



Les urgences en ophtalmologie: ce que l'interniste doit savoir

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72 congrès de la SNFMI, Tours

Jeudi 11 décembre 2014

Pitié-Salpêtrière

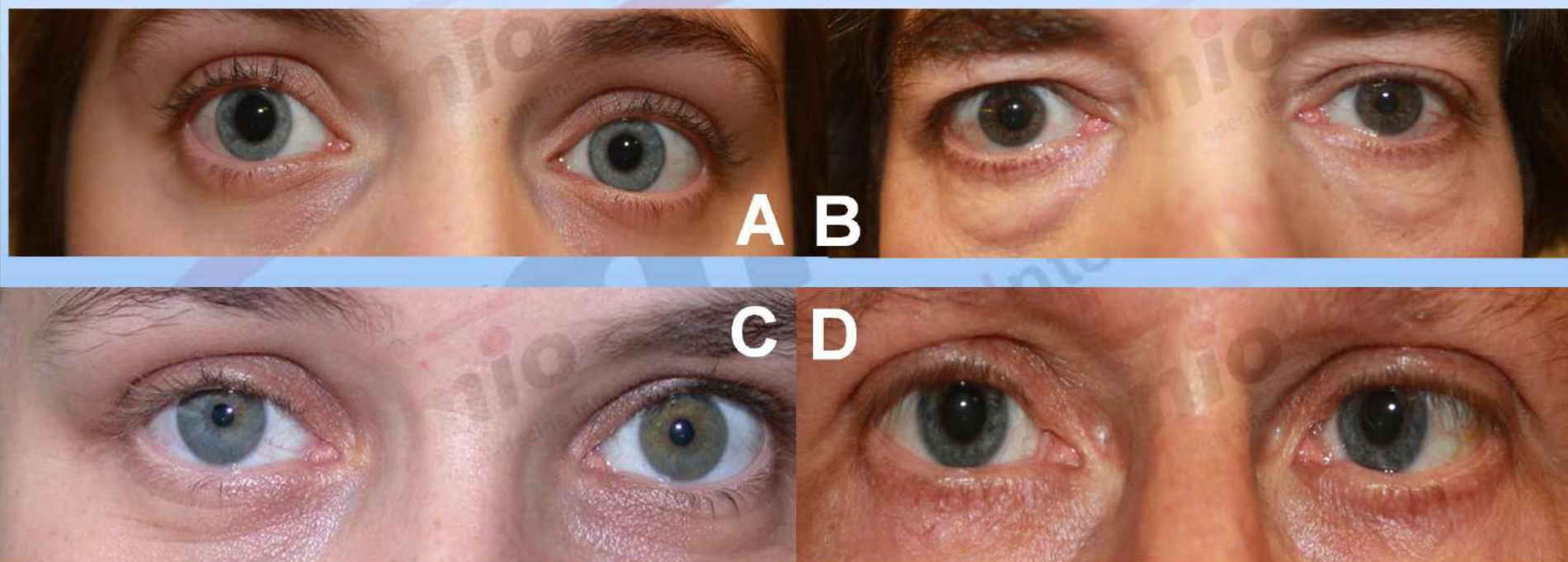
DHU Vision et Handicaps



Les urgences en ophtalmologie

1. Les urgences neurologiques
2. Les urgences oculaires

Les urgences neurologiques





A



B



C



D

Cas clinique

- Mr P, 47 ans, consulte en urgence pour sensation de « pesanteur de sa paupière supérieure gauche depuis hier ».









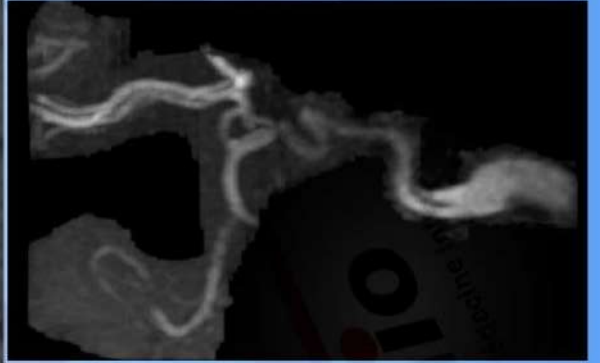
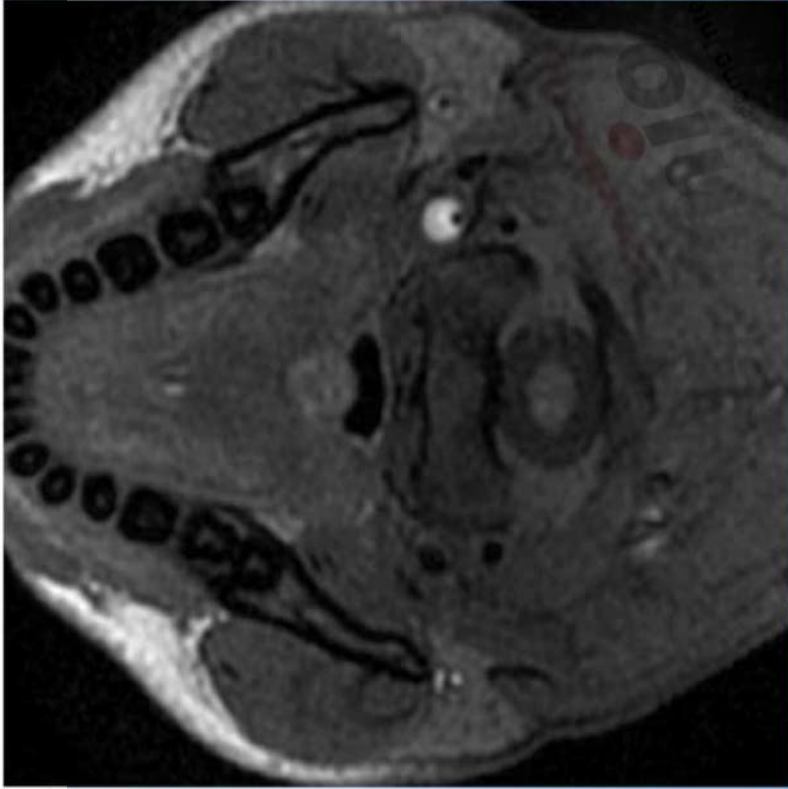
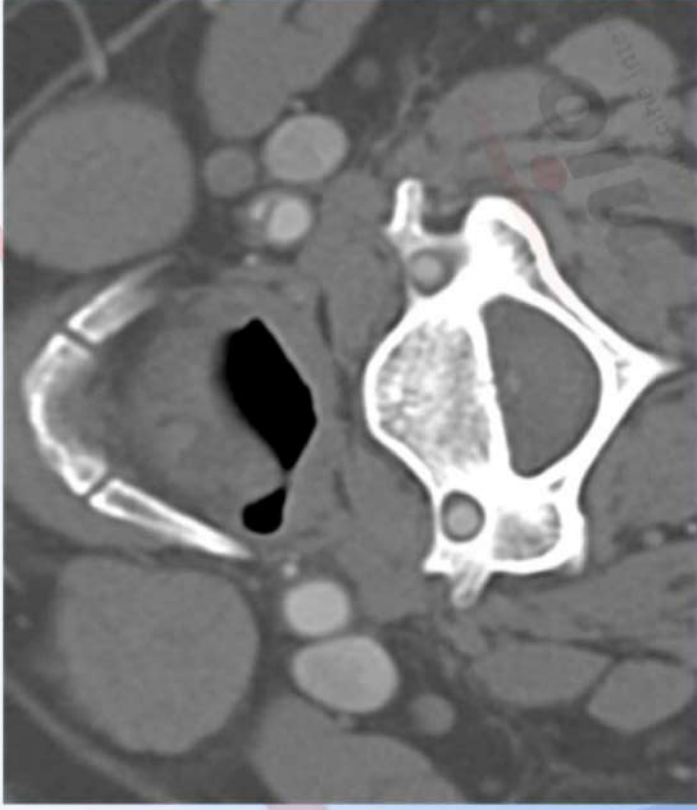
Test Iopidine



Apres 30mn



Apres 60mn



Site	Pour le diagnostic	Pour le diagnostic	Pour la localisation	Pour la localisation
	Cocaïne	Apraclonidine	Hydroxy-amphétamine	Phényléphrine 1 %
Normal	Dilatation	Pas de changement	Dilatation	Pas de changement
Syndrome central ou pré-ganglionnaire	Pas de changement/ changement mineur	Dilatation	Dilatation	Pas de changement
Syndrome post-ganglionnaire	Pas de changement	Dilatation	Pas de changement	Dilatation

Cas clinique

- Jeune femme de 23 ans, consulte pour mydriase droite depuis 15 jours
- Antécédents: 3 AVC dont le dernier il y a
- Traitement actuel: Kardégic







Anisocorie: éviter les pièges

Etape 1: Décider quelle est la pupille pathologique

- Examen dans le noir
- Examen à la lumière
- Examen en convergence

Etape 2: Signes cliniques associés

- Ptosis, oculomotricité, enophtalmie, céphalées etc...

Etape 3: Test aux collyres

Etape 4: Imagerie ciblée dans le délais requis

***Pupilles: 2 drapeaux rouges:
CBH et III douloureux !!!***

LES DRAPEAUX ROUGES

« CLASSIQUES »

1. BAV aiguës

- NORB
- NOIA-A, NOIAA-NA
- Apoplexie pituitaire

2. Pupilles

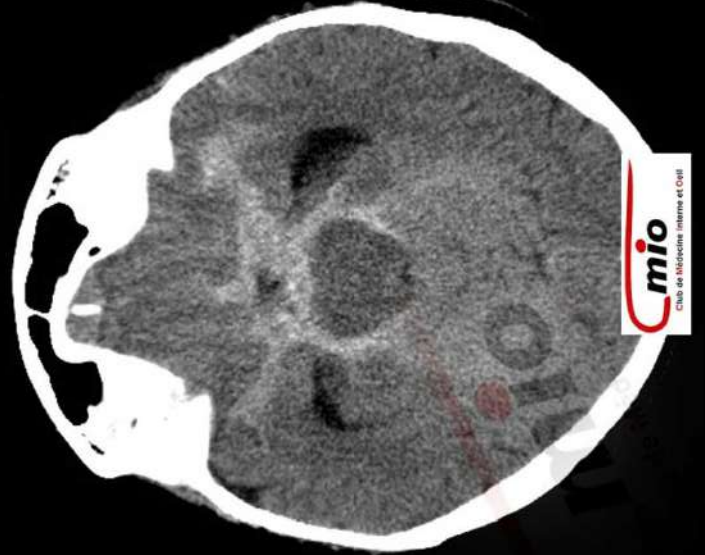
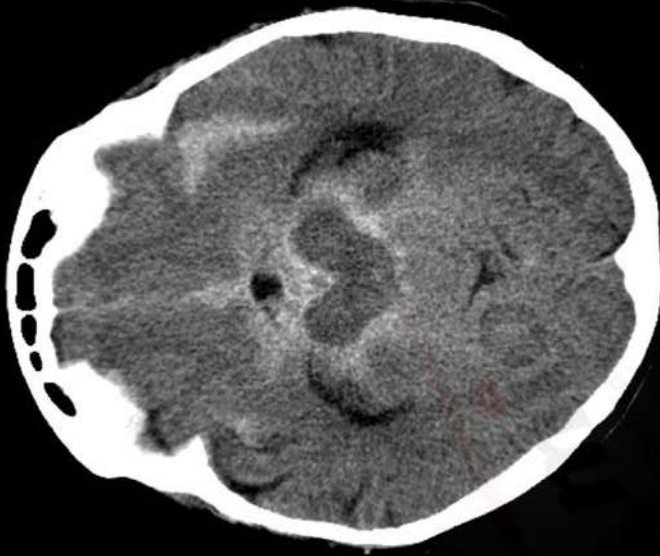
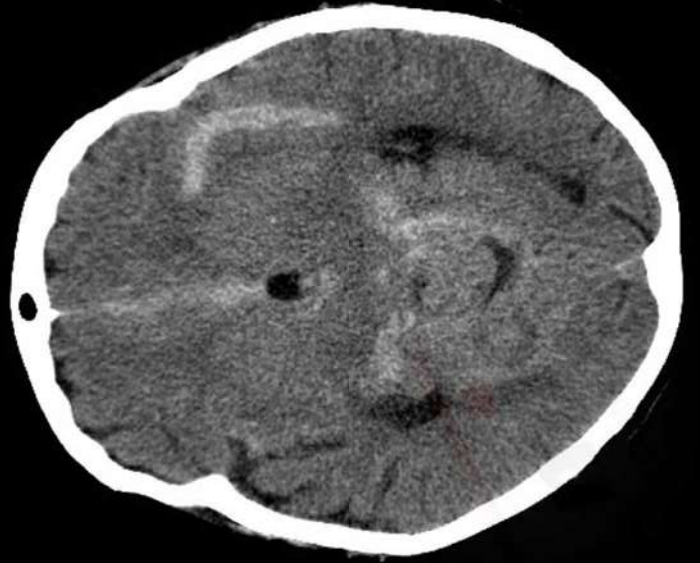
- III (mydriase)
- CBH (myosis)

