



Norwest Day Hospital - Meet the Staff!

Tony Scaramuzza

General Manager of the Norwest Day Hospital

Norwest Day Hospital is a fully licenced and accredited day hospital conveniently co-located with Norwest Eye Clinic. Tony is responsible for the overall management of the state-of-the-art ophthalmic surgery facility, including liaising with the NSW Department of Health, private health insurance funds and other regulatory authorities. An amazing team of nursing and administrative staff are involved in ensuring that Norwest Day Hospital continuously maintains the highest levels of safety and quality standards, independently audited and approved by the Global Mark external accreditation agency.

Isidro Turingan

Director of Nursing at Norwest Day Hospital

Isidro Turingan (also known as Sid) has completed an Associate Diploma in Pathology and graduated from University of Technology in Sydney. He has been practicing nursing since 2000 and specialises in perioperative nursing. He has extensive managerial experience and over the years has contributed to several surgical papers. He and the team at Norwest Day Hospital strive to maintain the highest quality of care and the best outcomes for their patients.



EYES ON NORWEST

VOLUME 1, ISSUE 3
SPRING 2014/SUMMER 2015

Dr Thomas Pham. Our new Doctor at Norwest!



Dr Thomas Pham specialises in medical and surgical diseases of the retina, including age-related macular degeneration, diabetic retinopathy, retinal vein occlusion, retinal tear and detachment, epiretinal membrane and macular holes.

He graduated from the University of Sydney Medical School in 2000 and was awarded a Master of Medicine from the University of Sydney in 2006 for his research in the relationship between macular degeneration and cataract surgery. He completed general ophthalmology training in Christchurch, New Zealand before undertaking further fellowship training in

vitreoretinal surgery at the Princess Alexandra Hospital, Queensland and University of Toronto, Canada.

Dr Pham has authored and presented research papers at Australian and international meetings and has an ongoing interest in researching disorders of the retina. He is also involved in teaching registrars, medical students, local GPs and optometrists.

The majority of Dr Pham's work is in medical and surgical diseases of the retina. He has ongoing commitments to providing a vitreoretinal service to rural areas of Central West NSW and has weekly clinics in Orange and Dubbo.

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Like us on Facebook- just search Norwest Eye Clinic

Ongoing Education Series

Thank you to all the GPs and Optometrists that have attended our education sessions this year.

As a practice we are committed to these evenings and we ensure all our current referrers are the first to receive invitations to these wonderful nights.

If there is any topic you wish to have covered in the upcoming sessions please e-mail us at info@norwesteye.com.au and we will get one of the Doctors to cover the topics next year.

Additionally we have also been running educational AMD patient seminars at the clinic for our patients every few months.

Get to know the staff

Practice Manager

Georgia studied as an Orthoptist at Sydney University and worked for a large laser eye surgery practice for 10 years before working for a practice management software company doing sales and technical support. She then went back to Ophthalmology and managed an expanding practice on the North Shore before assisting with the building and fit out of the Norwest Eye Clinic.

Reception

Angela comes to Norwest from Dr Lert's Liverpool rooms which she left due to her expanding family and move to Castle Hill. She has a wealth of knowledge in Ophthalmology, surgery bookings and costing.

Clinical

We have had a new Orthoptist, Gurpreet, start with us since last August. She also studied Orthoptics at Sydney University and before joining us here at Norwest worked in a very busy private practice and Day Hospital in Blacktown.



School Screening

School Screening has continued this year with a number of children being flagged to return to their Optometrist or GP for further review.

The feedback we receive from this free service has been very positive and we will continue to provide this service to schools that require it.

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Season's Greetings

All the staff and Doctors at Norwest Eye Clinic wish you a Merry Christmas and prosperous New Year.

We would like to take this opportunity once again to thank you all for your continued support.

We have now been open for 5 years and we hope that you have received positive feedback from your patients about our clinic.

