Borderline Ocular Hypertension

Dr J C
General Medical Practitioner
Ground Floor
Supreme House
300 Regents Park Road
Finchley London N3 2JX

7th March 2012

Dear Judy

Re: Mrs A A DOB 22/12/1928
65 Spencer Close London N3 3TY

This is a routine report concerning Mrs A whom I wrote to you about in January last year. She attended for an eye examination today with no significant symptoms. Her brother has and a paternal uncle had glaucoma. She takes propanol; nifedipine; losartan and doxazosin.

Refraction & VAs gave R. +1.75 /-1.25 X105 = 6/6- L. +0.50 /-0.50 X 90 = 6/6 Add +2.75DS = N5 at 35 cm.

External eyes, pupillary reflexes, ocular motility, colour vision and ocular motor balance were all normal. A single assessment of Humphrey SITA 24-2 fast visual fields showed an inferior GHT anomaly LE but Zeiss Cirrus HD-OCT showed normal retinal nerve fibre layer and neural rim thickness thickness measurements with no change from a year ago.

Anterior chamber angles are grade 3 wide. Central corneal thicknesses are R. & L. 580µ. Intraocular pressures were R. 22 L. 22 mmHg by Pascal DCT at 15.20 am. Both eyes show grade 2+ nuclear and cortical age related cataract. The ocular fundi appear normal. Assessment of cup disc ratios showed R. 0.4 L. 0.5. Comparison with the OCT measures from last year shows no change. Similarly the OCT shows no change in RNFL and neural rim thickness which remain normal.

In conclusion, Mrs A is content with her vision and the cataracts have not progressed significantly. Intraocular pressures remain at the upper end of the normal distribution and Mrs A should be monitored at regular intervals with regard to glaucoma risks. I would suggest a re-examination including visual fields in six months time.

Regards

Dr Simon Barnard PhD FCOptom FAAO DipCL DipClinOptom DipTh(IP)

Raised intraocular pressures without glaucomatous damage

Mr Jeremy Joseph MD FRCS FRCOphth
Spire Bushey Hospital
Heathbourne Road
Bushey Heath
Herts WD23 1RD

6th February 2012

Dear Jeremy

Re: Mr G B DOB 01/03/1963

You will recall that I referred Mr B to you in 2005 with slightly raised left intraocular pressure. He came to see me again today complaining that the vision of his left had been "foggy" of late. He reports good health, is not taking any medications and there is no family history of ocular disease.

Refraction gave R -3.75/-0.75 x107. 5 = 6/5 L -3.50/-1.25 x 90 =6/5 Add +1.75DS for reading = N4 at 40cm. This constitutes a change in prescription.

External eyes, pupillary reflexes, ocular motility and ocular motor balance are normal. Anterior chamber angles appear wide. There is longstanding melanosis-like pigmentary deposition on the inferior left corneal endothelium. Central corneal thicknesses are R. 544 L. 552 microns

Intraocular pressures all around 15.45 were

- R. 23 L. 43 mmHg by Pascal DCT
- R. 20 L. 33 mmHg by Goldmann applanation
- R. 17 L. 32 mmHg by Keeler Pulsair

The ocular media are clear. The ocular fundi appear normal. The optic discs are small and the right slightly crowded. OCT measured cup disc ratios R. 0.1 L. 0.36. RNFL thicknesses to OCT appeared normal although asymmetric. Visual fields were full although somewhat unreliable.

I should be grateful if you would again review his glaucoma risks. I have not proceeded with changing his spectacles until you have seen him,

Regards

Dr Simon Barnard PhD FCOptom FAAO DipCLP DipClinOptom DipTh(IP)

Cc Dr M H, GP

Normal pressure glaucoma

Mr Jeremy Josephs
Ophthalmic Surgery Clinic,
Unit 6, The Technology Park,
Colindeep Lane,
London NW9 6BX

2nd February 2006

Dear Jeremy,

Re: Mrs. S G D.O.B. 1946
…..

You have seen Mrs. G once before and wrote to me about her on 1st July 2003. You also look after her mother, Mrs. Ml G, who you treat for glaucoma. There is also glaucoma on Mrs. G's paternal side and because of this I have been monitoring her carefully.

