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Academia Ophthalmologica Belgica

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PROGRAMME BOOK

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Contents

LUMIGAN® Samenvatting van de produktkenmerken: Naam van het geneesmiddel: Lumigan 0,3 mg/ml oogdruppels, oplossing. **Kwalitatieve en kwantitatieve samenstelling:** Een ml bevat 0,3 mg bimatoprost, Conserveermiddel benzalkoniumchloride 0,005% **Klinische gegevens: Therapeutische indicaties:** Vermindering van verhoogde intra-oculaire druk in chronisch open kamerhoek glaucoom en oculaire hypertensie. -Als monotherapie in patiënten:- onvoldoende respons op eerstelijns therapie - intolerantie of contra-indicatie voor eerstelijns therapie. Als aanvullende behandeling met bètablokkers. **Dosering en wijze van toediening:** De aanbevolen dosis is eenmaal daags een druppel in het (de) aangetaste oog (ogen), 's avonds toegediend. De eenmaal daagse dosis mag niet worden overschreden aangezien frequentere toediening het effect van de intra-oculaire drukverlaging kan verminderen. Wanneer er meer dan één topisch opthalmisch geneesmiddel wordt gebruikt, moet tussen elk der toediening van een geneesmiddel minstens 5 minuten zitten. Gebruik bij kinderen en adolescenten (beneden de 18 jaar): Lumigan is alleen onderzocht bij volwassenen en daarom wordt het gebruik ervan bij kinderen of adolescenten afgeraden. Gebruik bij lever- en nierfunctiestoornissen: Lumigan is niet onderzocht bij patiënten met nier- of leverfunctiestoornissen en moet daarom met voorzichtigheid worden gebruikt bij dergelijke patiënten. **Contra-indicaties:** Overgevoeligheid voor bimatoprost of voor één van de hulpstoffen. Bijzondere waarschuwingen en bijzondere voorzorgen bij gebruik. De patiënten dienen vóór de start van de behandeling geïnformeerd te worden over de mogelijkheid dat de wimpers gaan groeien, de huid van het ooglid donkerder kan worden en de versterkte irispigmentatie aangezien dit is waargenomen tijdens behandeling met Lumigan. Een aantal van deze veranderingen kan permanent zijn en kan leiden tot veranderingen in het uiterlijk tussen de ogen wanneer er maar een oog wordt behandeld. De verandering in iris pigmentatie treedt langzaam op en kan een aantal maanden onopgemerkt blijven. Lumigan is niet onderzocht bij patiënten met verstoorde ademhalingsfunctie en moet daarom met voorzichtigheid worden gebruik bij dergelijke patiënten. Bij klinische studies, bij die patiënten met een geschiedenis van een verstoorde ademhalingsfunctie, zijn geen significante ongunstige ademhalingseffecten opgemerkt. Lumigan is niet onderzocht in patiënten met hartblokkade ernstiger dan eerstegraads of ongecontroleerd congestief hartfalen. Lumigan is niet onderzocht in patiënten inflammatoire oculaire condities, neovasculair, inflammatoir, gesloten kamerhoek glaucoom, congenitaal glaucoom of nauwe kamerhoekglaucoom. Cystoide maculair oedeem is zelden gerapporteerd (≥ 1 op 1.000 en < 1 op 100) na Lumigan gebruik en dient daarom met voorzichtigheid te worden gebruikt in patiënten die bekend zijn met risico factoren voor maculair oedeem.. **Bijwerkingen:** Bij klinische studies zijn meer dan 1800 patiënten behandeld met Lumigan. Wanneer de gegevens van Fase III monotherapie en aanvullend Lumigan gebruik worden gecombineerd zijn de meest gemelde en aan de behandeling gerelateerde bijwerkingen: groei van wimpers bij maximaal 45%, conjunctivale hyperemie (meest zeer licht tot mild) bij maximaal 44% en oculaire pruritis bij maximaal 14% van de patiënten. Minder dan 9% van de patiënten zijn gestopt in verband met bijwerkingen. De volgende bijwerkingen die beslist, waarschijnlijk of mogelijk verband hielden met de behandeling werden gemeld tijdens klinische trials met Lumigan. De meeste waren oculair, mild tot middelmatig en geen ervan was ernstig: Infecties en parasitaire aandoeningen: Soms (≥ 1 op 1.000 en < 1 op 100): infectie (primair verkoudheid en hogere luchtweginfecties). Zenuwstelselaandoeningen: Vaak (≥ 1 op 100 en < 1 op 10): hoofdpijn. Soms (≥ 1 op 1.000 en < 1 op 100): duizeligheid. Oogaandoeningen: Zeer vaak (≥ 1 op 10): conjunctivale hyperemie, groei van wimpers, oculaire pruritis. Vaak (≥ 1 op 100 en < 1 op 10): allergische conjunctivitis, asthenopie, blefaritis, cataract, conjunctivaal oedeem, corneale erosie, oogafscheiding, donker worden van wimpers, oogpijn, gevoel van vreemd lichaam, versterkte rispigmentatie, oculair branden, oculaire droogte, oculaire irritatie, fotofobie, oppervlakkige keratitis punctata, tranen, zichtstoornis en verslechtering van visuele scherpte. Soms (≥ 1 op 1.000 en < 1 op 100): blefarospasme, cystoïd maculair oedeem, ooglidretractie, iritis, retinale bloeding, uveitis. Bloedvataandoeningen: Vaak (≥ 1 op 100 en < 1 op 10): hypertensie. Huid- en onderhuidaandoeningen: Vaak (≥ 1 op 100 en < 1 op 10): ooglid-erytheem, ooglidpruritus, pigmentatie van peri-oculaire huid. Soms (≥ 1 op 1.000 en < 1 op 100): ooglidoedeem, hirsutisme. Algemene aandoeningen en toedieningsplaatsstoornissen: Soms (≥ 1 op 1.000 en < 1 op 100): asthenie, perifeer oedeem. Onderzoeken: Vaak (≥ 1 op 100 en < 1 op 10): afwijkend resultaat leverfunctietest. **Lijst van hulpstoffen**: benzalkoniumchloride natriumchloride dinatriumwaterstoffosfaat heptahydraat, citroenzuur monohydraat, zoutzuur of natriumhydroxide (om pH aan te passen), gezuiverd water. **Houder van de vergunning voor het in de handel brengen:** Allergan Pharmaceuticals (Ireland) Ltd Castlebar Road, Westport Co. Mayo, Ierland. **Nummer van de vergunning voor het in de handel brengen:** EU/1/02/205/001 UR. **Afleveringswijze** uitsluitend op medisch voorschrift. **References:** 1. Rossetti L et al. A 12-week comparison of bimatoprost 0.03% and a fixed combination of latanoprost 0.005% and timolol 0.5% in reducing the 24-hour IOP in glaucoma patients. Ophthalmology 2007. E pub doi:10.1016/j.ophtha.2007.01.025.

LUMIGAN® Résumé des caractéristiques du produit: Dénomination du médicament: Lumigan 0,3 mg/ml, collyre en solution. **Composition qualitative et quantitative:** Un ml contient 0,3 mg de bimatoprost. Conservateur, chlorure de benzalkonium 0,005 %. **Données cliniques: Indications thérapeutiques:** Réduction de la pression intraoculaire élevée chez les patients atteints de glaucome chronique à angle ouvert ou d'hypertonie intraoculaire. En monothérapie chez les patients : . qui répondent de manière insuffisante à leur traitement de première intention . qui présentent une intolérance ou une contre-indication à leur traitement de première intention. En association aux bêtabloquants. **Posologie et mode d'administration:** La posologie recommandée est d'une goutte dans l'oeil ou les yeux atteints une fois par jour, administrée le soir. La dose ne doit pas dépasser une instillation par jour, un usage plus fréquent pouvant diminuer l'effet réducteur de la pression intraoculaire. Si plusieurs médicaments ophtalmologiques à usage local sont utilisés, chacun doit être administré à un intervalle d'au moins 5 minutes. Utilisation chez les enfants et les adolescents (moins de 18 ans): Lumigan n'a été étudié que chez les adultes. En conséquence, son utilisation n'est pas recommandée chez les enfants ou les adolescents. Utilisation en cas d'insuffisance hépatique ou rénale: Lumigan n'a pas été étudié chez les malades atteints d'insuffisance rénale ou hépatique. En conséquence, il doit être utilisé avec précaution chez ces patients. **Contre-indications:** Hypersensibilité au bimatoprost ou à l'un des excipients. Mises en garde spéciales et précautions particulières d'emploi: Avant le début du traitement, les patients doivent être informés que Lumigan est susceptible d'entraîner une croissance des cils, un assombrissement de la peau de la paupière et une augmentation de la pigmentation de l'iris, comme il a pu l'être observé au cours des études chez les patients traités par Lumigan. Certains de ces changements peuvent être définitifs et peuvent entraîner des différences d'apparence entre les yeux si un seul oeil est traité. Le changement de pigmentation de l'iris se produit lentement et peut ne pas être décelable avant plusieurs mois. Lumigan n'a pas été étudié chez les malades souffrant d'insuffisance respiratoire et doit donc être utilisé avec précaution chez ces patients. Dans les études cliniques, aucun effet indésirable respiratoire n'a été observé chez les malades souffrant d'insuffisance respiratoire. Lumigan n'a pas été étudié chez les patients présentant un bloc cardiaque plus sévère qu'un bloc de premier degré ou une insuffisance cardiaque congestive non contrôlée. Lumigan n'a pas été étudié chez les patients présentant une inflammation oculaire, une néovascularisation, un glaucome à angle fermé, un glaucome congénital ou un glaucome à angle étroit. De rares cas d'œdème maculaire cystoïde ont été rapportés (>1/1000 à <1/100) après traitement avec Lumigan. Lumigan doit donc être utilisé avec précaution chez les patients présentant un facteur de risque connu d'œdème maculaire. **Effets indésirables:** Dans les études cliniques, plus de 1800 patients ont été traités par Lumigan. En regroupant les données des études cliniques de phase III de Lumigan en monothérapie ou en association, les événements indésirables liés au traitement les plus fréquents étaient : croissance des cils jusqu'à 45 % la première année avec une incidence de nouveaux cas réduite à 7 % à 2 ans et 2 % à 3 ans, hyperhémie conjonctivale (la plupart du temps minime à légère et considérée comme étant de nature non inflammatoire) jusqu'à 44 % des patients la première année avec une incidence de nouveaux cas réduite à 13 % à 2 ans et 12 % à 3 ans et prurit oculaire jusqu'à 14 % des patients la première année avec une incidence de nouveaux cas réduite à 3 % à 2 ans et 0 % à 3 ans. Moins de 9 % des patients ont dû arrêter le traitement en raison d'un événement indésirable la première année, avec une incidence d'arrêts supplémentaires de 3 % la deuxième et la troisième année. Les effets indésirables décrits ci-dessous, d'imputabilité probable ou certaine, ont été rapportés pendant les essais cliniques sur le Lumigan. La plupart étaient oculaires, d'intensité légère à modérée et aucun n'était grave. Infections et infestations : Peu fréquentes (>1/1 000 à <1/100) : infection (principalement des refroidissements et des infections des voies respiratoires hautes). Troubles du système nerveux : Fréquents (>1/100 à <1/10) : céphalées. Peu fréquents (>1/1 000 à <1/100) : sensations vertigineuses. Troubles oculaires: Très fréquents (>1/10) : hyperhémie conjonctivale, croissance des cils, prurit oculaire. Fréquents (>1/100 à <1/10) : conjonctivite allergique, asthénopie, blépharite, cataracte, œdème conjonctival, érosion de la cornée, écoulement oculaire, assombrissement des cils, douleur oculaire, sensation de corps étranger, augmentation de la pigmentation de l'iris, brûlure oculaire, sécheresse oculaire, irritation oculaire, photophobie, kératite ponctuée superficielle, larmoiements, trouble visuel et baisse de l'acuité visuelle. Peu fréquents (>1/1000 à <1/100) : blépharospasme, œdème maculaire cystoïde, rétraction de la paupière, iritis, hémorragie rétinienne, uvéite. Troubles vasculaires : Fréquents (>1/100 à <1/10) : hypertension. Troubles de la peau et des annexes : Fréquents (>1/100 à <1/10) : érythème de la paupière, prurit de la paupière, pigmentation de la peau périoculaire. Peu fréquents (>1/1000 à <1/100) : œdème de la paupière, hypertrichose. Troubles généraux et anomalies au site d'administration: Peu fréquents (>1/1000 à <1/100) : asthénie, œdème périphérique. Effets sur les constantes biologiques : Fréquents (≥1/100 à <1/10) : Anomalies des tests de l'exploration fonctionnelle hépatique. Liste des excipients : chlorure de benzalkonium , chlorure de sodium, phosphate disodique heptahydraté, acide citrique monohydraté, acide chlorhydrique ou hydroxyde de sodium (pour ajuster le pH), eau purifiée. **Titulaire de l'autorisation de mise sur le marché:** Allergan pharmaceuticals (Ireland) Ltd Castlebar Road, Westport Co. Mayo, Irlande. **Numéro d'autorisation de mise sur le marché:** EU/1/02/205/001. **Statut légal de délivrance :** exclusivement sur prescription médicale. **References:** 1. Rossetti L et al. A 12-week comparison of bimatoprost 0.03% and a fixed combination of latanoprost 0.005% and timolol 0.5% in reducing the 24-hour IOP in glaucoma patients. Ophthalmology 2007. E pub doi:10.1016/j.ophtha.2007.01.025.

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MESSAGE FROM THE PRESIDENT

Geachte collega's, Beste vrienden,

OB 2010 staat voor de deur. Dankzij de inspanningen van alle wetenschappelijke verenigingen, is het programma van deze 18de editie van OB van hoogstaande kwaliteit en rijk aan nieuwigheden.

Dit jaar is er voor het eerst een symposium toegewijd aan de update van een onderwerp betreffende zowel de diagnostische als de therapeutische methoden.

De "Belgian Glaucoma Society" zal tijdens OB 2010 dit symposium presenteren als "The Ten Commandments in Daily Glaucoma Management".

Het SBO-BOG rapport, gecoördineerd door Prof. Philippe Kestelyn met de medewerking van talrijke internationale sprekers, zal "Infectieuze Uveitis" behandelen.

De "Urgenties in neuro-oftalmologie" zullen, in het kader van het OBAO, door talrijke Europese neuro-oftalmologen op zeer praktische wijze worden voorgesteld met behulp van klinische gevallen.

De thema's die door het BSONT werden gekozen, zijn actueel en zullen zeker beantwoorden aan de verwachtingen van uw medewerkers, die ik bijgevolg wil aanmoedigen om zich in groten getale in te schrijven.

De klinische cursussen (ICC) zijn steeds meer interactief en ook dit jaar worden u nieuwe onderwerpen voorgeschoteld. Donderdagmiddag zal de interactieve cursus chirurgie (ISC) de ooglidheelkunde behandelen.

Tijdens de middagpauze op woensdag, krijgt u de kans om te discussiëren met de auteurs van de talrijke posters.

Het galadiner van donderdagavond zal plaatsvinden in het uitzonderlijke kader van de Villa Empain die wij bij deze gelegenheid zullen ontdekken.

Daarenboven wil ik de bedrijven die ons elk jaar steunen in de verwezenlijking van OB hartelijk bedanken.

Afspraak dus op 24, 25 en 26 november in Brussels Expo, alwaar ik u met genoegen in groten getale hoop te ontmoeten.

Prof. Antonella Boschi
Voorzitter OB 2010

MESSAGE FROM THE PRESIDENT

Chers Collègues, chers Amis,

Nous voilà à la veille d'OB 2010. Le programme de cette 18 ème édition d'OB, grâce à l'effort de chaque société scientifique, est de grande qualité et riche en nouveautés.

Nous inaugurons cette année, le premier des symposiums dédiés à la mise à jour d'un sujet bien spécifique tant concernant les méthodes diagnostiques que thérapeutiques.

C'est le « Belgian Glaucoma Society » qui lors d'OB 2010 initiera ce symposium en présentant « The Ten Commandments in Daily Glaucoma Management ».

Le rapport, organisé par le Prof. Philippe Kestelyn, avec la collaboration de nombreux conférenciers internationaux, traitera des «Uvéites Infectieuses».

Les «Urgences en Neuro-ophtalmologie», dans le cadre de l'OBAO, seront présentées de façon très pratique à l'aide de cas cliniques par de nombreux neuro-ophtalmologues européens.

Les thèmes choisis par le BSONT sont d'actualité et vont certainement répondre aux attentes de vos collaborateurs, que j'encourage à s'inscrire nombreux.

Les cours cliniques (ICC) sont de plus en plus interactifs et des nouveaux arguments, vous sont proposés cette année encore. Le jeudi midi, le cours interactif de chirurgie (ISC) traitera de la chirurgie oculo-palpébrale.

Enfin, le mercredi pendant la pause de midi, n'oubliez pas de venir discuter avec les auteurs des nombreuses présentations affichées (poster).

Quant au dîner de gala du jeudi soir, il se tiendra dans le cadre exceptionnel de la Villa Empain, que nous aurons le plaisir de découvrir à cette occasion.

De plus, je souhaiterais adresser un remerciement tout particulier aux firmes qui chaque année nous soutiennent dans la réalisation d'OB.

Rendez-vous le 24-25 et 26 novembre à Brussels Expo, au plaisir de vous y rencontrer nombreux.

Prof Antonella Boschi
Présidente OB 2010

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BGS	Belgian Glaucoma Society
BIO	Belgian Immuno Ophthalmology Club
BOV-ABO	Belgische Orthoptische Vereniging Association Belge d'Orthoptie
BSA	Belgian Strabismological Association
BSCRS	Belgian Societies of Cataract and Refractive Surgery
BSONT	Belgian Society of Ophthalmic Nurses & Technicians
BSOPRS	Belgian Society of Oculoplastic and Reconstructive Surgery
BVVB-OBPC	Belgische Vereniging ter Voorkoming van Blindheid Organisation Belge pour la Prévention de la Cécité
FAB	Fluorescein Angiography Club Belgium
NOC	Neuro Ophthalmology Club
OBAO	Organisatie van Belgische Assistenten in Oftalmologie Organisation Belge des Assistants en Ophtalmologie
PED & LOW	Pediatric Ophthalmology & Low Vision Rehabilitation
SBO	Société Belge d'Ophtalmologie
BOG	Belgisch Oftalmologisch Gezelschap

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OB Office
AOB vzw - asbl - OB 2010: Werkgroep - Groupe de travail
Kapucijnenvoer 33, 3000 Leuven - OB2010@ophthalmologia.be
BE 0862.155.596

Venue and dates
The congress will take place from Wednesday 24 to Friday 26, November 2010 at Brussels EXPO, Pal. 10 - Place de Belgique - Belgiëplein, 1020 Brussels.

Exhibition
The exhibition will be open during the congress from 09:00 to 18:00.

Registration
All participants will receive their congress material at the registration desk. The registration desk will be open from 08:00 to 18:00.

Entitlements
Payment of the registration fee entitles delegates to participate at the entire congress programme and the admission to the permanent coffee bar and sandwich lunch in the exhibition hall. The final programme will be sent to the preregistered participants in order of payments before November 1, 2010. The others will receive their documents at the registration desk.

Catering
Coffee during the whole congress and sandwiches during lunchtime are included in the registration fee and will be served at the coffee bar in the foyer and during the poster session in the poster area.

Badges
Please remember to wear your badge throughout the congress. In case of loss of the name badge, a fee of 15 EUR will be charged for a duplicate.

Audiovisual support room
Will be open on Tuesday from 17:00 to 20:00 and from Wednesday to Friday from 07:30 to 17:30. Bring your presentation at least two hours prior to your session to the Audiovisual support room.

Internet
Internet access is available at the internet corner, located in the Foyer.

Accreditation
Accreditation is requested and will be organised on site for each half day of attendance to the scientific programme of OB2010.

Cancellation and refunds
Refunds up to 75% of the advance registration fee will be granted for cancellation received in writing prior to November 16, 2010. Refund will not be granted for later cancellations or no-shows.

