EYES ON

Structured Oral Sheets: FREE SAMPLE

Three sample topics from the full book (201 topics).
Optic neuritis, giant cell arteritis, intravitreal injections.
Each topic: the opening sentence, the answer structure, key points,
likely follow-up questions, pitfalls and a fallback answer.

Full book: 201 topics, six instrument plates, four parts.
Order and enquiries: WhatsApp +20 107 012 3233
Email: metwaly925@icloud.com

This sample is for personal study. Check thresholds and doses against current guidelines.

TOPIC 102

Optic Neuritis

Typical presentation · ONTT · MRI and multiple sclerosis risk · atypical features

OPEN WITH

Painful loss of vision in a young adult with an RAPD is optic neuritis until proven otherwise. I would confirm it, image the brain, and look for atypical features.

STRUCTURE OF YOUR ANSWER

1. **History.** Subacute loss over days, pain on eye movement, colour desaturation, Uhthoff phenomenon, age 20 to 45.
2. **Examine.** Acuity, RAPD, colour vision, central field defect, disc normal (retrobulbar) or swollen. Check for uveitis and other neurology.
3. **Image.** MRI brain and orbits with contrast: demyelinating lesions predict MS. OCT of the nerve fibre layer.
4. **Atypical.** No pain, severe or very slow loss, bilateral, disc haemorrhage, no recovery, over 50: think NMOSD, MOG, GCA, compression, infection.
5. **Treat.** IV methylprednisolone 1 g daily for 3 days speeds recovery but does not change final vision. Oral steroid alone is not advised.
6. **Counsel.** Most recover over weeks to months. Discuss MS risk and refer to neurology.

KEY POINTS TO HIT

- ONTT: IV steroid hastened recovery with similar final acuity. Oral prednisolone alone raised recurrence.
- Fifteen-year MS risk about 50%: about 25% with a normal MRI and about 70% with one or more lesions.
- Recurrent optic neuritis points to NMOSD, MOG antibody disease or chronic relapsing inflammatory optic neuropathy.
- Neuroretinitis (disc swelling with macular star) suggests Bartonella or other infection.
- Check syphilis, TB and sarcoid in atypical cases.

LIKELY FOLLOW-UPS

Q What does the Optic Neuritis Treatment Trial tell us?

IV methylprednisolone then oral prednisolone sped recovery but did not improve final vision. Oral steroid alone raised recurrence. MRI lesions predicted multiple sclerosis.

Q Which features are atypical for demyelinating optic neuritis?

No pain, bilateral onset, severe loss, disc haemorrhage, marked swelling, slow progression, no recovery, or age over 50. Consider NMOSD, MOG, infection, compression and ischaemia.

Q How do you counsel the patient?

Vision usually recovers over weeks to months, though colour and contrast may stay reduced. MS risk depends on the MRI, and neurology can discuss disease-modifying therapy.

PITFALLS

- Giving oral steroid alone.
- Missing an atypical cause.
- Not imaging the brain.

IF YOU ARE UNSURE

Say you would confirm optic neuritis, image the brain and orbits, give IV steroid for severe loss, and refer to neurology.

FREE SAMPLE · metwaly925@icloud.com · not for resale

TOPIC 105

Giant Cell Arteritis

Recognition · urgent steroid · biopsy and ultrasound · steroid-sparing therapy

OPEN WITH

Giant cell arteritis is a sight-threatening emergency in anyone over 50 with new headache, jaw claudication or visual symptoms. I would start steroid immediately and confirm the diagnosis in parallel.

STRUCTURE OF YOUR ANSWER

1. **Recognise.** New headache, scalp tenderness, jaw or tongue claudication, amaurosis fugax, diplopia, polymyalgia, fever, weight loss.
2. **Eye signs.** Arteritic ischaemic optic neuropathy, central or cilioretinal artery occlusion, ocular ischaemia, cranial nerve palsy.
3. **Test.** ESR, CRP and platelets, blood count. Normal markers do not exclude GCA.
4. **Treat.** With visual symptoms: IV methylprednisolone 500 mg to 1 g daily for up to 3 days, then oral prednisolone 60 mg. Without: 40 to 60 mg orally.
5. **Confirm.** Temporal artery biopsy (ideally within 2 weeks of starting steroid) or ultrasound. Rheumatology review.
6. **Long term.** Slow steroid taper, bone protection, and tocilizumab as a steroid-sparing option.