Looking back at her intraocular pressures I have recorded R. 19 L. 19mmHg by Goldmann applanation in October 2000; R. 14 L. 13mmHg by Keeler Pulsair in November 2001; R. 16 L. 15mmHg by Keeler Pulsair in November 2002; R. 16 L. 16mmHg by Keeler Pulsair in December 2003; R. 17 L. 18mmHg by Keeler Pulsair in January 2005 and today R. 21 L. 21mmHg by Pascal tonometry.

I have carried out Humphrey 24-2 sita or Humphrey 30-2 sita on every occasion that I have seen her and visual fields have been always completely full. The visual fields today were substantially normal although Mrs. G found it very difficult to fixate and her responses were somewhat unreliable.

I have observed a gradual increase in cup/disc ratio over the last two or three visits and the right cup is larger than the left.

I have carried out serial GdX assessments and this shows a subtle decrease in nerve fibre layer thickness over time. I enclose plots and a serial analysis.

Mrs. G takes Thyroxine and Paracetomol. It may be significant that she also suffers from Raynaud's.

I am obviously thinking that Mrs. G has an early normal pressure glaucoma and I would be most grateful for your opinion at this stage.

Regards.

Dr. Simon Barnard PhD, BSc, FCOptom, FAAO, DCLP, DipClinOptom

c.c. Dr. C. R GP

Pseudoexfoliative Glaucoma

Professor Philip Bloom
Western Ophthalmic Hospital

171 Marylebone Road
London NW1 5QH

9th May 2012

Dear Phil

Re: Mrs M S DOB 1948

Reason for referral: R. Pseudoexfoliative glaucoma and cataract

Thank you for seeing Mrs S as an emergency today. I saw her lady for the first time for seven years earlier this afternoon. She seems to be asymptomatic and came requesting a check to see if her spectacles needed updating. She takes Amias; Atenolol; lipitor; omeprazole; and 2 aspirin per week. Her father and a sister have glaucoma.

VA with present spectacles is R. 3/60 L. 6/5. Refraction gave R. -3.00DS = 6/9 L +1.75/-025 x 105 = 6/5 Add +2.50 DS = N4 for reading at 40cm.

The right eye shows pseudoexfoliation of anterior lens capsule and iris pupil margin. The right eye shows marked cataract.

Goldmann tonometry gave R. 45 L. 22 mmHg at 12 noon. Fields attached.

Kindest regards

Dr Simon Barnard PhD FCOptom FAAO DipCLP DipClinOptom DipTh(IP)

Cc Dr D A GP

Crowded Optic Nerves – Symptomatic

Professor Chris Bentley
2nd Floor
The Wellington Hospital (South)
Wellington Place
London NW8 9LE

29th October 2012

Dear Chris

Re: Miss LS (age 12)
London HA

I should be grateful for your opinion on L who presented reporting that her eyes and head have been hurting intermittently, about every three weeks, mostly right sided for a number of months. She had been seen by my colleague MS for a routine examination on 3rd September 2012 and did not appear to have mentioned this at that time. Last night she had experienced pain in her left eye which woke her up and earlier this morning the pain was quite bad. On questioning she described he pain as being sharp. There is no associated nausea or visual disturbance. Her general health is good, she takes occasional Tynelol and there is no family history of ocular disease.

Refraction gave R -3.00/-1.25 x 5 = 6/75 L -2.75/-1.00 x 5 = 6/9-1. I also confirmed this under cycloplegia. This is very similar to the spectacles prescribed by Menachem Salasnik in September.

External eyes, pupillary reflexes, ocular motility and ocular motor balance are normal. Anterior chamber angles are wide and quiet. The ocular media are clear. The ocular fundi appear normal but I did note bilateral mild crowding of the nasal optic nerve heads which I have explained to Mrs S is probably physiological.. This was noted by M in September. Previous records going back to 2009 only alluded to small cup disc ratios.

In view of the symptoms, which I do not believe have a visual cause, I have suggested to Mrs S that a routine ophthalmological opinion would be wise.

With kindest regards

Dr Simon Barnard PhD FCOptom FAAO DipCLP DipClinOptom DipTh(IP)

Cc Dr MW

Mrs S

Diabetes – Routine Report

Dr J A

18th July 2012

Dear J

Re: Mr. J S D.O.B. 14.2.1954
37 ……..London N…….