CONVENTION CENTER

Brussels EXPO, Hall 10
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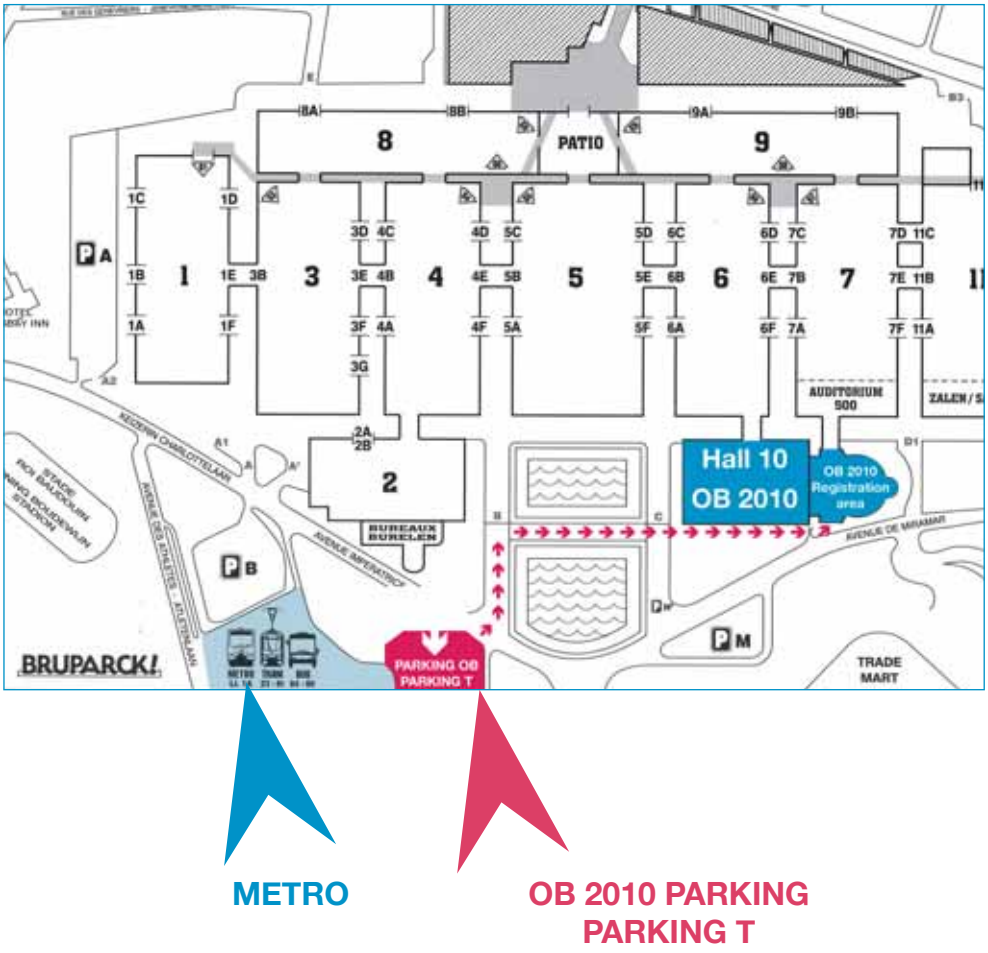

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For more info: **www.bruexpo.be**

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14 URSAPHARM Benelux
15 CORILUS nv/sa
16 PHYSIOL sa
17 VAN HOPPLYNUS Ophtalm nv
18 LABO RX
19 VAASSEN Sterile Products vsp bvba
20 ERGRA-ENGELEN bvba Low-Vision
21 ESSILOR
22 MEDA Pharma
23 VISIONTech sprl
24 REVOGAN nv
25 JOHNSON & JOHNSON Vision
26 MORIA
27 MERCK SHARP & DOHME
28 NOOTENS sa
29 ABBOTT Products sa/nv
30 OPHTALMO SERVICE nv
31 TRUSETAL VERBANDSTOFFWERK
32 PFIZER nv
33 MEDICAL WORKSHOP bv
34 MMI Informatique Médicale
35 HOSPITHERA division Lensita sa
36 DORC
37 OPTELEC
38 OPS Eyewear
39 BAUSCH & LOMB
40 ALCON
41 THEA Pharma nv
42 DE CEUNYNCK Medical
43 EDC LAMY
44 OMNIVALENT
45 ALLERGAN nv
46 SIMOVISION bvba
47 NOVARTIS Pharma nv
48 MEDICARE-HTM

GUIDELINES FOR SPEAKERS

Language

All audiovisual material should be presented in English (slides, films, ...). Presentations can be made in one of the three national languages (French, Dutch and German) or in English. If possible however the OB 2010 committee would like to recommend English oral presentations in order to increase the international attractiveness of the congress.

Technical instructions

Speakers are kindly requested to respect the alocated time to guarantee a smooth running of the sessions.

- A single computerized system will manage all projections and will send the presentations to the assigned congress rooms automatically. This method guarantees an easier management, a higher quality of projection and a quicker and smoother running of the presentations. The use of personal laptops for presentations will be actively discouraged. Dia projection will not be used anymore.

- Speakers are invited to use either PowerPoint programme for Windows or Macintosh/ Apple.

- **PowerPoint presentations on disk, CD Rom or USB memory stick** must be delivered at the Slide Centre at least one hour before the beginning of the session

- **Presentation loaded on a laptop** must be downloaded and copied at the Slide Centre at least two hours before the beginning of the session

- In case of **film projection, DVD format is recommended** and must be delivered at the Slide Centre with the author's name **at least two hours before the beginning of the session**.

- Please inform the Organizing Secretariat about your particular requests in due time.

Some suggestions to make a PowerPoint presentation:

- Write the title of the presentation and the speaker's name in the first slide indicating any possible conflict of interest (please specify any consultancy relation to pharmaceutical companies, industries, etc..).

- Save the presentation with the speaker's name + date to avoid that all presentations are called OB 2010 or Brussels 2010.

- Any video/film/image file must be in the same folder of the PowerPoint presentation and must be copied in the folder before being included in the presentation. (1) Alternatively use "Pack and go" or "Package to CD/DVD/USB" in PowerPoint.

GUIDELINES FOR SPEAKERS

- Films must have the following extensions: .avi, .mpeg, .wmv (.wmv is recommended). Furthermore, during the presentation they do not have to start with the mouse double-click on the image, but automatically when the slide opens. (2)

- We suggest putting maximum one film per slide.

- Reduce the images before putting them in the PowerPoint presentation, by using a graphics programme such as “Imaging”, “Photoshop”, “Photo Paint”, “Paintshop Pro”, etc. Or reduce image size by compressing the images in PowerPoint to screen format. Images with .gif and .jpg extensions are recommended to obtain a light presentation (other kinds of extensions - recognizable by PowerPoint - will be accepted).

- The following supports are recommended to facilitate downloading of the presentation at the Slide Centre: CD-roms, DVD, USB pens and memory sticks. It is also possible to download the presentation from a personal laptop at the Slide Centre, provided that the speaker stops at the Slide Centre at least two hours before the beginning of the session.

- Only single projection is available in the congress rooms, since PowerPoint does not support double projection.

For further information please contact the Organising Secretariat directly.

NOTE (1) Example: create the folder “PRESENTATION” and copy the necessary files for the presentation in it; then create the PowerPoint presentation including the films that were in the “presentation” folder. Finally save everything in the “presentation” folder.

NOTE (2) To avoid it, follow this procedure: Select the slide where to put the film, then the “Films and sounds...” item in the “insert” menu. Now click on “Film from file...”. Select the desired film and press the button “OK”. To the question “do you want to reproduce the film during the presentation automatically?” answer “YES”.

Procedure

- The AV support room is open on Tuesday from 17:00-20:00 and on Wednesday, Thursday and Friday from 07:30-17:30.

- The presentation on CD-rom or USB-stick should be checked in the AV support room and should be handed over to the support personnel at least two hours before your presentation. For early morning sessions we recommend to contact the AV support the day before.

- The speakers will be asked to respect the allocated time.

- The moderators and the scientific faculty of each session are responsible to organize the session within the given time table.

Centrally stored data will be deleted irrevocably right after the congress.

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GUIDELINES FOR POSTER PRESENTATION

- The image area of poster boards is 190 cm wide and 100 cm high (landscape format)

- Posters must be mounted on the assigned poster board on Tuesday 23 November 2010 from 12:00 onwards through 19:00, or at the latest on Wednesday morning 24 November 2010 from 7:30 and before 8:30.

- Poster boards are located in the poster area on the 1st floor behind Hall A of the Brussels EXPO Convention Centre and all carry a unique number. The number of the poster board to which the poster is assigned is mentioned in the programme.

- Posters must remain on display until Friday, November 26, 15:30. Posters not removed by Friday, November 26, 19:00 will be removed and discarded.

- Material for mounting will be available at the registration desk.

- Poster presenters are required to stand beside their poster during the poster sessions on Wednesday 12:30 - 14:00 and on Thursday 16:00-18:00 in poster area, Foyer +1. During this time the jury will be circulating for the poster award.

- During the poster session on Wednesday sandwiches will be served.

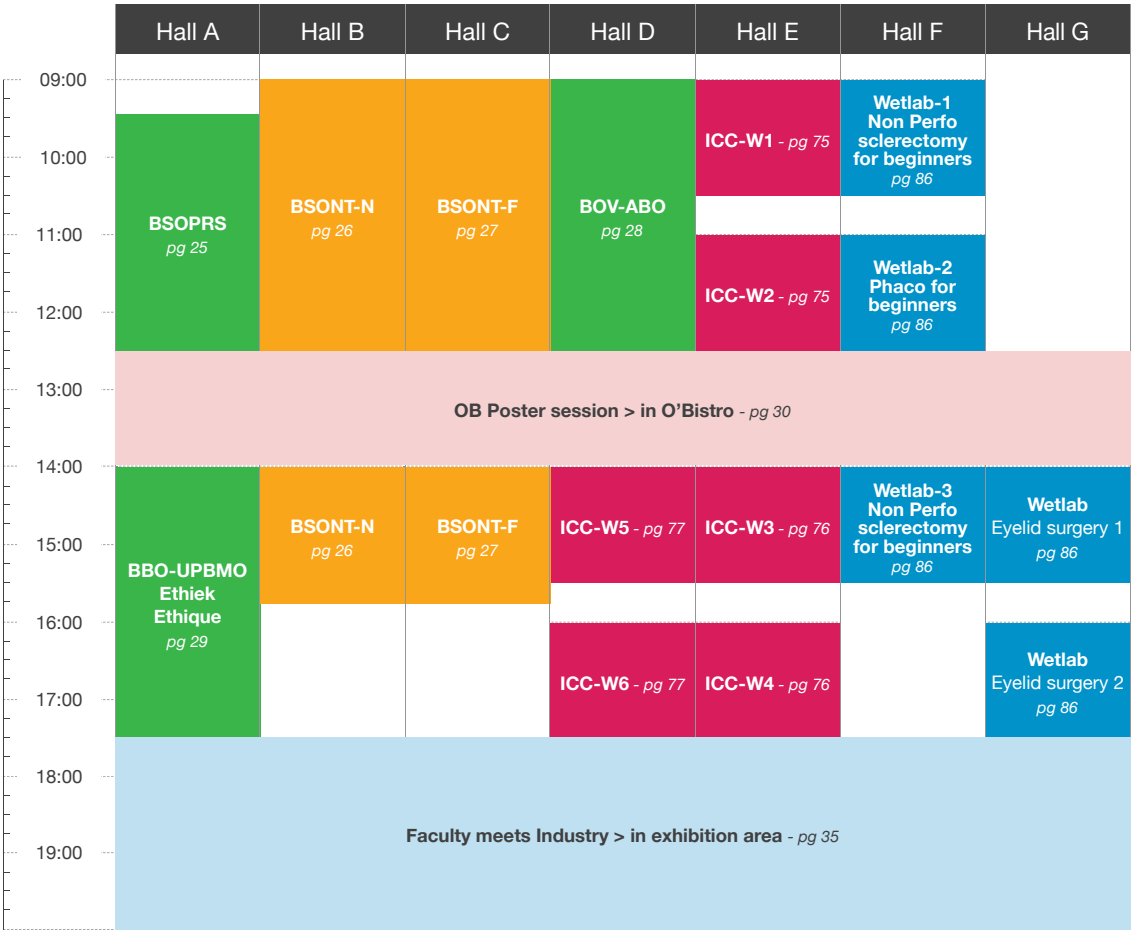
- All posters are eligible for a Poster Award.
    - Best case: 300 EUR
    - AOB best resident's poster prize: 500 EUR – Travel grant EVER 2011

  An independent panel appointed by the Board of OB 2010 decides on the Poster Awards through voting. Their decision is final.

- The poster awards ceremony will be held on Friday 26 November 2010 at 12:30 to 13:00 in Hall A. In order to receive the prize the presence of poster presenters who are awarded a poster prize is mandatory.

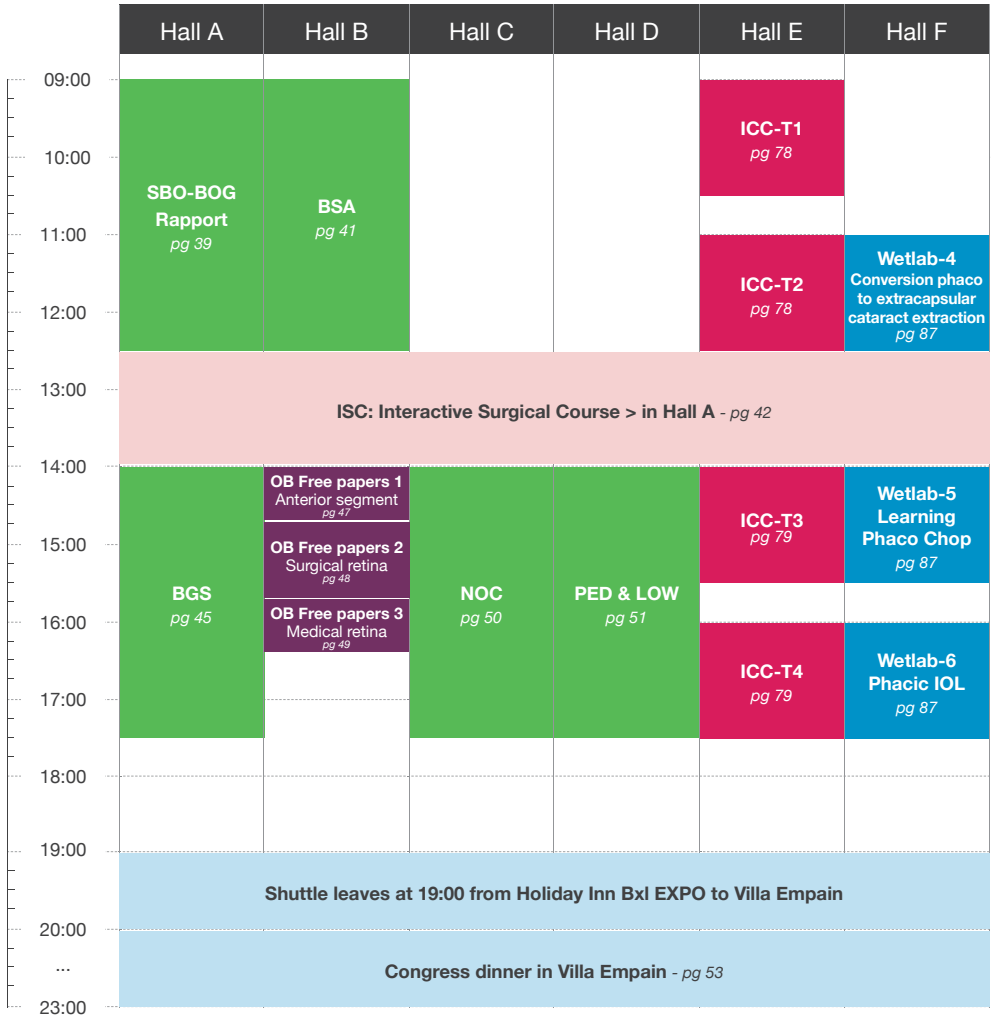
OVERVIEW

Wednesday, 24 November 2010



OVERVIEW

Thursday, 25 November 2010



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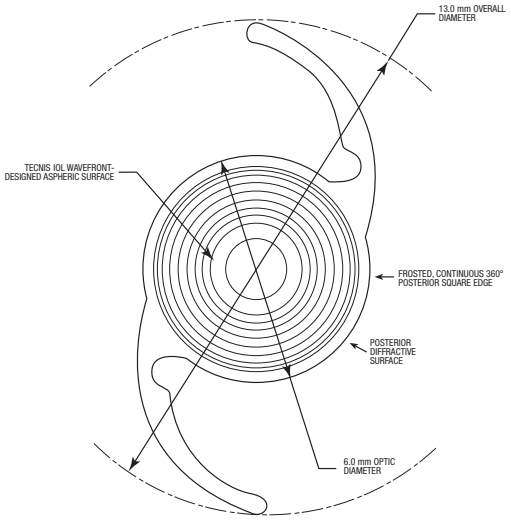

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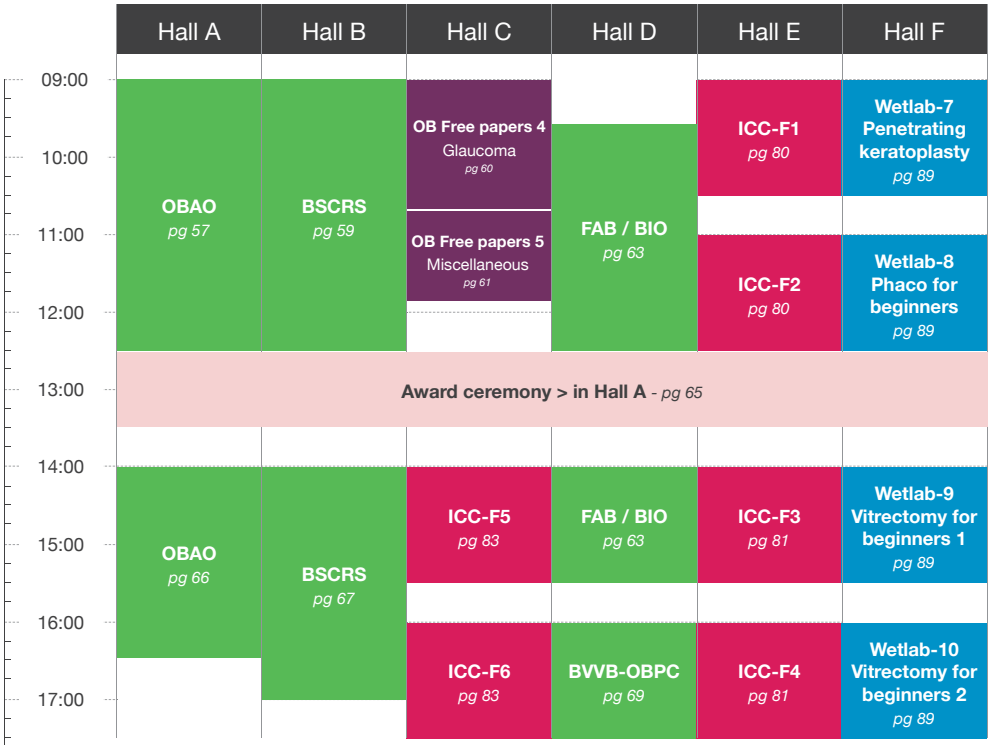
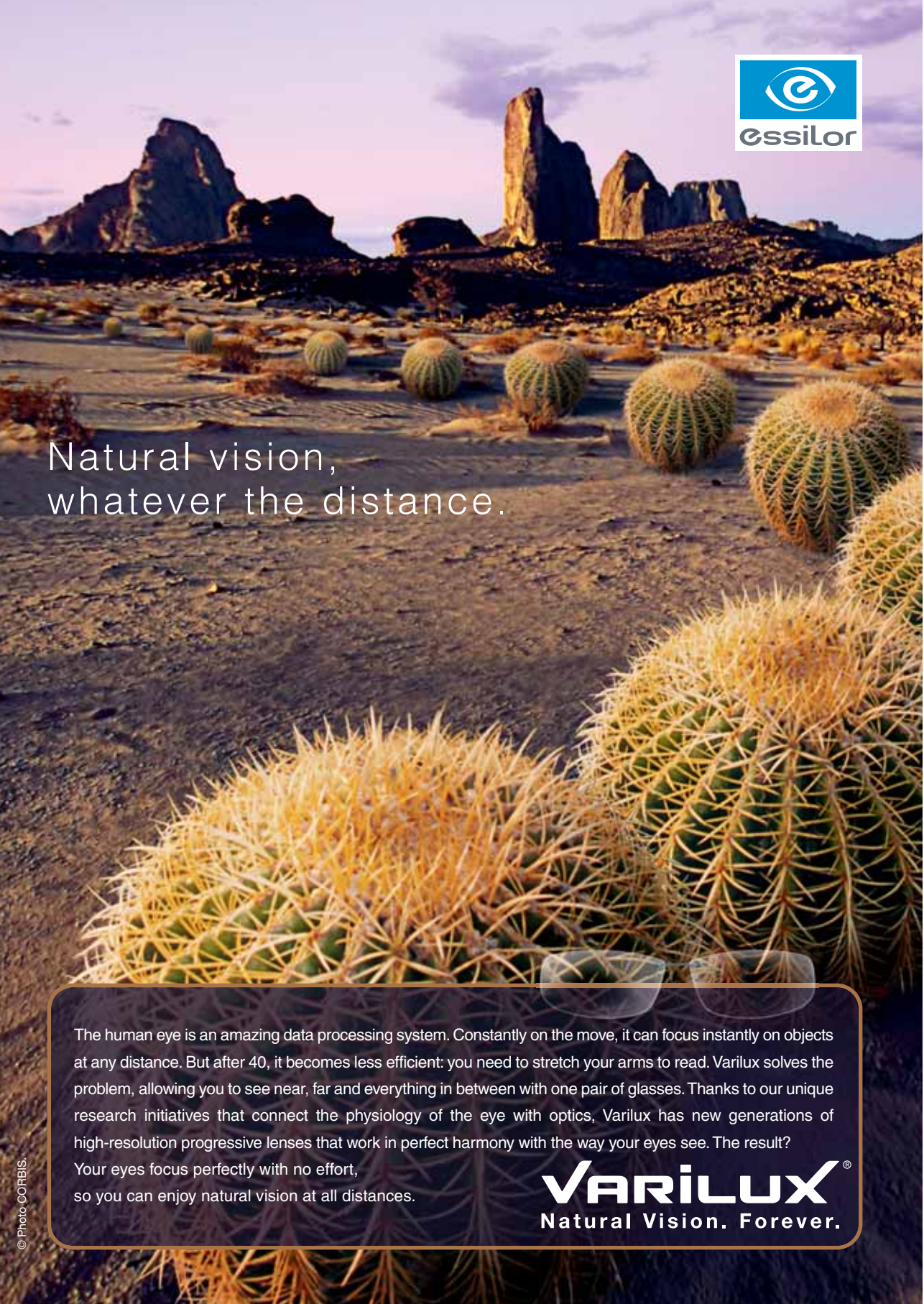
OVERVIEW

Friday, 26 November 2010

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Wednesday
24 November 2010

Notes

BSOPRS

HALL A

Belgian Society of Ophthalmic Plastic and Reconstructive Surgery

Oculoplastic traumatology

Moderators: Paul JONCKHEERE, Jean - Michel LEMAGNE

09:30 Trauma of the eyelids
101 PARIDAENS D - Rotterdam

10:00 Trauma of the orbit
102 REYCHLER H - Brussels

10:30 Break

11:00 Trauma of the lacrimal system
103 FAYET B - Paris

11:45 Iatrogenic trauma
104 DE GROOT V, JONCKHEERE P - Antwerp, Deurne

12:30 End of session

BSONT HALL B

Belgian Society of Ophthalmic Nurses & Technicians

NEDERLANDSTALIG

Diabetes / Oogtumoren, Oogprothesen
Omgaan met patiënten / Sterilisatie instrumenten

Moderators: Peter VAN ELDEREN, Lies VAN GENECHTEN

09:00 Inschrijving en verwelkoming
10:00 Openingswoord door Prof. A. Boschi, voorzitter OB 2010
10:05 Openingswoord door C. Timmerman, voorzitter BSONT
10:10 Inleiding door Prof. M.J. Tassignon, meter van het congres

