

| TYPE OF PATHOLOGY | COMMENTS ON PATHOLOGY TYPES |
|-------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Cataracts | pathological blindness if not treated, leading cause of blindness in the 3rd world, no access to care |
| Glaucoma & or suspect | pathological blindness-treatment just slows it down,most treated patients will pass before blindness |
| Pterygium | can cause pathological blindness if not treated |
| Laser Peripheral Irdotomies(narrow angles) | can cause angle closure glaucoma, potentially blinding and very painful |
| Strabismus | functional blindness if amblyopia develops., VT/ surgery aims for cosmetic/functional cure. |
| Dry Macular Degeneration, life style advice | pathological blindness |
| 6 month follow up on background diabetic retinopathy | monitor to treat if diabetic maculopathy and or proliferative changes occur.. Pathological blindness |
| Na Yag capsulotomy for a secondary cataract | pathological blindness if not treated. Easily treated with access to care |
| Laser treatment for proliferative diabetic retinopathy | pathological blindness if not treated, highly likely |
| Retinal Detachment | pathological blindness if not treated. |
| Amaurosis fugax | loss of vision out of one eye secondary to an embolus, condition can cause a stroke/death |
| Laser treatment for diabetic MACULOPATHY | pathological blindness, treatment usually maintains current level of vision, but does not improve it. |
| Laser treatment for proliferative retinopathy (sickle cell) | similar to proliferative diabetic retinopathy. |
| Dilated Fundus Examination for flashes & floaters | has the potential to cause a tear in the retina and subsequent retinal detachment (15% of cases) |
| Treatment for Neovascular Glaucoma/ Diabetes | pathological blindness: highly likely even with treatment |
| Excision of a sebaceous cyst | typical not a issue, other than cosmetic |
| Work up for recent onset of diplopia/strabismus | need to determine etiology, could signify vascular problems or a brain tumor. |
| Treatment for a corneal abrasion | potential for pathological blindness |
| Optic Neuritis | may represent initial sign of multiple sclerosis or represent a vascular or viral origin. Can cause loss of vision/blindness |
| Bacterial Conjunctivitis | usually self limiting, easily treated; but can cause corneal scarring and other issues in serious cases |
| Allergic Conjunctivitis | usually self limiting, easily treated in most cases, not usually associated with blindness issues. |
| Seborrheic Blepharitis | rather common, treatments help reduce complaints, but problem is usually chronic in nature |
| Work up for optic disc pallor | its presence could represent a tumor compressing the optic nerve or part of its pathway. Also could have vascular/MS issue |
| 3 month follow up on diabetic retinopathy | monitor to treat if diabetic maculopathy and or proliferative changes occur.. Pathological blindness |
| Ptosis sugery | upper eyelid/s drop down and obscure vision. Can represent a paresis/paralysis of the 3rd cranial nerve. |
| Dilated Fundus Examination for high myopia | high myopia is associated with more peripheral degenerative changes in the retina, that may be prophylactically treated. |
| HGP fit for irregular cornea and keratoconus | hard gas permeable contact lenses are the initial treatment for patients that cannot see well enough with glasses. |
| Ectropion Surgery | the lower eyelid falls away from the eyeball, causing excessive tearing and increased risk for corneal/eyelid dessication |
| Macula Hole | potential to cause blindness as the patient loses central vision to a significant level |
| Penetrating Keratoplasty secondary to corneal scar | scars dense enough and causing irregularity in the cornea need to be removed and have a donor cornea sown in place |
| Right homonymous hemianopic visual field loss | can represent a symptom of a stroke or tumor in the visual pathway |
| Pupillary defect | can represent a variety of causes that need to be ruled out. |
| Intermittent diplopia | a general binocular dysfunction, usually just functional in origin, but could represent the residual effect of a pathologic origin |
| Optic Atrophy | sign of a current or previous pathology causing damage to the optic nerve from various causes: tumor/vascular/MS, etc.. |
| Unilateral Aphakia | patient has had their natural lens removed from the eye and no intra-ocular implant, needs a contact lens to see |
| Anterior Uveititis | could lead to increased probability for cataract formation/glaucoma and may be associated with systemic diseases |
| Transient bilateral loss of complete visual field | typically associated with a vascular cause; requires a complete cardio-vascular assessment |
| Lacrimal dilation/probing/irrigation | blockage in the lacrimal drainage system increases the risk for infections and constant tearing that flows down the face |
| Prosthetic shell | eyes that have been damaged beyond repair and or that have been removed generally require a glass eye for appearance. |
| Bilateral optic disc edema | while there are several possible causes, a brain tumor is always assumed the cause until ruled out. A potentially life/visually threatening condition. |
| Optic disc shunt vessels | may represent a previous vascular compromise to the retina and or a compressive lesion to the optic nerve. |
| Branch Retinal Venous Occlusion | may cause blindness depending on location/severity and macular involvement. Needs a systemic vascular workup. |
| Central Retinal Venous Occulsion | may cause blindness depending on ischemic or non-ischemic severity and or secondary complications. Needs a systemic workup. |
| Wet Macular Degeneration | may cause blindness, needs appropriate treatment. |
| Pars Planitis | may cause blindness from the secondary effects of chronic inflammation in the eye. |
| Blepharospasm | may cause various levels of visual impairment secondary to the degree of eyelid closure, various treatment options exist. |
| Conjunctival mass lesion | concern over a mass lesion that is not normally present and is growing in size, raises the concern over cancer. Excision/Biopsy needed. |
| Marginal Keratitis | usually a chronic condition that can lead to corneal scarring, irregularity and neovascularization. Untreated can cause loss of vision. |
| Conjunctival cyst | usually removed secondary to comfort and or cosmetic reasons. Not typically associated with blindness issues. |
| Retinal Mass Lesion, vascularized | lesion may be benign, however needs to be photo-documented, A & B scanned and followed for change. Increasing size raises concern for malignancy/enucleation. |
| Convergence Insufficiency | patient experiences double vision when reading, needs visual therapy to enhance his visual systems ability converge at near. Not a pathological concern. |
| Systemic workup for a Hollenhorst plaque | this embolus lodged in the retinal artery/arterioles represents an increased risk for stroke/death. |
| Retinal Hole / Retinal Tear | a hole / tear in the retina may need to be prophylactically treated if it appears likely to lead to a retinal detachment |
| Episcleritis | usually self limiting and uncomfortable, however recurrent flare ups raises the suspicion of a systemic auto-immune disease |
| Central Serous Chorio-retinopathy | typically resolves on its own without treatment, however some cases may leave the patient with some central vision loss |
| Low Vision Workup | patient has lost vision from trauma and or pathology and may benefit from certain low vision devices to help enhance what residual vision they have. |
| Corneal ulcer | bacteria, viruses and fungus are among the common causes of a potentially vision threatening condition. Topical and sometimes systemic treatment is warranted. |
| Choroidal nevus vs. malignant melanoma | a choroidal nevus can transform itself over time (increased diameter and thickness), as this growth reaches a certain size, there is an increased risk for it to become malignant. |
| Corneal Foreign Body | a foreign object imbeded in the cornea needs to be removed and covered with antibiotics for comfort and the prevention of a corneal ulcer which could lead to serious problems. |
| Vitreous Hemorrhage | sometimes the hemorrhage is large/dense enough not to allow visualization of the back of the eye. Its presence can be related to diabetes, retinal tears/detachments, etc. |