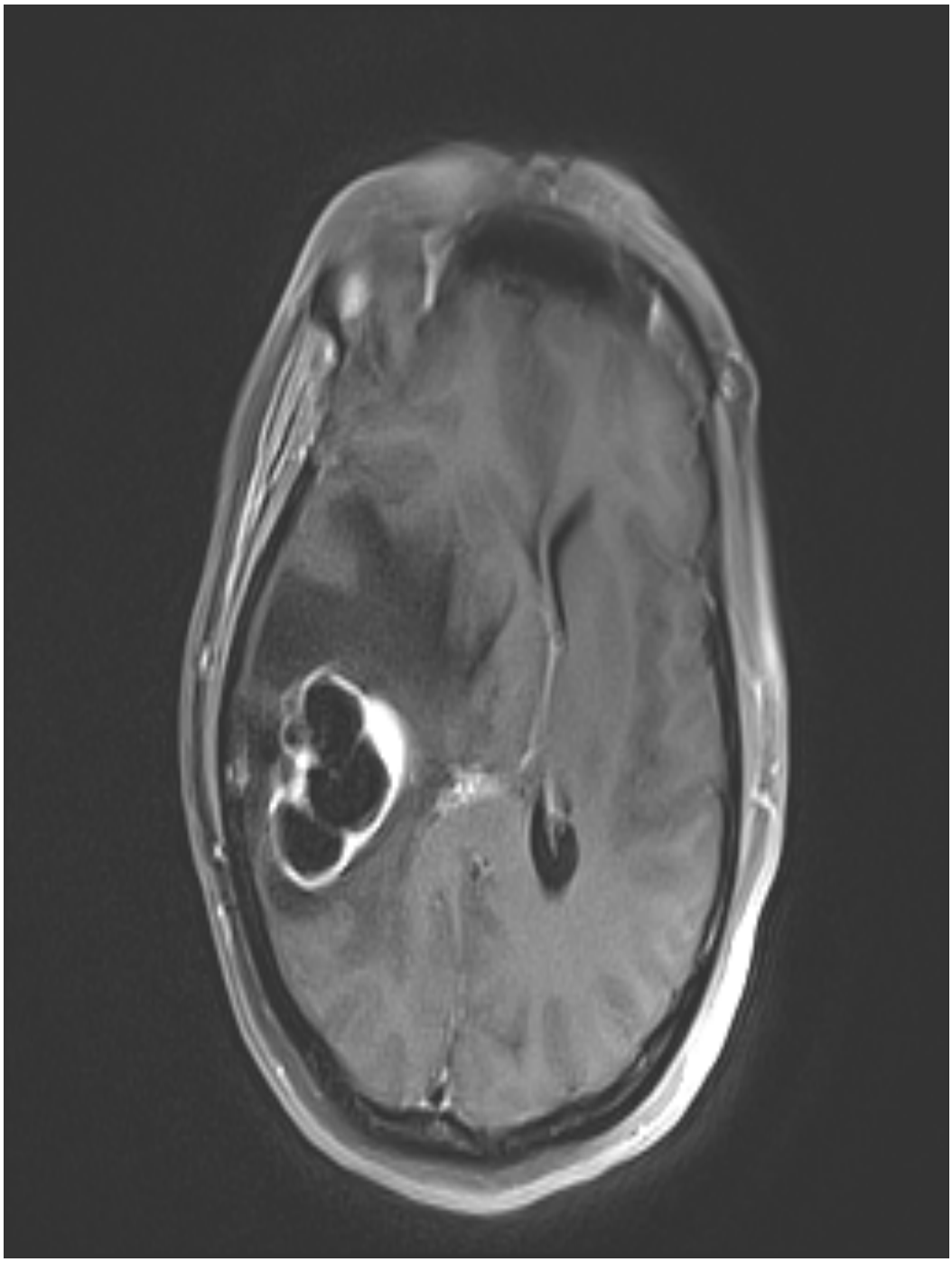
Little edema



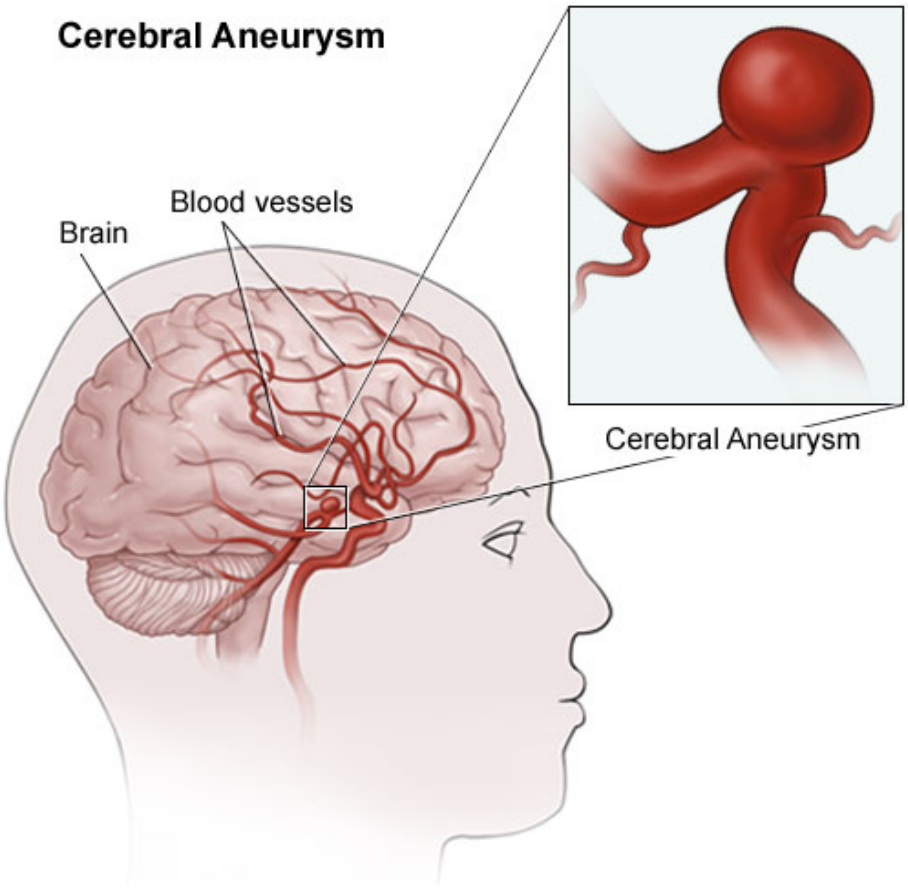

ESPARZA, LINDA
02-24847-5
1/12/2009
16