10:15 Diabetes door de ogen van een endocrinoloog
105 KEYMEULEN B - Brussels

10:45 Diabetes door de ogen van een oogarts
106 VAN CALSTER J - Leuven

11:15 Oogtumoren
107 DE POTTER P - Brussels

11:45 Enucleatie
108 DECOCK C - Ghent

12:15 Oogprothesen
109 de JONG S - Leuven

12:45 Lunch

14:00 Omgaan met patiënten: agressie, angst
124 VANDENBERGH K - Leuven

14:45 Sterilisatie en omgaan met instrumenten (wegwerp)
125 THEEUWES C, MERTENS W - Antwerp

15:30 Vraagstelling

15:45 Einde

BSONT HALL C

Belgian Society of Ophthalmic Nurses & Technicians

FRANCOPHONE

Chirurgie réfractive / Le diabète / La low-vision Patient agressif / L'uvéite

Moderator: Carine VERBIEST

09:00 Accueil, inscription, café
09:45 Ouverture par la présidente de l'OB, Prof. Boschi Antonella
09:50 Mot de la présidente de la BSONT, Madame Timmerman Caroline
09:55 Introduction par le Prof. Verougstraete Claire qui parraine le BSONT 2010

10:00 Chirurgie réfractive:
1. Laser 2. Implant 3. Dernières technologies
110 *ASSAF J - Brussels*

10:45 Le diabète et ses complications
111 *VANDELEENE B - Brussels*

11:08 Le diabète et l'oeil
112 *SNYERS B, GUAGNINI AP - Brussels*

11:30 Vision basse chez l'adulte et l'enfant: "Réadaptation fonctionnelle pour déficients visuels"
113 *RENS AF - Ottignies*

12:30 Lunch

14:00 Comment faire face à un patient agressif?
126 *MARLIER E*

14:45 L'inflammation de l'oeil
127 *CASPERS L - Brussels*

15:30 Questions et réponses

15:45 Fin

BOV-ABO

HALL D

Belgische Orthoptische Vereniging
Association Belge d'Orthoptie

Visual comfort

09:00 Welcome

Contrast sensitivity, lightening and filters

Moderator: Inge JONIAU

09:05 Vision beyond visual acuity
114 LEROY BP - Ghent

09:25 Contrastgevoeligheid binnen de visuele revalidatie
115 COECKELBERGH T - Antwerp

09:45 Functie-ondersteuning bij slechtzienden d.m.v. verlichting
116 RIEMSLAG F - Zeist

10:15 Optical aids in photophobia
117 VANMECHELEN M - Brussels

10:30 Break

Asthenopia

Moderators: Odile VAN DAELE, Ann DECKX

11:00 Asthenope klachten: inleiding en diagnostisch schema
118 VAN LAMMEREN M - Leuven

11:15 New spectacle lenses and complaints
119 DE VRIES V - Brussels

12:05 Binocular causes of asthenopia; cases

12:30 End of session

Sessie Ethiek & Economie / Session Ethique & Economie
in samenwerking met het SOOS / en collaboration avec le SOOS

BBO-UPBMO HALL A

Belgische Beroepsvereniging van Oogheelkundigen
Union Professionnelle Belge des Médecins Spécialistes en Ophtalmologie et Chirurgie Oculaire

Recente (r)evoluties in de Belgische oogheelkunde
(R)évolutions récentes dans l'ophtalmologie Belge

Moderators: Edgard MAES, Ludo GEERTS

14:00 Y at-il un avenir pour la chirurgie oculaire en milieu hospitalier?
120 VAN DEN OEVER R

14:45 Is er een toekomst voor de extramurale oogheelkunde?
121 CALCOEN P

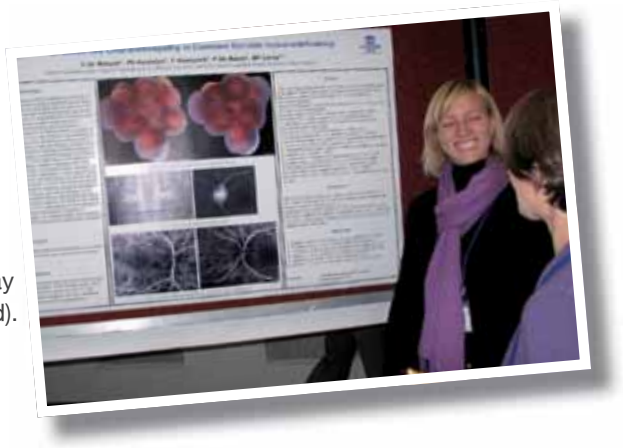
15:00 Break

15:30 Lignes directrices pour les injections intra-vitréennes
122 POSTELMANS L

16:15 Een "all-in" pathologiefinanciering voor Belgische ziekenhuizen?
123 VAN DE VOORDE C

17:00 End of session

POSTER SESSION



Each poster is exhibited in the poster area during the all congress. All posters should be erected before Wednesday 9:00. Poster presenters are required to stand beside their poster during the poster session on Wednesday from 12:30 to 14:00 (sandwiches will be served). During this time, the jury will be voting for the poster prizes.
Poster abstracts on pages 95 - 101.

Poster jury:
DE POTTER Patrick, KESTELYN Philippe, LIBERT Jacques, SPILEERS Werner, TASSIGNON Marie-José

128 The use of propranolol in the treatment of periocular infantile hemangiomas
BUIJSROGGE M, CLAERHOUT I, DECOCK C - Ghent

129 A new treatment for obstructive meibomian gland dysfunction - Blephasteam®
PURSLOW C, GILL FR - Cardiff

130 Plasma omega 3 fatty acids and risk for age-related maculopathy: the Alienor Study
ROUGIER MB, MERLE B, KOROBELNIK JF, DELYFER MN, LE GOFF M, DELCOURT C - Bordeaux

131 Analysis of progression with Peridata TM and guided progression analysis (GPA) in glaucoma patients
FORTUNATI M, MOREL-DETRY M, POURJAVAN S - Brussels

132 Contrast Sensitivity & Colour Vision in Pseudophakic & Normal Eyes: A Thorough Comparison
UVIJLS A, DE DONCKER R, SALU P, KESTELYN P, BUYL R, LEROY BP - Ghent, Brussels

133 Juvenile xanthogranuloma of the corneoscleral limbus
DE KEYSER C, MAUDGAL P, LEGIUS E, VANGINDERDEUREN R, CASTEELS I - Leuven

134 Pigment dispersion after Artiflex phakic lens implantation : myth or fact ?
GOES F jr - Antwerp

POSTER SESSION

135 Three-dimensional optical coherence tomography of optic nerve pathology: a comparative illustration and discussion
GOUT T, GOUT II, KHETERPAL S - Cambridge, Windsor

136 Histology of Vitreous Floaters, after removal by pars plana vitrectomy
VAN GINDERDEUREN R, STALMANS P, VAN CALSTER J - Leuven

137 Angioid Streaks beyond Pseudoxanthoma Elasticum
DE ZAEYTIJD J, VANAKKER OM, COUCKE PJ, DE PAEPE A, LEROY BP - Ghent

138 Laser-induced retinal injury following a recreational laser show: Two case reports and a clinicopathological study
BOOSTEN K, VAN GINDERDEUREN R, SPILEERS W, STALMANS I, WIRIX M, VAN CALSTER J, STALMANS P - Leuven

139 Unilateral cytomegalovirus panuveitis in a diabetic patient following an intravitreal injection of triamcinolone acetonide
TEK A, HUA M-T, BETZ P, BONNET S - Liège

140 Radiation-induced optic neuropathy: is the diagnosis really that easy?
DE KEYZER THW, DE KEIZER RJW, MENOVSKY T, PARIZEL P - Antwerp

141 Contributiuon of spectral-domain optical coherence tomography in a case of familial occult macular dystrophy.
PIENS I, CORDONNIER M, RASQUIN F - Brussels

142 Iridium Brachytherapy for conjunctival melanoma of the fornix
MISSOTTEN GS, VAN LIMBERGEN E, VAN GINDERDEUREN R, VANDELANOTTE S, SPILEERS W - Leuven

143 Orbital Inflammation after use the of Zoledronic Acid for metastasized prostate carcinoma
MISSOTTEN GS, VERHEEZEN Y - Hasselt

144 Heavy silicone oil, indications and complications
CLAES C - Antwerp

145 Ocular findings after a pregnancy complicated by HELLP-syndrome
GHEKIERE S, BLANCKAERT J, MULLIEZ E, VERHULST L - Leuven, Ieper

146 Sudden bilateral blindness due to methanol intoxication in an abstemious patient
NYST BN, CORDONNIER MC - Brussels

Notes

AOB prize 2009

POSTER SESSION

147 First clinical experience with the new Tecnis 1-Piece Multifocal IOL
GOES F sr - Antwerp

148 Retrolental opacities in acute anterior uveitis
VAN OS L, SMETS RM, CLAESKENS W - Edegem, Kapellen

149 Leukaemic infiltration of the optic nerve
AERTS L, DE VEUSTER I - Edegem

150 Epiretinal membrane maculopathy and poor visual function in childhood
BUISSERET D, DEPASSE F, SERPE JN, CORDONNIER M - Brussels

151 Bifocal Optic and Facial Nerve Infiltration with intraocular spread in Systemic T cell Lymphoma
VAN HOEY A, SHAH A, DE ZAEYTIJD J, LEROY BP, DECOCK C - Ghent

152 A fast growing squamous cell carcinoma of the lower eyelid.
VAN GRASDORFF S, DE KEIZER R, DE GROOT V - Antwerp

153 Blue cone monochromacy and pellucid marginal corneal degeneration: a case report
LENFANT T, CORDONNIER M - Brussels

154 Atypical dural carotid cavernous sinus fistula presenting as direct carotid cavernous sinus fistula
ATTHA E, LUBICZ B, JANSSENS S, CORDONNIER M - Brussels

155 Congenital Corneal Staphyloma: Dramatic Ophthalmological Findings in a Newborn
VERSCHOOTEN R, FOETS B, DE RAVEL T, VAN GINDERDEUREN R, LOMBAERTS R, CASTEELS I - Leuven

Notes

FACULTY MEETS INDUSTRY

Wednesday, November 24, 2010
17:30 - 20:00
Exhibition area

Open to all participants of the congress and the exhibition

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Thursday
25 November 2010

Notes

RAPPORT BOG - SBO

HALL A

Belgisch Oftalmologisch Gezelschap
Société Belge d'Ophtalmologie

Infectious uveitis, an update

Moderator: Philippe KESTELYN

09:00 New diagnostic modalities for infectious uveitis
201 DEGROOT J - Utrecht

09:15 Syphilis: reemergence of an old enemy
202 CASPERS L - Brussels

09:30 Tuberculosis in areas of high prevalence
203 ABU EL ASRAR A - Riyadh

09:45 Tuberculosis in areas of low prevalence
204 WILLERMAIN F - Brussels

10:00 Cat Scratch disease
205 KERKHOFF FT - Utrecht

10:15 Lyme disease
206 LEFEBVRE P - Brussels

10:30 Break

11:00 Fuchs uveits: syndrome or disease?
207 HERBORT C - Lausanne

11:15 Anterior uveitis and viral pathogens
208 DE SCHRYVER I - Ghent

11:30 The widening spectrum of herpetic retinopathies
209 BODAGHI B - Paris

11:45 Posterior uveitis and new viral pathogens
210 KHAIRALLAH M - Monastir

12:00 New insights in the epidemiology and the pathogenesis of ocular toxoplasmosis
211 PAVESIO C - London

12:15 Onchocerciasis: a new look at an old disease
212 KESTELYN P - Ghent

12:30 End of session

Notes

BSA HALL B

Belgian Strabismological Association

How to manage torticollis?

Moderator: Carl GOBIN

09:00 Introduction: Vincent PARIS

09:05 Causes for abnormal head posture besides strabismus
213 *DE TEMMERMAN S - La Louvière*

09:30 **Neurological approach of torticollis in children**
214 *Guest speaker: NASSOGNE MC - Brussels*

10:00 Dampening position of nystagmus
215 *DE NIJS E - Aalter*

10:20 Discussion

10:30 Break

11:00 Ocular strategies associated with abnormal torsion
216 *PARIS V - Marche-en-Famenne*

11:20 Infantile strabismus and fixation
217 *FRESON MC - Liège*

11:40 Restrictive and paretic oculomotor disorders
218 *ANDRIS C - Liège*

12:00 Discussion

12:30 End of session

INTERACTIVE SURGICAL COURSE

Open to all participants
of the congress

ISC HALL A

A panel of surgeons will show short videos of their preferred technique and discuss pro and cons

Interactive Surgical Course

Moderator: Veva DE GROOT

12:30 Entropion : Is the pentagonal resection still good enough ?
254 DECOCK C, VANDELANOTTE S - Ghent, Bruges, Leuven

12:55 Punctum stenosis : 1 snip, 2 snip or 3 snip ?
255 LEMAGNE JM, DE WILDE F - Brussels, St. Martens Latem

13:10 Punctal occlusion for dry eyes : with a conjunctival patch or occluders ?
256 JONCKHEERE P, RAUS P - Deurne, Mol

13:25 Conjunctivochalasis : resection or cauterisation ?
257 DE GROOT V, JONCKHEERE P - Edegem, Deurne

13:40 Pterygium resection followed by a conjunctival graft is a simple procedure
258 XHAUFLAIRE G, BETZ P, LEMAGNE JM - Liège, Brussels

14:00 End of session

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The dose should not exceed one drop in the affected eye(s) daily. **Administration :** Contact lenses should be removed before instillation of the eye drops and may be reinserted after 15 minutes. If more than one topical ophthalmic drug is being used, the drugs should be administered at least five minutes apart. Use in children and adolescents : Safety and effectiveness in children and adolescents has not been established. **Contraindications** Xalacom is contraindicated in patients with: Reactive airway disease including bronchial asthma or a history of bronchial asthma, severe chronic obstructive pulmonary disease. Sinus bradycardia, second or third degree atrioventricular block, overt cardiac failure, cardiogenic shock. Hypersensitivity to the active substance or to any of the excipients. **Undesirable effects** For latanoprost, the majority of undesirable effects relate to the ocular system. In data from the extension phase of the Xalacom pivotal trials, 16 - 20% of patients developed increased iris pigmentation, which may be permanent. In an open 5 year latanoprost safety study, 33% of patients developed iris pigmentation (see 4.4). Other ocular undesirable effects are generally transient and occur on dose administration. For timolol, the most serious undesirable effects are systemic in nature, including bradycardia, arrhythmia, congestive heart failure, bronchospasm and allergic reactions. Treatment related undesirable effects seen in clinical trials with Xalacom are listed below. Undesirable effects are categorized by frequency as follows: very common (≥1/10), common (≥1/100, <1/10), uncommon (≥1/1000, <1/100), rare (≥1/10,0000, <1/1000) and very rare (<1/10,000). Nervous System Disorders: Uncommon: Headache. Eye Disorders : Very common: Increased iris pigmentation. Common: Eye irritation (including stinging, burning and itching), Eye pain. Uncommon : Eye hyperaemia, Conjunctivitis, Vision blurred, Lacrimation increased, Blepharitis, Corneal disorders. Skin and Subcutaneous Tissue Disorders : Uncommon: Skin rash, Pruritus. Additional undesirable effects have been reported specific to the use of the individual components of Xalacom in either in clinical studies, spontaneous reports or in the available literature. For latanoprost, these are: Nervous System Disorders : Dizziness. Eye Disorders: Eyelash and vellus hair changes (increased length, thickness, pigmentation, and number), Punctate epithelial erosions, Periorbital oedema, Iritis/uveitis, Macular oedema (in aphakic, pseudophakic patients with torn posterior lens capsules or in patients with known risk factors for macular oedema), Dry eye, Keratitis, Corneal oedema and erosions, Misdirected eyelashes sometimes resulting in eye irritation. Cardiac Disorders : Aggravation of angina in patients with pre-existing disease, palpitations. Respiratory, Thoracic and Mediastinal Disorders Asthma, Asthma aggravation, Dyspnoea. Skin and Subcutaneous Tissue Disorders : Darkening of palpebral skin. Musculoskeletal, Connective Tissue and Bone Disorders : Joint pain, Muscle pain. General disorders and Administration Site Conditions : Chest pain For timolol, these are : Immune System Disorders : Signs and symptoms of systemic allergic reactions including angioedema, urticaria, and localized and generalized rash. Psychiatric Disorders : Depression, Memory loss, Decreased libido, Insomnia, Nightmares. Nervous System Disorders : Dizziness, Paresthesia, Cerebral ischemia, Cerebrovascular accident, Increase in signs and symptoms of myasthenia gravis, Syncope. Eye Disorders: Signs and symptoms of ocular irritation including keratitis, decreased corneal sensitivity and dry eyes, Visual disturbances including refractive changes (due to withdrawal of miotic therapy in some cases), Diplopia, Ptosis, Choroidal detachment (following filtration surgery). Ear and Labyrinth Disorders : Tinnitus. Cardiac Disorders: Palpitation, Arrhythmia, Bradycardia, Cardiac arrest, Heart block, Congestive heart failure. Vascular Disorders: Hypotension, Raynaud's phenomenon, Cold hands and feet. Respiratory, Thoracic and Mediastinal Disorders : Bronchospasm (predominantly in patients with pre-existing bronchospastic disease), Dyspnoea, Cough. Gastrointestinal Disorders: Nausea, Diarrhoea, Dyspepsia, Dry mouth. Skin and Subcutaneous Tissue Disorders : Alopecia, Psoriasiform rash or exacerbation of psoriasis. Musculoskeletal, Connective Tissue and Bone Disorders: Systemic lupus erythematosus. Reproductive System and Breast Disorders : Peyronie's disease. General Disorders and Administration Site Conditions : Asthenia/fatigue, Chest pain, Oedema. **Marketing authorisation holder** Pfizer SA, Boulevard de la Plaine 17, 1050 Brussels **Marketing authorisation number** BE226597 **Date of revision of the text** November 2008.

Pfizer Ophthalmics

XCM010E0010883

BGS HALL A

Belgian Glaucoma Society

The Ten Commandments in daily glaucoma management

Moderators: Roberte HERZEEL, Thierry ZEYEN

14:00 Pfizer Research Award 2010

14:10 You shall examine the optic disc carefully
219 DE GROOT V - Edegem

14:28 The thicker the better
220 HOSTE A - Antwerp

14:46 Never walk without your gonioscope
221 DETRY M - Brussels

15:04 You shall evaluate rates of progression
222 ZEYEN T - Leuven

15:22 When in doubt, refer to another specialist
223 GOETHALS M - Overijse

15:40 Decide how low you ought to go
224 HONDEGHEM K - Antwerp

15:58 You shall not exceed maximum medical treatment
225 EHONGO A - Brussels

16:16 When in doubt, leave BAK out
226 STEVENS AM - Ghent

16:34 Don't delay surgery
227 COLLIGNON N - Liège

16:52 Honor phaco, for it can lower intraocular pressure
228 KESTELYN P - Ghent

17:10 End of session

Notes

OB FREE PAPERS 1 HALL B

Anterior segment

Moderators: Marie-José TASSIGNON, Jean - Luc MELARD

14:00 Cataract surgery and iris reconstruction in posttraumatic zonular instability and traumatic aniridia
229 *GOES F jr - Antwerp*

14:10 Lens Surgery after previous Refractive surgery .Review of 145 eyes.
230 *GOES F sr, GOES F jr - Antwerp*

14:20 Evaluate clinical outcomes of a trifocal diffractive pattern IOL.
231 *HENRY JM - Charleroi*

14:30 FRO - Immunomodulation of corneal epithelial cells following electroporation with cDNA encoding IL-10
232 *ZAKARIA N, COOLS N, VAN TENDELOO V, BERNEMAN Z, TASSIGNON MJ - Antwerp*

OB FREE PAPERS 2 HALL B

Surgical retina

Moderators: Joachim VAN CALSTER, Sabine BONNET

14:40 Retinal detachment following 23-gauge vitrectomy: incidence, characteristics, and prognosis
233 *BARBRY J, GRIBOMONT AC - Brussels*

14:50 Results of the MIVI-trust phase III clinical trial using microplasmin in the treatment of vitreomacular traction and macular hole
234 *STALMANS P, MIVI-TRUST STUDY GROUP - Leuven*

15:00 Novel developments to increase surgical safety during (phaco)vitrectomy
235 *STALMANS P - Leuven*

15:10 Oxymap: a novel tool to measure retinal oxygenation
236 *JANSEN J, DEGHISLAGE C, VAN CALSTER J, STALMANS P - Leuven*

15:20 Is there a role for prophylactic antibiotics after vitreoretinal surgery?
237 *HAVERBEKE G - Uppsala*

15:30 Ambulatory Locoregional Vitreoretinal Surgery: Pilot Study of first 40 cases
238 *HAVERBEKE G, RIEMS J, CLAEYS C - Kortrijk, Brussels*

OB FREE PAPERS 3 HALL B

Medical retina

Moderators: Ann - Pascale GUAGNINI, Julie DE ZAEYTIJD

15:40 Efficacy of Placental growth factor Inhibition in AMD
239 *VAN DE VEIRE S, VAN BERGEN T, MOONS L, CARMELIET P, STALMANS I - Leuven*

15:50 Functional and structural ophthalmological outcome in cryo- or lasertreated premature babies with retinopathy of prematurity (ROP) between 1989 and 2008
240 *CASSIMAN C, STALMANS P, VAN CALSTER J, ALLEGAERT K, CASTEELS I - Leuven*

16:00 Intravitreal bevacizumab for myopic choroidal neovascularization: 1-year and 2-year results
241 *COPPENS G, SPIELBERG L, LEYS A - Leuven*

16:10 Dépistage de la rétinopathie diabétique chez les patients admis en hospitalisation d'un jour
242 *FORTUNATI M, HAUTENAUVEN F, GUAGNINI AP - Brussels*

16:20 End of session

NOC

HALL C

Neuro Ophthalmology Club

How do I manage an optic neuropathy?