3. Oculomotricité

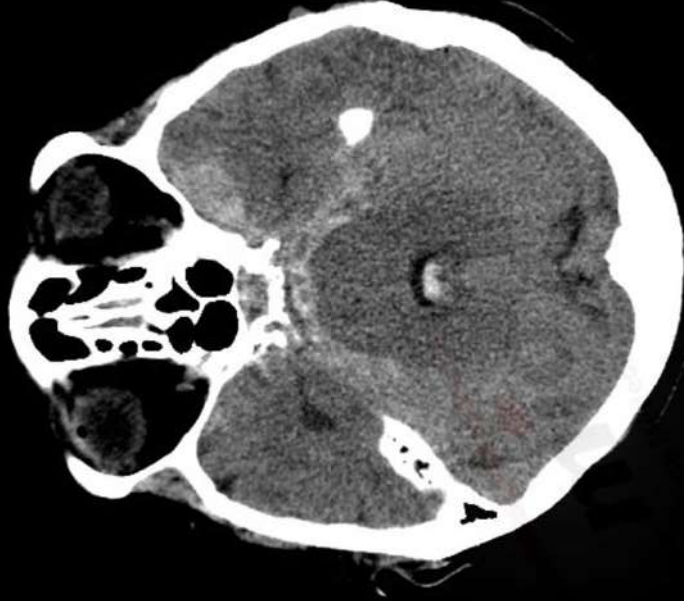
- Anévrisme
- Myasthénie
- FCC
- Horton
- Apoplexie pituitaire

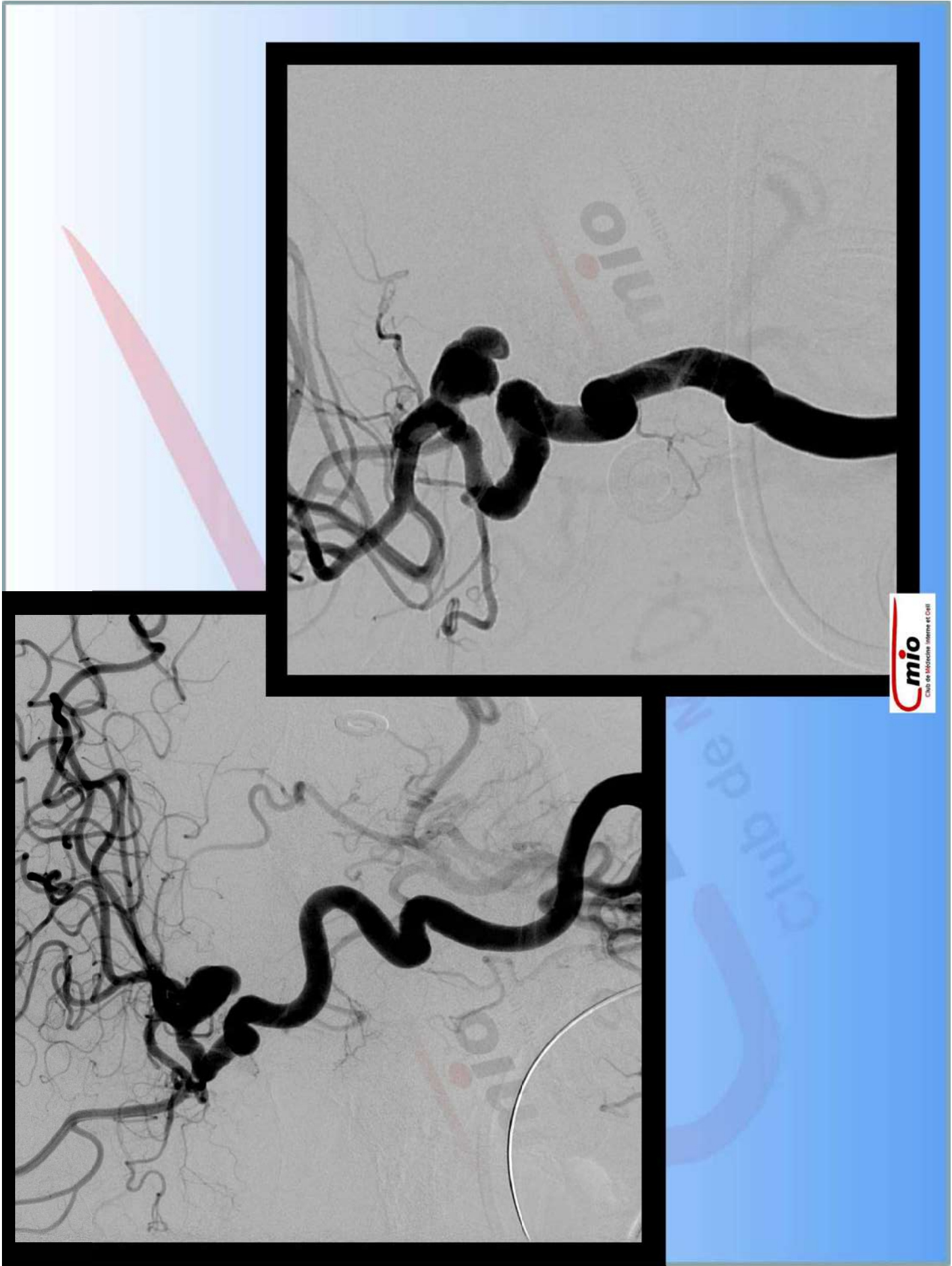
4. Œdème papillaire





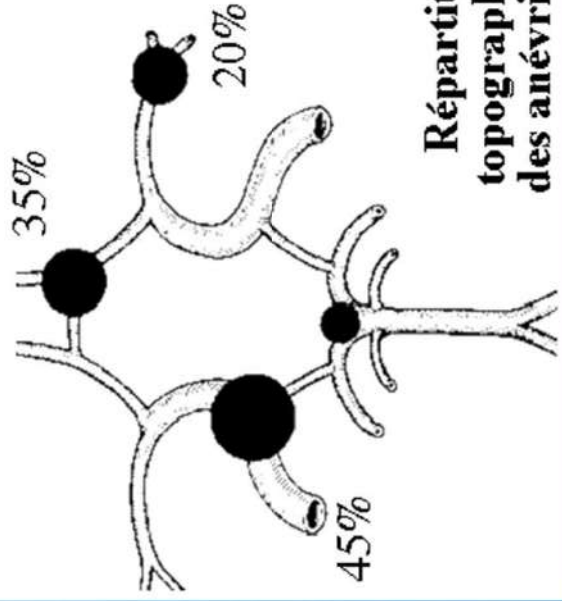
mio
CLUB DE MEDICINA INTERNA Y CIR



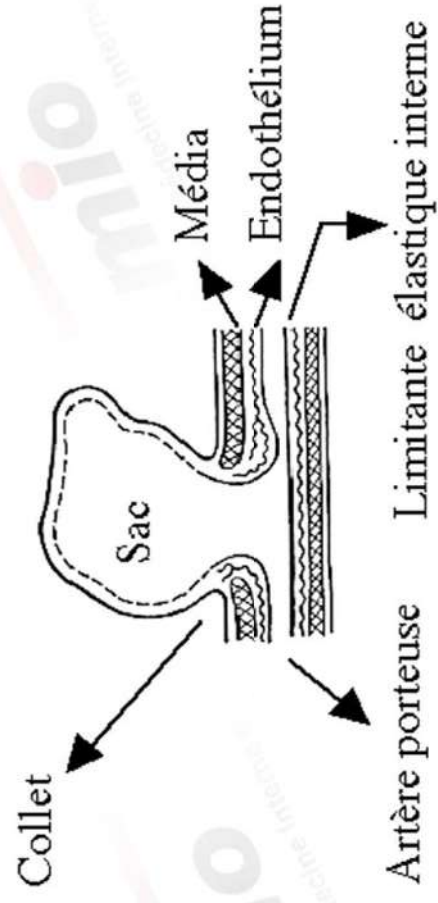








**Répartition
topographique
des anévrismes**



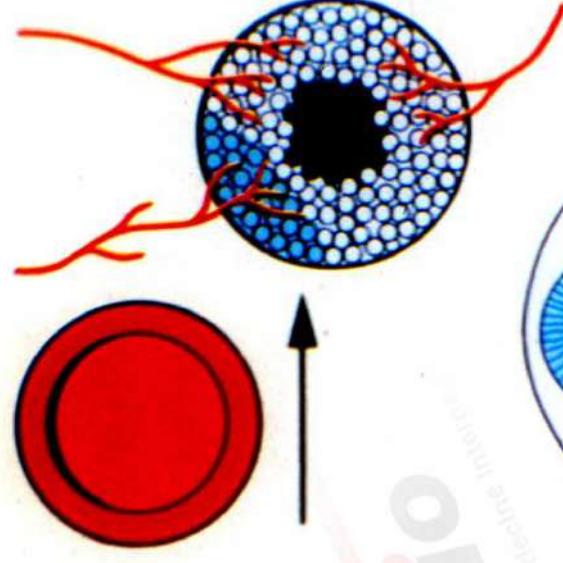
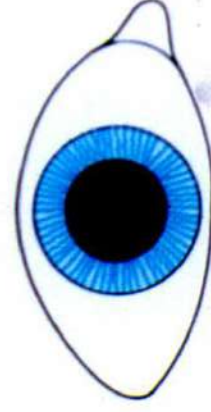
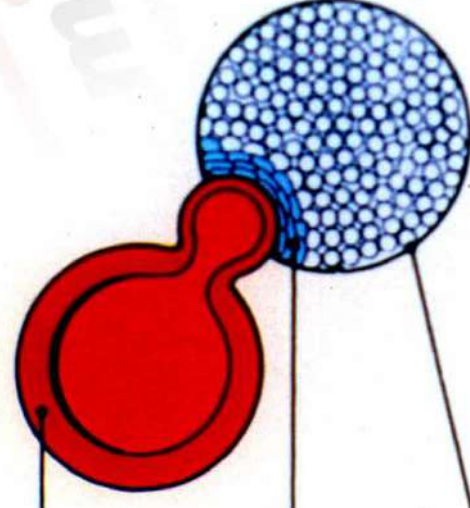
Structure schématique d'un anévrisme

artère
communicante
postérieure

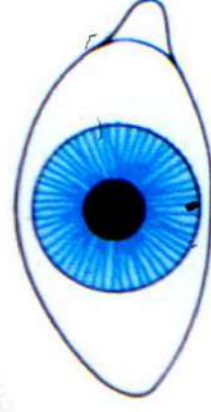
compression
des fibres
pupillaires
par l'anévrysme

