

CENTRAL SEROUS RETINOPATHY

What is Central Serous Retinopathy?

Central Serous retinopathy is a collection of fluid under the retina that results from a leak of fluid under the retina. As the name suggest, the collection of fluid affects central vision where it causes visual loss and distortion.

What are the symptoms of Central Serous Retinopathy?

Patients often complain of a blind spot, decreased or blurry vision, and distortion of shapes such that straight lines may appear bent or crooked. The vision may be minimally to significantly affected with visual acuity ranging from normal (20/20) to 20/200.

Who get Central Serous retinopathy?

The disease primarily affects young adults ages 20-45. Men are affected 10 times more frequently than women. Many patients with Central Serous Retinopathy are noted to live under a high level of stress.

Why does Central Serous Retinopathy occur?

The exact etiology of central serous retinopathy is highly controversial. However, there appears to be an imbalance in the amount of fluid which enters the subretinal space and the ability to remove it, resulting in a net accumulation of fluid beneath the retina. Some experimental evidence suggests high blood levels of epinephrine and cortisol hormones may be responsible.

What is the prognosis?

Most patients with Central Serous Retinopathy will spontaneously recover visual acuity in 6 months (average time to recover 3-4 months). Many patients will have some residual symptoms such as distortion, decreased color and contrast sensitivity, as well as visual difficulty at night. Despite an overall good prognosis, 40-50% of patients experience one or more recurrences.

Is there treatment available?

There is no medical treatment proven to be effective in treating central serous retinopathy. Laser photocoagulation treatment is effective in shortening the duration of the disease; however, it does not appear to alter the final acuity or the recurrence rate. Treatment with laser is often recommended when fluid persists more than four months or in eyes with multiple recurrences of Central Serous Retinopathy

Informed consent

In an extensive discussion, Dr. Mann reviewed all the risks, benefits alternatives, nature and intent of the laser procedure. Patient understood the above and stated they had a good understanding of their clinical situation and wished to proceed with laser treatment.

Common complications

Scotoma (field loss) or grey spots about fixation
Ocular irritation, discomfort or redness

Rare or uncommon complications

Corneal abrasion
Hemorrhage or bleeding
Retinal artery or vein occlusion
Choroidal neovascularization or abnormal new subretinal vessels
Inadvertant foveal ablation or laser treatment of the reading center
Retinal tears/detachment

INFORMED CONSENT

I, _____ have been given the brochure(s) on Central Serous, Retrobulbar Anesthesia. I have had the opportunity to read, understand and ask questions regarding this procedure(s). Dr. Mann has explained this procedure to me in depth. I have been informed in regard to the potential benefits, complications, risks and alternatives of the procedure. Sufficient time was allowed for me to ask questions and these questions were answered to my satisfaction.

Patient signature

date

Witness signature

date

PERIBULBAR & RETROBULBAR ANESTHESIA

Absence of pain (anesthesia) and immobilization of the eye (akinesia) are often necessary to allow effective laser and cryotherapy treatment or intraocular surgery. Both anesthesia and akinesia can be obtained to a variable degree by injection of anesthetic (Lidocaine and/or Marcaine) around and behind the eyeball prior to treatment or surgery.

The following are **common** effects of the anesthetic injection but are usually temporary:

1. Blurring of vision
2. Numbness and swelling around the eye
3. Ptosis (drooping of the eyelid)
4. Diplopia (double vision)

The following are **uncommon** complications of the anesthetic injection:

1. Retrobulbar or periorbital hemorrhage (bleeding behind or around the eyeball)
2. Globe perforation (puncture of the eyeball by the needle used for anesthetic injection)
3. Optic nerve injury or vascular damage (central retinal artery or vein occlusion)
4. Allergic reaction to the anesthetic
5. Seizure
6. Cardiorespiratory arrest (death)
7. Bilateral akinesia

These uncommon complications may result in permanent loss of vision, need for further surgery or treatment, or loss of the globe. Other less common complications may be discussed as well.