Moderator: Cécile ANDRIS

14:00 Topical Diagnosis of acquired optic nerve disorders
243 ANDRIS C - Liège

14:10 **Is it a Papilledema? What is the best management for pseudotumor cerebri?**
244 Guest speaker: MILEA D - Angers

14:40 What is the evaluation of Optic Neuritis?
245 BELACHEW S - Liège

15:10 Ischemic Optic Neuropathies
246 ANDRIS C, SPRYNGER M - Liège

15:40 Chronic Optic disc cupping. Is it Glaucoma? Or Not?
247 COLLIGNON N - Liège

16:00 Should traumatic optic neuropathy be treated? When and how? Compressive and infiltrative optic neuropathies /How do you manage toxic and nutritional optic neuropathies?
248 ANDRIS C - Liège

16:15 **Hereditary Optic Neuropathies**
249 Guest speaker: MILEA D - Angers

17:00 Conclusions

17:20 End of session

PED & LOW HALL D

Pediatric Ophthalmology & Low vision Rehabilitation

Corneal disorders in children: how to treat these amblyogenic pathologies

Moderator: Françoise MEIRE

14:00 Introduction

14:10 Megalocornea
250 MEIRE F - Damme

14:30 Congenital opaque cornea: diagnostic techniques, classification and surgical approach
251 NISCHAL KK - London

15:30 Break

16:00 Corneal endothelial dystrophy
252 DESIR J - Brussels

16:15 Corneal ulcus in children; diagnosis, treatment and results of corneal graft in children
253 DUCHESNE B - Liège

16:45 Presentation of cases and discussion on therapeutic management
Panel: K.K. Nischal and B. Duchesne

17:30 End of session

Notes

CONGRESS DINNER

Thursday, November 25, 2010
20:00
Villa Empain

Shuttle leaves at
19:00 from Holiday INN
Bxl EXPO to Villa Empain

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26 November 2010

Notes

OBAO HALL A

Organisatie van Belgische Assistenten in Oftalmologie
Organisation Belge des Assistants en Ophtalmologie

Emergency in neuro-ophthalmology

Moderator: Julie BARBRY

09:00 Acute unilateral visual loss
301 MILEA D - Angers

09:45 Acute bilateral visual loss
302 BORRUAT FX - Lausanne

10:30 Transient visual loss
303 ANDRIS C - Liège

10:50 Break

11:20 Anisocoria
304 KAWASAKI A - Lausanne

11:55 Imaging in neuro-ophthalmology
305 SPILEERS W - Leuven

12:30 Lunch

Notes

BSCRS HALL B

Belgian Societies of Cataract and Refractive Surgery

Astigmatism : diagnosis and clinical signs
Contactlenses and astigmatism

Moderators: Robert VAN HORENBEECK, Pieter BOGHOSSIAN, Carina KOPPEN

09:00 Epidemiology and diagnosis
306 ROZEMA J - Antwerp

09:15 Topographical signs of astigmatism
307 SALLET G - Aalst

09:30 Corneal biomechanics
308 GATINEL D - Paris

09:45 Is it necessary to correct all astigmatism?
309 LEMAGNE JM - Brussels

10:00 How to improve your clinical results after toric IOL
310 TASSIGNON MJ - Antwerp

10:15 Discussion
10:30 Break

10:45 Soft lenses
311 DELCOURT JC - Barchon

11:15 Rigid lenses
312 KOPPEN C - Antwerp

11:30 Hybrid lenses
313 BEIRNAERT V - Maldegem

11:45 Scleral lenses
314 LEYSEN I - Antwerp

12:00 New managment paradigm for treatment of keratoconus
315 KOPPEN C - Antwerp

12:15 Discussion

12:30 Break

OB FREE PAPERS 4 — HALL C

Glaucoma

Moderators: Sayeh POURJAVAN, Anna - Maria STEVENS

09:00 **FRO** - Can peroperative bevacizumab (Avastin) improve trabeculectomy outcome? A prospective, randomized, placebo-controlled study.
316 *VANDEWALLE E, ZEYEN T, SPIELBERG I, STALMANS I - Leuven, Rotterdam*

09:10 The role of LOX and LOXL2 in wound healing after glaucoma filtration surgery.
317 *VAN BERGEN T, VAN DE VEIRE S, VANDEWALLE E, MOONS L, HERMAN J, STALMANS I - Leuven*

09:20 **FRO** - Evaluation of cerebrospinal fluid pressure in patients with Alzheimer's disease as a possible cause of glaucoma
318 *KIEKENS S - Antwerp*

09:30 Correlation between visual field index and ganglion cell complex parameter, global loss volume and focal loss volume, measured by RTVue OCT
319 *HAUTENAUVEN F, JANSSEN X, POURJAVAN S - Brussels*

09:40 **FRO** - The effect of microplamin on wound healing after glaucoma filtration surgery
320 *VAN BERGEN T - Leuven*

09:50 The range of Waveform score of ocular response analyzer (ORA) in healthy subjects: Interim analysis
321 *VANTOMME M, POURJAVAN S - Woluwe-St-Lambert*

10:00 Relationship between central corneal thickness and visual field loss in a glaucomatous cohort
322 *SCHAUWVLIEGHE P, SCHAUWVLIEGHE AS - Ghent*

10:10 Patient reported outcomes in glaucoma: associations between the NEI VFQ-25 and the GQL-15 and clinical measures of visual function
323 *POURJAVAN S, SPRATT A, KOTECHA A - Brussels, London*

10:20 24 hour-intraocular pressure fluctuation monitoring using an ocular telemetry Sensor: functionality and tolerability in healthy subjects.
324 *DE SMEDT S, MERMOUD A, SCHNYDER C - Lausanne*

10:30 Le syndrome de pseudoexfoliation capsulaire chez les patients Congolais
325 *KAIMBO WA KAIMBO D - Kinshasa*

OB FREE PAPERS 5 HALL C

Miscellaneous

Moderators: Patrick DE POTTER, Philippe KESTELYN

10:40 Long-term results of primary transpupillary thermotherapy of posterior uveal melanoma in 88 consecutive cases
326 *DE POTTER P, JAMART J, DE CLERCQ C - Brussels*

10:50 **FRO** - Investigating the influence of light intensity and wavelength on retinal straylight
327 *ROZEMA J - Antwerp*

11:00 Vaccination for prevention of metastases of uveal melanoma
328 *MISSOTTEN GS, PARIDAENS AD, SPILEERS W - Leuven, Rotterdam*

11:10 **FRO** - Study of the immune response in patients with uveitis and latent tuberculosis
329 *MAKHOUL D - Brussels*

11:20 **FRO** - Gene transfer of disease regulated promoters during experimental autoimmune uveitis
330 *ELMALEH V - Brussels*

11:30 Toxic optic neuropathy secondary to disulfiram: a case series
331 *LUCAS RS, LEROY BP - Ghent*

11:40 **FRO** - The effect of upregulated LOX and LOXL2 on inflammation and fibrosis in a laser induced CNV model
332 *VAN DE VEIRE S - Leuven*

11:50 End of session

Notes

FAB / BIO

HALL D

Fluorescein Angiography Club Belgium

Retinal Vascular Disease

Moderator: Anne DEWACHTER

09:30 Challenging cases of retinal vascular disease

10:20 Case reports

11:10 Break

11:40 **Macular Telangiectasis**
Guest speaker: EGAN C - London

12:30 Lunch

Belgian Immuno Ophthalmology Club

Moderators: Anne DEWACHTER, Laure CASPERS

14:00 Case reports

15:30 End of session

AWARD CEREMONY

Friday, November 26, 2010
12:30 - 13:30
Hall A

AWARD CEREMONY HALL A

Moderator: Patrick De Potter

Poster awards

All posters are eligible for a Poster Award.

- Best case: 300 EUR
- AOB best resident's poster prize: 500 EUR – Travel grant EVER 2011

An independent panel appointed by the Board of OB 2010 decides on the Poster Awards through voting. Their decision is final.

FRO awards

stichting **brailleliga**
fondation **ligue braille**

Prizes of the Stichting Brailleliga / Ligue Braille Foundation

EBO Diploma

Abi Saab, Edy
Bal, Tina
Boosten, Kathleen
De Maeyer, Veronique
Heireman, Steven
Motulsky, Elie
Nyssen, Valentine
Rocha Lafeta, Anna Paula
Schaeken, Natalie
Serpe, Jean Nicolas
Thys, Julie
Van Den Berghe, Alexia
Vandewalle, Evelien
Vertes, Dora
Viel, Audrey
Yuma Idrissa, Marcel

OBAO HALL A

Organisatie van Belgische Assistenten in Oftalmologie
Organisation Belge des Assistants en Ophtalmologie

Les urgences en neuro-ophtalmologie

Moderator: Julie BARBRY

14:00 Transient-recurrent diplopia gaze evoked
334 *CORDONNIER M - Brussels*

14:20 Painful ophthalmoplegia
335 *DE KEIZER R - Antwerp*

14:50 Break

15:00 Persistent diplopia-workup for acute oculomotor palsies
336 *BOSCHI A - Brussels*

15:30 Clinical cases:
Pr. BOSCHI, Pr. ANDRIS, Pr. BORRUAT, Pr. SPILEERS, Pr. CORDONNIER, Pr. DE KEIZER, Pr. MILEA, Pr. KAWASAKI

16:15 End of session

BSCRS HALL B

Belgian Societies of Cataract and Refractive Surgery

Astigmatism correction: corneal and intra-ocular surgery

Moderators: Guy SALLET, Benoît GOLENVAUX

14:00 Incisional techniques vs toric IOLs in cataract surgery
337 GOLENVAUX B - Brussels

14:15 Topographical and wavefront-guided laser treatment of astigmatism
338 MATHYS B - Brussels

14:30 What are the options in surgical rehabilitation of Keratoconic patients : Topo-guided PRK, ICSR or Phacic IOLs
339 VRYGHEM JC - Brussels

14:45 Crosslinking and/or Intracorneal rings for iregular astigmatism
340 VAN HORENBEECK R - Antwerp

15:00 Correction of astigmatism by optic tilt
341 GALAND A - Rotheux-Rimière

15:15 Handling high amounts of astigmatism
342 SALLET G - Aalst

15:30 Advantage of one sided toric IOL implantation
343 TASSIGNON MJ - Antwerp

15:45 Break

Communications by the Members

16:15 Oculentis M-plus: a new concept of multifocal intraocular lens technology: 6 months results
344 VRYGHEM JC - Brussels

16:25 Pseudophakic add-on IOL in residual astigmatism and ametropia after phacoemulsification
345 GOLENVAUX B - Brussels

16:35 Physiol FineVision, a new trifocal diffractive intraocular lens: early results
346 VRYGHEM JC, HEIREMAN S - Brussels

16:45 Mid-term results with the butterfly mini-incision intraocular lens
347 GOLENVAUX B, RACZKO A - Brussels

16:55 Discussion

17:00 End of session

Notes

BVVB-OBPC HALL D

Belgische Vereniging ter Voorkoming van Blindheid
Organisation Belge pour la Prévention de la Cécité

Hulp bij mobiliteit en gebruik van mentale voorstellingen en modellen
Aides à la mobilité et images mentales

Moderators: Michel MAGIS, Jean-Marie VAN HOVE

16:00 Aperçu des aides : Mobilité - Orientation - Navigation
348 DESORBAY T

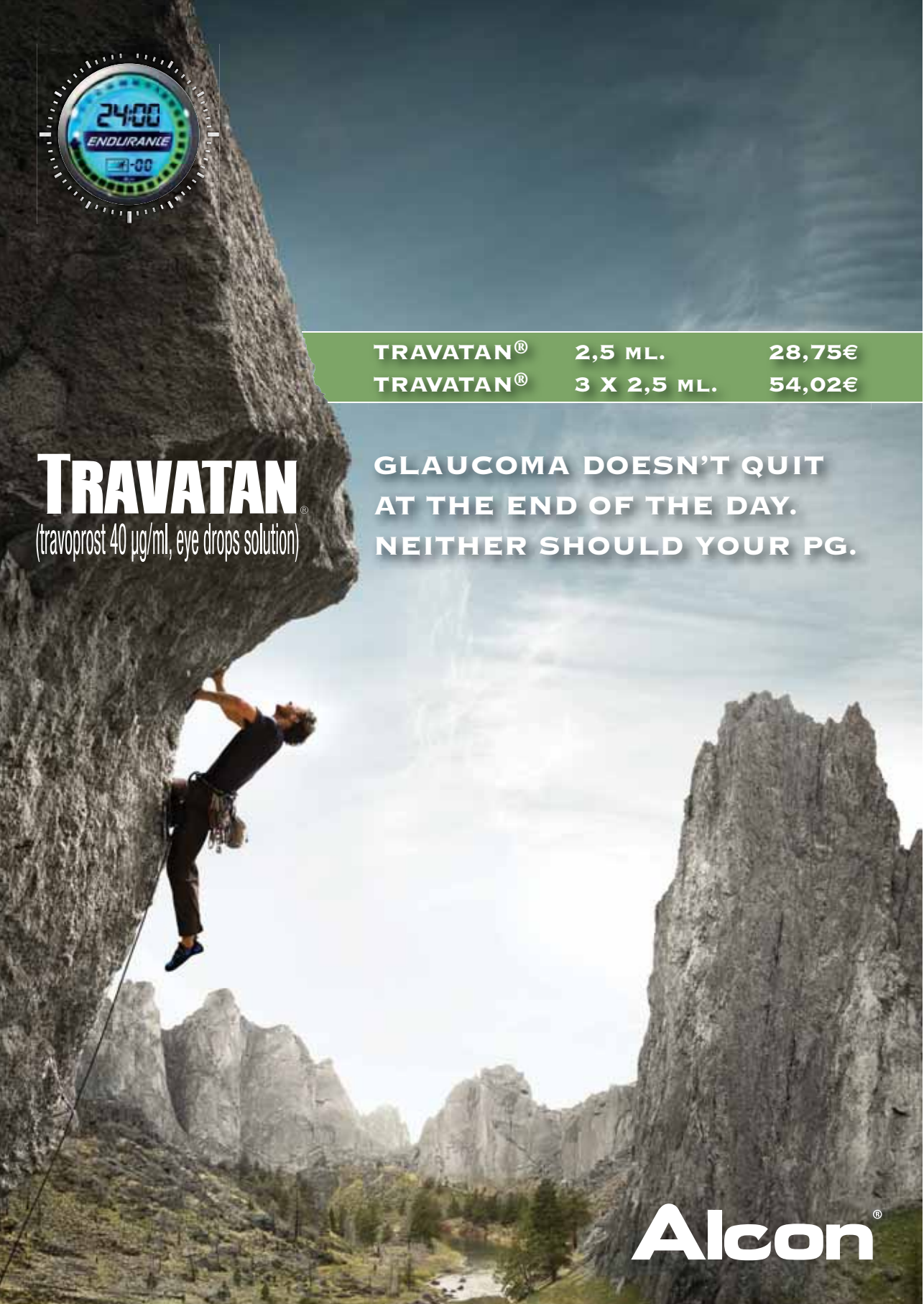
16:15 Satellietnavigatie en sprekende bakens voor blinden en slechtzienden
349 VAN DEN BREEDE

16:30 Echolokalisatie en electronic travel aids
350 NACHTERGAELE MJ

16:45 Mobilité et gestion mentale
351 EYCKERMANN A, ROGIER C

17:00 'Vivre sans les yeux'

17:30 End of session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Farmaceutische vorm : Oogdruppels, oplossing. Heldere, kleurloze oplossing.
Therapeutische indicaties
Verlaging van verhoogde intraoculaire druk bij patiënten met oculaire hypertensie of open kamerhoekglaucoom.
Dosering en wijze van toediening : Voor oculair gebruik.
Gebruik bij volwassenen, inclusief ouderen
De dosis bedraagt eenmaal daags één druppel TRAVATAN in de conjunctivale zak van het (de) aangedane oog (ogen). Het beste resultaat wordt behaald wanneer de dosis 's avonds wordt toegediend. Nasolacrimale occlusie of het zachtjes sluiten van het ooglid na toediening wordt aanbevolen. Dit kan de systemische absorptie van oculair toegediende geneesmiddelen verminderen en leiden tot een vermindering van de systemische bijwerkingen.
Indien meer dan één topisch oftalmisch geneesmiddel wordt gebruikt, moeten deze geneesmiddelen met een tussenperiode van minimaal 5 minuten worden toegediend. Als een dosis wordt vergeten, wordt de behandeling volgens schema voortgezet met de volgende dosis. De dagelijkse dosis mag niet hoger zijn dan één druppel in het (de) aangedane oog (ogen). Wanneer een ander oftalmisch antiglaucoommiddel wordt vervangen door TRAVATAN, moet het gebruik van het andere middel worden stopgezet en de volgende dag met TRAVATAN worden gestart.
Kinderen
De werkzaamheid en veiligheid van TRAVATAN bij patiënten jonger dan 18 jaar werden niet vastgesteld en het gebruik wordt niet aanbevolen bij deze patiënten tot er meer gegevens beschikbaar zijn.
Gebruik bij lever- en nierfunctiestoornissen
TRAVATAN werd bestudeerd bij patiënten met matige tot ernstige leverfunctiestoornissen en bij patiënten met matige tot ernstige nierfunctiestoornissen (creatinineklaring zo laag als 14 ml/min). Een aanpassing van de dosis is niet nodig bij deze patiënten. Het beschermende foliezakje moet vlak vóór het eerste gebruik worden verwijderd door de patiënt. Om besmetting van de druppelaar en de oplossing te voorkomen, mag de druppelaar van het flesje niet in contact komen met de oogleden, het omringende gedeelte of andere oppervlakken.
Contra-indicaties : Overgevoeligheid voor het werkzame bestanddeel of voor één van de hulpstoffen.
Bijwerkingen : In klinische studies met meer dan 4200 patiënten werd TRAVATAN eenmaal daags toegediend als monotherapie of als aanvullende therapie bij timolol 0,5%. Er werden in geen van de klinische studies ernstige oftalmische of systemische bijwerkingen met TRAVATAN gemeld. De meest gemelde bijwerking die met de behandeling van TRAVATAN als monotherapie in verband kon worden gebracht, was hyperemie van het oog (22,3%), waaronder oculaire, conjunctivale of sclerale hyperemie. De hyperemie was mild bij 83,0% van de patiënten bij wie deze bijwerking zich voordeed. Bijna alle patiënten (98%) die hyperemie ondervonden, beëindigden de behandeling als gevolg van deze bijwerking niet. In fase III klinische studies, variërend in duur van 6 tot 12 maanden, verminderde de hyperemie na verloop van tijd. De volgende bijwerkingen konden in verband worden gebracht met de behandeling (van TRAVATAN monotherapie). Zij zijn als volgt ingedeeld: zeer vaak (≥ 1/10), vaak (>1/100 tot <1/10), soms (>1/1.000 tot ≤ 1/100), zelden (>1/10.000 tot ≤ 1/1.000), of zeer zelden (≤ 1/10.000). Binnen iedere frequentiegroep worden bijwerkingen gerangschikt naar afnemende ernst.
Infecties en parasitaire aandoeningen : Soms: herpes simplex.
Immuunsysteemaandoeningen : Soms: overgevoeligheid, seizoensgebonden allergie.
Zenuwstelselaandoeningen : Vaak: hoofdpijn. Soms: dysgeusie.
Oogaandoeningen : Zeer vaak: conjunctivale hyperemie, oculaire hyperemie. Vaak: keratitis punctata, voorste oogkamercellen, voorste oogkamer "flare", oogpijn, fotofobie, oogafscheiding, oculair ongemak, oogirritatie, abnormaal gevoel in het oog, corpus-alienum gevoel in de ogen, verminderde gezichtsscherpte, wazig zien, droog oog, pruritis aan het oog, verhoogde tranenvloed, erytheem van het ooglid, ooglidoedeem, pruritis van de oogleden, groei van de wimpers, hyperpigmentatie van de iris, verkleuring van de wimpers. Soms: corneale erosie, iridocyclitis, iritis, uveïtis, stoornis van het gezichtsveld, keratitis, ontsteking van de voorste oogkamer, zwelling van het oog, verkleuring van de cornea, fotopsie, blefaritis, conjunctivaal oedeem, allergische conjunctivitis, aandoening van de cornea, conjunctivitis, conjunctivale follikels, hypoaesthesie van het oog, ectropion, keratoconjunctivitis sicca, madarose, cataract, oogallergie, pijn aan het ooglid, ooglidaandoening, korstvorming op de ooglidranden, sclerale hyperemie, asthenopie
Hartaandoeningen : Soms: onregelmatige hartslag, palpitaties, vertraagde hartslag
Bloedvataandoeningen : Soms: verlaagde bloeddruk, verhoogde bloeddruk, hypotensie
Ademhalingsstelsel-, borstkas- en mediastinumaandoeningen : Soms: dyspnoe, astma, ademhalingsstelselaandoening, faryngolaryngeale pijn, hoesten, dysfonie, nasale congestie, irritatie van de keel.
Maagdarmstelselaandoeningen : Soms: gereactiveerde ulcus pepticum, maagdarmstelselaandoening, constipatie.
Huid- en onderhuidaandoeningen : Vaak: hyperpigmentatie van de huid (peri-oculair). Soms: allergische dermatitis, periorbitaal oedeem, contactdermatitis, erytheem, veranderingen van haarkleur, abnormale haarstructuur, hypertrichose.
Skeletspierstelsel-, bindweefsel- en botaandoeningen : Soms: pijn in de schouders.
Algemene aandoeningen en toedieningsplaatsstoornissen : Soms: asthenie, malaise.
De volgende bijwerkingen werden vastgesteld tijdens post-marketing ervaringen en werden niet eerder in klinische studies met TRAVATAN als monotherapie gemeld :
Oculair: macula-oedeem
Systemisch: bradycardie, tachycardie, verergeren van astma, vertigo, tinnitus, toename van PSA, abnormale haargroei
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Aflevering: Geneesmiddel op medisch voorschrift.
Datum van herziening van de tekst: 1 maart 2007