III^e nerf

dilatation
pupillaire



atteinte des
vasa vasorum
provoquant
l'ischémie
des fibres
centrales

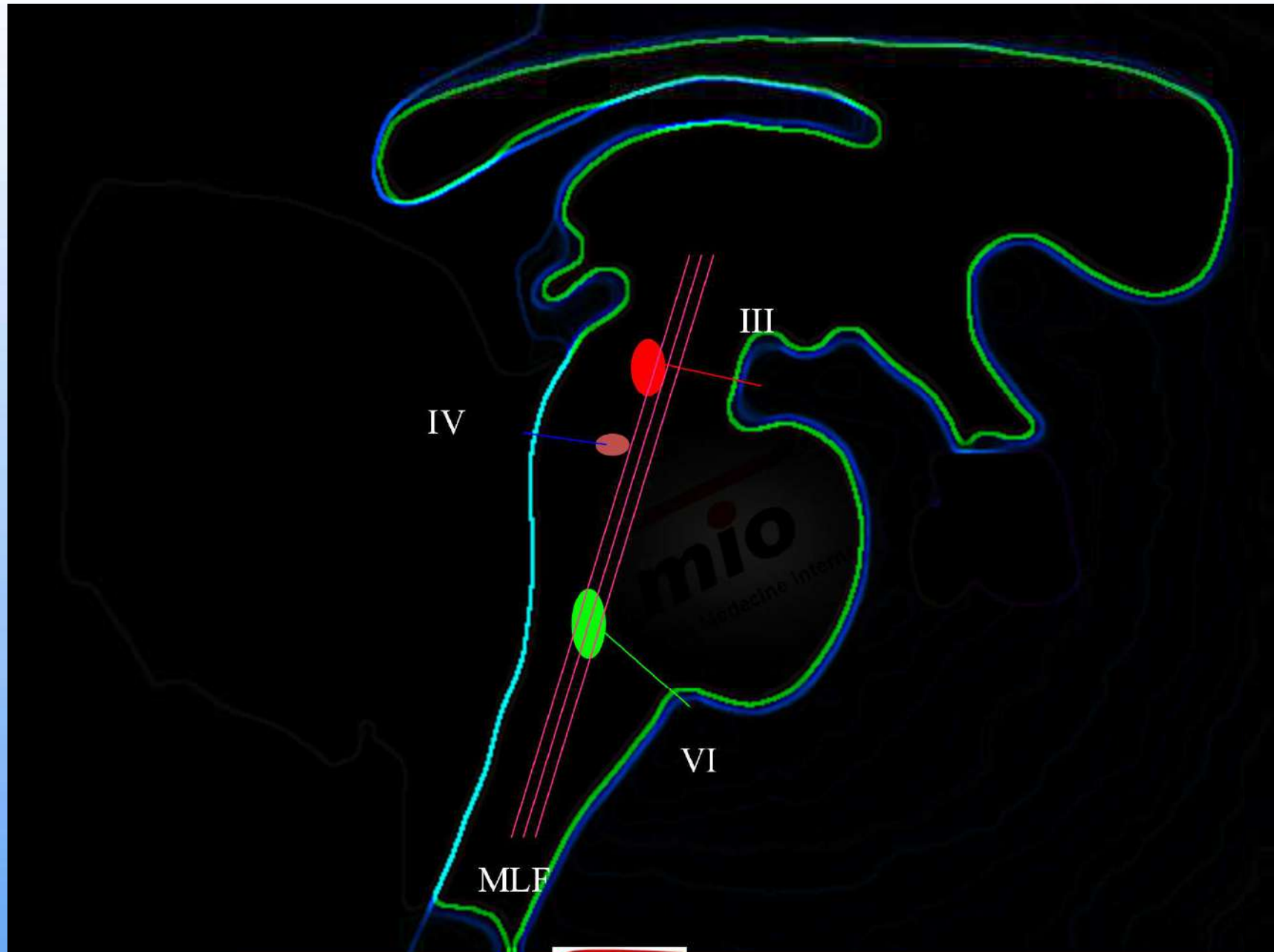


pupille normale

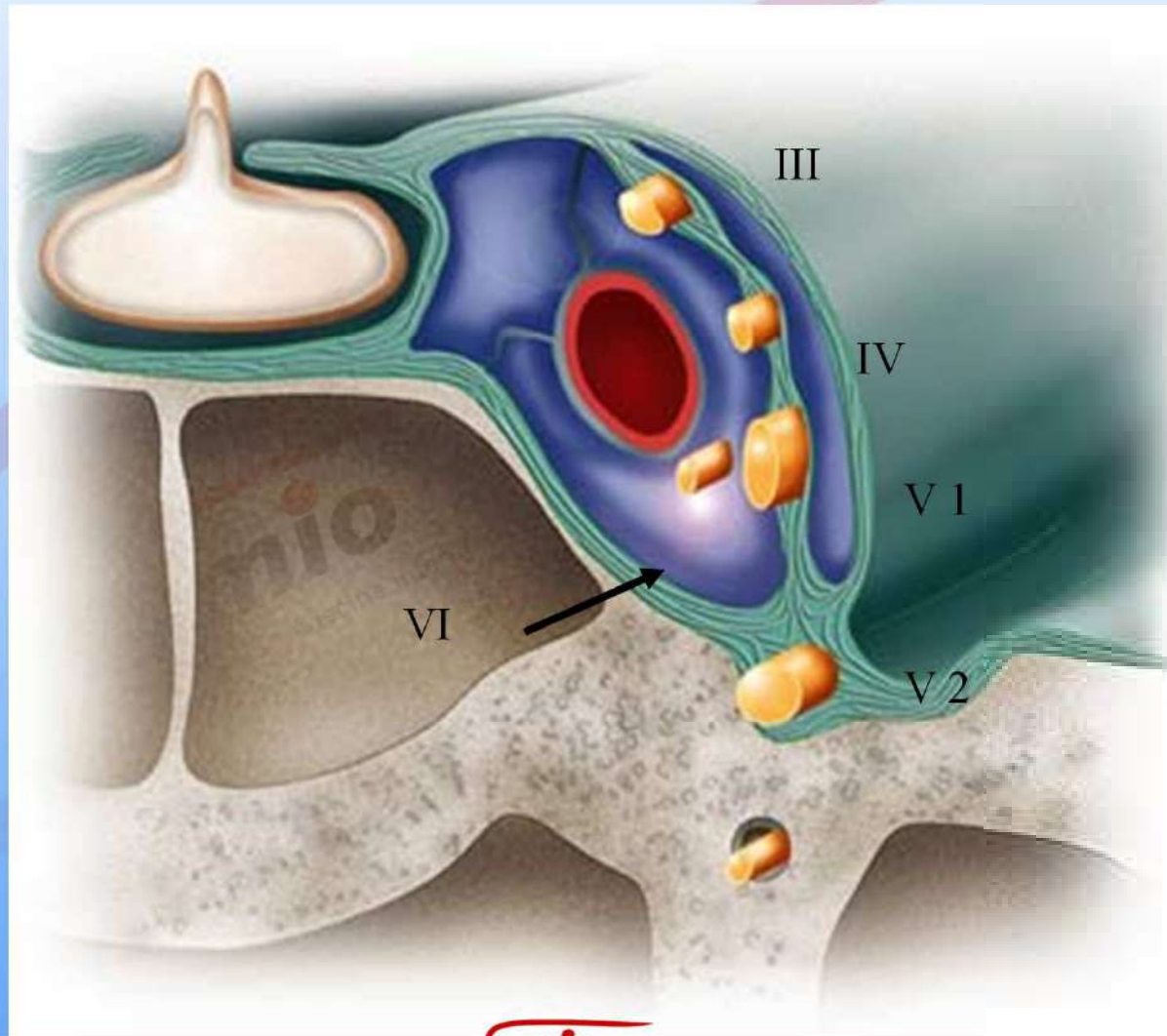
Cas clinique







Trajet intracaverneux





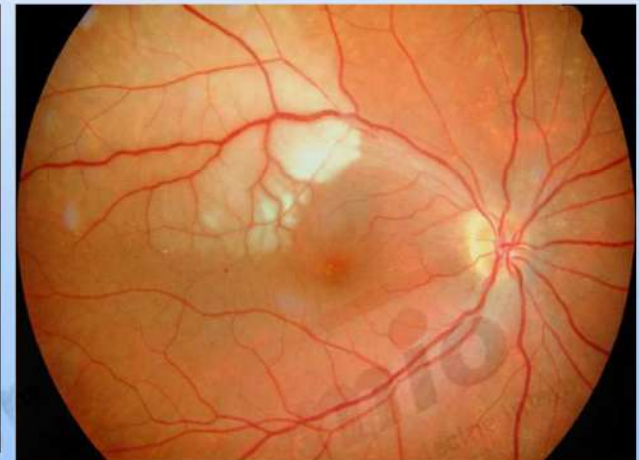
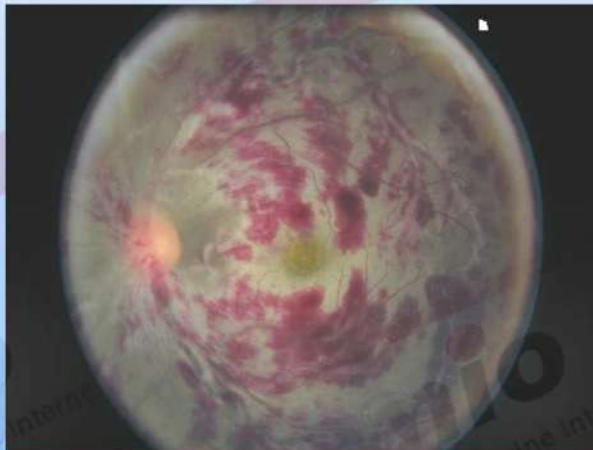
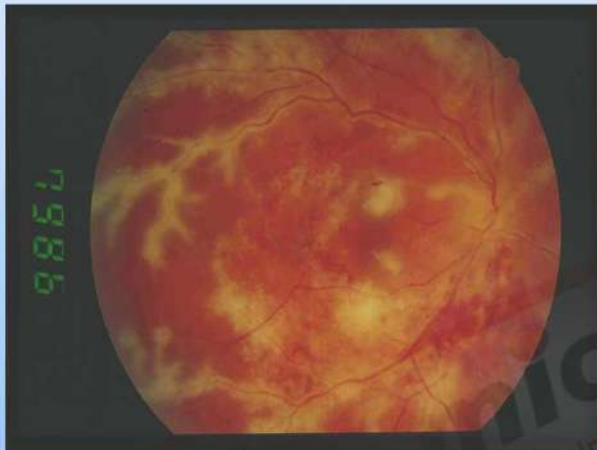


Les urgences vitales

- Myasthénie
- Horton
- Apoplexie pituitaire
- Anévrisme
- Dissection carotidienne

Les urgences ophtalmologiques

Diagnostic différentiel des vascularites rétiniennes



Introduction

- Epidémiologie mal connue
- Entité majeure du groupe des inflammations intraoculaires entre UI and UP/PanU
- Spectre large de sévérité des atteintes
- Importance de l'orientation diagnostique
- Challenge thérapeutique

Questions principales

- BAV
- Hyalite
- Type d'atteinte vasculaire
- Maladie systémique associée
- Stratégie thérapeutique
- Complications

Bilan

- Généralement extensif
- Toujours éliminer une infection
- Déterminer si atteinte oculaire pure ou associée à une maladie systémique
- Répéter le bilan si nécessaire