Post treatment care may include applying ointment to the eye and wearing a patch for 24 hours.

PROCEDURE NOTE

PATIENT: _____ SS# _____ DATE: _____

SURGEON: DR. ERIC MANN

PROCEDURE: Focal Laser, _____

INDICATIONS: Central Serous Retinopathy _____

VA: OD _____ OS _____

INFORMED CONSENT:

All the risks, benefits, alternatives and intent of laser treatment with anesthesia were presented to the patient in an extensive discussion and in written form(s) _____. The patient understood that laser treatment is performed not to improve vision, but to hopefully stabilize vision and prevent further visual loss. The patient stated that he/she had a good understanding of his/her clinical situation, including the specific ocular and anesthetic risks (loss of vision, need for further surgery, and rarely, loss of globe) and consented to laser treatment.

TREATMENT: Under topical anesthesia

Under retrobulbar anesthesia: with the patient supine and fixating straight ahead, 3 cc of 2% lidocaine were injected into the retrobulbar space, using a #25 gauge needle and a 10 cc syringe. Adequate anesthesia and akinesia were obtained. Following treatment, the eye was patched for 24 hours.

Under fluorescein guidance with a _____ lens and the argon green laser, focal laser treatment of leaking microaneurysms were performed to whiten the aneurysms. Grid laser treatment was performed with grade 1 intensity burns, one spot width apart in areas of diffuse capillary leakage with corresponding retinal thickening. Laser parameters and pattern are below. Laser treatment was performed without complication. The patient tolerated the procedure well and left the laser suite in good condition. Post-operative photographs were requested.

PARAMETERS: 0.1-0.2 sec, 100-200 microns, _____ mW, & _____ total spots.

POST-OPERATIVE CARE & MANAGEMENT: The patient was instructed to return in follow-up _____ or immediately upon any decreased vision, pain, or symptoms of RD or RB (which were reviewed). Specific post-operative instructions included no ASA, HOB elevated and restricted activities with no physical exertion.

ERIC S. MANN M.D. Ph.D

DATE

RECEIPT OF POST-OP INSTRUCTIONS

I _____ have been given postoperative instruction information. I have had the opportunity to read, understand and ask questions regarding my planned surgical procedure(s). Dr. Mann has explained this procedure to me in depth. I have been informed in regard to the potential benefits, complications, risk and alternatives of the procedure. Sufficient time was allowed for me to ask questions and these questions were answered to my satisfaction.

Patient signature

Date

Witness signature

Date

**INSTRUCTIONS FOLLOWING LASER/CRYOTHERAPY
TREATMENT**

1. You may resume all of your normal activities immediately except for heavy lifting, exercise or physical exertion which you may resume in 3 to 4 weeks.
2. You may have discomfort or a headache following laser/cryotherapy treatment. Please take Tylenol but **NO** aspirin, Ibuprofen (Advil), indomethacin (Indocin) or other NSAIDS for pain unless your medical doctor recommends you take an aspirin a day for your heart or to “thin” your blood.
3. Due to intense brightness of the laser beam, there is a light-induced “dazzling” or “flashbulb” effect, and consequently your vision may be slightly decreased after the laser treatment. It may require a few hours to recover from this glare effect.
4. Please take pain pills as instructed and call immediately if you have persistent pain or sudden, new onset decreased vision at office phone number listed below or 866-856-7882 (after hours).
5. If you received retrobulbar anesthesia, keep the treated eye patched for 24 hours.
6. If you received eye drop prescriptions, please follow directions on the bottle.