ESPARZA, LINDA
02-24847-5
1/12/2009
2

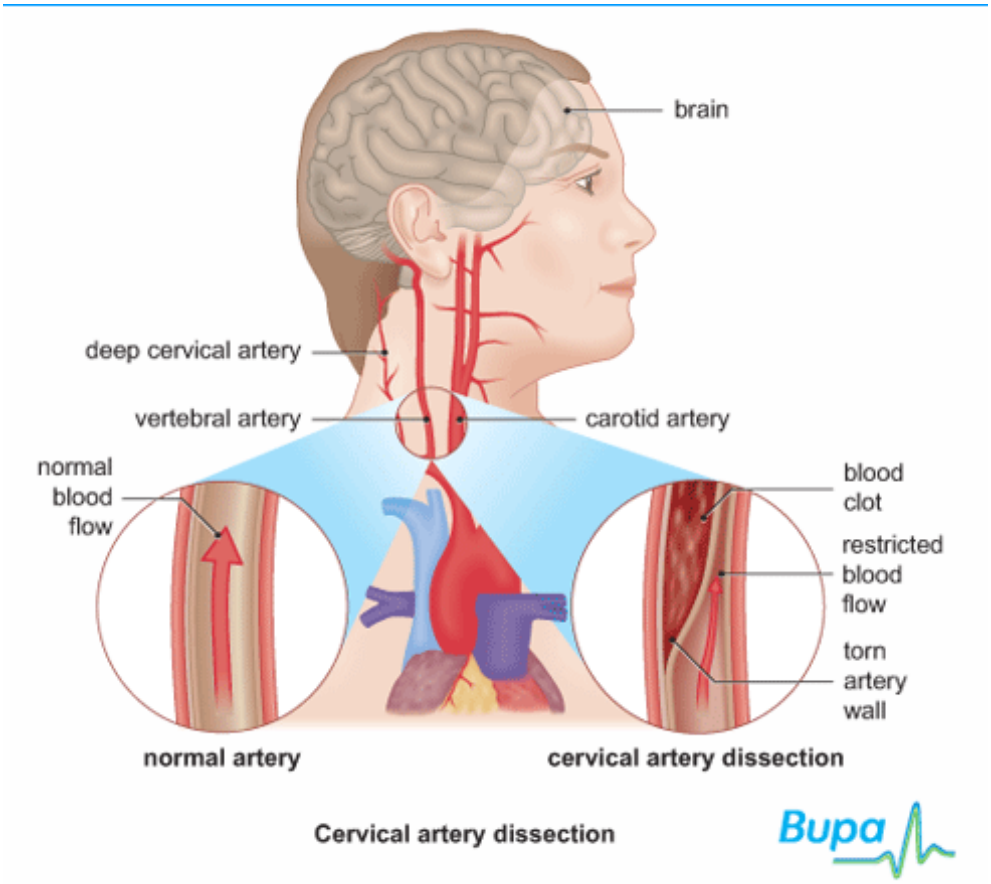
Little edema can be Big problem

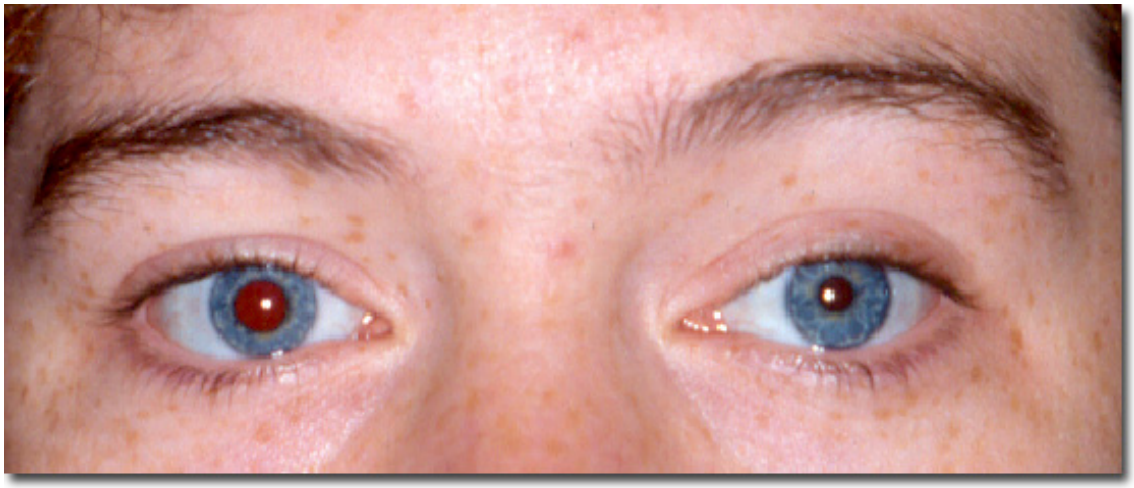