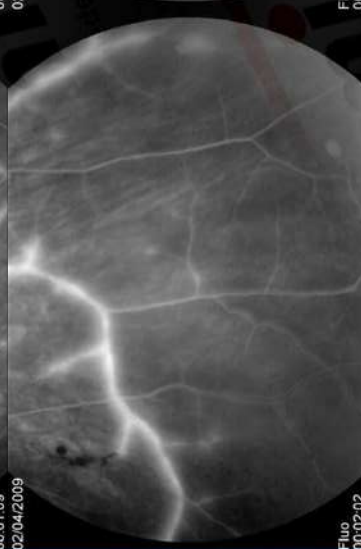
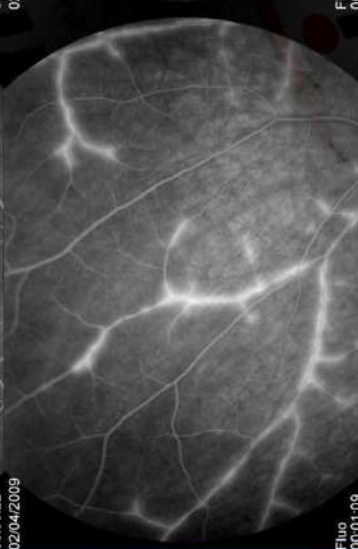
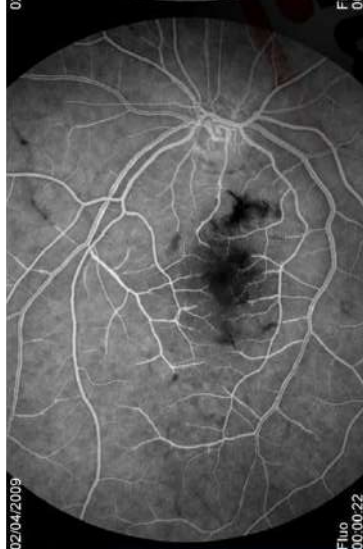
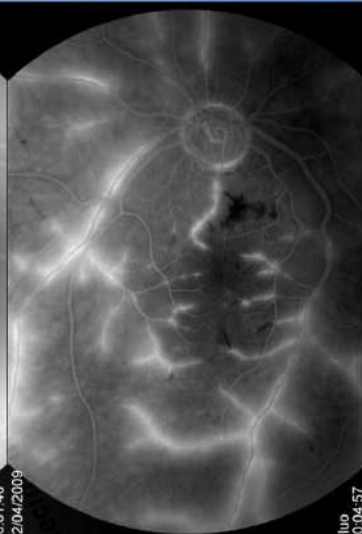
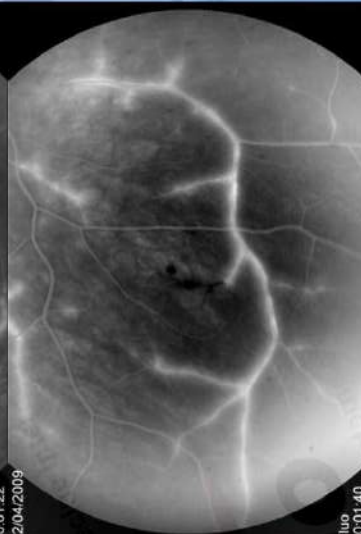
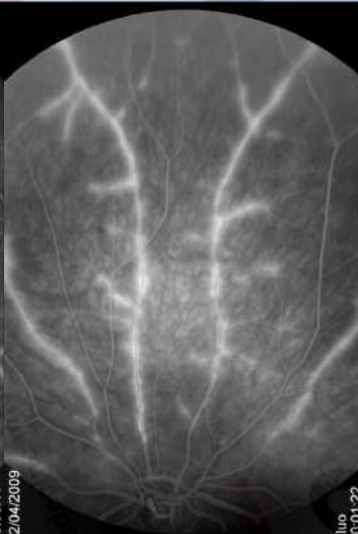
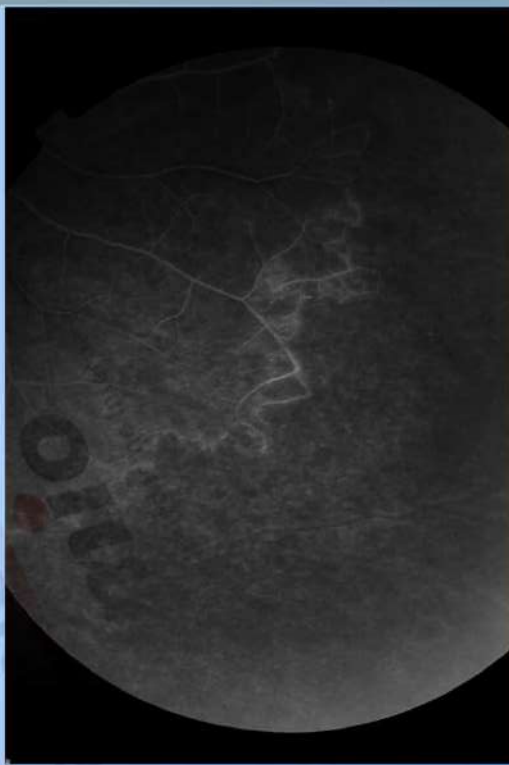
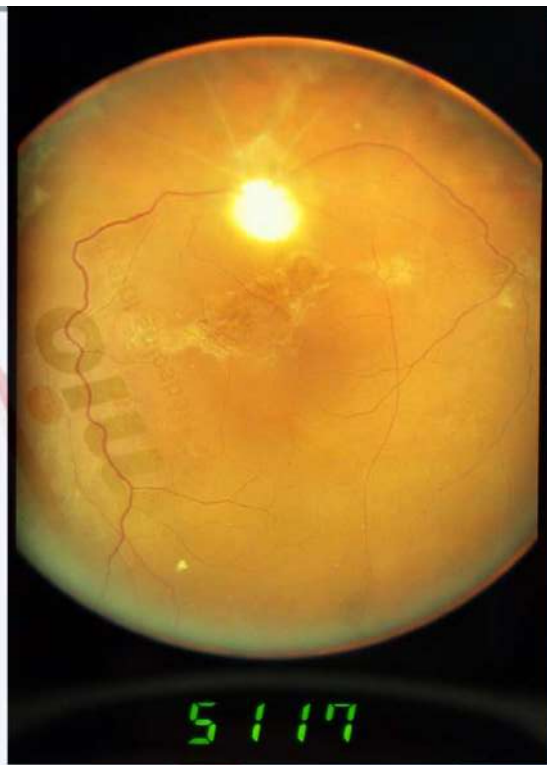
Complications

- Occlusions vasculaires
- Ischémie
- Néovascularisation rétinienne
- Rubéose irienne
- Oedème maculaire cystoïde
- Hémorragie intravitréenne
- Décollement de rétine



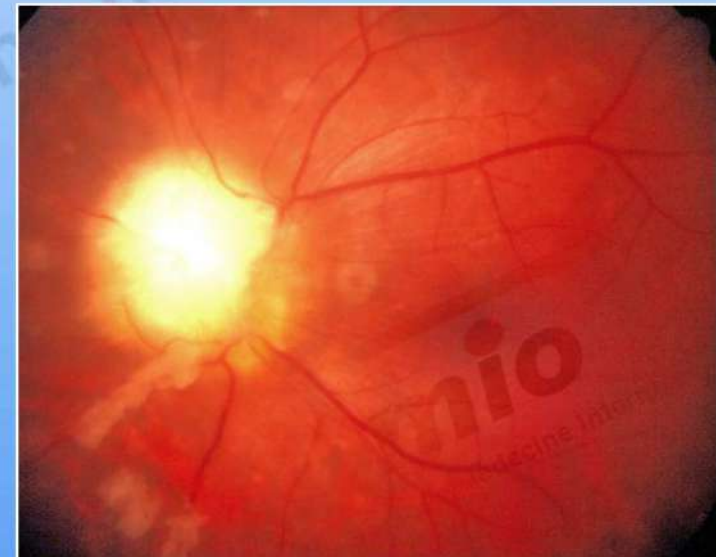
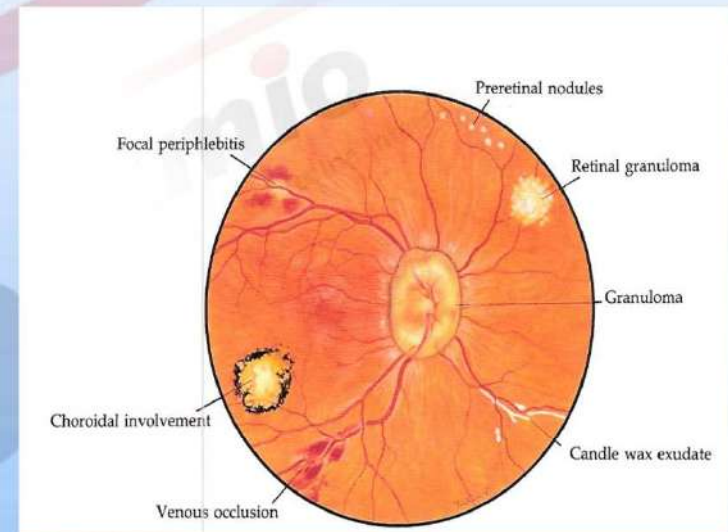
Maladies systémiques

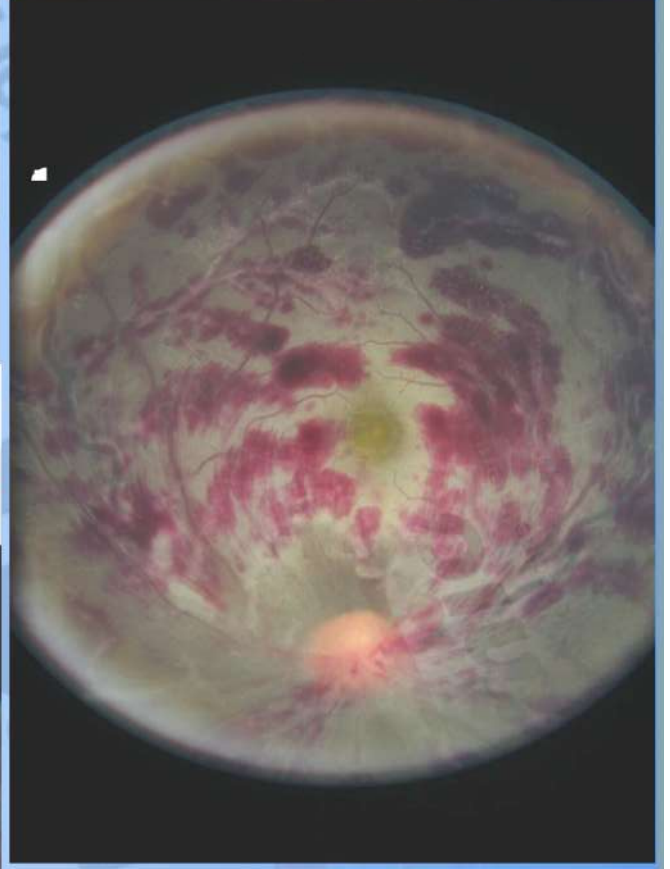
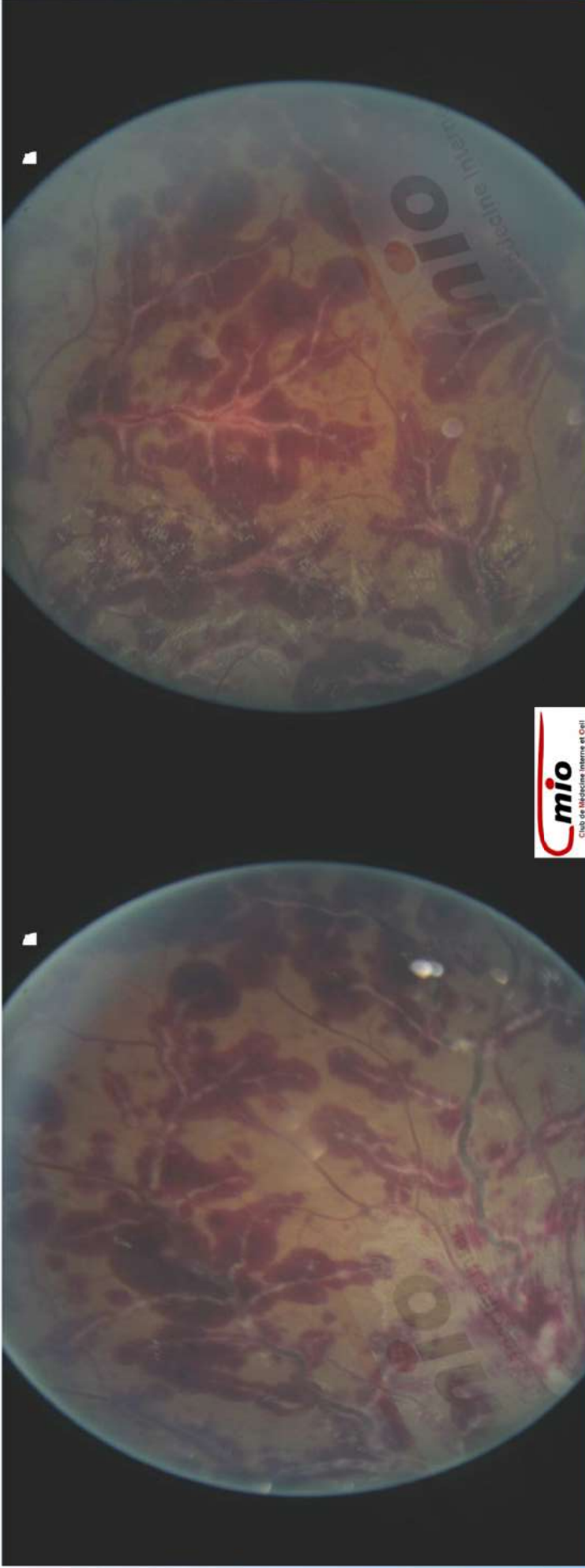
mio
Club de Médecine Interne et Oeil