TRAVATAN©

Dénomination du médicament : TRAVATAN 40 microgrammes/ml collyre en solution.
Composition qualitative et quantitative : 1 ml de solution contient 40 microgrammes de travoprost. Liste des excipients: chlorure de benzalkonium, huile de ricin hydrogénée polyoxyéthylénée 40 (HCO-40), trométamol, edétate disodique, acide borique (E284), mannitol (E421), hydroxyde de sodium et/ou acide chlorhydrique (ajustement du pH), eau purifiée.
Forme pharmaceutique : Collyre en solution. Solution incolore et limpide.
Indications thérapeutiques : Réduction de la pression intraoculaire élevée chez les patients atteints d'hypertonie intraoculaire ou de glaucome à angle ouvert.
Posologie et mode d'administration : Voie oculaire.
Utilisation chez les adultes et les sujets âgés : La posologie est de une goutte de TRAVATAN dans le cul de sac conjonctival de l'œil ou des yeux atteint(s) une fois par jour. L'effet est optimal si le traitement est administré le soir. Une occlusion nasolacrymale ou une fermeture douce des paupières après administration est recommandée. Ceci peut réduire l'absorption systémique des médicaments administrés par voie oculaire et conduire à une diminution des effets indésirables systémiques. En cas d'utilisation de plusieurs collyres, les médicaments doivent être administrés avec au moins 5 minutes d'écart. Si une instillation est oubliée, le traitement doit être poursuivi avec l'instillation suivante comme prévu. La posologie ne doit pas dépasser une goutte par jour dans l'œil ou les yeux atteint(s). En cas de remplacement d'un autre traitement antiglaucomateux ophtalmique par TRAVATAN, l'autre traitement doit être interrompu et TRAVATAN doit être commencé le jour suivant.
Sujets pédiatriques
L'efficacité et la tolérance de TRAVATAN chez les patients de moins de 18 ans n'ont pas été établies et son utilisation n'est pas recommandée chez ces patients jusqu'à ce que de nouvelles données soient disponibles.
Utilisation chez les insuffisants hépatiques et rénaux
TRAVATAN a été étudié chez les insuffisants hépatiques modérés à sévères et chez les insuffisants rénaux modérés à sévères (clairance de la créatinine jusqu'à 14 ml/min). Aucune adaptation de la posologie n'est nécessaire chez ces patients. Le patient doit retirer le sachet protecteur juste avant la première utilisation. Pour éviter la contamination de l'embout compte-gouttes et de la solution, il faut faire attention de ne pas toucher les paupières, les surfaces voisines ou d'autres surfaces avec l'embout compte-gouttes du flacon.
Contre-indications : Hypersensibilité au principe actif ou à l'un des excipients.
Effets indésirables : Au cours des études cliniques incluant plus de 4200 patients, TRAVATAN a été administré, une fois par jour, en monothérapie ou en association avec du timolol 0,5%. Aucun effet indésirable grave, ophtalmique ou systémique, lié à TRAVATAN n'a été rapporté dans aucune des études cliniques. L'effet indésirable, lié à TRAVATAN en monothérapie, le plus fréquemment rapporté était une hyperémie oculaire (22,3 %) incluant hyperémie oculaire, conjonctivale ou sclérale. L'hyperémie était légère chez 83,0 % des patients. Chez la plupart des patients (98 %), l'hyperémie n'a pas entraîné d'arrêt du traitement. Dans les études cliniques de phase III d'une durée de 6 à 12 mois, l'hyperhémie a diminué avec le temps. Les effets indésirables suivants ont été considérés comme liés au traitement (TRAVATAN en monothérapie) et ont été classés de la façon suivante : très fréquents (≥ 1/10), fréquents (>1/100, <1/10), peu fréquents (>1/1.000, ≤ 1/100) et rares (>1/10.000, ≤ 1.000) ou très rares (≤ 1/10.000). Dans chaque groupe de fréquence, les effets indésirables sont présentés dans l'ordre décroissant de gravité.
Infections et infestations: Peu fréquentes : herpès simplex.
Affections du système immunitaire : Peu fréquentes : hypersensibilité, allergie saisonnière.
Affections du système nerveux: Fréquentes : céphalées. Peu fréquentes : dysgueusie.
Affections oculaires : Très fréquentes : hyperémie conjonctivale, hyperémie oculaire Fréquents : kératite ponctuée, inflammation de la chambre antérieure (Tyndall protéique et cellulaire), douleur oculaire, photophobie, écoulement, gêne oculaire, irritation oculaire, sensation anormale dans l'œil, sensation de corps étrangers dans les yeux, baisse d'acuité visuelle, vision floue, sécheresse oculaire, prurit oculaire, augmentation du larmoiement, érythème des paupières, œdème des paupières, prurit des paupières, poussée de cils, hyperpigmentation de l'iris, coloration des cils. Peu fréquentes : érosion cornéenne, irido-cyclite, iritis, uvéite, défaillance du champ visuel, kératite, inflammation de la chambre antérieure, gonflement de l'œil, coloration cornéenne, photopsie, blépharite, œdème conjonctival, conjonctivite allergique, affection conjonctivale, conjonctivites, follicules conjonctivaux, hypoesthésie oculaire, ectropion, kératoconjonctivite sèche, madarose, cataracte, allergie oculaire, douleur des paupières, troubles des paupières, formation de croûtes sur le bord des paupières, hyperémie sclérale, asthénopie.
Affections cardiaques : Peu fréquentes : fréquence cardiaque irrégulière, palpitations, baisse de la fréquence cardiaque.
Affections vasculaires : Peu fréquentes : diminution de la pression artérielle, augmentation de la pression artérielle, hypotension.
Affections respiratoires, thoraciques et médiastinales :Peu fréquents : dyspnée, asthme, trouble respiratoire, douleur pharyngo-laryngée, toux, dysphonie, congestion nasale, irritation de la gorge.
Affections gastro-intestinales : Peu fréquentes : réactivation d'ulcère gastroduodénal, affection gastro-intestinale, constipation.
Affections de la peau et du tissus sous-cutané : Fréquentes : hyperpigmentation cutanée (péri-oculaire).
Peu fréquentes : dermatite allergique, œdème périorbital, dermatite de contact, érythème, changement de la couleur des cheveux, texture des cheveux anormale, hypertrichose.
Affections musculo-squelettiques et systémiques : Peu fréquentes : douleur aux épaules.
Troubles généraux et anomalies au site d'administration : Peu fréquents : asthénie, malaise.
Des effets indésirables identifiés après la commercialisation et non rapportés précédemment lors des études cliniques avec TRAVATAN en monothérapie sont les suivants : oculaire : œdème maculaire, Systémique : bradycardie, tachycardie, asthme aggravé, vertiges, bourdonnement d'oreilles, augmentation de la PSA, croissance des cheveux anormale.
Prix public incl. TVA : Travatan 2,5 ml : 28,75 € ; 3 x 2,5 ml : 54,02€.
Titulaire d'enregistrement : Alcon Laboratories (UK) Ltd., Boundary Way, Hemel Hempstead, Herts HP2 7UD, Royaume Uni.
Fabricant : SA ALCON-COUVREUR NV, Rijksweg 14, 2870 Puurs, Belgique.
Numéro d'enregistrement : EU/1/01/199/001-002.
Délivrance : Médicament soumis à prescription médicale.
Date de mise à jour du texte: 1 mars 2007.
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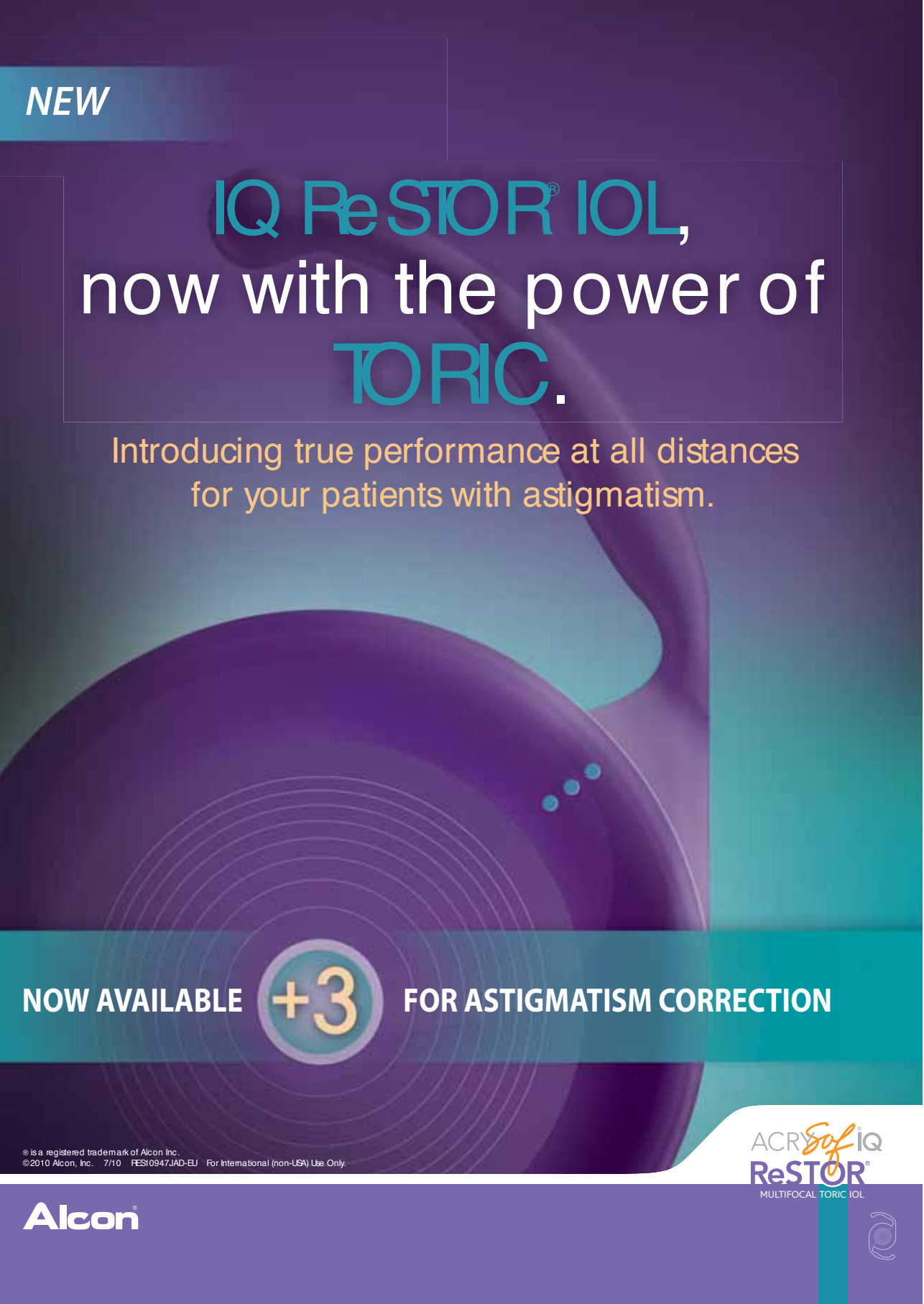

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INTERACTIVE CLINICAL COURSES

Notes

Interactive Clinical Courses

Organizer: Veva De Groot
- Registration required -

Wednesday, 24/11/2010

09:00 - 10:30 **ICC - W1 | Intermediate** **Hall E**

Artisan/Artiflex Lens Implantation : a step by step approach

BUDO C, GOES F jr, NUIJTS R, TERMOTE H

Indications and preoperative examinations(OCT) will be outlined. Videos will be used to teach the different steps of this procedure in a didactic manner. Postoperative long term results and encountered peroperative difficulties and their solutions will be shared. The various advantages of this procedure over other phakic IOL solutions to correct high myopia, (hyperopia) and astigmatism will become evident.

11:00 - 12:30 **ICC - W2 | Basic** **Hall E**

Le traitement de l'amblyopie

CORDONNIER M, SOYER T

Les aspects pratiques, diagnostiques et thérapeutiques de l'amblyopie strabique et non strabique seront abordés, avec démonstration de cas cliniques associée à une session de questions-réponses pour chaque étape du traitement.

Interactive Clinical Courses

Organizer: Veva De Groot
- Registration required -

Wednesday, 24/11/2010

14:00 - 15:30 **ICC - W3 | Basic** **Hall E**

Sensorial ophthalmological treatments revisited

PARIS V

Our knowledges concerning the duration of occlusion in the treatment of functional amblyopia has deeply changed. The use of small power prims is successefully and extensively used by optometrists but rarely by ophtalmologists . Sensorial indications of strabismus surgery in adults developped but rarely indicated by ophthalmologists. The aim of this course is to learn about new but crucial aspects of treatment of monocular and binocular vision in the daily practice.

16:00 - 17:30 **ICC - W4 | High** **Hall E**

Advanced Cataract Surgical tricks and tips

TASSIGNON MJ, BUDO C, BLANCKAERT J, GALAND A, VAN LOOVEREN J

The aim of this course is to propose different surgical tips and tricks to solve difficult cases of cataract surgery. This course will be mainly video based and will cover difficult cases like small pupils, iris repair, toric IOLs, IOL exchange, posterior capsulorhexis for bag-in-the-lens IOL and which implant in the absence of the capsular bag. It will also cover the management of posterior capsule rupture and dropped nucleus. The attendees will be stimulated to discuss the pros and cons of the surgical proposals with the faculty.

Interactive Clinical Courses

Organizer: Veva De Groot
- Registration required -

Wednesday, 24/11/2010

14:00 - 15:30 **ICC - W5 | Intermediate** **Hall D**

Démarche diagnostique devant une uvéite antérieure

MAKHOUL D, KOCH P, WILLERMAIN F

Les uvéites antérieures sont les formes les plus fréquentes d'inflammation intraoculaire. Elles touchent essentiellement des patients jeunes entre 20 et 50 ans et peuvent avoir de nombreuses causes. Récemment, une origine virale a pu être attribuée à des atteintes que l'on pensait idiopathique. Le but de ce cours est de proposer une démarche diagnostique devant une uvéite antérieure en se basant en premier lieu sur les différentes caractéristiques cliniques. Les nouvelles techniques biologiques appliquées sur les liquides intraoculaires seront également introduites.

16:00 - 17:30 **ICC - W6 | Basic** **Hall D**

Prise en charge orthoptique de la diplopie

DEFRETIN MH, SCHMIT P

Le but de cette rencontre est de donner et/ou de rappeler aux participants les points essentiels et de leur donner les clefs diagnostiques permettant d'analyser une diplopie binoculaire et d'en orienter au mieux la prise en charge. Les diplopies d'origine paralytique (acquises ou congénitales), post-opératoires et les décompensations phoriques seront envisagées. Leur attitude thérapeutique sera discutée. Cette approche pragmatique contribuera à rendre plus aisée la prise en charge de ces pathologies invalidantes.

Interactive Clinical Courses

Organizer: Veva De Groot
- Registration required -

Thursday, 25/11/2010

09:00 - 10:30 **ICC - T1 | Basic** **Hall E**

Updates in keratoconus and other corneal ectasias

CHAVES A

The goal of this course is to discuss about the corneal ectasias starting from their differential diagnosis, updating the new techiniques and tools available for the diagnostic, as well as their clinical and surgical different treatment modalities.

11:00 - 12:30 **ICC - T2 | Intermediate** **Hall E**

La tomographie par cohérence optique à haute résolution (Spectralis): interprétation et aspects pratiques

RASQUIN F, DEMOLS P

L'imagerie rétinienne obtenue par les nouvelles techniques de tomographie par cohérence optique à haute résolution nous apporte une meilleure définition des structures rétiniennes et ainsi des informations supplémentaires utiles dans notre compréhension des pathologies rétiniennes. Le but de ce cours est de familiariser les participants à cette nouvelle imagerie au travers de nombreux cas cliniques.

Interactive Clinical Courses

Organizer: Veva De Groot
- Registration required -

Thursday, 25/11/2010

14:00 - 15:30 **ICC - T3 | Basic** **Hall E**

Les Uvéites Postérieures: n'en ayons plus peur !

LEFEBVRE P, KOZYREFF A

Les uvéites postérieures sont souvent une source d'inquiétude. Nous expliquerons comment reconnaître un panel d'uvéites postérieures, comment les traiter, quand les référer.

16:00 - 17:30 **ICC - T4 | Intermediate** **Hall E**

Anisocorie! Wat nu?

SPILEERS W

Als we geconfronteerd worden met een anisocorie is een gestructureerde onderzoeksplanning noodzakelijk: pupilreflexen, anisocorie in licht en donker, ooglid ?, subjectieve klachten?, ...
Zijn collyriumtesten nuttig/noodzakelijk? Is verdere (neurologische) investigatie noodzakelijk?
Een praktisch plan wordt voorgesteld en interactief getoetst.

Interactive Clinical Courses

Organizer: Veva De Groot
- Registration required -

Friday, 26/11/2010

09:00 - 10:30 **ICC - F1 | Basic** **Hall E**

Ophtalmoplegies inter et supranucleaires une fois pour toutes

BARLET T, VAN NECHEL C

Les désordres inter et supranucléaires : Seront abordés, les bases anatomocliniques, les bases physiologiques et physiopathologiques et surtout les pathologies et syndromes concernant l'ophtalmologue dans sa pratique régulière.
Vous avez du mal à repérer,à les examiner et la conduite à tenir face à de tels diagnostics vous échappe.
Voici une manière claire et épurée d'approcher les désordres inter et supranucléaires. Ce cours vise à présenter les choses sous un angle pertinent et aisé à appliquer en pratique.

11:00 - 12:30 **ICC - F2 | Basic** **Hall E**

Interprétation du champ visuel Humphrey en pratique courante

EHONGO A

But : Pouvoir interpréter un relevé de champ visuel en périmétrie automatique standard Humphey en évitant les pièges classiques. De façon systématique, et en s'appuyant de cas cliniques, les données de la feuille des résultats sont parcourues. Pour chaque paramètre, les pièges, les limites et les solutions sont abordés, ainsi que les alternatives éventuelles. Pour les glaucomes débutants, l'intérêt de la périmétrie en doublage de fréquence est discuté.

Interactive Clinical Courses

Organizer: Veva De Groot
- Registration required -

Friday, 26/11/2010

14:00 - 15:30 **ICC - F3 | Basic** **Hall E**

Onverklaarde visusdaling: een reisgids

SPILEERS W

Een praktische handleiding voor de exploratie van onverklaarde visusdaling wordt voorgesteld.
Wanneer is electrofysiologie nuttig? Wat leert het gezichtsveldonderzoek? Dan toch beeldvorming (CT-NMR?) aanvragen ? Is de visusdaling objectief? Een interactieve rondleiding eindigt met een praktisch en dagelijks toepasbaar schema.

16:00 - 17:30 **ICC - F4 | Basic** **Hall E**

I2I, een commucatietechniek om therapie-ontrouw op te sporen

HONDEGHEM K, DE GROOT V, STEVENS A

Het is geweten dat de meerderheid van onze patienten vaak niet therapietrouw zijn en dat dit een zeer belangrijke rol speelt in de progressie van een ziekte. Toch is het moeilijk om deze therapieontrouw te ontdekken en om de oorzaken van non-compliance te identificeren.
Tijdens deze cursus demonstreren we een aanbevolen communicatietechniek om slechte therapietrouw op te sporen en zelfs in te spelen op de onderliggende oorzaak van deze ontrouw. Dit wordt gedemonstreerd aan de hand van enkele patiënt-dokter scènes. Deze praktische tips kan U dagelijks gebruiken in uw praktijk, zonder veel extra tijdverlies.

Notes

Interactive Clinical Courses

Organizer: Veva De Groot
- Registration required -

Friday, 26/11/2010

14:00 - 15:30 **ICC - F5 | Intermediate** **Hall C**

Patient selection for Multifocal and or accomodative IOLs. How can we improve!

GOES FJ, SCHMICKLER S

To present outcomes of a prospective study whereby patients were recruited for multifocal or accomodative IOL implantation after having filled in a questionnaire based upon psychology tests such as: LP 50+ Test-. Personality aspects of competence, tidiness, sense of duty, ambition, self-discipline and deliberateness were analysed beforehand and tested against outcomes afterwards. The goal is to exclude the eventual unhappy patient after multifocal IOL implantation before they undergo surgery. Outcomes will demonstrate if any preoperative analysis of patient's personality will be helpful in patient selection.

16:00 - 17:30 **ICC - F6 | Basic** **Hall C**

I2I, ou comment détecter les causes de non-observance d'un patient glaucomateux à son traitement

DETRY M, COLLIGNON N, EHONGO A

La non-observance au traitement antiglaucomateux est fréquente et difficile à déceler en pratique. I2I est un outil de formation à la communication pour apprendre à poser les « bonnes » questions au patient, détecter rapidement si celui-ci est observant à son traitement et identifier quelles sont les causes de non-observance et d'absence de préoccupation du patient vis-à-vis de sa maladie. i2i propose quelques solutions pour remédier aux problèmes décelés.

Notes

WETLABS

Registration required

Wetlabs

Coordinator: Jean-Luc MELARD
- Registration required -

Wednesday, 24/11/2010

Hall F

09:00 - 10:30 **Wetlab 1** — **Basic**

Glaucoma - Non Perfo sclerectomy for beginners
KESTELEYN P

11:00 - 12:30 **Wetlab 2** — **Basic**

Cataract - Phaco for beginners
HOEBEKE M

14:00 - 15:30 **Wetlab 3** — **Basic- intermediate**

Glaucoma - Non Perfo sclerectomy for beginners
COLLIGNON N

Hall G
O'Bistro in exhibition hall

14:00 - 15:30 **Wetlab Eyelid surgery 1** — **Basic**
JONCKHEERE P - BETZ P

16:00 - 17:30 **Wetlab Eyelid surgery 2** — **Basic**
JONCKHEERE P - BETZ P

Wetlabs

Coordinator: Jean-Luc MELARD
- Registration required -

Thursday, 25/11/2010

Hall F

11:00 - 12:30 **Wetlab 4** **Intermediate**

Cataract - Conversion from phaco to extracapsular cataract extraction
LEMAGNE JM

14:00 - 15:30 **Wetlab 5** **Advanced**

Cataract - Learning Phaco Chop
HAUSTERMANS A

16:00 - 17:30 **Wetlab 6** **Advanced**

Refractive - Phacic IOL
TERMOTE H

Notes

Wetlabs

Coordinator: Jean-Luc MELARD
- Registration required -

Friday, 26/11/2010

Hall F

09:00 - 10:30 **Wetlab 7** **Basic**

Cornea - Penetrating keratoplasty
SCHROOYEN M

11:00 - 12:30 **Wetlab 8** **Basic**

Cataract - Phaco for beginners
DE GROOT V

14:00 - 15:30 **Wetlab 9** **Basic - intermediate**

Vitrectomy - Vitrectomy for beginners 1
NERINCKX F

16:00 - 17:30 **Wetlab 10** **Basic - intermediate**

Vitrectomy - Vitrectomy for beginners 2
NERINCKX F

Notes

ABSTRACTS

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Chirurgie réfractive:
1. Laser
2. Implant
3. Dernières technologies

ASSAF J
Brussels

Le cours abordera le thème de la chirurgie réfractive pour corriger la myopie, l'hypermétropie, l'astigmatisme et la presbytie.Seront précisés dans le cours, les indications du :

1. Laser Excimer dans ses différentes techniques : PRK, Lasek, Lasik

2. Les implants myopies pour les fortes amétropies : Artisan, Artiflex, ICL

3. Les implants pseudo-accommodatifs.Nous discuterons les indications de ces techniques, leurs limites et leurs complications.