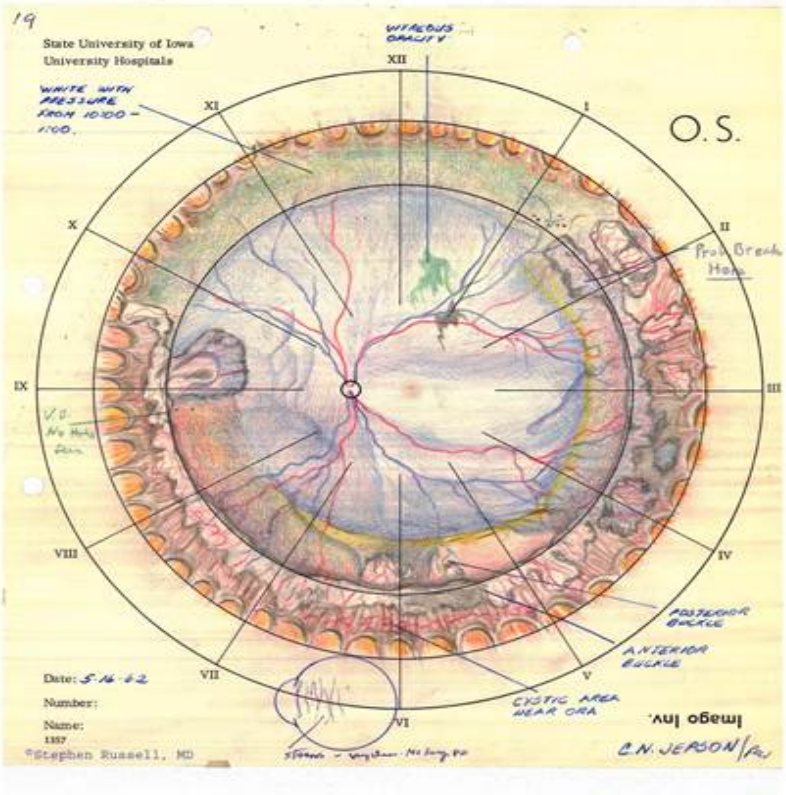
Little anisocoria or little ptosis can be Horner syndrome or Third nerve palsy