Routine report No diabetic retinopathy

This is a routine report following Mr. S's annual check. I understand that his medication is unchanged.

On examination I found his refraction and visual acuities to be R. -2.25/-1.25 x 80 = 6/5-.
L. -2.25/-1.50 x 80 = 6/5-. Add +2.50DS for reading = N5 at 40cms.

External eyes, pupillary reflexes, ocular motility, ocular media are normal. The anterior chamber angles were grade 2.

The ocular fundi appeared normal. There are no retinal diabetic changes. I photographed the retinas (OptoMap laser scanning 200° field).

Intraocular pressures were R. 11 L. 13 mmHg. Visual fields were full to Humphrey C40 screening.

I have advised a routine examination in twelve month time.

Regards

Dr. Simon Barnard PhD, BSc, FCOptom, FAAO, DCLP, DipClinOptom DipTh(IP)

Diabetic Retinopathy

Dr M H
…..
London N….

28th November 2012

Dear Dr M

Re: Mr D D DOB 05/01/1953
9…. London, N……

Reason for referral: Macula oedema and cystic changes left macula
Background retinopathy RE & LE

I saw Mr D for review today. He is happy with his vision. I understand he underwent laser therapy since I last saw him.

Refraction today was R. -5.50 /-1.25 X100 = 6/5-1 L. -3.50 /-2.75 X15 = 6/7.5+2 Add +2.50DS for reading = N4 at 40 cm.

Both eyes show diabetic retinopathy. The left macula shows cystic macula oedema with an increase in retinal thickness of 50 microns since I last saw him in September 2011. Intraocular pressures were R. 18 L. 19 mmHg. Visual fields were full to Humphrey C40 screening.

In conclusion, since I last saw Mr D the L. VA has reduced to 6/7.5 and there are cystic changes at the left macula. I would be grateful if he could be reviewed by his consultant ophthalmologist I have copied this to Dr E his endocrinologist with a further copy for the ophthalmologist.

Regards

Dr Simon Barnard PhD FCOptom FAAO DipCL DipClinOptom DipTh(IP)

Cc Mr D
Dr E

Dry AMD

Tim Fallon
Consultant Ophthalmologist
Hospital of St John and St Elizabeth
60 Grove End Rd
London NW8 9NH

29th November 2010

Dear Tim

Re: Mr S D D.O.B. 1931
……..

I last referred Mr D to you in 2005. Since then he has had cataract operations on both eyes. He came to see me today complaining of a deterioration in vision recently. He takes thyroxine; Insulin; Clopidogrel; Simvastatin; B12 injections every 3-months; quinine; aspirin; folic acid; errous gluconate; omeprozole and two medications for vascular hypertension.

Refraction & VAs today were R. +0.50 /-0.75 X90 = 6/7.5- L. +0.50 /-0.75 X 90 = 6/9 Add +3.25DS gave N5 for reading at 30 cm.

Anterior chambers appear wide and quiet. IOPs were R. 11 L. 11 mmHg. The ocular media, including capsules appear clear. Both eyes show extensive drusenoid macular changes

Mr D will be making an appointment to see you. I have delayed prescribing a change in spectacle prescription.

Regards

Dr Simon Barnard PhD FCOptom FAAO DipCL DipClinOptom

Cc

Wet AMD

Mr Riaz Asaria
Hospital of St Johns & St Elizabeth
60 Grove End Road
London NW8 9NH

30th July 2012

Dear Riaz

Re: Ms MW dob 1923
Reason for referral: Suspected Wet macula changes RE

I saw Ms W this morning. She reported difficulty recently with her vision for reading. She is a bilateral pseudophake following successful bilateral phako by Jeremy Joseph in 2010. She takes Amlodopine, thyroxine; and aspirin 75mg twice a week.

Her VAs when I last saw her on 11th July 2011 were R. 6/6 L. 6/9+.

Unaided vision today was R. 6/12 L. 6/9. Refraction today gave R -0.50DS = 6/12 L +0.75/-0.50 x 90 6/7.5- Add +3.00 for reading = N5 at 40cm.

External eyes, pupillary reflexes, ocular motility and ocular motor balance are normal. Anterior chamber angles are wide and intraocular pressures were R. 9 L. 10 mmHg. The ocular media were clear apart from minimal posterior capsular thickening. The right eye macula changes and I suspect that the reduction in VA RE suggests wet changes. The left eye shows some dry macular changes. Ms W reports distortion RE with the Amsler chart.