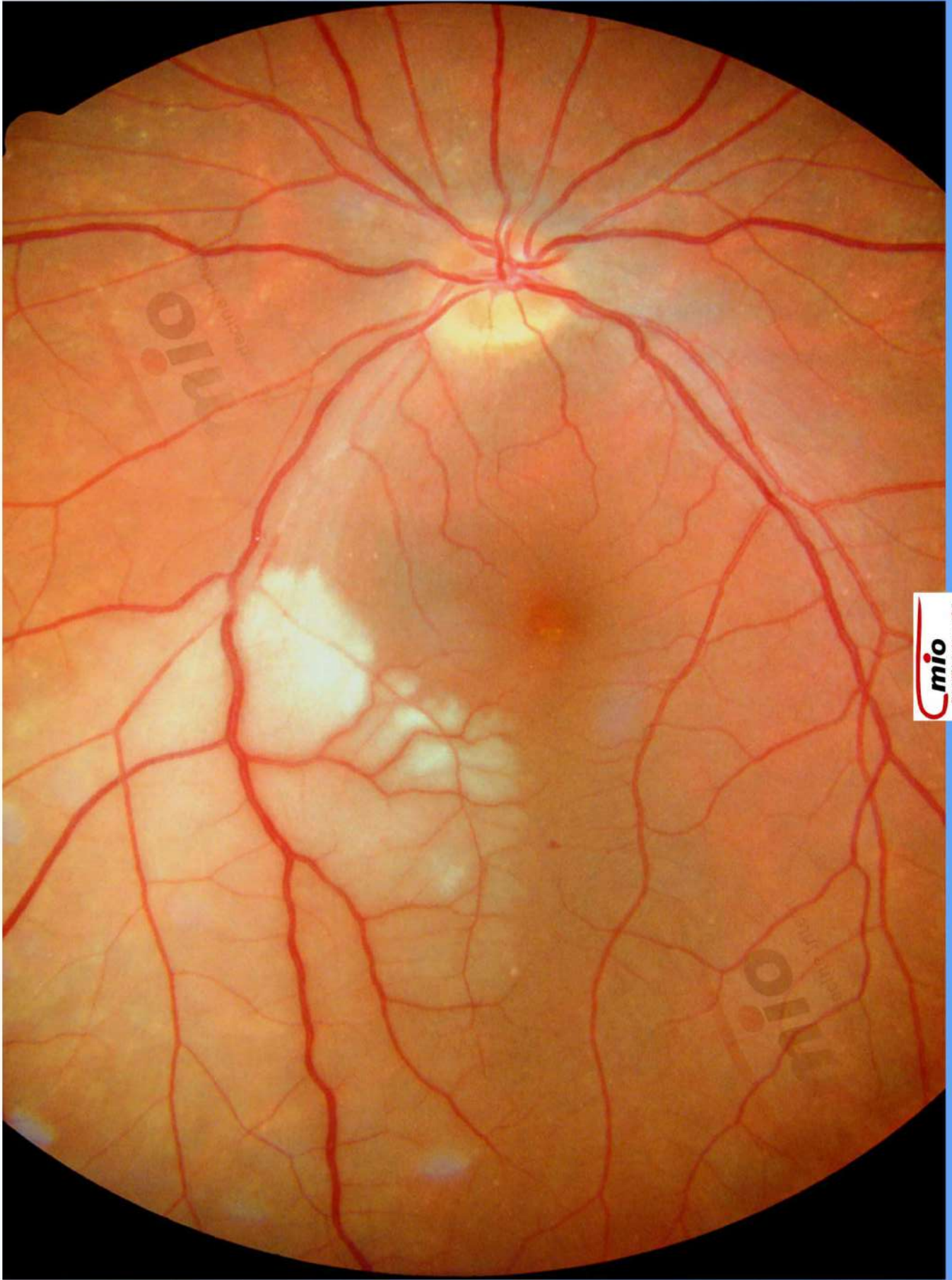


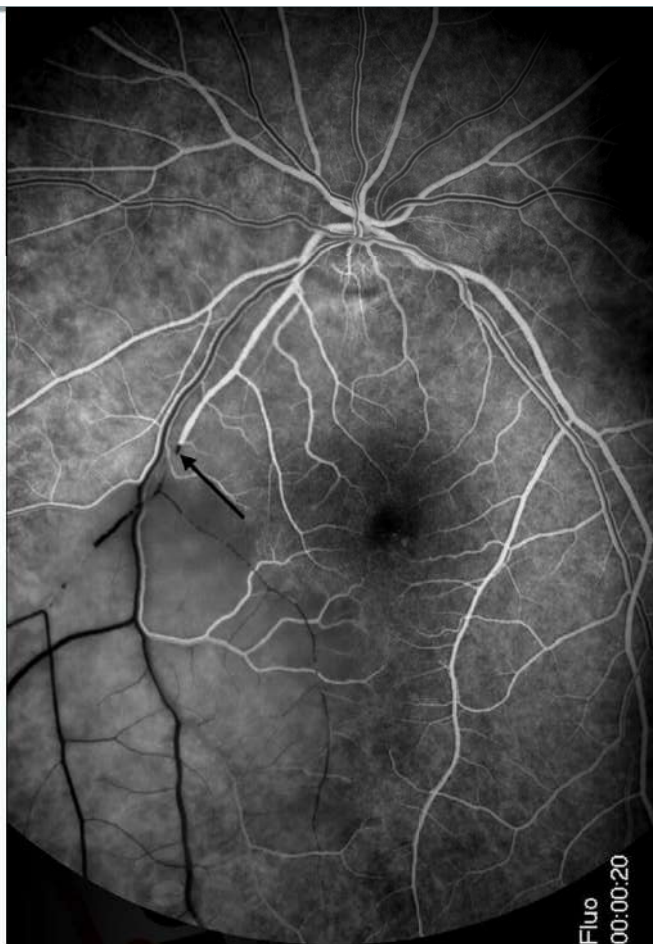
Périphlébite segmentaires et/ou nodulaires ($\pm$ coulées de bougie)
et/ou macroanevrismes dans un oeil inflammatoire

20 à 40% des cas

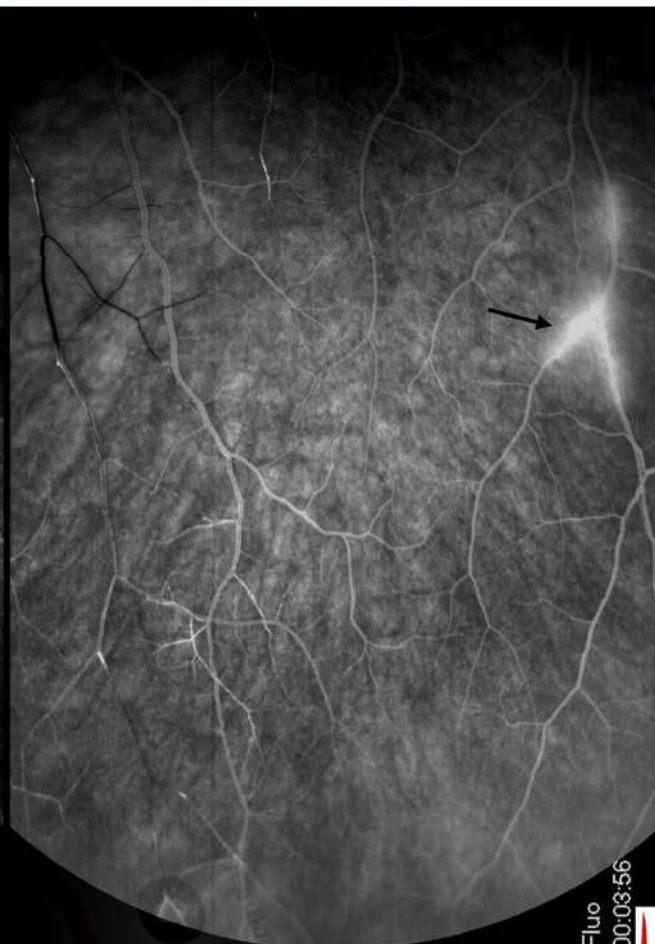








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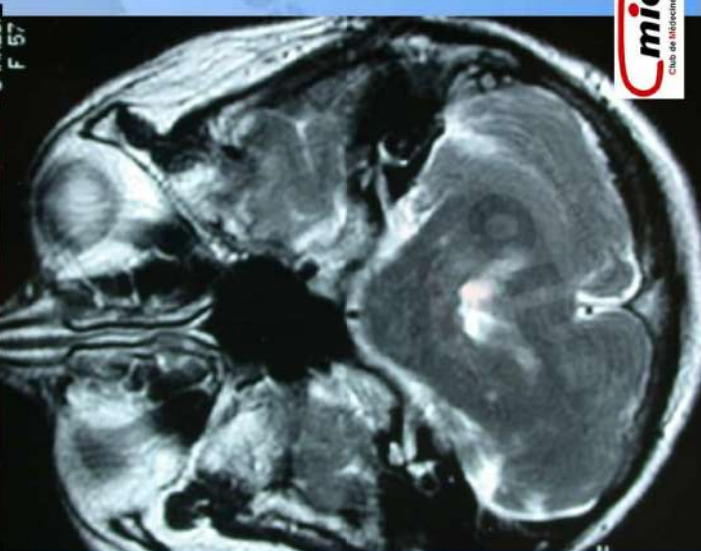
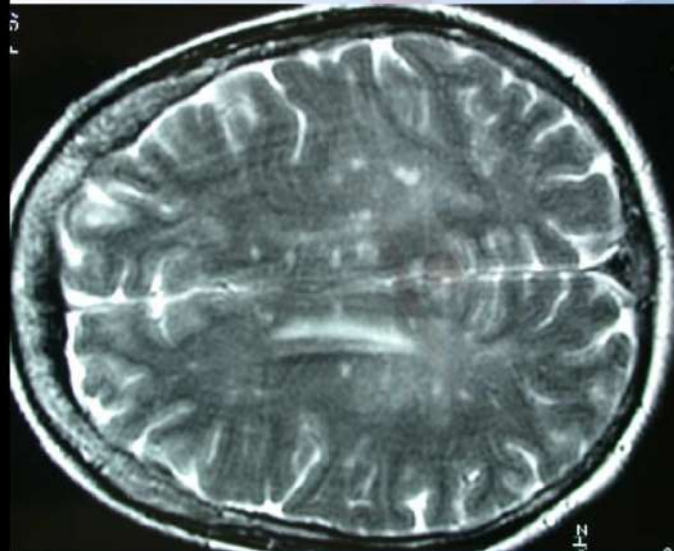
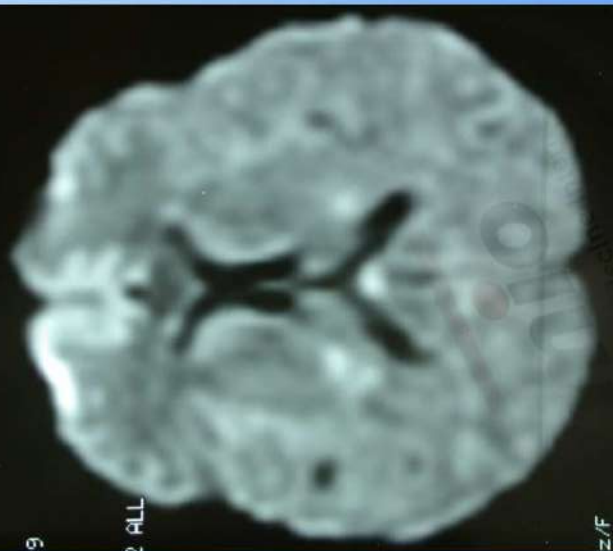
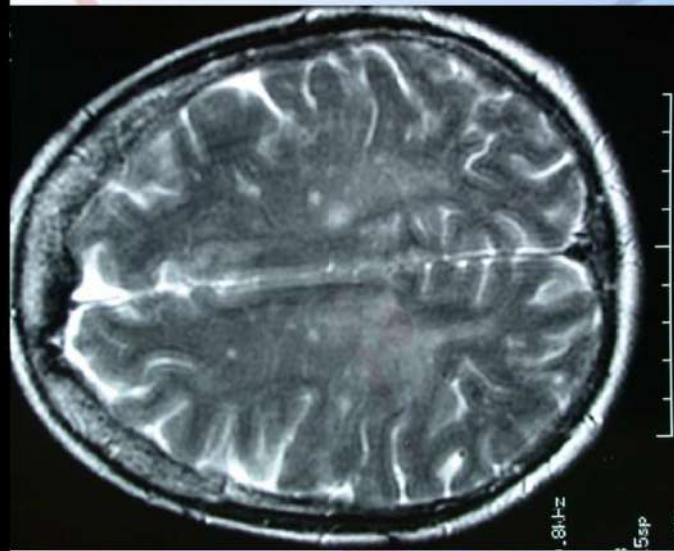


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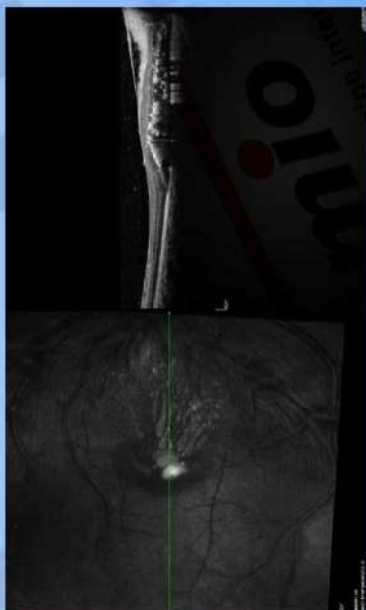
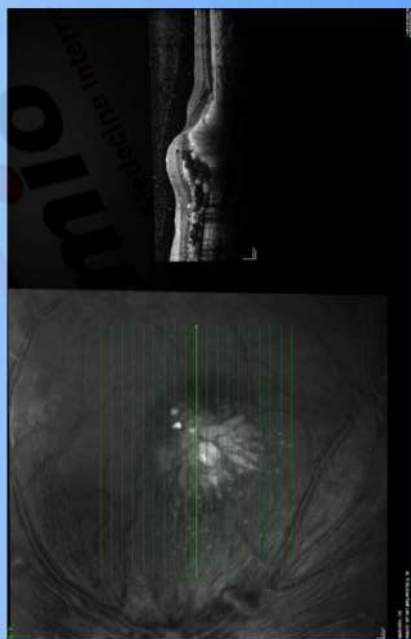