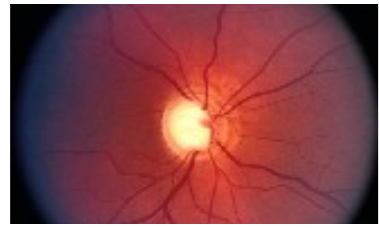
Please remember that we do accept emergencies and have a clinician able to speak with you everyday during our opening hours.

We are open from 8:30am to 4:30pm everyday and have after hours emergency contact instructions on our answering machine.

We will be closed from the Thursday 25th December and will re-open on Tuesday the 6th January 2015.

Nocturnal Blood Pressure Dipping in Normal-Tension Glaucoma (NTG).

with Dr Anne Lee



NTG is one of the more challenging forms of glaucoma, where IOP plays a less important role and vascular risk factors such as migraines, cool peripheries and Raynaud's syndrome, systemic hypertension and nocturnal hypotension have an increasing contribution. As the optic nerve is a watershed zone, any decrease

in blood flow, i.e. ocular perfusion pressure (which is defined as arterial blood pressure (BP) minus IOP), can potentially lead to optic nerve damage. When BP falls below a critical level, autoregulation kicks in to ensure perfusion of the optic nerve, however as the insult persists, hypoperfusion can lead to ischaemia and nerve damage.

Hypotension during sleep has been shown to predict progressive visual field loss in NTG. A significant correlation has been found between progression and both the length of time that the mean nocturnal BP dropped below the mean diurnal BP

and the magnitude of the drop.

Thus, it may be worthwhile to perform ambulatory 24-hour BP monitoring in patients with NTG progressing for no apparent reason to assess for nocturnal dipping, especially those patients with systemic hypertension on multiple medications, in particular beta-blockers. A patient may require less aggressive BP lowering treatment or simply have their BP medications switched to a morning regime, after consultation with their cardiologist or GP. In those patients without a diagnosis of hypertension, salt-loading at night may be of limited benefit.

When is it time to have Cataract Surgery?

with Dr Alvin Goh

"When is it time to have the cataract operation, Doc?" is the common question I am asked by patients who present with cataracts. Or they want me to make the decision for them. Cataracts come in varying configurations and they affect the quality of vision differently. During the development of a cataract, the nucleus of the lens becomes hardened and changes colour (nuclear sclerosis). The posterior aspect of the lens can become opacified (posterior subcapsular cataract), the cortical portions become opacified (cortical cataract), and the clefts and vacuoles



formations in the lens cause changes in refraction through the lens. All these

different types of cataracts cause degradation of images that the patients perceive. Some complain that they can't read, some can't recognise faces, some can't read road signs, some are afraid of driving at night whilst some are troubled by glare.

The time to proceed with cataract surgery is not determined by the type

"The time to proceed with cataract surgery is not determined by the type of cataract or what stage it is in"

of cataract or what stage it is in.

The visual needs of individuals vary enormously in the community.

Whenever a patient needs or wants to see better in order to carry out their daily activities, be it at home or at work, it is then time for the patient to choose to have the operation.

Central Serous Chorioretinopathy (CSR)

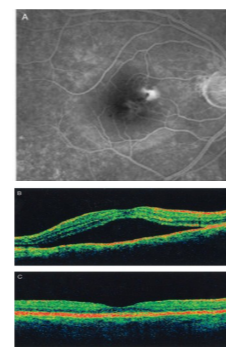
with Dr Thomas Pham

Central Serous Chorioretinopathy (CSCR) is a disease in which there is a serous detachment of the neurosensory retina causing visual impairment. It is thought to occur over an area of leakage from the choroid through the retinal pigment epithelium which may have focal or diffuse dysfunction. It has an incidence of 1 in 10,000, affecting individuals between 20-50 years and is 6 times more common in men than in women. The majority of cases (80-90%) resolve spontaneously within 3 months and can achieve 6/7.5 or better vision. However, there is 40-50% recurrence rate and a minority

(5-10%) have a chronic course (>6 months) with visual acuity 6/9 or worse even after resolution. Risk factors include increased endogenous corticosteroids which help explain the possible association with stress and those with type A personality, and exogenous corticosteroids use whether inhaled or topical.