113

Vision basse chez l'adulte et l'enfant: "Réadaptation fonctionnelle pour déficients visuels"

RENS AF
IRSA et asbl Points de vue - Clinique Saint-Pierre, Ottignies

Nous sommes un petit centre de rééducation fonctionnelle situé à Ottignies en face de la clinque Saint Pierre. Nous avons réalisé nos premières démarches accompagnées par l'IRSA école pour enfants déficients visuels.L'équipe, composée de 9 thérapeutes, est dirigé par l'ophtalmologue. Dans l'équipe il y a une psychologue, coordinatrice, une assistante sociale, une orthoptiste, deux spécialistes en basses visions, une spécialiste en orientation et mobilité, une ergothérapeute travaillant les activités de la vie journalière ainsi qu'une kiné psychomotricienne qui pratique l'eutonie. Le centre s'adresse à des patients à partir de l'âge de 1an jusqu' à 95 ans et plus. Le nombre de séances varient de 15 séances pour les personnes au- delà de 65 ans à 120 séances pour les autres pour des périodes de trois ans renouvelable plusieurs fois. Nous réalisons d'abord un bilan pluridisciplinaire puis entamons les prises en charge.Notre centre essaie d'accueillir au mieux, de manière conviviale et professionnelle des patients afin de leur donner un nouveau plaisir de voir autrement.

114

Vision beyond visual acuity

LEROY BP
Dept of Ophthalmology & Ctr for Medical Genetics, Ghent University Hospital and Ghent University, Ghent

PURPOSE To describe aspects of vision beyond measurement of best-corrected visual acuity.

METHODS A review focused mainly on measurement of contrast sensitivity and colour vision tests, illustrated with findings from clinical cases.

RESULTS Mainly in the early stages, many ocular conditions cause a decrease in contrast sensitivity and/or colour vision, before best-corrected visual acuity declines. Using specific tests, such deficiencies of contrast sensitivity and colour vision can be picked up early.

CONCLUSION Contrast sensitivity and colour vision can be evaluated using commonly available tests, and can aid in making a diagnosis in a patient who complains of visual loss whilst best-corrected visual acuity is still within the normal range.

115

Contrastgevoeligheid binnen de visuele revalidatie

COECKELBERGH T
Universitair Ziekenhuis Antwerpen, Universiteit Antwerpen, Antwerp

Contrast sensitivity has often been reported as a major risk factor for falls in older people and a better predictor for mobility than visual acuity in patients with ocular pathology. Despite its high predictive validity, contrast sensitivity is not assessed on a regular basis. We assessed Pelli-Robson contrast sensitivity in low vision patients to determine the relationship between visual acuity and contrast sensitivity and to evaluate the importance of contrast sensitivity for rehabilitation.

116

Functie-ondersteuning bij slechtzienden d.m.v. verlichting

RIEMSLAG F
Bartimeus, Zeist

“Support of the visually impaired at the function level by means of lighting”The International Classification for Functioning (WHO, 2001) provides a strong guideline for the rehabilitation practice. The system classifies the consequences of disorders in terms of the dimensions Functioning, Activities and Participation. Planning of rehabilitation activities should always follow that order of dimensions. Adequate lighting of the living- and/or working environment of the visually impaired provides support at the level of functioning: it makes available the optimal use of the remaining vision. It turns out that many visually impaired show there best daily vision at luminance levels far above the normal 100 lux. On the other hand, many visually impaired have serious problems with high luminances, which makes there vision less than optimal. These seemingly contradictory boundary conditions require an adequate procedure to quantify the specific needs of a subject. In our light laboratories in the Netherlands (Cornelissen, Vision Research 1995) we measure the performance of the subject as a function of the illumination level. Furthermore we quantify subjectively the upper- and the lower limit of illumination within which the subject can perform best. From that information a meticulous technical advice for the illumination of the living- and/or working area of the subject is produced. In this advice the choice of luminaires proved all important. In the Netherlands the implementation of the illumination often can be financed by the municipality on the basis of a national law (WMO) that defines the support of impaired people to encourage their participation.

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Optical aids in photophobia

VANMECHELEN M
HORUS Visueel Revalidatiecentrum Brussel, Brussels

Many of our patients suffer from photophobia. Available solutions are hats, sunglasses, medical filtres, etc...These solutions will be discussed and documented with clinical cas reports.We will conclude with the reimboursement rules in Belgium.

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Asthenope klachten: inleiding en diagnostisch schema

VAN LAMMEREN M
UZ KULeuven, Leuven

PURPOSE Patients with asthenopic complaints are often refered for orthoptic assessment and treatment.It is the purpose of this presentation to discuss the orthoptic approach to these problems.

METHODS Besides a range of causes of a different nature, asthenopia can be caused by a number of accommodative and/or binocular problems. Refraction correction will also play a role in the patient's visual comfort (or lack of it).An extensive history followed by a full orthoptic assessment may be necessary to uncover the presence of one or more of these causes of asthenopia.

RESULTS A systematic diagnostic approach is presented.Special attention will be paid to the appropriate refractive correction, to the examination of the binocular status and of accommodation and to prolonged occlusion as a diagnostic tool.

CONCLUSION This systematic approach helps to clarify the nature of asthenopic complaints in many patients and provides a basis for the management of their complaints.

119

New spectacle lenses and complaints

DE VRIES V.
Hogeschool-Universiteit Brussel, Brussels

Buying new spectacles or spectacle lenses can sometimes result in "non-adaptation" complaints (asthenopia, blurred vision, distorsion) for the wearer.This lecture resumes the key factors for success in fitting spectacle lenses (refraction, design, centration procedures) and how to realise effective trouble shooting in case of non-adaptation.Frame data, personal data, history, lifestyle and refraction procedures are very important parameters to increase or decrease visual comfort.

128

The use of propranolol in the treatment of periocular infantile hemangiomas

BUIJSROGGE M, CLAERHOUT I, DECOCK C
UZ Gent, Ghent

PURPOSE Infantile capillary hemangiomas (IH) are the most common tumours of the eyelid and orbit in infants. Despite their self-limited course, IH can impair visual function. Recently, the use of propranolol was found to reduce the size of IH. We will present our own case series of patients with periocular IH treated with propranolol to illustrate these findings.

METHODS We conducted a retrospective study on 10 children with IH treated with propranolol. After exclusion of any contra-indication, propranolol was initiated at a dose of 1 mg/kg/d. After 10-14 days, patients were checked again for side-effects. If these were absent, propranolol was increased to 2 mg/kg/d. Further follow-up consists of monthly clinical and photographical evaluations of the IH, monitoring of treatment compliance and tolerance. Success of treatment is defined as stopping growth or reducing size. The response to treatment was rated by 3 blinded, independent observers.

RESULTS The age range at start of treatment with propranolol was between 2 and 19 months (mean 6,8 months). The mean age at stopping propranolol was 14,4 months. The mean duration of treatment was 7,6 months and only 1 patient had to stop treatment because of side effects. Two patients (20%) had a rebound after temporary stop of propranolol. The success rate in our case serie was 100%. Half of the group had excellent results, 30% had a good response and 20% had a fair response. We also obtained objective measures of astigmatism and anisometropia in 6 patients. We report a reduction in anisometropic astigmatism in 5 of these 6 patients.

CONCLUSION These data support the current perception that propranolol is a highly effective first line treatment for IH with very limited and mild side effects.

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A new treatment for obstructive meibomian gland dysfunction - Blephasteam®

PURSLOW C, GILL FR
School of Optometry & Vision Sciences, Cardiff University, UK

PURPOSE Obstructive meibomian gland dysfunction (MGD) frequently becomes a chronic complaint with various symptoms related to dry eye and discomfort. Research indicates a pivotal role for heat therapy as part of any successful management plan, but delivery of constant temperature is vital. This study evaluated the performance of a novel device designed to deliver controlled, latent, moist heat to the eyelids and surrounding area.

METHODS The signs, symptoms and ocular temperature of 25 normal subjects (M8, F17; age 29.2±5.7yrs) were recorded before and after a ten minute application of the Blephasteam® device. Ocular temperature (non-invasive ocular thermography; A40 Flir, UK), tear film stability, intra-ocular pressure (IOP), ocular hyperaemia and surface staining were recorded. Results were checked for normality and compared using paired t-tests.

RESULTS Temperatures in both eyelids remained significantly greater after application (upper +1.7±0.9C; lower +2.1±0.7C, $p<0.0005$). Bulbar conjunctival hyperaemia significantly decreased after treatment ($p<0.005$), but limbal and palpebral hyperaemia were remained similar ($p=0.33$ and $p=0.11$ respectively). No significant change in corneal or conjunctival staining was observed ($p=0.74$ and $p=0.97$, respectively). Tear film stability was unchanged in this normal cohort ($p=0.12$). There was no significant change in IOP (13.8±2.0mmHg vs 12.9±2.2mmHg; $p=0.092$).

CONCLUSION The Blephasteam® device provides effective levels of warming that would be sufficient to melt meibum, and no adverse ocular responses were recorded in this cohort. Even in this normal cohort, ocular surface redness appears less after treatment.

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Plasma omega 3 fatty acids and risk for age-related maculopathy: the Alienor Study

ROUGIER MB (1), MERLE B (2), KOROBELNIK JF (3), DELYFER MN (3), LE GOFF M (2), DELCOURT C (2)
(1) CHU, Bordeaux, France
(2) Inserm, U897, Bordeaux
(3) CHU, Bordeaux

PURPOSE To assess the associations of age-related maculopathy (ARM) with plasma concentrations of omega 3 polyunsaturated fatty acids (PUFA).

METHODS Subjects were recruited from the ongoing 3C cohort, bearing on the vascular risk factors for dementia. They were initially included in 1999-2001 and followed-up every two years. In 2006-2008, 963 subjects, aged 73 years or more, had an eye examination. ARM was graded from non mydriatic colour retinal photographs into 4 stages, according to the international classification: early ARM 1, early ARM 2, late atrophic ARM and late neovascular ARM. Plasma fatty acids were measured by gas chromatography, from fasting blood samples drawn at baseline of the 3 City Study (1999-2001).

RESULTS After multivariate adjustment, higher plasma total and long-chain omega 3 PUFA were associated with reduced risk for late atrophic ARM (OR=0.50 for 1-standard deviation increase, 95 % confidence interval (CI) : 0.27-0.93 and OR=0.52, 95 % CI: 0.28-0.97, respectively), but not with other stages. Among specific omega 3 PUFA, only eicosapentaenoic acid (EPA) was significantly associated with reduced risk for late atrophic ARM (OR=0.33, 95 % CI: 0.15-0.89). Other types of fatty acids (saturated, monounsaturated, polyunsaturated) were not significantly associated with the risk for ARM.

CONCLUSION This study shows an inverse association of ARM with plasma omega 3 PUFA, consistently with previous observations concerning dietary intakes. Omega 3 PUFA may prove useful for the prevention of ARM, in particular in its atrophic form, for which no treatment is available.

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Analysis of progression with Peridata TM and guided progression analysis (GPA) in glaucoma patients

FORTUNATI M (1), MOREL-DETRY M (1), POURJAVAN S (2)
(1) Cliniques universitaires Saint Luc- UCL, Brussels
(2) Cliniques universitaires Saint Luc, Brussels

PURPOSE To compare the rate of progression of GPA with the progression analysis calculated by Peridata in a mixed glaucoma group.

METHODS Retrospective, observational study including 25 patients (46 eyes) of know glaucoma patients who underwent filtering surgery or laser trabeculoplasty during the follow-up period were excluded. Mean age was 70 +/- 18 yrs. Each patient performed a mean number of 13 +/- 4,6 (range: 9 to 28) standard automated perimetry visual test (Sita Standard 24-2) per eye and with a mean follow-up of 7,5 +/- 1,3 yrs.

RESULTS The mean of progression by Peridata (dB/year) and GPA (%/year) were: -0,2 +/- 0,38 and -0,55 +/- 0,71 respectively. This difference in progression was not signifiantly different (p value= 0,06). There was an excellent correlation between Peridata progression analysis and GPA (< 0,001)

CONCLUSION Rate of progression with GPA and progression analysis of Peridata are two trend analysis. This could explain the excellent correlation. They represent complementary information and methods for progression of visual field. To date, our results didn't show significant difference between GPA and Peridata.

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Contrast Sensitivity & Colour Vision in Pseudophakic & Normal Eyes: A Thorough Comparison

UVIJLS A (1), DE DONCKER R (1), SALU P (2), KESTELYN P (1), BUYL R (3), LEROY BP (4)
(1) Dept of Ophthalmology, Ghent Univ Hospital
(2) Dept of Ophthalmology, Univ Hospital Brussels
(3) Dept of Biostatistics & Med Informatics, Brussels University
(4) Dept of Ophthalmology & Ctr for Med Genetics, Ghent Univ Hospital

PURPOSE To determine contrast sensitivity (CST) and colour vision (CV) in eyes with either aspheric or spheric intra-ocular lens implants (IOLs) and compare those with normal age-matched controls.

METHODS Eyes with either spheric (11) or aspheric (34) IOLs and normal eyes (34) were tested for CST for 5 spatial frequencies using a Vistech C configuration at different background illumination levels with best correction.In addition, in a set of normals and eyes with aspheric IOLs, CV testing was performed, including the Farnsworth-Munsell 100 Hue test.All BCVAs were within the normal range both for eyes with IOLs and normal controls.

RESULTS CST levels were generally higher in eyes with aspheric IOLs than in those with spheric IOLs. This difference was more pronounced in mesopic than in photopic environments.CST in eyes with aspheric IOLs was only mildly inferior to that in normal controls in mesopic conditions, whereas no difference was observed in photopic environments.CV in eyes with aspheric IOLs was virtually identical than in normal eyes.

CONCLUSION CST is better in eyes with aspheric IOLs than in those with spheric IOLs. This effect is more pronounced at low light levels. CST is only slightly better in normal than in eyes with aspheric IOLs in mesopic environments, whereas no difference is observed in photopic conditions. CV shows no major differences between eyes with aspheric IOLs and normals.

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Juvenile xanthogranuloma of the corneoscleral limbus

DE KEYSER C, MAUDGAL P, LEGIUS E, VANGINDERDEUREN R, CASTEELS I
UZ Leuven, Leuven

PURPOSE To report the clinical and histopathologic findings of limbal juvenile xanthogranuloma (JXG) in two children.

METHODS Two case reports with slit-lamp photography and histopathological examination.

RESULTS Two children (a 9-month old boy and a 4-year old girl) presented with an enlarging yellowish mass at the corneoscleral limbus. The girl had been diagnosed with neurofibromatosis 1 (NF1). Both lesions underwent simple excision. Histopathologic examination revealed foamy histiocytes within an inflammatory infiltrate with the presence of multiple multinucleated giant cells. In both cases intraoperative subconjunctival steroids and postoperative topical steroids were administered during one month.

CONCLUSION Juvenile xanthogranuloma may rarely present as a mass occurring at the corneoscleral limbus. Therefore it should be considered in the differential diagnosis of any corneoscleral limbal mass lesion, particularly in children. Most are isolated lesions without systemic involvement which are treated by simple excision. Here we report on an isolated case and a case of a limbal xanthogranuloma associated with neurofibromatosis type 1. Both were treated by simple excision and showed no recurrence after 9 months.

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Pigment dispersion after Artiflex phakic lens implantation : myth or fact ?

GOES F jr
Goes Eye Centre, Antwerp

PURPOSE To evaluate the stability, safety, efficacy, and predictability of the non-toric foldable Artiflex iris-fixated intraocular lens (IOL) (Ophtec BV, Groningen, The Netherlands) for the correction of myopia in phakic eyes, and to report amount of pigment deposition on top of the Artiflex Phakic IOL and possible clinical importance.

METHODS 70 eyes of 37 patients underwent implantation of the foldable iris-fixated Artiflex phakic intraocular lens (PIOL) with an optic zone of 6 mm. Change in spherical equivalent, best spectacle-corrected visual acuity (BSCVA), uncorrected visual acuity (UCVA), complications and patient satisfaction were recorded. In cases of pigment deposition, change in best corrected visual acuity was studied

RESULTS Mean preoperative spherical equivalent was -8.82 D. A high refractive stability was achieved: after 1 year, mean spherical equivalent was -0.17 D. 88 % achieved less than 1 D defocus equivalent after 1 month.. 94 % achieved a postoperative refractive outcome with an error less than +/- 0.5 D. Safety was extremely high: after 3 months, no eye lost one or more lines, 33 % gained one line, while 33 % gained two lines 9 out of 70 eyes developed pigment deposition on top of the Artiflex P-IOL. Of these eyes, no eye developed a decrease in BCVA.

CONCLUSION The implantation of the foldable iris-fixated Artiflex intraocular lens proved to be a stable, safe, effective and predictable treatment for the correction of myopia in phakic eyes. Pigment deposition occurs but did not prove to cause a decrease in BCVA.

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Three-dimensional optical coherence tomography of optic nerve pathology: a comparative illustration and discussion

GOUT T (1), GOUT II (2), KHETERPAL S (2)
(1) Cambridge University, School of Clinical Medicine, Cambridge
(2) Prince Charles Eye Unit, King Edward VII Hospital, Windsor

PURPOSE To analyse and discuss the imaging of prevalent and serious optic nerve pathologies using three-dimensional Optical Coherence Tomography (3D OCT) in contrast to other imaging modalities.

METHODS The following imaging modalities were used to illustrate, compare and contrast optic nerve pathology: 3D-OCT, 2D OCT and colour imaging. A selection of optic nerve conditions of papilloedema, myopia, optic disc pit and disc drusen are presented in comparison to the normal physiological state. The images were carefully selected, annotated and described to clearly demonstrate the most striking deviations. Analysis of the underlying architectural pathology using 3D OCT technique and measurements allowed us to evaluate this modality as a diagnostic tool.

RESULTS The data we report are based on the analysis and evaluation of 3D OCT in imaging prevalent optic nerve conditions. The high-resolution of 3D OCT makes it a useful diagnostic tool with a high power for pathological detection, such as revealing subtle areas of subretinal fluid that may be overlooked on ophthalmoscopy and fundus fluorescein angiography. However, it was noted that 3D OCT should still be used in conjunction with other imaging modalities for a comprehensive pathological evaluation.

CONCLUSION At present, 3D OCT has been widely documented and applied in imaging, diagnosing, staging, managing and follow up of retinal pathology. Optic nerve pathology imaging has equal potential.

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Histology of Vitreous Floaters, after removal by pars plana vitrectomy

VAN GINDERDEUREN R, STALMANS P, VAN CALSTER J
Oogziekten, UZLeuven, Leuven

PURPOSE To investigate the histopathology of vitreous floaters.

METHODS Ten consecutive (10) patients with vitreous floaters creating visual disturbance and affecting their daily life underwent 23G vitrectomy. First, a core vitrectomy was performed. If not already present, a posterior vitreous detachment was created. Next, a shaving of the vitreous base was done. All the aspirated fluid was collected in the vitrectomy cassette and fixed in Cytorich Red. After fixation, the fluid was centrifugated and the pellet was embedded in paraffin and sectioned and stained routinely for microscopy with H&E and PAS. Immunostainings for lymphocytes (CD3, CD20), macrophages (CD68) and retinal (nse) and glial tissue (gfap) were performed.

RESULTS In all cases sufficient material was collected for histology. The vitreous core consisted of fine fibrillar tissue in which floaters were recognised as a small fragment of glial tissue with cells with fibrillar cytoplasm, staining specifically for gfap. In most cases macrophages were randomly and diffuse present.

CONCLUSION Vitreous floaters seem to originate from glial origin

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Angioid Streaks beyond Pseudoxanthoma Elasticum

DE ZAEYTIJD J (1), VANAKKER OM (2), COUCKE PJ (2), DE PAEPE A (2), LEROY BP (3)
(1) Dept Ophthalmology, UZ, Ghent
(2) Ctr Medical Genetics, UZ, Ghent
(3) Dept Ophthalmology & Ctr Medical Genetics,UZ, Ghent

PURPOSE Angioid streaks (AS) are funduscopic findings, caused by crack-like dehiscences in elastic portions of Bruch membrane. AS are a manifestation of underlying systemic conditions, such as pseudoxanthoma elasticum (PXE), Paget disease, sickle cell anemia, other blood dyscrasias and, rarely, Ehlers-Danlos syndrome. By far the commonest association is PXE. Differences and similarities of AS in -thalassemia minor, PXE-like syndrome and Savanna haemoglobinopathy with AS seen in PXE are discussed. The description of AS in Savanna haemoglobinopathy is a first.

METHODS Angioid streaks were detected in one patient with -thalassemia minor, one with PXE-like syndrome and one with Savanna haemoglobinopathy. They underwent a full ophthalmic work-up. Molecular analysis of the ABCC6 gene to exclude PXE was performed by dHPLC (denaturing high-performance liquid chromatography) and direct sequencing.

RESULTS A 34 year old lady with -thalassemia minor had a fundus appearance which was an exact phenocopy of PXE retinopathy, including angioid streaks, peau d'orange and comets. In contrast, a 51 year old lady with PXE-like syndrome and a 55 year old man with Savanna haemoglobinopathy had a limited number of short, thick, feathered, white streaks around the optic disc.

CONCLUSION AS differ in aspect depending on the underlying condition. The exact etiology of AS in these systemic conditions has not yet been elucidated. However, it is tempting to suggest that distinct pathogenetic mechanisms underlying very different blood dyscrasias as well as PXE, meet at a final common pathway, leading to breaks in Bruch membrane.