SUSAC / SICRET sd

- • John O. Susac
- • 1975
- • 2 cas en 3 semaines
- • Microangiopathie du SNC et retine (1979)
- • Occlusion d'artères rétiniennes et hypoacousie
- • Microangiopathie (arterioles $< 100\mu\text{m}$)
- • Origine immunologique
- • Triade : encephalopathie/ hypoacousie/ occlusion artères rétiniennes



Non infectieuses limitées à l'oeil

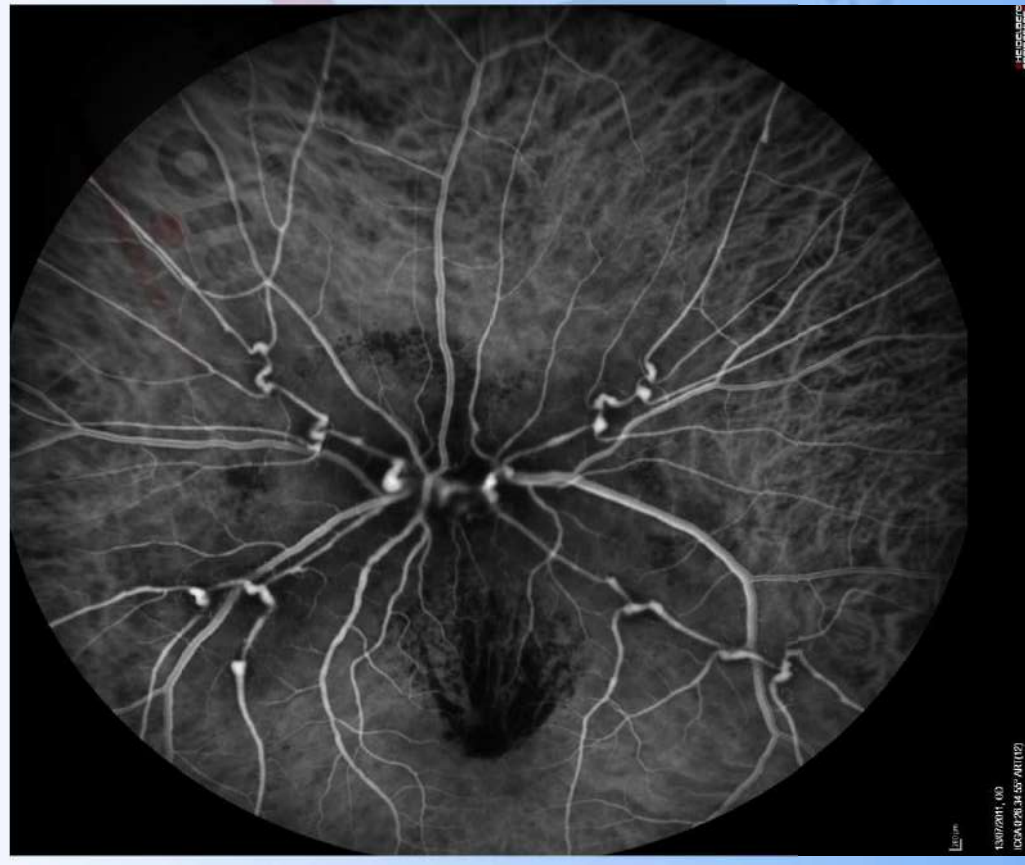


FA 5:45.97 55° ART [HS]



FA 4:22.33 55° ART [HS]





IRVAN

- *Idiopathic Retinal Vasculitis*
- *Aneurysms and Neuroretinitis*
- Rare
- 3 critères majeurs: VR, RN, dilation anévrismales des bifurcations artérielles
- 3 critères mineurs : Zones ischémies périphériques, neovascularisation rétinienne, exsudats maculaires
- Pronostic à long-terme sombre
- Traitement : PPR, anti-VEGF et corticothérapie locale et systémique

Idiopathic Retinitis, Vasculitis, Aneurysms, and Neuroretinitis (IRVAN)

New Observations and a Proposed Staging System

Michael A. Samuel, MD,¹ Robert A. Equi, MD,² Tom S. Chang, MD, FRCSC,³ William Mieler, MD,⁴ Lee M. Jampol, MD,⁵ Dawn Hay, RN,⁶ Lawrence A. Yannuzzi, MD⁷

Purpose: To review the clinical features, disease progression, and effects of treatment on idiopathic retinitis, vasculitis, aneurysms, and neuroretinitis (IRVAN).

Design: Retrospective interventional case series.

Participants: Ten patients with IRVAN originally reported in 1995 and 12 additional patients identified since the original series.

Intervention: Patients in the series had testing that may have included fluorescein angiography, indocyanine green angiography, and systemic evaluation. Treatments included panretinal laser photocoagulation, cryotherapy, vitrectomy surgery, and injection of pericocular or intravitreal steroids.

Main Outcome Measures: Initial visual acuity (VA), initial stage at diagnosis, clinical course, surgical intervention, final VA, and complications of disease.

Results: A total of 44 eyes of 22 patients were studied; 9 eyes had reached stage 1 or 2 disease at last follow-up, 17 had reached stage 3, and 12 had reached stage 4 or 5. At the time of last follow-up, 14 eyes had maintained 20/20 vision, 15 had between 20/40 and 20/200 vision, and 9 had 20/300 vision or worse. Later stages of retinal ischemia are associated with worse VA. Thirty-two of 38 followed eyes were treated. Twenty-five were treated initially with panretinal laser photocoagulation. The clinical course of each eye after initiation of panretinal laser photocoagulation was evaluated with respect to the final VA and stage of ischemic retinopathy at the initiation of treatment. Panretinal laser photocoagulation was initiated in 3 eyes at stage 2, 16 at stage 3, 5 at stage 4, and 1 at stage 5. Seven eyes underwent grid laser retinal photocoagulation of the macula for macular edema.

Conclusions: Idiopathic retinitis, vasculitis, aneurysms, and neuroretinitis is an isolated retinal vascular disease that can progress rapidly to severe vision loss due to ischemic sequelae despite treatment with panretinal laser photocoagulation. Based on our review of the largest cohort of IRVAN patients, early panretinal laser photocoagulation should be considered when angiographic evidence of widespread retinal nonperfusion is present, and before (or shortly after) the development of neovascularization. A functional staging system is proposed to improve treatment paradigms. *Ophthalmology* 2007;114:1526–1529 © 2007 by the American Academy of Ophthalmology.



The diagnosis of idiopathic retinitis, vasculitis, aneurysms, and neuroretinitis (IRVAN) is based on a constellation of clinical features. Three major criteria (retinal vasculitis, aneurysmal dilations at arterial bifurcations, and neuroretinitis) and 3 minor criteria (peripheral capillary nonperfu-

sion, retinal neovascularization, and macular exudation) are used to diagnose IRVAN.¹ Although IRVAN was believed initially to be a benign self-limiting condition,

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⁴ Department of Ophthalmology and Visual Science, University of Chicago, Chicago, Illinois.

⁵ Department of Ophthalmology, Feinberg School of Medicine, Northwestern University, Chicago, Illinois.

⁶ Department of Ophthalmology, University of British Columbia, Vancouver, Canada.

⁷ Vitreous-Retina-Macula Consultants of New York, New York, New York.

Supported in part by grants from Research to Prevent Blindness, New York, New York (Wills Eye Hospital, Northwestern University).

The authors have no conflicting or financial relationship in anything discussed.

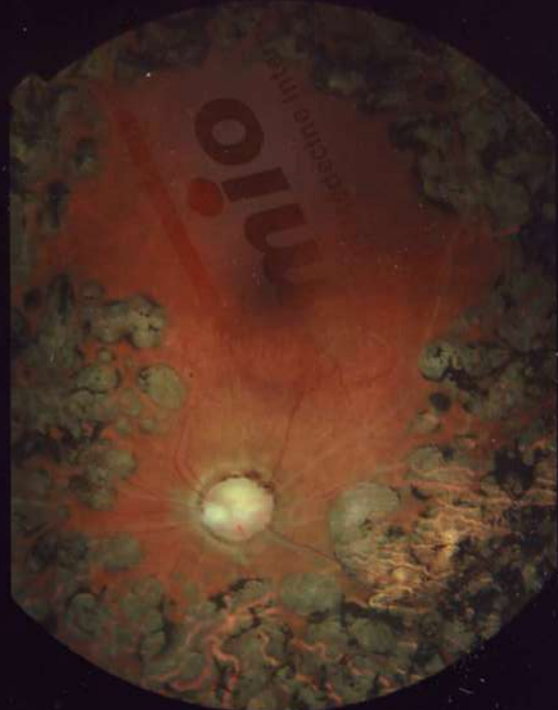
Reprint requests to Tom Chang, MD, FRCSC, Retina Institute of California, 800 South Fairmount Avenue, Suite 312, Pasadena, CA 91105. E-mail: tchang@retinainstitute.com.



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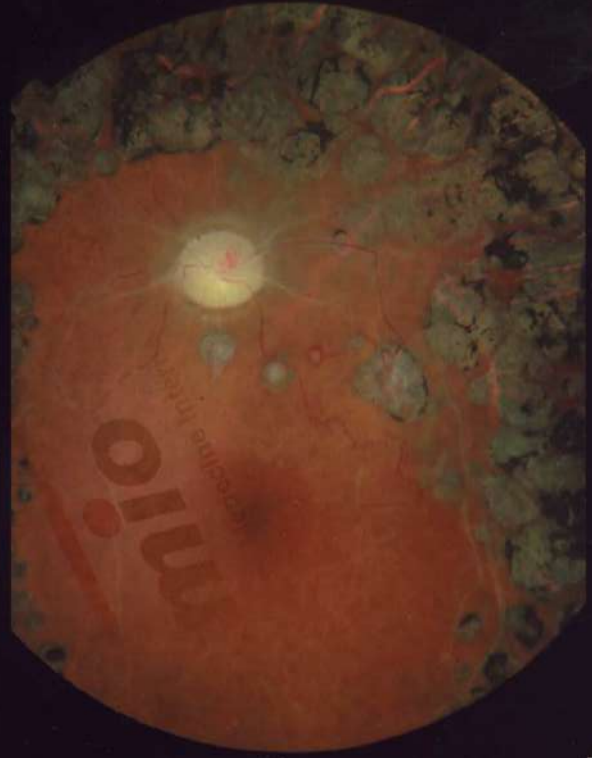


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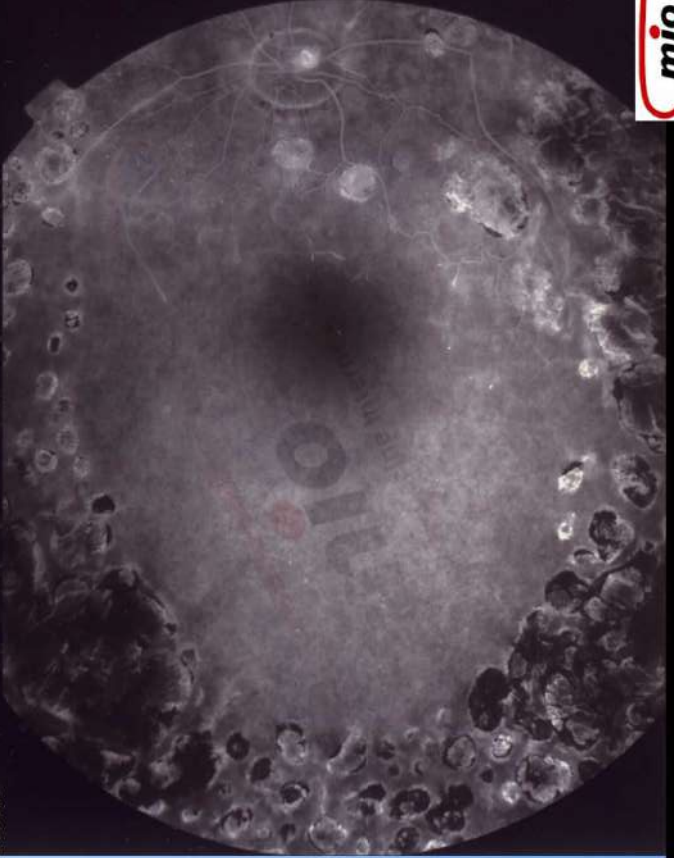