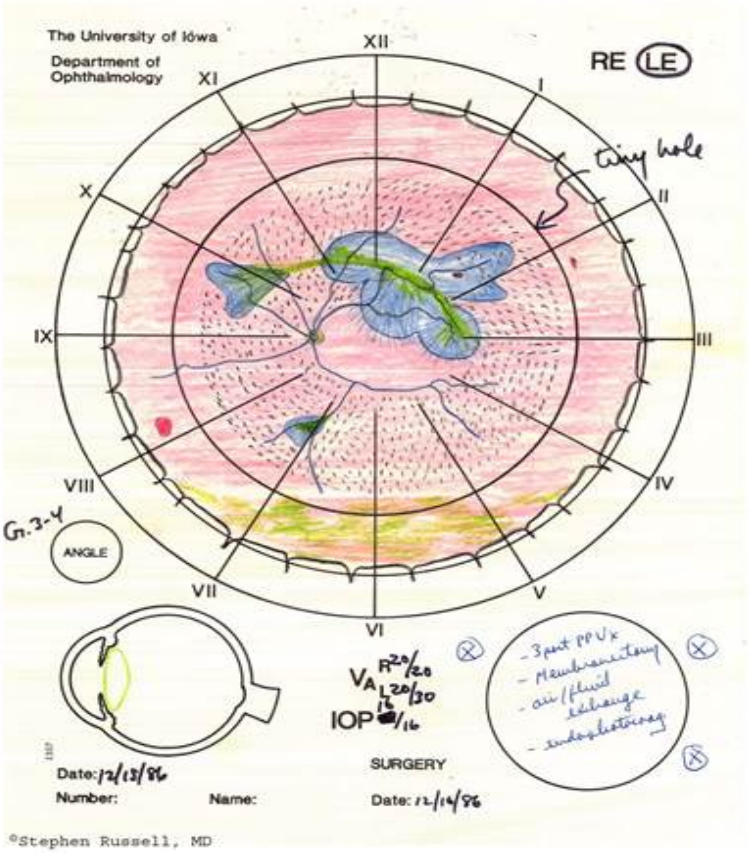



brain
deep cervical artery
vertebral artery
carotid artery
normal blood flow
blood clot
restricted blood flow
torn artery wall
normal artery
cervical artery dissection
Cervical artery dissection
Bupa