Mrs W will be telephoning you today to arrange an appointment.

Kindest regards

Dr Simon Barnard PhD FCOptom FAAO DipCLP DipClinOptom DipTh(IP)

Cc Mr Jeremy Joseph
Dr Leora Harverd

Vascular Hypertension

Dr N W
London… NW11….

8th April 2013

Dear N

Re: Mrs B D DOB 03/06/1960
3….

Reason for referral: One tiny haemorrhage posterior pole right eye

I saw B today for a routine examination. She reports good health, is not taking any medications and there is no family history of ocular disease.

Refraction gave R -1.75/-0.75 x90 = 6/4 L -1.00/-2.25 x 7 = 6/5 Add +2.00DS for reading = N4 at 40cm.

External eyes, pupillary reflexes, ocular motility and ocular motor balance are normal. Anterior chamber angles are wide and intraocular pressures were R. 23 L.24 mmHg by Goldmann tonometry. Central corneal thickness are R 564µ L. 568 µ . Visual fields remain full to Humphrey 24-2 SITA fast and retinal nerve fibre thickness remains normal and unchanged from previous measures with optical coherence tomography (OCT).

The ocular media were clear. The ocular fundi are entirely normal apart from a single dot haemorrhage at the posterior pole right eye. Because of the latter subtle sign I carried out three consecutive casual systemic BP readings and found: **134/97; 134/84; and 146/88**.

I have suggested that you might wish to carry out a routine medical exam but have explained that is very likely that the the tiny dot haemorrhage is idiopathic and not correlated with anything else. I should be grateful if you would let me know the outcome.

With kindest regards

Dr Simon Barnard PhD FCOptom FAAO DipCLP DipClinOptom DipTh(IP)

Mrs BD

Retinal Tear – Part 1

Mrs A
W Road
London N

3rd November 2010

COPY

Dear Mrs A

It was a pleasure to see you today for your routine eye examination. This is a routine report for your records. I note your history of laser refractive surgery in London in 2005, that you take thyroxin, Prempak and various vitamins, and that there is no family history of ocular disease.

Your unaided vision is R. 6/6+ L. 6/6. Refraction gave R. -0.25 /-0.25 X90 =6/5+ L. +0.00DS = 6/6 Add +1.00DS for reading = N4 at 40 cm. Zeiss i-Profiler Aberrometry shows significant high order aberrations (including coma) in both eyes. Central corneal thicknesses (CCT) are 480µ in each eye.

External eyes, pupillary reflexes, ocular motility and ocular motor balance are normal. Anterior chambers are wide and intraocular pressures are R. 9 L. 10 mmHg by Pascal DCT at 09.00. Visual fields were full to C40 Humphrey screening.

There is grade 1 corneal epithelial down-growth in each eye. Both eyes show partial uncomplicated posterior vitreous detachment (PVD). The ocular media are otherwise clear. The ocular fundi are normal apart from some minor peripheral sensory retinal changes in the extreme periphery of each eye.

We discussed that due to the PVD and your previous moderate myopia, if you ever notice flashes of light or "floaters" (spots) in your vision, you are to seek attention straight away.

I would suggest a routine examination in twelve months.

I have attached copies of your various scans for your records.

Regards

Dr Simon Barnard PhD FCOptom FAAO DipCL DipClinOptom

Retinal Tear – Part 2

Mr Riaz Asaria

Consultant Vitreo-Retinal Surgeon

Wellington Hospital

NW8

Dear Riaz

Re: Mrs A DOB 1959

Thank you for seeing Mrs A tomorrow (Friday) at 15.30 at the Wellington (Platinum).

She had telephoned me this morning reporting seeing a black spot floating in her vision and I asked her to come in to see me today and I saw her at 15.00 hours.

Unaided vision is R & L 6/6.

There is a small flap tear superior nasal (2 o'clock) flap tear right eye. There are peripheral retinal changes (white without pressure; PSRD) elsewhere in both eyes but I could not see any other tears.

By way of a history, I have attached a copy of a report I wrote in 2010.

With kindest regards

Simon Barnard

This patient provided her own description . Go to

www.barnardlevit.co.uk/about-us/testimonials/