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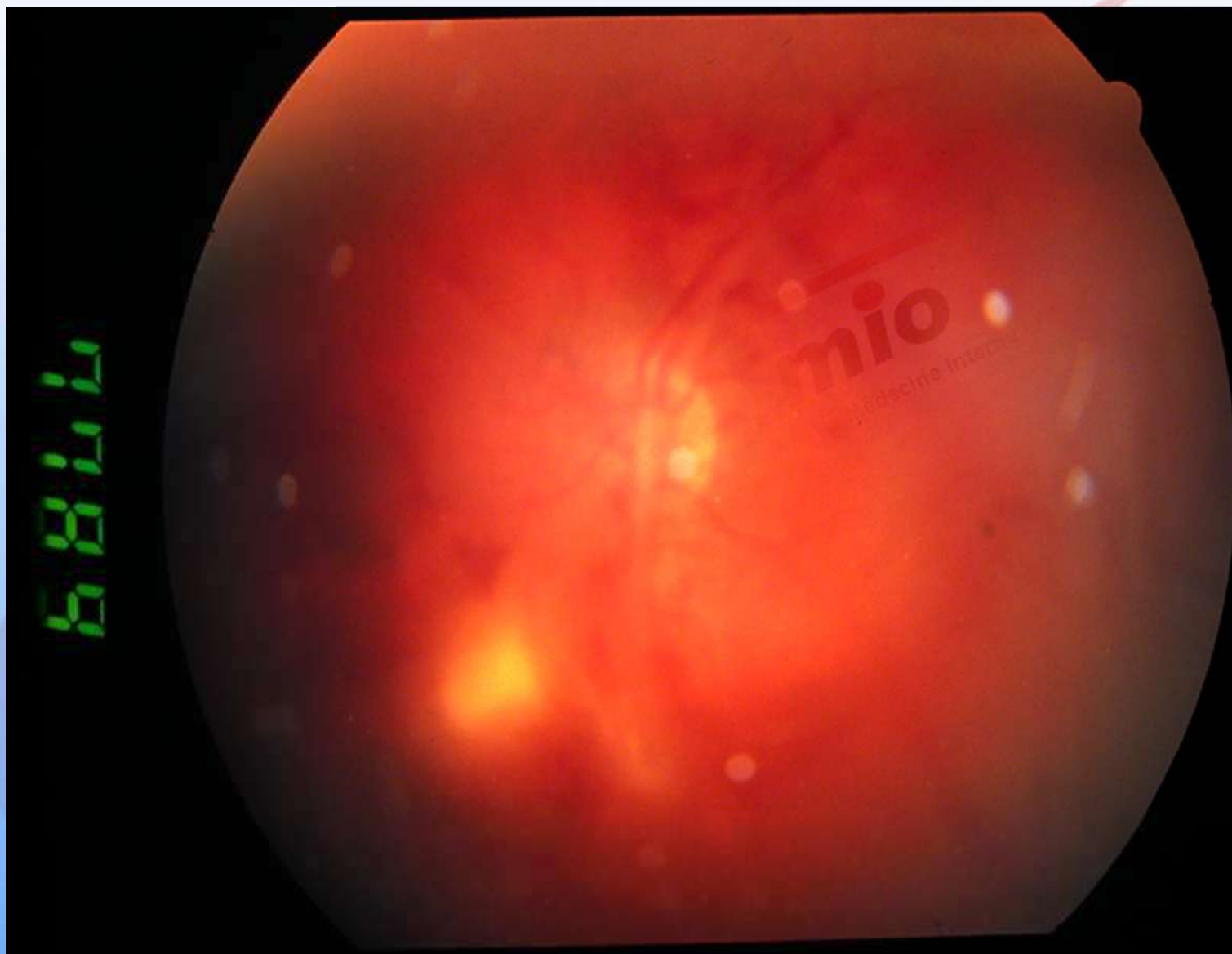


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Infectieux

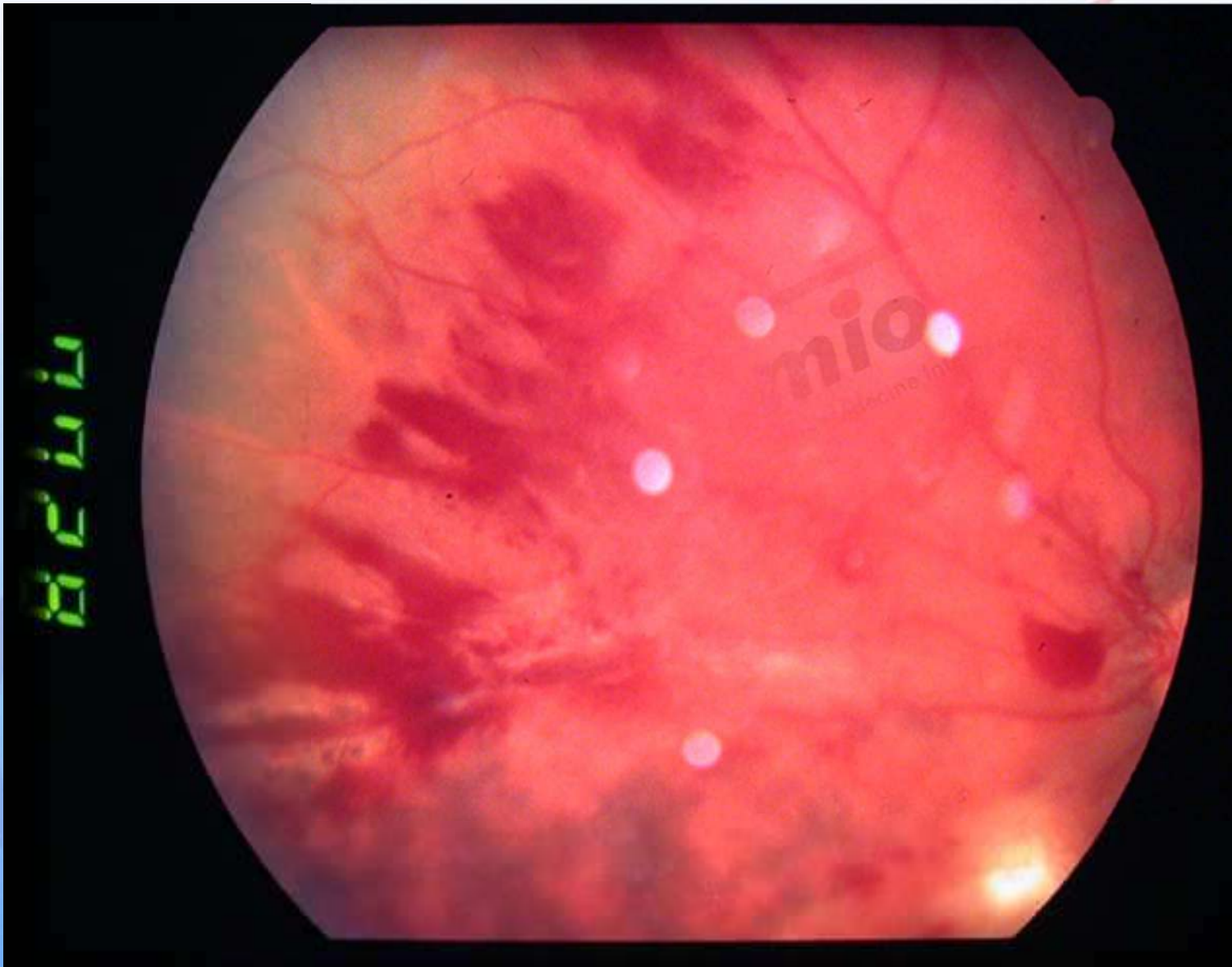
- ● Toxoplasmose
- ● Syphilis
- ● Tuberculose
- ● Lyme
- ● Whipple
- ● Griffe du chat
- ● Brucellose
- ● Leptospirose
- ● Infections virales



