Tanta University
Ophthalmology Department
Faculty of Medicine

Department of Ophthalmology
MD Examination
Ophthalmic Medicine
22-8-2020

All questions to be answered
Each "Text" question is marked 20 degrees
Each "MCQ" question is marked 4 degrees
Exam Duration 3 hours

Discuss BRIEFLY

1. Perimetric features of chiasmal & retrochiasmal lesions?
2. Management of a case of neurotrophic keratitis?
3. Differential diagnosis of unilateral acute intraocular pressure elevation?
4. Differential diagnosis of enlarged extraocular muscles?
5. First aid management of a case of central retinal artery occlusion?
6. Causes and differential diagnosis of pseudo-papilledema
7. Updates on management of Behcet's disease
8. Visual rehabilitation of a child with congenital cataract

Good luck

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MD Commentary Exam
August, 2020

Time Allowed: 1.30 hour.
Answer All Questions:

Question 1: **(70 marks)**

Presentation: A 63-year-old Caucasian female without past ocular history presented with two to three weeks of black floaters in her vision. She reported an abrupt onset of the spots in her left eye upon waking the day after colonoscopy for left lower quadrant abdominal pain, the findings of which were benign. Over the course of the next few weeks, she had progressively worsening headaches, light sensitivity and redness in her left eye. Review of systems was negative for new rashes, new onset joint pain or shortness of breath, though she did have persistent left lower quadrant pain.

Medical History: Past medical history was significant for depression, hypothyroidism, chronic left lower quadrant abdominal pain of unclear etiology, and diverticulosis. Of note, no inflammatory bowel disease, cancer or infection was found on her colonoscopy. She had an allergy to sulfa. She never smoked, used illicit drugs or drank alcohol. Her medication list included levothyroxine 75 mcg daily and multiple antidepressants and anxiolytics, including bupropion 100 mg, risperidone 2 mg, duloxetine 30 mg, armodafinil 150 mg and trazodone 50 mg, all dosed daily or nightly, and clonazepam 0.5 mg as needed.

Examination: The patient's vital signs were stable and within normal limits. Ocular examination demonstrated a best corrected visual acuity of 20/40 OD and CF at 1 foot OS. She had full extraocular movements. There was no relative afferent pupillary defect. Her visual fields were full OD but globally diminished OS. The periorbita and adnexae were normal.

Anterior slit lamp examination of the right eye was normal. The left eye had corneal haze with 1 to 2+ Descemet's membrane folds and diffuse inferior non-granulomatous keratic precipitates. The anterior chamber had 2+ cell without hypopyon. The iris revealed broken posterior synechiae with a ring of pigment on the anterior capsule of the lens. Intraocular pressure was 14 mmHg OD and 7 mmHg OS.

Fundoscopic examination was normal in the right eye. There was a hazy view to the back of the left eye with 1+ vitreous cells, and fluffy white-yellow lesions with a "string of pearls" appearance. The optic disc was normal. The vessels were without sheathing or vasculitis. The macular exam showed no edema, thickening and hemorrhage. However, there was focal chorioretinitis in the posterior pole.

What is your diagnosis? What further workup would you pursue? And how to treat this case??