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Fairview Hgts., IL 62208
Phone: (618) 632-8100
Fax: (618) 632-8101**

**533 Couch Ave., Ste 255
Kirkwood, MO 63122
Phone: (314) 835-9400
Fax: (314) 835-9401**

CONSENT SPECIAL/INFORMED TO SURGERY OR OTHER PROCEDURE

Name: _____

Date: _____

Medical record number /SS# _____

1. I hereby authorize Dr. Mann and / or such assistants, associates, or other health care providers that may be selected by him, to perform the following procedure (s)
FOCAL LASER TREATMENT FOR CENTRAL SEROUS RETINOPATHY EYE

2. Dr. Mann has discussed with me the procedure(s) listed above and the items of information that are briefly summarized below:
 - a. The nature and purpose of the proposed procedure(s): **FOCAL LASER IS PERFORMED IN AN ATTEMPT TO HALT OR DECREASE THE AMOUNT OF FLUID UNDER THE RETINA CAUSED BY CENTRAL SEROUS RETINOPATHY..**
 - b. The risks and possible consequences of the proposed procedure(s), including the risk that treatment may not accomplish the desired objective(s) and including, but not limited to: scotoma (field loss) or gray spots bout fixation, ocular irritation, discomfort or redness, corneal abrasion, hemorrhage or bleeding, retinal artery or vein occlusion choroidal neovascular or abnormal new subretinal vessels, inadvertent foveal ablation or laser treatment of the reading center, retinal tears or detachment.
 - c. All reasonable alternative treatment, including risks, probable effectiveness of each and consequences if this proposed treatment is not received:
Alternative treatment of focal laser is observation.

3. I am aware that, in addition to the risk specifically described in Item 2 above, there are other risks, such as severe loss of blood, infection, cardiopulmonary arrest, respiratory difficulties, injury to proximate/adjacent blood vessels, nerves, organs or structures, unanticipated allergic reaction to substances, pressure/position related injuries and other risks related to the performance of any surgical procedure.

4. I acknowledge that no guarantees have been made to me as to the results of the procedure(s) and am also aware that complications and risks may occur despite precautions.

5. I consent to the performance of unforeseen operation(s) and procedure(s) in addition to or different from those now contemplated and describe herein that the named doctor and his associates or assistants may deem necessary or advisable during the course of the presently authorized procedure(s).

6. I consent to the administration of such anesthetics as may be considered appropriate by the physician responsible for anesthesia administration or such assistants or associates as may be selected by him. I understand that this procedure is to be performed using **retrobulbar/topical** anesthesia. I understand that all types of anesthesia involve some risk. I further understand that if a regional, spinal or epidural anesthesia is planned, it may be necessary to also administer a general anesthetic. I understand that the risk of a general, spinal, epidural or regional anesthesia include, but are not limited to, mouth and/or throat pain or injury, cardiopulmonary arrest, cardiac arrhythmias, heart attack, respiratory difficulties, stroke, brain damage, headache, backache and other sensory, nerve, focal and systemic injuries.

7. I also consent to the administration of blood or blood components, drugs, medicines and other substances considered advisable by the physician(s) responsible for this procedure and the use of x-rays or other diagnostic testing, procedures and devices, which the above-named physician or his associates, consultants or assistants may consider useful.
8. I hereby authorize The Retina Group Ltd. Dr. Eric Mann or staff to preserve for scientific or teaching purposes or to otherwise dispose of any tissues, parts, organs, or implants removed during this procedure.
9. For teaching or educational purposes, I consent to the admittance of students, staff or other observers to the operating and procedure rooms, and to the taking of any videos or photographs deemed appropriate or necessary by the physician in the course of the procedure(s). I also consent to the taking of photographs or videos for the purpose of documenting the condition or procedure in the medical record. I understand that if data, photographs, videos or other information are used for teaching/educational purposes or for scientific publication, that my (the patient's) identity will remain confidential unless otherwise authorized by the undersigned.
10. I certify that I have read or have had the above information read to me and that I understand the above consent to operation or diagnostic procedure, that the explanations referred to were made to my satisfaction and I hereby give my informed and voluntary consent to the proposed procedure(s) or operation(s).

Signature of patient:

If the patient is unable to give informed consent because of physical or mental incapacity or mental incapacity or is a minor (under 18 and unemancipated), complete the following:
 Patient is unable to give consent because _____

:

 Witness to signature

I certify that I have explained to the above individual the nature, purpose, risk and potential benefits of the above procedure and have answered any questions that have been raised.

 Signature of Physician