Sequence 1



Sequence 2



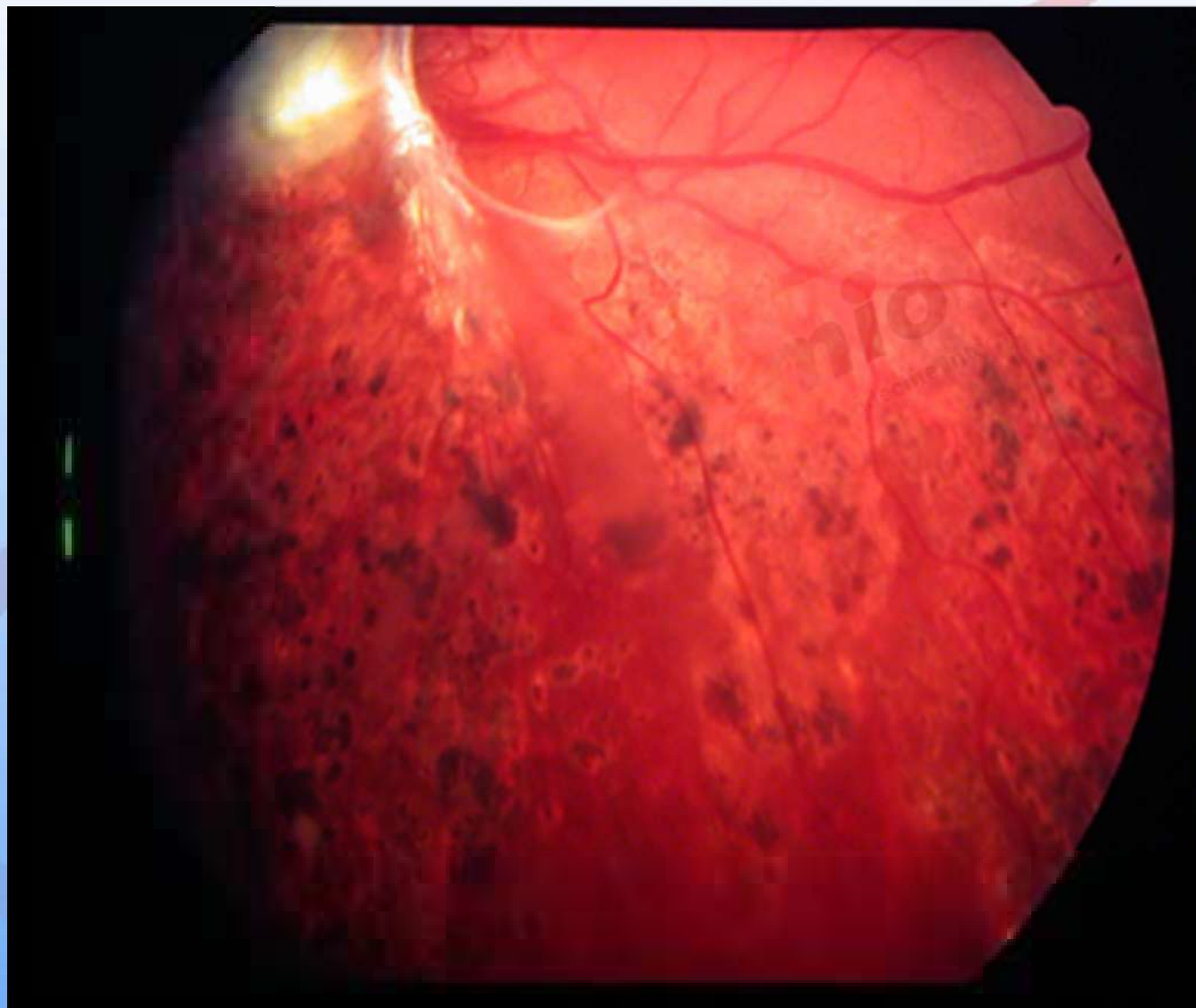
Sequence 3



Sequence 4

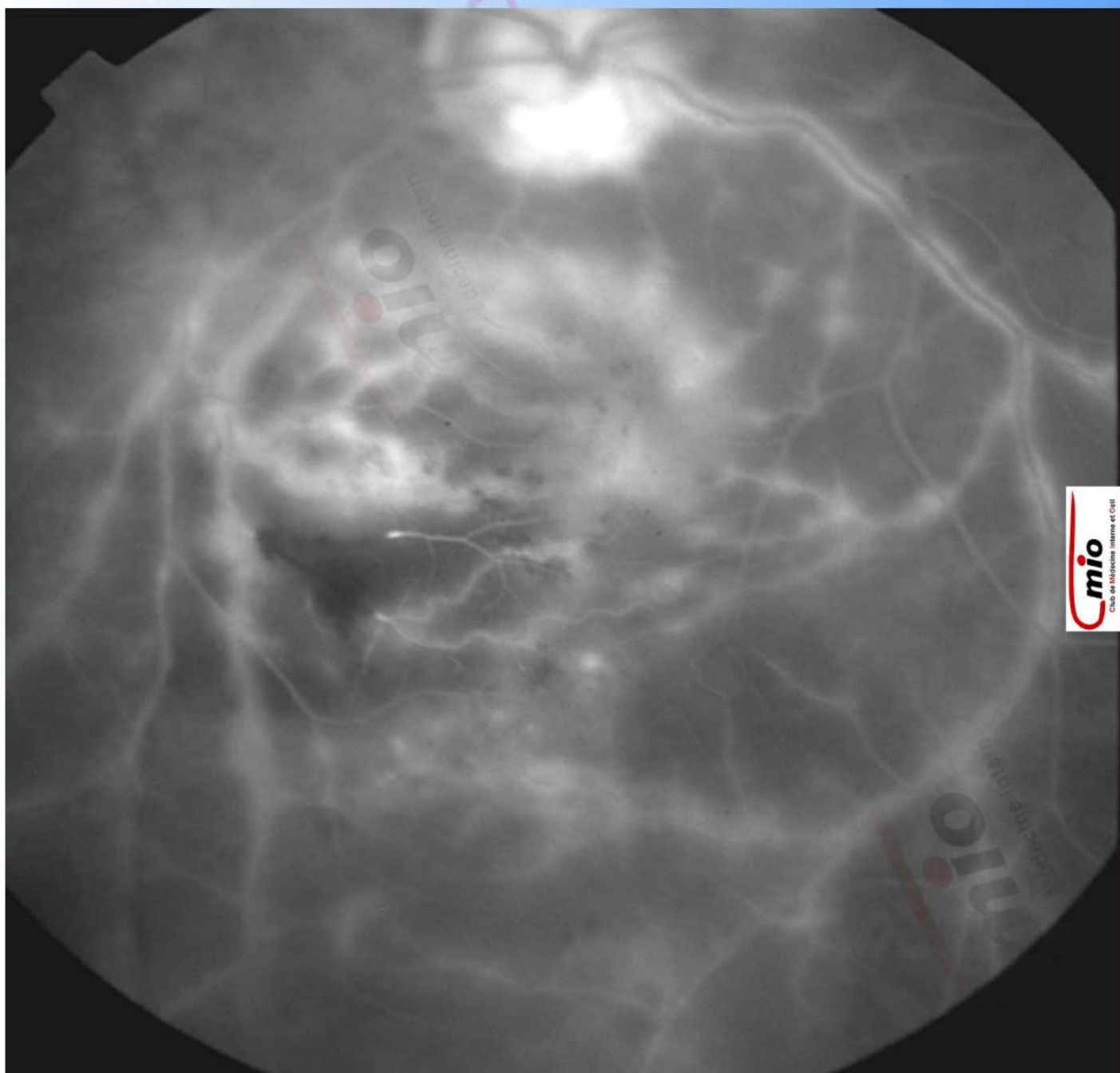


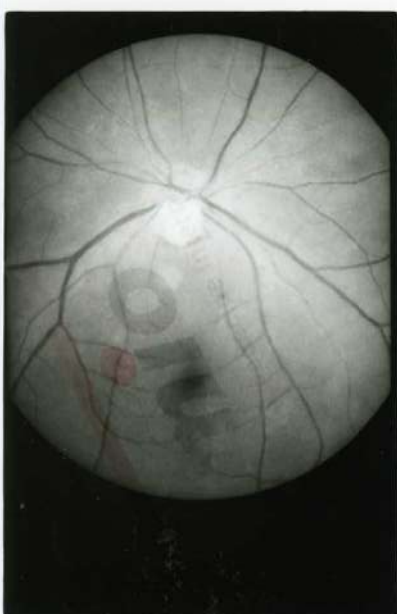
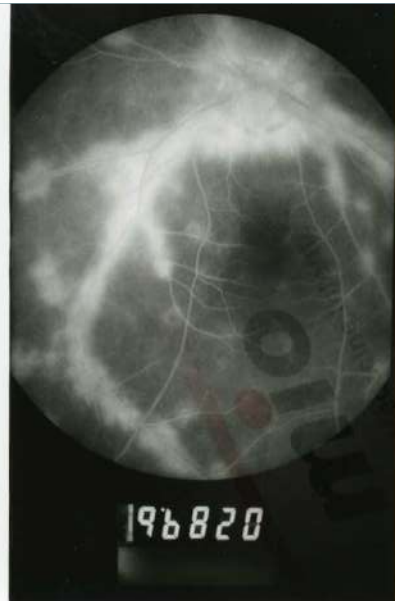
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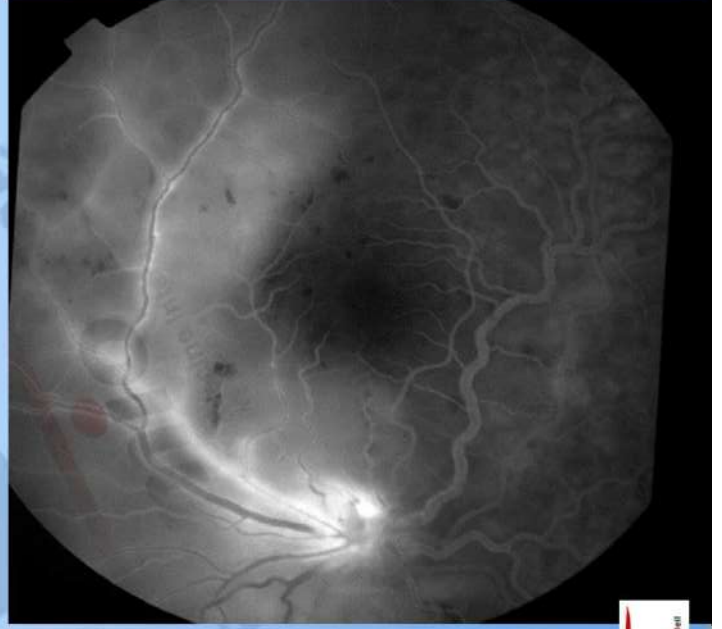
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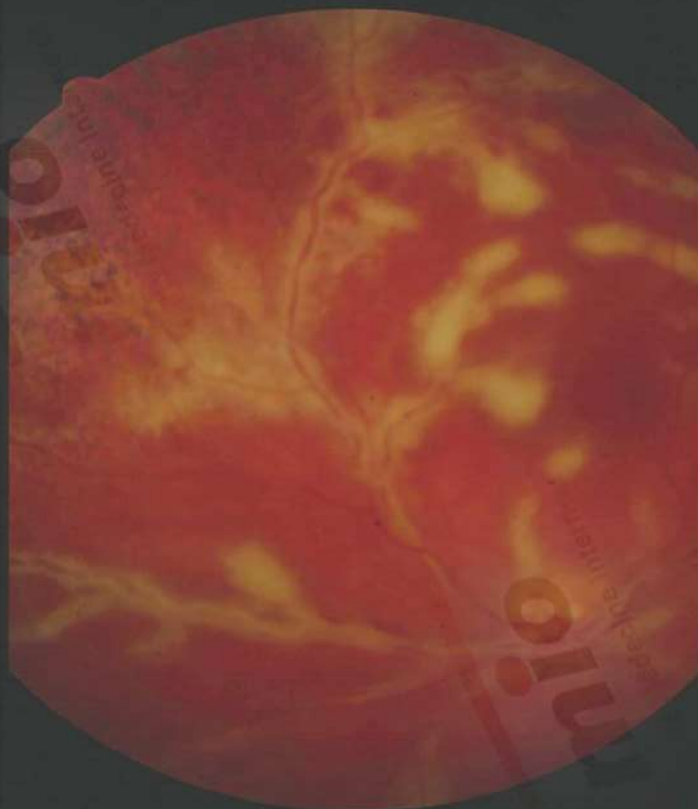












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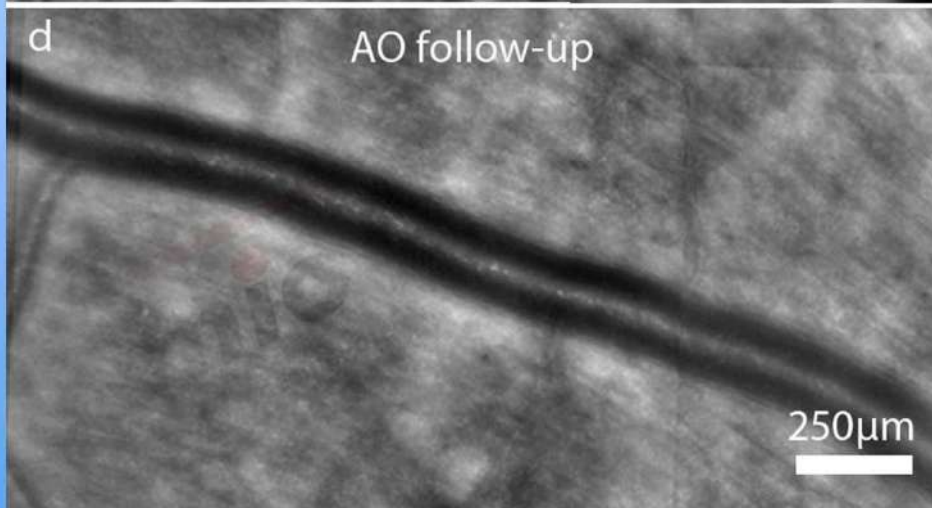
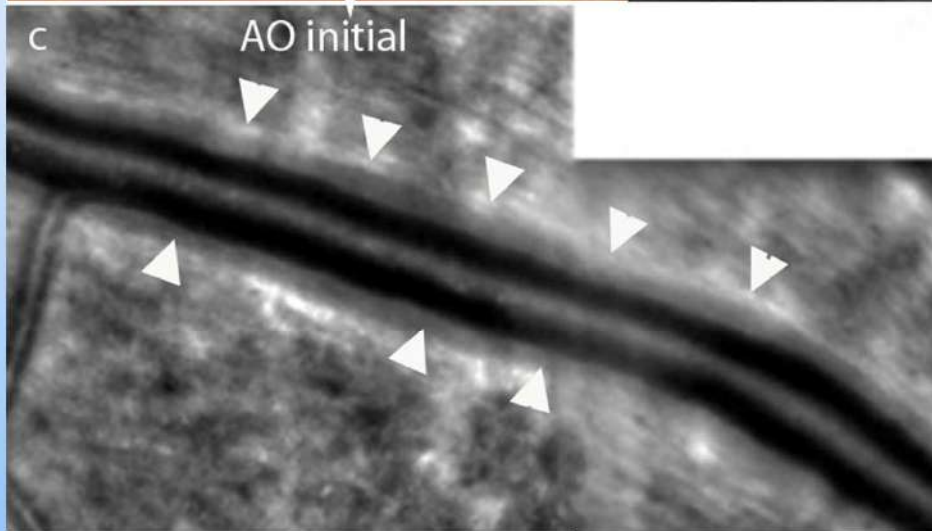
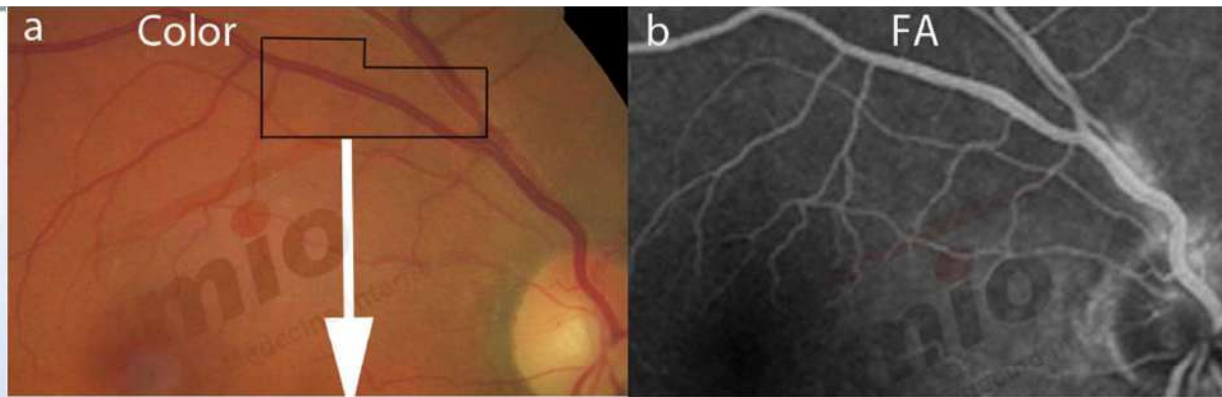


Photo MH Errera

Modalités thérapeutiques

- Trtt anti-infectieux spécifique
- Corticothérapie orale ou systémique
- IS conventionnels
- Agents biologiques: IFN, anti-TNF α , anti-IL6
- Anti-VEGF
- Photocoagulation laser