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Laser-induced retinal injury following a recreational laser show: Two case reports and a clinicopathological study.

BOOSTEN K (1), VAN GINDERDEUREN R (1), SPILEERS W (1), STALMANS I (1), WIRIX M (2), VAN CALSTER J (1), STALMANS P (1)
(1) Dept. of Ophthalmology UZLeuven, Belgium, Leuven
(2) Dept. of Ophthalmology H.Hart Ziekenhuis, Leuven, Belgium, Leuven

PURPOSE Background: Two patients who attended a dance festival with an audience-scanning lasershow presented in our department with a decrease in visual acuity from a direct laser hit in one eye. Ophthalmoscopy showed a similarly sized retinochoroidal coagulation spot, which had led to a retinal hemorrhage in both patients. Because the organizers of the show concluded that the retinal injury was caused by powerful, handheld laser pointers in the crowd, we were interested in determining if these laser pointers could cause this kind of acute retinopathy.

METHODS A 44-year-old man with an extrafoveal, temporal choroidal melanoma was scheduled for enucleation. The eye (visual acuity 20/20) had a healthy-appearing macula. Prior to enucleation, the retina was exposed to eight different durations (0.5-64 seconds) of laser beam from a commercially available, handheld, class 3B green laser pointer (500 mW).

RESULTS Histologic analysis was unable to identify any abnormalities in the choriocapillaris, thephotoreceptors or the retinal pigment epithelium (RPE).

CONCLUSION The use of powerful laser appliances (class 4 lasers) directed into the audience (audience-scanning laser show) can cause significant retinal injuries with lifelong visual consequences. It is unlikely that laser pointers, even those of class 3B, can cause these ocular injuries.

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Unilateral cytomegalovirus panuveitis in a diabetic patient following an intravitreal injection of triamcinolone acetonide

TEK A (1), HUA M-T, BETZ P, BONNET S
CHR Citadelle , Liège

PURPOSE To describe the case of a patient with cytomegalovirus (CMV) panuveitis following an intravitreal triamcinolone acetonide (IVTA) injection.

METHODS Ophthalmic examination, blood analysis and diagnostic anterior chamber paracentesis.

RESULTS A 75-year-old man presented with a red and painful left eye. Eleven weeks ago, he underwent an IVTA injection for a severe diabetic retinopathy. Bilateral panretinal photocoagulation was done years ago. Vision in the right eye was 2/10 and 1/10 in the left eye. Slit-lamp examination revealed mutton fat keratic precipitates, 4+ cells and flare in the left anterior chamber. Intraocular pressure was 42 mmHg. Fundus examination showed extensive area of necrotizing retinitis associated with vitritis, optic disc edema, vasculitis and haemorrhages. Serologic testing for HIV, HSV and VZV was negative. Serum testing for CMV was postitive for IgG but IgM was undetectable. PCR detected CMV DNA in the aqueous humor in the affected eye. Intravenous ganciclovir was initiated, but was discontinued after a week due to a poor renal function. Ganciclovir was then given intravitreously on a weekly basis. Topical therapy included atropine, corticosteroid, beta-blocker and carbonic anhydrase inhibitor. Systemic carbonic anhydrase inhibitor was contra-indicated because of renal failure. Despite treatment, the retinal lesions didn't improve and the intraocular pressure remained high. The treatment was discontinued after four intravitreal injections of ganciclovir.

CONCLUSION CMV retinitis is a potentially devastating complication of IVTA injection. Local immunosuppression in the vitreous with IVTA and the immunocompromised status related to diabetes mellitus may have caused CMV retinitis.

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Radiation-induced optic neuropathy: is the diagnosis really that easy?

DE KEYZER THW (1), DE KEIZER RJW (1), MENOVSKY T (2), PARIZEL P (3)
(1) Department of Ophthalmology, University Hospital, Antwerp
(2) Department of Neurosurgery, University Hospital, Antwerp
(3) Department of Radiology, University Hospital, Antwerp

PURPOSE To discuss the difficulty in making the differential diagnosis of a thickened optic chiasm and optic nerve in a patient who received radiotherapy for a temporal lobe astrocytoma.

METHODS Case report

RESULTS The case of a 46-year old woman is presented with bilateral visual loss. In the medical history she had a resection of an anaplastic astrocytoma WHO grade III on the right temporal lobe in oktober 2008, followed by radiotherapy and chemotherapy. The vision deteriorated very fast in both eyes to 4/20 with a left homonimous hemianopsia. MRI scan showed a thickened optic chiasm and diffuse enhancement of the optic nerves Differential diagnosis as well as possible therapeutic strategies are discussed.

CONCLUSION The diagnosis of radiation-induced optic neuropathy can only be confirmed when all other possibilities are excluded.

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Contributiuon of spectral-domain optical coherence tomography in a case of familial occult macular dystrophy.

PIENS I, CORDONNIER M, RASQUIN F
Hopital Erasme, Brussels

PURPOSE To document the interest of using spectral-domain optical coherence tomography (SD-OCT) for the diagnosis and for the comprehension of macular dysfunction in occult macular dystrophy (OMD).

METHODS OMD is characterized by a progressive decline of visual acuity with normal fundus, normal fundus auto-fluorescence and normal fluo-angiography. In this clinical context, abnormal mf-ERG remains until now the gold standard to allow the diagnosis of OMD. However, SD-OCT may demonstrate significant anatomic changes in the photoreceptors layer. Morphologic photoreceptors layer abnormalities were investigated with SD-OCT in a member of a family with OMD.

RESULTS The SD-OCT demonstrated a foveal well-defined disruption of the inner segment-outer segment junction of photoreceptors.

CONCLUSION OMD is a rare macular disorder which is very difficult to diagnose. The diagnosis can be promoted by using SD-OCT, demonstrating a disruption of the photoreceptors layer. These OCT findings most probably participate in the pathophysiology of vision lowering associated with OMD.

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Iridium Brachytherapy for conjunctival melanoma of the fornix

MISSOTTEN GS (1), VAN LIMBERGEN E (2), VAN GINDERDEUREN R (1), VANDELANOTTE S (1), SPILEERS W (1)
(1) Katholieke Universiteit Leuven, Leuven
(2) Katholieke Universiteit Leuven - Radiotherapie, Leuven

PURPOSE To investigate the usefullness of brachytherapy in stead of exenteration in the management of high-risk conjunctival melanoma patients. A patient was referred with a recurrent conjunctival melanoma of the upper fornix. The patient had previously two excisions of conjunctival melanoma of the temporal conjunctiva, without adjuvant therapy.

METHODS To demonstrate the use of iridium brachytherapy for a large, recurrent conjunctival melanoma at an unfavorable position. In a large series patients who underwent exenteration were compared with patients who underwent brachytherapy and local surgery. To advocate, once again, that adjuvant brachytherapy is the golden standard for the treatment of conjunctival melanoma.

RESULTS In the case, that will be used as illustrative example, the local tumor was excised and iridium brachytherapy was administered for 3 days. At the moment of excision, there were no locoregional or distant metastases. Nine months after excision there is no recurrence.

CONCLUSION Iridium brachytherapy can pospone or even avoid exenteration in the treatment of conjunctival melanoma.

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Orbital Inflammation after use the of Zoledronic Acid for metastasized prostate carcinoma.

MISSOTTEN GS (1), VERHEEZEN Y (2)
(1) Virga Jesse Ziekenhuis, Hasselt
(2) Virga Jesse Ziekenhuis - Oncologie, Hasselt

PURPOSE To descibe a case of orbital inflammation and unilateral exophthalmia after the use of zoledronic acid for metastasized prostate carcinoma.

METHODS Case description and literature review

RESULTS A 71-year old male was referred to the ophthalmology department with swelling of upper and lower eyelids and conjunctiva, redness of the right eye and pain. There were no complaints of the left eye. Visual acuity was 0.8 on both sides. There was no anterior uveitis. Fundus examination results were normal OU. Exophthalmometry measured 3 mm proptosis of the right eye. Computed Tomography (CT) showed proptosis, fat stranding, but no identifiable mass in the right orbit (figure 1). Ultrasound did not show signs of scleritis OD. Blood screening showed no abnormalities, except a decreased Thyroid Stimulating Hormone (TSH). The inflammation of the right orbital tissue was diagnosed at the end of treatment with intravenous zoledronic acid for metastasized prostate carcinoma (with bone metastases). As such, a bisphosphonate-triggered orbital inflammation was diagnosed, the bisphosphonates were discontinued and oral prednisone 32 mg was started for 3 weeks. Within five days the symptoms disappeared, and did not return (follow-up 7 months).

CONCLUSION In conclusion, in patients receiving bisphosphonates close attention should be given to ocular signs or symptoms

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Heavy silicone oil, indications and complications

CLAES C
St Augustinus, Antwerp

PURPOSE To demonstrate the indications and side-effects of heavy silicone oil.

METHODS Comparison is made with conventional silicone oil and case reports are presented.

RESULTS Benefits and disadvantages of heavy silicone oil are highlighted.

CONCLUSION The chemical characteristics of heavy silicone oil bring unique qualities for use as a longstanding intra-ocular tamponade. Nevertheless, caution should be taken in its use.

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Ocular findings after a pregnancy complicated by HELLP-syndrome.

GHEKIERE S (1), BLANCKAERT J (1), MULLIEZ E (2), VERHULST L (2)
(1) Jan Yperman Ziekenhuis- UZ Leuven, Ieper-Leuven
(2) Jan Yperman Ziekenhuis, Ieper

PURPOSE To present a case-report of a female patient with parapapillary retinal cotton wool spots as an ophthalmological manifestation of the HELLP-syndrome.

METHODS Case-report.A thirty-five-year-old woman presented to the ophthalmology department with complaints of visual field defects affecting her both eyes. She gave a history of delivery after 26 weeks of gestation. The pregnancy was complicated by uncontrolled pre-eclampsia (HELLP syndrome). The patient complained of black spots in the visual field of her both eyes since the delivery. Her best-corrected visual acuity was 1.0 and 0.8. Intra-ocular pressures and anterior segment examination findings were normal bilaterally. Fundus examination showed an optic nerve head surrounded by cotton wool spots. Humphrey Field Analyzer revealed a bilateral enlarged blind spot. Ocular tomography showed swelling of the inner retinal layers surrounding the optic nerve head. Fluo-angiography of both eyes showed several cotton wool spots but no choroïdal infarcts.

RESULTS Lesions caused by hypertension can be found in different anatomical structures of the eye. Photodocumentation of the case will be shown.In this case hypertension is a known gynaecological complication of pregnancy and the underlying mechansms will be highlighted.

CONCLUSION Herein, we reported a case of severe hypertension with clinical presentation of cotton wool spots surrounding the optic nerve head.

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Sudden bilateral blindness due to methanol intoxication in an abstemious patient

NYST BN, CORDONNIER MC
Hôpital Erasme, Brussels

PURPOSE To report an unusual case of methanol intoxication in a non-alcoholic man.

METHODS Report of a case of a 28 year-old man presenting as an emergency with vomiting and abdominal pain and ending in bilateral blindness.

RESULTS At the emergency department, the patient became unconscious and had to be intubated. A severe metabolic acidosis was found in blood tests. When awakening, the patient complained of bilateral blindness. MRI showed a bilateral putamen necrosis which, when associated with metabolic acidosis, is typically seen in methanol intoxication. As the patient had no alcoholic habits, this diagnosis was initially missed, preventing an antidote treatment in an appropriate delay. He did not recover and developed a bilateral optic nerve atrophy.

CONCLUSION Methanol intoxication is rare in our country. Symptoms, managing and treatment of methanol intoxication should be known and the diagnosis suspected even in non-alcoholic patients since an early diagnosis and treatment allows a higher rate of recovery.

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First clinical experience with the new Tecnis 1-Piece Multifocal IOL

GOES F sr
GOES EYE CENTRE, Antwerp

PURPOSE To evaluate the performance of the new diffractive Tecnis 1-Piece Multifocal IOL ZMB00

METHODS In a prospective study the Tecnis 1-piece multifocal IOL (Abbott Medical Optics Inc) was implanted bilaterally in 20 patients. Routine cataract surgery was performed with IOL placement into the capsular bag. One day and three months after surgery, the following examinations were performed: refraction, monocular and binocular visual acuity (near and distance), contrast sensitivity with the Ginsburg box, Radner reading speed as well as slit-lamp biomicroscopy

RESULTS All surgeries were uneventful and first results on patients with Tecnis multifocal IOL are promising: While mean UCDVA was 20/25 1 week after surgery, patients with 3 month follow-up (n=12) improved to 20/20 or better. At that time UCNVA was 20/25 or better in all patients at 33cm. When patients were free to choose best individual reading distance, mean best UCNVA was > 20/20. 5 out of 20 patients reported on slight halos postoperatively. Patient satisfaction was very high in all these multifocal patients due to complete spectacle independence.

CONCLUSION First results with the new Tecnis Multifocal IOL indicate that combining a diffractive posterior surface with an established 1-Piece hydrophobic acrylic design results in ease of implantation, very good visual outcome and high patient satisfaction.

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Retrolental opacities in acute anterior uveitis

VAN OS L (1), SMETS RM (1), CLAESKENS W (2)
(1) Department of ophthalmology, Antwerp University Hospital, Edegem
(2) Kapellen

PURPOSE To present a case of dense retrolental opacities occurring during the recovery of an acute anterior uveitis.

METHODS Case report.

RESULTS An 18-year old woman suffered a first episode of acute anterior uveitis of the left eye, responding well to topical corticosteroid therapy. However, 3 weeks later an acute loss of vision was reported and dense opacities in the retrolental space became apparent. A 6-week course of oral methylprednisolone resulted in a slow clearing of the opacities. HLA B27 proved to be positive. Three months after resolution of the uveitis she developed a malleolar arthritis and was diagnosed with psoriatic arthritis.

CONCLUSION A rare cause of visual loss in acute anterior uveitis is reported. Possible causes are discussed.

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Leukaemic infiltration of the optic nerve

AERTS L, DE VEUSTER I
Antwerp University Hospital, Department of Ophthalmology, Edegem

PURPOSE To report the importance of an ophthalmological consult in a patient with headache and blurred vision, who had a previous history of acute myelocytic leukaemia (AML) and was in succesfull remission.

METHODS A case report

RESULTS A 39-year old woman suffered from headache and blurred vision. Fundoscopy showed bilateral prominent papil edema. Additional ophthalmological examinations were all abnormal, but contrast MRI of the brain was normal. We insisted on doing a lumbar puncture to evaluate intracranial pressure and collect CSF. This lumbar puncture showed a very high opening pressure and cytology revealed massive presence of leucocytosis from leukaemic blasts. The diagnosis of meningeal leukaemia was made and an urgent treatment of intrathecal chemotherapy and pancraniel radiotherapy could be started till disappearance of the malignant cells.

CONCLUSION In a patient with headache and blurred vision with a history of AML, an urgent ophthalmological consult has to be made, because optic disc swelling could be the only sign of relapse with leukaemic infiltration of the optic nerve. Further examinations and immediate therapy are required to preserve vision.

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Epiretinal membrane maculopathy and poor visual function in childhood

BUISSERET D (1), DEPASSE F (1), SERPE JN (2), CORDONNIER M (1)
(1) Departement of ophthalmology, Hôpital Erasme, Brussels
(2) Departement of ophthalmology, HUDERF, Brussels

PURPOSE Description of two cases of epiretinal membrane (ERM) maculopathy responsible for poor visual function in children

METHODS Retrospective observational case series of 2 young patients with an ERM maculopathy leading to abnormal visual function at an early age

RESULTS Macular epiretinal membrane is an uncommon pathology in childhood, most frequently associated with traumatic or uveitic causes. More rarely, it can be associated with neurofibromatosis type 2 (with or without a retinal pigment epithelium hamartoma) or persistent hyperplastic primary vitreous. In the absence of the aforementioned causes, as in our two cases, the diagnosis is idiopathic ERM maculopathy

CONCLUSION ERM maculopathy is rare in children and may be idiopathic. Its presence can explain failure of a well conducted anti-amblyopia treatment. Optical coherence tomography (OCT) is a useful and powerful tool to highlight an ERM maculopathy unrevealed by simple ophthalmoscopy

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Bifocal Optic and Facial Nerve Infiltration with intraocular spread in Systemic T cell Lymphoma

VAN HOEY A (1), SHAH A (1), DE ZAEYTIJD J (1), LEROY BP (2), DECOCK C (1)
(1) Dept of Opththalmology, Ghent Univ Hosp, Ghent
(2) Dept of Opththalmology & Ctr for Medical Genetics, Ghent Univ Hosp, Ghent

PURPOSE To report an extremely rare case of biopsy proven infiltration of the optic nerve (ON), its sheath, the eye and the facial nerve (FN), without central nervous system (CNS) involvement, in a patient with systemic T cell lymphoma.

METHODS A complete clinical work-up was performed, followed by an optic nerve biopsy. Histopathology and immunohistochemistry on the biopsy specimen confirmed the diagnosis of T cell lymphoma. A thorough systemic workup ruled out additional locations elsewhere.

RESULTS A 63 year old female with systemic T cell lymphoma in clinical remission presented with loss of vision and pain in the left eye (LE). She had initially been treated for presumed recurrent optic neuritis. Best corrected visuel acuity was no perception of light in the LE. Fundoscopy showed significant optic disc edema and a large peripapillary, subretinal infiltration. MRI of the brain and orbit showed thickening and contrast enhancement of the entire left ON and temporal aspect of the right FN. ON biopsy showed a necrosis and infiltration with CD3 positive lymphocytes. A complete systemic workup revealed no evidence of disease elsewhere.

CONCLUSION Optic nerve infiltration from systemic lymphoma is rare and generally occurs with central nervous system involvement. However, a bifocal pattern of recurrence from systemic T cell lymphoma involving the right facial nerve and left optic nerve is possible.

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A fast growing squamous cell carcinoma of the lower eyelid.

VAN GRASDORFF S, DE KEIZER R, DE GROOT V
University Hospital, Antwerp

PURPOSE To report a case of a fast growing epidermal tumor of the lower eyelid.

METHODS A 88-year-old man had complicated cataract surgery in februari 2010 with severe inflammation. During follow-up a lesion was noticed in the lower eyelid and was resected in may. Pathological report : infiltrative well differentiated squamous cell carcinoma, very close to the resection margin at the conjunctival side. The patient was referred in august with eyelid swelling. The lesion involved the medial third of the eyelid boarder and a subcutaneous mass extended over the whole lower eyelid, prolapsing in the lower fornix and medial canthus. According to the patient the tumor returned one month after the first excision, and is growing very fast. Imaging revealed a lower eyelid mass extending medially from to the eyeball close to the medial rectus muscle with an antero-posterior diameter of 17 mm. The treatment plan consisted of surgical exploration with excisional biopsy if possible without major surgery, because of the old age of the patient. Additional radiotherapy will be planned anyway because of a previous unknown resection method of this very aggressive tumor.

RESULTS Peroperatively the large lesion did not involve the anterior orbit, it was just pressed next to the eye. It could be resected, followed by lower eyelid reconstruction with a free tarsal graft and lateral cantholysis.Pathologic examination revealed a well differentiated keratotic squamous cell carcinoma.

CONCLUSION Periorbital squamous cell carcinoma are less common than basal cell carcinoma. The clinical appearance of these slowly progressive lesions are diverse.

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Blue cone monochromacy and pellucid marginal corneal degeneration : a case report

LENFANT T, CORDONNIER M
Erasme, Brussels

PURPOSE To report a clinical association of blue cone monochromacy and pellucid marginal corneal degeneration

METHODS A 44-year-old man presented since birth with a poor bilateral visual acuity, photophobia, impaired color vision and pendular nystagmus. The red reflex with direct ophthalmoscopy showed an irregular inferior reflection bilaterally. The rest of the examination was unremarkable. His clinical situation was rather stationary.

RESULTS The full field photopic ERG was severely abnormal (single flash and flicker stimulation) while the scotopic ERG was normal. These ERG anomalies suggested a cone dysfunction.The family tree was typical for X-linked recessive disease and genetic analysis found a Cys203Arg mutation on red green opsin genes. This genetic anomaly is the most frequent mutation in blue cone monochromacy.To investigate the abnormal red reflexes, we performed a corneal topography which showed a butterfly wing shape. This confirmed the suspected pellucid marginal corneal degeneration.

CONCLUSION To our knowledge, this is the first description of blue cone monochromacy associated with pellucid marginal degeneration.

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Atypical dural carotid cavernous sinus fistula presenting as direct carotid cavernous sinus fistula

ATTHA E (1), LUBICZ B (1), JANSSENS S (2), CORDONNIER M (1)
(1) CUB hôpital Erasme, Brussels
(2) CHU hôpital St Pierre, Brussels

PURPOSE To report a case of spontaneous dural carotid cavernous sinus fistula (CCSF) with symptoms and signs similar to traumatic direct CCSF fistula.

METHODS Case report

RESULTS CCSF are abnormal communications between the carotid arterial system and the venous cavernous sinus. Most often they are classified as either direct o indirect (also named dural). Clinical manifestations of CCSF frequently involve ophthalmic abnormalities. Direct CCSF results from a direct connection between the intracavernous carotid artery and the cavernous sinus, while dural CCSF arises from abnormal shunts to the cavernous sinus from the meningeal branches of the carotid artery. Typically, signs and symptoms of direct fistulas have an acute onset and dramatic ophthalmologic consequences, while dural fistulas have a gradual onset and milder ophthalmologic consequences. Our patient had acute and severe symptoms. Unexpectedly, the arteriography diagnosed a dural CCSF. It also revealed a recent homolateral petrous sinus thrombosis that possibly prevented further posterior drainage of the fistula, precipitating anteriorly redirected high flow and favouring an acute and dramatic clinical onset.

CONCLUSION Dural CCSF may have an acute onset and present signs and symptoms as severe as in direct CCSF if a local thrombotic event abruptly modifies its blood drainage.

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Congenital Corneal Staphyloma: Dramatic Ophthalmological Findings in a Newborn

VERSCHOOTEN R (1), FOETS B (1), DE RAVEL T (2), VAN GINDERDEUREN R (1), LOMBAERTS R (3), CASTEELS I (1)
(1) Department of Ophthalmology, Leuven
(2) Human Genetics, Leuven
(3) Pediatrics, Leuven

PURPOSE To describe the clinical spectrum of congenital corneal staphyloma.