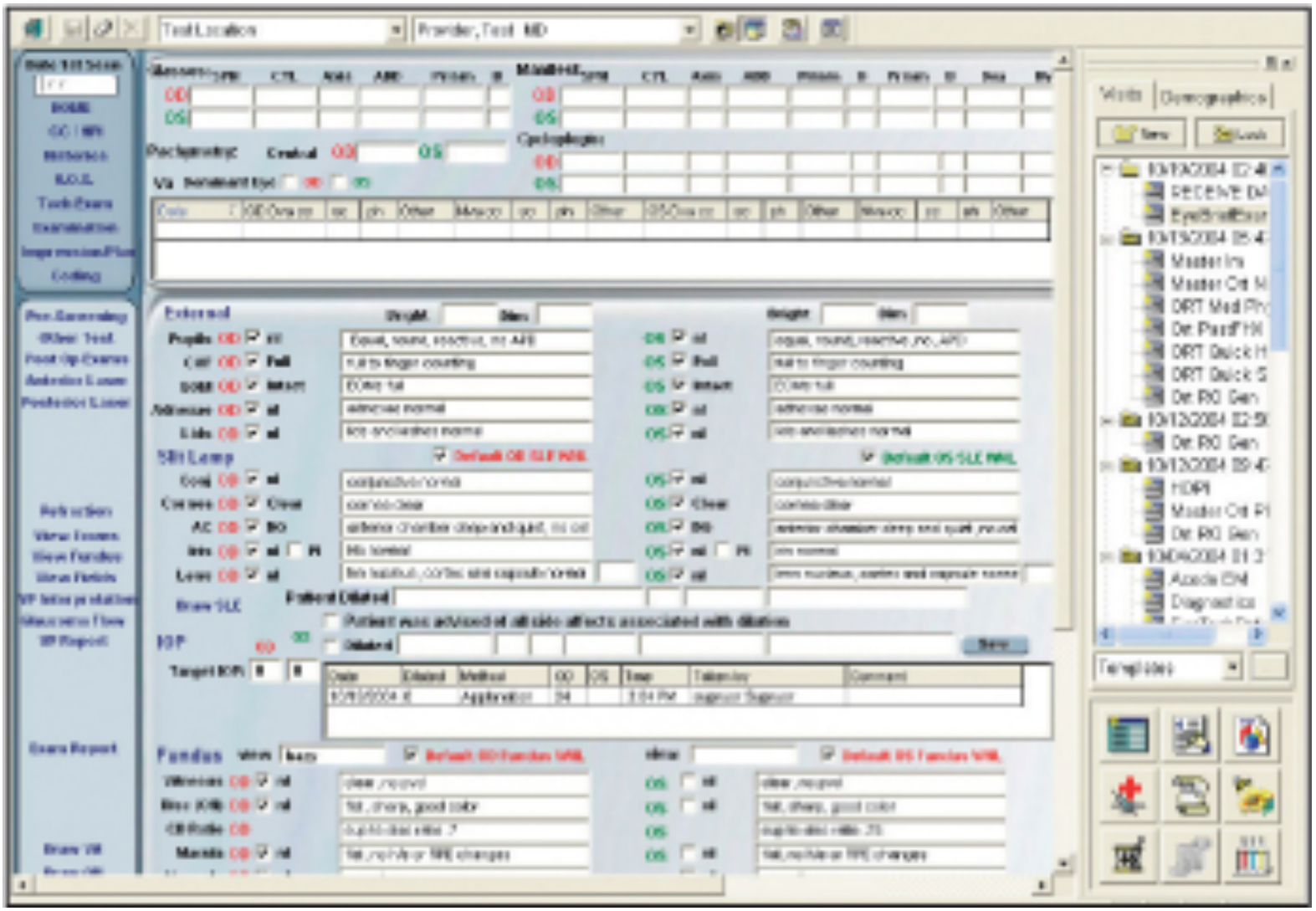


What the retina charting used to look like…



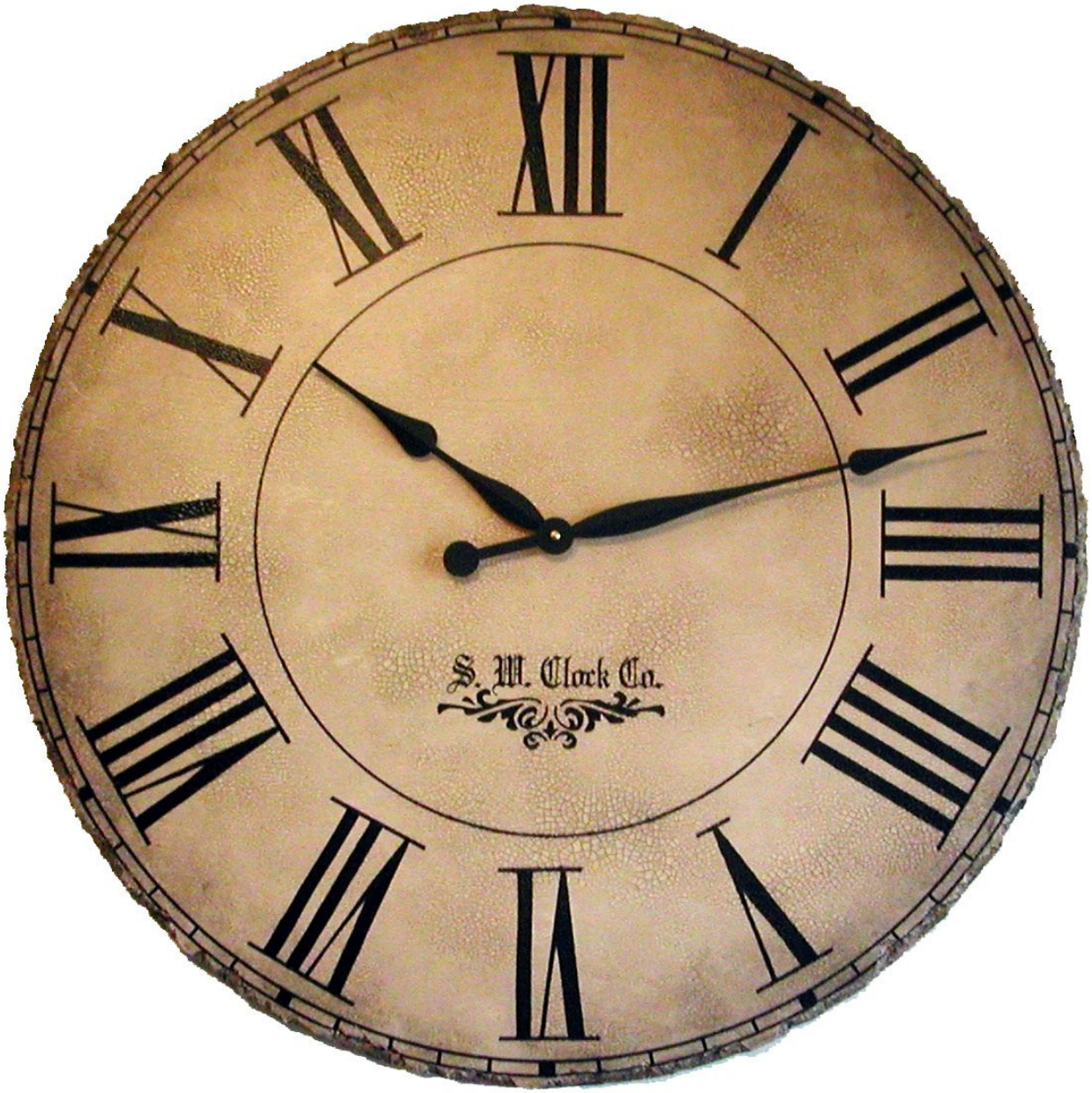


What retina charting looks like now…



Templates are slightly dangerous in EMR for ophthalmology

Something not right



EMR keeps bringing forward the error record after record

As if death weren’t enough….

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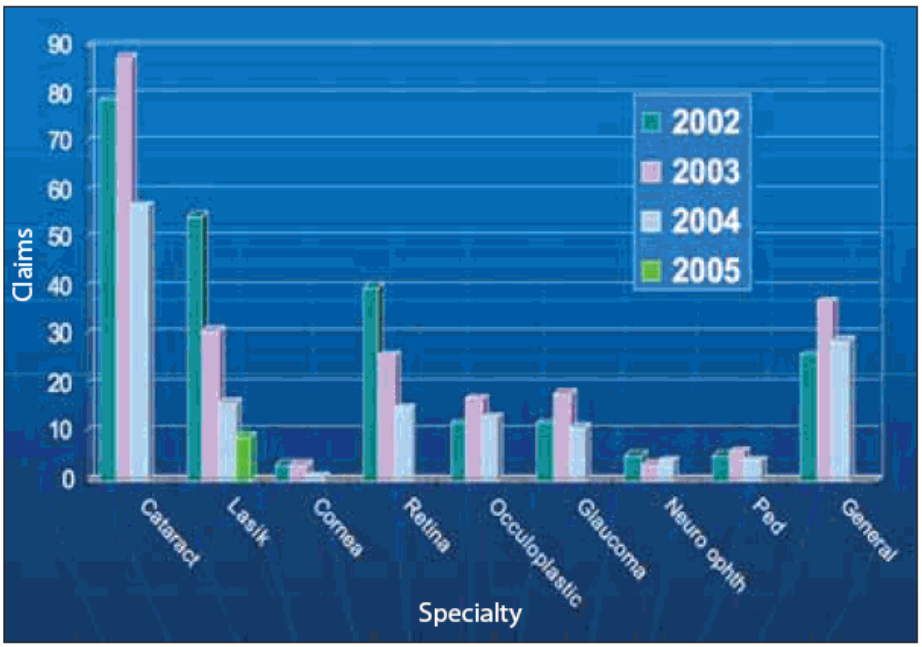

(Courtesy of Ophthalmic Mutual Insurance Company.)

Figure 1. This graph shows OMIC's malpractice insurance claims by specialty,

8.00 x 10.75 in 6 of 32

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he plaintiff that she was not
candidate for this procedure.
ndant's failure to do so was
to be below the appropriate
l of care.

tter: In my experience, a good
s attorney will sway the jury by
ng it that the doctor could have
mething more for the benefit of
nt. The jury will not believe
ysician would have done some-
liberately and willfully harmful
ent. During the course of the
plaintiff's attorney will plant in
s mind a seed of doubt that, if
or had just been a little more
e could have prevented the
from suffering loss of vision and
mages.