Patients present with decreased and distorted vision often associated with micropsia (miniaturisation of images). Examination shows localised or multifocal serous retinal detachment in the macular region. Diagnosis is supported by optical coherence tomography (OCT), fluorescein

angiography (FA), indocyanine green and fundus autofluorescence. The differential diagnoses are exudative macular degeneration, choroidal tumours and optic disc pits. Observation with reduction in risk factors is usually sufficient for visual recovery. For recurrent or chronic cases, focal laser and photodynamic therapy (PDT) have good evidence for efficacy.



Retinal tears and detachment

with Dr Andrew Chang

Retinal tear and detachment is a blinding ocular condition. Early diagnosis and referral for treatment is sight saving. The symptoms of photopsia and floaters are classic symptoms of vitreous detachment and will alert the eyecare professional of the potential of peripheral retinal pathology that requires further examination and treatment.

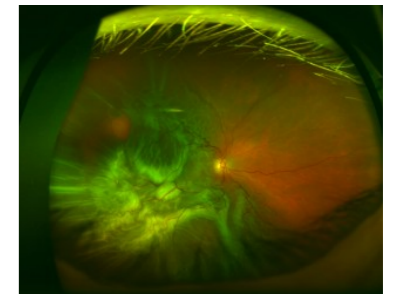
Small retinal tears and peripheral retina detachment may result in few symptoms and will be diagnosed only on retinal examination. Peripheral retinal lesions, such as



lattice degeneration and atrophic holes, have the potential to give rise to retina detachment, and are able to be observed on clinical examination.

Indirect ophthalmoscopy with scleral depression enables visualisation of very peripheral retinal lesions. Other methods to examine the peripheral retina include slit lamp biomicroscopy using wide-angle contact lenses or 3-mirror lens.

Posterior vitreous separation is due to an age-related liquefaction of the vitreous gel. The loosened collagen framework causes the vitreous gel to become more mobile. This movement of the gel causes traction within areas of the vitreous still adherent to the retina. During an acute PVD, up to 20% of patients may have a tear or detachment on initial presentation. If no tear is found at initial presentation, there is a 2-5% chance of developing tears in



subsequent weeks.

Risk factors for developing retina detachment include myopia, lattice degeneration, trauma, retina detachment in the fellow eye or family history of retina detachment.

Treatment of retinal tears with minimal surrounding subretinal fluid may be possible with laser photocoagulation. More extensive retinal detachment will require surgery with vitrectomy (an internal approach) or scleral buckling surgery (an external globe approach).

The link between Uveitis and tattoos

with Dr Sam Lerts

With a recent surge in popularity of body tattoos among young Australians, it is inevitable that we will see an increase in tattoo related medical complications. Apart from the risk of hepatitis infection through contaminated tattoo equipment, there is a risk of granuloma or keloid formation among susceptible individuals. The tattooed skin may also react to MRI scans, causing burning sensation and interfere with the images. In rare cases, there may be an allergic reaction to the pigments that may only occur many years later. There have been a few recent reports of bilateral uveitis coinciding with skin reaction to tattoo pigment (Ostheimer et al, AJO 2014 Sept). The authors note a sudden rise in the incidence of tattoo related uveitis. For the first time in my 20 year career I saw the first case only

a few months ago. Is this just a coincidence or is there a supporting science?

The Experimental Induced Uveitis model was designed by scientists at the National Eye Institute, Bethesda, Maryland in the early 1990s where uveitis can be induced in mice by injecting toxin into the abdominal cavity. The toxin induces an allergic reaction in the body that expresses in the immune privileged uveal tissues. The EIU serves as an important research tool for the treatment of uveitis ever since. One can feel sorry for the experimental mice that were injected

with the toxin, but how about the young people who deliberately inject themselves with pigments that can cause severe inflammatory eye disease? The effects of which can last for years as tattoo removal is both problematic but also involves the use of laser to dissolve the pigment. The problem is that the dissolved pigments go into the blood stream and potentially exacerbate more allergic reactions.