KEY POINTS TO HIT

- Do not delay steroid for biopsy: the risk is blindness in the second eye within days.
- Biopsy stays informative after short steroid courses. Skip lesions cause false negatives.
- Visual loss is usually permanent once it occurs. Treatment protects the other eye.
- Tocilizumab (GiACTA) reduced steroid exposure and relapse.
- Associated with polymyalgia rheumatica and aortitis.

LIKELY FOLLOW-UPS

Q How do you manage suspected GCA with visual loss?
Same-day high-dose steroid, IV methylprednisolone for 3 days then oral prednisolone, with blood tests and temporal artery biopsy or ultrasound. Rheumatology and bone protection.

Q Can you exclude GCA with a normal ESR?
No. A small proportion have normal inflammatory markers. Clinical suspicion drives treatment.

Q What are the ocular presentations?
Arteritic anterior ischaemic optic neuropathy, central retinal artery occlusion, cilioretinal artery occlusion, ischaemic cranial nerve palsy and ocular ischaemia.

PITFALLS

- Waiting for biopsy to start steroid.
- Relying on a normal ESR.
- Forgetting bone protection and rheumatology.

IF YOU ARE UNSURE

Say you would treat on suspicion with high-dose steroid, confirm with biopsy or ultrasound, and involve rheumatology.

FREE SAMPLE · metwaly925@icloud.com · not for resale

Intravitreal Injections: Technique and Safety

Aseptic technique · injection site · anti-VEGF and steroid · complications

OPEN WITH

I would describe the aseptic technique, the injection site and the monitoring, and explain the risks so the patient can consent.

STRUCTURE OF YOUR ANSWER

1. **Preparation.** Consent, correct eye, drug check. Povidone-iodine 5% to the sac and 10% to the lids, sterile speculum, no-touch.
2. **Site.** 3.5 to 4 mm from the limbus in phakic eyes, 3 to 3.5 mm in pseudophakic eyes, pars plana, temporal quadrants.
3. **Injection.** 30 gauge needle, perpendicular, inject slowly, withdraw and swab. Anti-VEGF or steroid implant.
4. **Check.** Hand motion vision and disc perfusion. IOP if needed.
5. **Complications.** Endophthalmitis (about 1 in 3000), raised IOP, retinal tear or detachment, lens injury, haemorrhage.
6. **Aftercare.** Warning symptoms, no routine antibiotic. Return urgently for pain, redness or reduced vision.

KEY POINTS TO HIT

- Povidone-iodine is the key antiseptic: antibiotics add no benefit.
- Retinal detachment risk is low but should be mentioned at consent.
- IOP rises transiently after injection, and can be sustained with repeated injections or steroid.
- Steroid implants cause cataract and glaucoma.
- Systemic arterial events have been debated for anti-VEGF.

LIKELY FOLLOW-UPS

Q How do you reduce endophthalmitis risk?
Povidone-iodine 5%, sterile speculum and gloves, no-touch technique, correct needle size, and avoiding talking over the field.

Q What are the risks?
Endophthalmitis, raised IOP, retinal tear or detachment, lens injury, vitreous haemorrhage and inflammation.

Q What would you do if a patient has pain and reduced vision after an injection?
See urgently. Look for endophthalmitis, take a vitreous sample and give intravitreal antibiotics.

PITFALLS

- Touching the lashes or speculum.
- Missing early endophthalmitis.
- Not warning about retinal detachment.

IF YOU ARE UNSURE

Say you would use povidone-iodine and a no-touch technique, inject at the correct site, and see any painful eye urgently.

FREE SAMPLE · metwaly925@icloud.com · not for resale