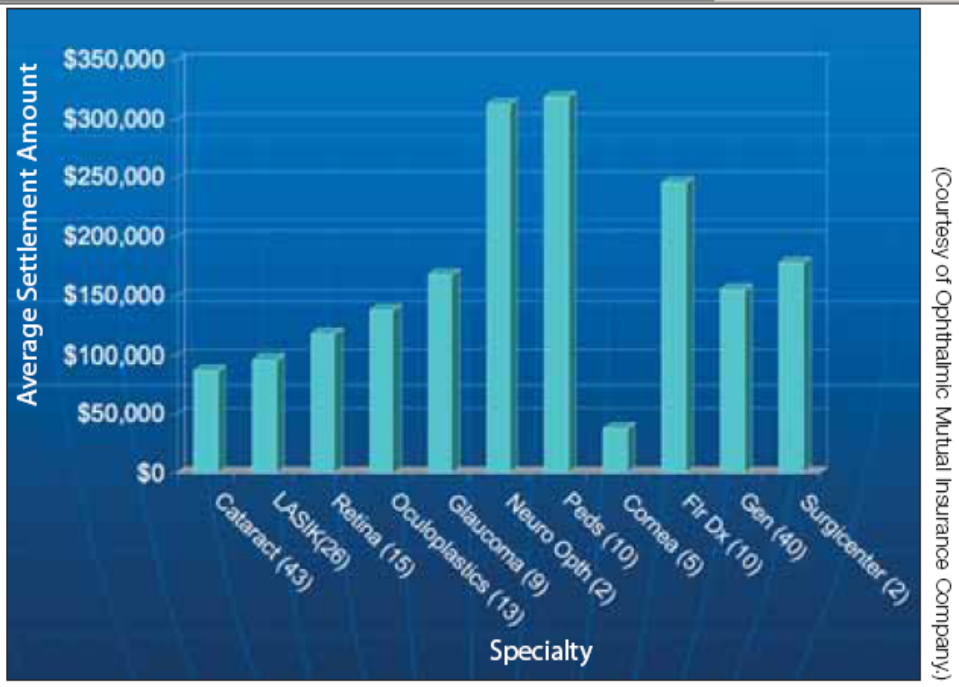


Figure 2. This chart shows OMIC's average malpractice settlement payment per specialty from 2001 to 2004.

8.00 x 10.75 in

8 of 32

Done Unknown Zone

Summary: Say this, not that

Keep Symptoms, Signs, Diagnosis separate

Don’t let sewage in your record

Differential diagnosis is mandatory

Don’t make up your own neuro -op rules

Plan (two choices): Beware that template

Work it up or….

Recognize, triage, and refer

Here is what I am doing for myself to defeat Satan's physician burnout

I devote 20% of my time to something that I believe is truly meaningful (teaching and mentoring medical students & residents) & teaching courses like this one

I concentrate on finding my passion through my educational efforts and personal satisfaction from helping others (i.e., I believe in my personal statement) and aligning my life goals with my career

I engage with my colleagues about what I love about medicine (even when all they want to talk about is RVUs, FTEs, collections, etc)

It doesn’t have to be about medicine


YOU ARE A REAL
DOCTOR

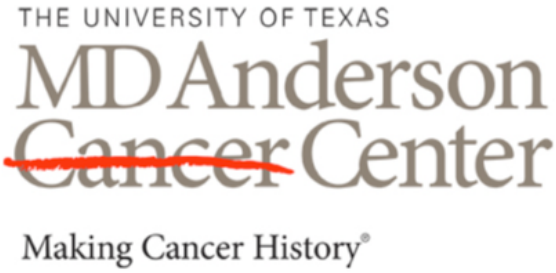
…and when the god of death comes for you or your patient…what shall we say?

“Not today!”

Thanks for your time & attention

Andrew G. Lee, MD

Chair Ophthalmology, Houston Methodist Hospital , Professor of Ophthalmology, Neurology, & Neurosurgery, Weill Cornell Medical College; Adjunct Professor of Ophthalmology, Baylor College of Medicine, University of Iowa & Clinical Professor of Ophthalmology, UTMB Galveston, UT MD Anderson Cancer Center



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