METHODS A complete ophthalmological examination with additional B-scan ultrasonography of both eyes. Evisceration of the right eye was performed on the day of birth. We referred the patient for a general pediatric investigation with ultrasound of the abdomen and brain. A blood sample was taken for mutation analysis of the PITX2, FOXC1 and the beta1,3-glucosyltransferase genes.

RESULTS A newborn girl was referred with an amorphous remnant of an intra-uterine perforated right eye and a buphalmic left eye with opacified cornea. Ultrasound of the left eye revealed a deep anterior chamber with adhesions of the peripheral iris to the posterior segment of the cornea. Histopathological examination of the remnants of the right eye revealed the characteristics of a congenital corneal staphyloma. No mutation was identified in the PITX2, FOXC1 and beta1,3-glucosyltransferase genes. Systemic examination was normal except for a hypoplastic right kidney with normal corticomedullary differentiation. At the age of 10 months a large diameter keratolimbal graft was performed on the left eye. Systemic immunosuppressive therapy was started to prevent a graft failure, but after three months phtysis was inevitable.

CONCLUSION This case represents a bilateral congenital corneal staphyloma, confirmed by histopathological examination of both corneas. Management of these infants is challenging with poor visual outcome in nearly all cases.

Notes

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Tuberculosis in areas of low prevalence

WILLERMAIN F
Ophthalmology CHU St-Pierre and Brugmann, Brussels

PURPOSE The diagnosis of intraocular tuberculosis is difficult due to the large variations in clinical presentations, lack of uniformity in diagnostic criteria, and the low yield of organisms from the eye. It is generally based on the association of compatible ophthalmological signs and evidences of systemic infection. Since tuberculosis uveitis is usually found in the latent form of the infection, its diagnosis relies on the analysis of systemic tuberculosis immunity. Nowadays, two diagnostic tests are available: the tuberculin skin test (TST) and the interferon gamma release assays (IGRAs: Quantiferon and T.spot.TB).

METHODS As for every screening test, disease prevalence will greatly influence their correct interpretation. Hence, a good screening test will have a good positive predictive value in a population where the disease have a high prevalence and a bad positive predictive value in a low prevalence context. The prevalence in Belgium has progressively decreased during the 20th century and in 2007 the incidence was below 10 cases/100000 inhabitants.

RESULTS However the distribution is different in the three main region of the country, and is particularly high in Bruxelles where the incidence is around 30 cases/100000 inhabitants/year. This is partially due to the important population of immigrants from high prevalence area, found in the capital.

CONCLUSION In this perspective, the interpretation of TST and IGRAs is particularly difficult and the diagnosis of tuberculosis uveitis must be made with caution.

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Causes for abnormal head posture besides strabismus

DE TEMMERMAN S
Jolimont, La Louvière

PURPOSE To describe the differential diagnosis of anomalous head posture when there is no strabismus.

METHODS Classification of causes illustrated by clinical cases.

RESULTS Causes of anomalous head posture can be divided into two major categories: ocular origin and musculoskeletal or neurologic origin.

CONCLUSION Ocular examination is essential in the work-up of an anomalous head posture. Every ocular cause should be excluded to attribute torticollis to an nonocular origin.

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Neurological approach of torticollis in children

NASSOGNE MC
Service de Neurologie Pédiatrique, Cliniques universitaires Saint-Luc, Brussels

Torticollis is a clinical sign with an abnormal head posture characterized by a lateral head tilt and chin rotation toward the side opposite to the tilt. Many conditions cause torticollis including benign and severe problems. The differential diagnosis is different for infants than for children and adolescents. Neurological causes include acute and chronic conditions. Chronic forms include the congenital muscular torticollis associated with a contracture of the sternocleidomastoid muscle in infants. This condition improves with physiotherapy and correct positioning. In some cases, congenital anomalies of the occipital condyles and upper cervical spine must be ruled out in a child with a severe torticollis or who fails to improve with physical therapy. In acute onset, infections like otolaryngological abscess or spondylodiscitis must be excluded. Torticollis associated with headaches, vomiting, or neurologic symptoms may be caused by tumors of the posterior fossa or of the upper cervical spinae. Intermittent torticollis must be a manifestation of Sandifer's syndrome resulting from gastroesophageal reflux in infants, or benign paroxysmal torticollis (migraine's equivalent) or of cervical dystonia in older children. A complete physical examination is frequently sufficient to eliminate serious entities. Cerebral MRI is necessary to eliminate tumoral diseases.

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You shall examine the optic disc carefully

DE GROOT V
University Hospital Antwerp

Clinical optic disc assessment is a crucial step in the diagnosis and follow-up of glaucoma and ocular hypertensive patients. The vertical cup/disc ratio is the most frequently used method, although not reliable in small or large discs. The importance of disc size, focal rim loss, baring of a vessel, disc haemorrhage, .. will be stressed and illustrated. Even without expensive equipment, every ophthalmogist is capable of diagnosing a suspect optic disc, which requires further examination even with normal pressures. If we all would take a quick but good look at every optic disc, many advanced glaucoma's would be detected earlier, before quality of live is compromised.

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When in doubt, refer to another specialist

GOETHALS M

Glaucoom is een multifactoriële aandoening, waarbij een verhoogde intra-oculaire druk een cruciale rol speelt. De rol van verminderde perfusiedruk als bijkomende risicofactor voor de ontwikkeling en progressie van glaucoomschade werd eveneens door multipele wetenschappelijke studies aangetoond, en erkend door de European Glaucoma Society. Het is dan ook belangrijk om aan deze vasculaire risicofactoren de nodige aandacht te besteden bij de verzorging van glaucoompatiënten, in het bijzonder wanneer progressieve glaucoomschade vastgesteld wordt ondanks goede oogdrukcontrole. Een goede anamnese is vaak richtingaangevend naar specifieke vasculaire problematiek toe. Deze laat dan ook toe om gerichte bijkomende onderzoeken aan te vragen om oorzaken van verminderde of onstabiele perfusie op te sporen, zoals een bloeddrukmonitoring, Holter ECG of Duplex halsvaten. Bovendien is alertheid geboden wanneer een inconsistentie geconstateerd wordt in het klinische beeld, zoals een discrepantie tussen gezichtsvelduitval en papilexcavatie, of een uitgesproken bleekheid van de papil. In deze situaties dient een niet-glaucomateuze oorzaak uitgesloten te worden met centrale beeldvorming. Samenvattend is het belangrijk om bij glaucoompatiënten alert te zijn voor vasculaire of andere concommittante aandoeningen, die een glaucoom kunnen verergeren of nabootsen, en zo nodig de patiënt te verwijzen naar een specialist voor verdere investigatie en/of oppuntstelling.

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Don't delay surgery

COLLIGNON N
CHU de Liège, Liège

PURPOSE Trabeculectomy still remains the most reliable surgical procedure to lower intraocular pressure (IOP) in the vast majority of patients with uncontrolled glaucoma. The typical indication for surgical intervention is progressive glaucomatous damage that is likely to lead to functional impairment during the patient's lifetime.

METHODS Physicians now have to estimate the patient's lifespan and judge what IOP level will help preserve a lifetime of useful visual function.

RESULTS On the one hand, there are patients in whom progressive of disease has been noted and the likelihood of this causing functional impairment during the patient'lifetime is high. Therefore don't delay surgery in those patients. On the other hand, a patient with a small nasal step that has slowly progressed over the last 10 years with the pressure in the low 20s may not require any intervention at all. The risks of surgery on this patient probably outweigh the possible benefits. This may temper one's judgement away from filtration surgery to other methods of pressure reduction that are less invasive.

CONCLUSION No matter what the case, it is always useful to remind the patient that glaucoma is treatable but not curable condition. This therapeutic dialogue opens the door to a lifetime of treatment.

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Cataract surgery and iris reconstruction in posttraumatic zonular instability and traumatic aniridia

GOES F jr
Goes Eye Centre, Antwerp

PURPOSE To discuss the different options in iris reconstruction and cataract surgery in cases with zonular instability due to trauma

METHODS Video images will be used to summarize different steps in dealing with aniridia and zonular instability. Different usefull tips will be shared in every different step of the procedure, highlighting eventual complications that could occur.

RESULTS A perfect restoration of visual acuity, centration of the lens, zonular stability, and correction of the aniridia was achieved.

CONCLUSION A good functional and esthetical result can often be achieved when choosing the right options and taking precautions for possible expected and unexpected complications. The knowledge of these complications and learning when to expect them can help in achieving better results.

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Lens Surgery after previous Refractive surgery. Review of 145 eyes.

GOES F sr, GOES F jr
GOES EYE CENTRE, Antwerp

PURPOSE To discuss indications , clinical outcomes , eventual complications , type of cataract and outcomes of Iol power calculation of lens surgery performed after previous Refractive surgery such as:RK-Refr Lensectomy-LTK-Lasik-CK

METHODS 145 eyes were reviewed: 106 after previous myopic Refractive surgery and 39 after hyperopic Refractive surgery. The mean time delay of surgery after the refractive procedure was 120 months after RK- 100 months after myopic and 78 months after hyperopic excimer laser. 57 eyes had a more than 5 year fup

RESULTS the Ucva and Bscva improved in all eyes. Not one eye lost lines and 47 eyes gained more than 2 lines. 76% of hyperopes and 66% of myopes came out between +/- 1 D of target.The mean age at time of cataract surgery was much lower in the myopic group -53 years -compared to the normal population-74 years .Piggy backing was necessary in 6 surgeries done before 2000.

CONCLUSION Lens Surgery after previous Refractive surgery is safe and very rewarding;the problems of iol power calculation are still(although)on a lower scale present.

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Evaluate clinical outcomes of a trifocal diffractive pattern IOL.

HENRY JM
Charleroi

PURPOSE Evaluate the clinical outcomes with a trifocal diffractive pattern IOL

METHODS 28 eyes from 21 patients (age 70 +/-8) were implanted with the Physiol MicroF new trifocal diffractive IOL between March and August 2010. This IOL distributes the energy usually lost in bifocal diffractive patterns to an intermediate focus. The far distance vision (both corrected and uncorrected), intermediate distance vision at 65 cm and near visual acuity (30 cm) in photopic and mesopic conditions are assessed together with the defocus curve and patient satisfaction.

RESULTS The mean follow-up is between 3.4+/-2.5 months. The mean spherical equivalent is 0.00±0.02. The mean uncorrected and best corrected visual acuity are 0.89±0.11 and 0.95±0.06 respectively. The mean corrected intermediate and near visual acuities are Parinaud 3.5±1.3 and Parinaud 2.3±0.7 respectively. There is no significant variance between the far visual acuity in photopic and mesopic conditions, whereas the intermediate and near visual acuities are lower in mesopic conditions. The defocus curve shows no peaks but a continuous visual acuity with respect to the negative defocus addition . Patient satisfaction with regard to spectacle independence is high with no complaint of halos or glare.

CONCLUSION The introduction of an intermediate focus point with conservation of the amount of energy allocated to far and near vision does not cause any ghost images. The diffractive pattern gives good visual performances. This pupil dependent design increases the amount of energy for far vision at night, clinically reducing the patient's perception of halos and glare.

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FRO - Immunomodulation of corneal epithelial cells following electroporation with cDNA encoding IL-10

ZAKARIA N, COOLS N, VAN TENDELOO V, BERNEMAN Z, TASSIGNON MJ
Center for Cell Therapy and Regenerative Medicine, University Hospital Antwerp, Antwerp

PURPOSE Limbal epithelial stem cell transplants have shown better success rates in patients where autologous transplants were performed compared to allogenic transplantation. This led us to investigate the possibility of immunomodulation of the corneal epithelial stem cells prior to their transplantation. IL-10 is capable of inhibiting synthesis of pro-inflammatory cytokines like IFN- , IL-2, IL-3, TNF and GM-CSF made by cells such as macrophages and the Type 1 T helper cells and also displays potent abilities to suppress the antigen presentation capacity of antigen presenting cells. The purpose of this study was to transfect corneal epithelial cells (CECs) with cDNA encoding IL-10 in order to evoke a down modulation of allogenic T cell response in an ex vivo model.

METHODS The CECs were electroporated initially with cDNA encoding a reporter gene, EGFP, in order to optimize the transfection efficiency using different combinations of voltage and capacitance settings. The efficiency and viability post transfection were determined using flow cytometry at days 1, 2, 3 and 6. Controls used included "mock" and "non" electroporated cells. Following this, the CECs were transfected with cDNA encoding IL-10 using the optimized electroporation (EP) settings. IL-10 secretion was determined in the supernatants of the electroporated CECs collected at days 1, 2, 3, 6 and 7 using ELISA.

RESULTS Optimal transfection efficiency of the CECs was observed using an exponential pulse and 300V with 1050µF capacitance. 5µg of EGFP cDNA was used for each EP giving a transfection efficiency of 46.7% 24hrs post EP. The viability of the CECs was 89% 24hrs post EP. When CECs were electroporated with cDNA encoding IL-10 (performed using the optimized settings) more than 1000pg of IL-10 was detected in 2.5x105 cells/ml already 24hrs post EP and was still present in the supernatant 7 days post EP.

CONCLUSION We conclude that by using the optimized EP settings, we can efficiently transfect the CECs with cDNA encoding IL-10. This study is ongoing and future experiments include setting up co cultures with allogenic T cells to compare with control co cultures of allo-T cells and mock EP CECs. Following 5 days in cultureT cells will be analyzed for allogenic reactivity by ELISA for IFN- production in the culture supernatant. This project aims to illustrate in an ex-vivo model, how gene insertion into corneal epithelial stem cells could lead to improved cultivated limbal stem cell graft acceptance in patients with limbal stem cell deficiency.

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Retinal detachment following 23-gauge vitrectomy: incidence, characteristics, and prognosis.

BARBRY J, GRIBOMONT AC
Cliniques Universitaires Saint-Luc, UCL, Brussels

PURPOSE to evaluate the incidence, characteristics and prognosis of retinal detachments (RD) following 23G vitrectomy for various indications and to compare these features with those of RD following 25G vitrectomy in a previous series operated on by the same surgeon.

METHODS in this retrospective study we reviewed the chart of all the patients who underwent 23G vitrectomy between 15/03/2008 and 15/08/2010 and developed RD postoperatively, provided no other intra-ocular surgery was performed in the mean time. The main parameters recorded were the delay between vitrectomy and RD, the indication for 23G vitrectomy, the peroperative complications, the preoperative risk factors, the characteristics of the RD, and the anatomical and functional success of RD surgery.

RESULTS 9 eyes out of 305 undergoing 23G vitrectomy in this consecutive series developed RD, that is an incidence of 2.9%. Two thirds occured less than one month after vitrectomy. Indication for 23G vitrectomy was an epimacular membrane in 5 cases, a vitreo-macular traction syndrome in 2 cases, synchisis scintillans and chronic vitreous hemorrhage in 1 case each. Even if 5/9 eyes had a macula-on RD, 2/9 eyes were finally functionally lost. No eye underwent more than one RD surgery. These results compared favorably with our previous 25G vitrectomy series and with other similar series published in the pertinent litterature.

CONCLUSION the incidence and prognosis of RD in our series compare favorably with the data found in other series dealing with 23G as well as 25G vitrectomies. Most of those RDs may be unrelated to the vitrectomy technique, 20, 23 or 25-gauge, but related to preoperative risk factors, and peroperative complications.

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Results of the MIVI-trust phase III clinical trial using microplasmin in the treatment of vitreomacular traction and macular hole.

STALMANS P, MIVI-TRUST STUDY GROUP
Dept. Ophthalmology UZLeuven, Leuven

PURPOSE Vitreomacular adhesion (VMA) can lead to vitreomacular traction (VMT) and macular hole (MH) formation, and is also associated with a worse prognosis in certain major eye conditions, including diabetic macular edema and age related macular degeneration.

METHODS This Phase III clinical trial is a randomized double-masked trial with control placebo injection. In total, 652 patients with decreased visual acuity and VMA (VMT or MH formation) were included. Patients were randomized to either receive a 125 µg microplasmin injection or a placebo (saline) injection.

RESULTS The trials met its primary endpoint, a statistically significant improvement in the resolution of VMA. The results showed that 26.4% of the 465 microplasmin treated patients achieved resolution of the VMA at 28 days, compared to 10.2% of the 182 patients who received a placebo injection (p=0.000002). In patients diagnosed with MH, 40.6% of the 106 patients saw closure of the hole at 28 days following a single 125µg injection of microplasmin without the need for a vitrectomy. This compares with 10.6% of the 47 patients in the placebo group (p=0.00015). The closure of FTMH also led to microplasmin treated patients experiencing a significant improvement in their visual acuity (VA) and quality of life compared to placebo.

CONCLUSION This phase III clinical trial showed that microplasmin:- Was successful in nonsurgical resolution of vitreomacular adhesion- Was able to cure macular holes without the need for surgery- Delivered an improvement in the vision of patients without the need for surgery- Was generally safe and well tolerated.

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Novel developments to increase surgical safety during (phaco)vitrectomy.

STALMANS P
Dept. Ophthalmology UZLeuven, Leuven

PURPOSE During (phaco)vitrectomy, the surgeon can encounter several complications: posterior capsule aspiration during lens surgery, retinal aspiration in the vitrectomy during vitreous base shaving and intra-operative hypotony (leading to eye collaps and even subchoroidal haemorrhage) or hypertony (compromising the retinal perfusion).

METHODS Software- and hardware attenuations were developed on the DORC Dual Associate to help the surgeon to address or avoid these difficulties.

RESULTS Using the venturi system with a vacuum sensor during lens aspiration and a threshold vacuum setting, a high vacuum during tip occlusion is obtained to ease the lens removal while an automated reduced vacuum is programmed without tip occlusion to avoid posterior lens capsule aspiration.-A constant fluid flow is the key factor to avoid inadvertent retinal aspiration when the vitrectome opening is moved in and out the remaining peripheral vitreous during vitreous base shaving. This is obtained using a persistalic pump system with automated vacuum adaptation.-The intra-ocular pressure during vitrectomy is determined by two components: the inflow of fluid through the infusion line and the amount of fluid removed from the eye, in its turn dependent on the amount of vacuum used and the size of the used vitrectome. By developing a feedback system between the aspiration rate (vitrectome) and infusion rate (air-driven infusion line), a highly stable intra-ocular pressure is obtained, regardless of the amount or speed of fluid aspirated from the eye.

CONCLUSION The newly developed hardware and software provides a markedly improved safety during vitrectomy, by avoiding surgical damage to the eye.

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Oxymap: a novel tool to measure retinal oxygenation

JANSEN J, DEGHISLAGE C, VAN CALSTER J, STALMANS P
University Hospitals , Leuven

PURPOSE Disturbances in retinal blood flow and oxygenation are involved in several ophtalmologic diseases . Those include some of the more common eye diseases such as retinal vascular occlusions, glaucoma and diabetic retinopathy.Studies suggest that some treatments, such as laser photocoagulation and vitrectomy, may improve retinal oxygenation. Hence, we wanted to evaluate if enzymatic detachment of the posterior hyaloid could also influence the retinal oxygenation.

METHODS Patients with adherent hyaloid were included in an open label phase II clinical trial (MIVI-008, 30 patients scheduled). In all patients, a retinal oxymetry was performed at baseline and at six months. Additionally, we screened patients scheduled for macular hole surgery (and adherent posterior hyaloid) with retinal oxymetry before and after surgery.

RESULTS Recently, it has been demonstrated in a phase 3 trial that a complete detachment of the hyaloid can be obtained in almost 15% of patients after one month. The resulting change in retinal oxygenation will be measured and compared to the effect documented after vitrectomy.

CONCLUSION The Oxymap is a novel diagnostic tool to perform retinal oxymetry in a non-invasive way. Our study will determine the effect of detachment of posterior hyaloid (enzymatic versus surgical) on the retinal oxygenation

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Is there a role for prophylactic antibiotics after vitreoretinal surgery?

HAVERBEKE G
Aademiska University Hospital, Uppsala

PURPOSE To evaluate the post-operative course when antiobiotics are not standardly used in the postoperative period after vitreoretinal surgery.

METHODS Retrospective, interventional , non-comparative non-randomized consecutive cohort study where all vitreoretinal surgeries performed in our department between 15/03/2005 and 14/12/2008. The medical records were reviewed of 986 patients after pars plana vitrectomy, recording the operation technique and the postoperative medical treatment, more specifically antibiotics. The pre-, peri- and postoperative prophylactic measures were also recorded.

RESULTS During the period of the study, we noted one case of endophtalmitis, where antiobiotics in the postoperative period was given in 12 patients of 950 operations in 780 patients.

CONCLUSION Despite not routinely using antibiotics in the postoperative care, the incidence of endophtalmitis in our series is within the range of previously published data. With the rise of acquired antimicrobial resistance to antibiotics and with the evidence that the absence of antibiotics in the standard postoperative care doesn't increase the rate of infections, the role for prophylactic antibiotics after vitreoretinal surgery becomes even more questionable.

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Ambulatory Locoregional Vitreoretinal Surgery : Pilot Study of first 40 cases

HAVERBEKE G (1), RIEMS J (2), CLAEYS C (3)
(1) Vitreoretinal Policlinic, Kortrijk
(2) Université Catholique de Louvain, Brussels
(3) Vitreoretinal Polilinic , Kortrijk

PURPOSE to evaluate the post-operative surgical results and patient satisfaction after vitreoretinal surgery performed on ambulatory basis with locoregional anesthesia in an extramural setting.

METHODS Retrospective, interventional , non-comparative non-randomized consecutive cohort studyParticipants : All vitreoretinal surgeries performed in our department between 01/12/2009 and 31/07/2010 Methods : The medical records were reviewed of 40 patients after pars plana vitrectomy, recording the operation technique and the postoperative complication rate. A questionnaire was submitted to patients with regard to procedure related comfort and inconveniences

RESULTS Fourty cases were recorded. The range of procedures was wide. One patient developped a postoperative retinal detachment, caused by a pre-existing retinal weakness. The patients described being pain-free in a significantely high precentage of cases and 'comfortable during surgery' in nearly all of the procedures. The outpatient setting was described as being threshold-lowering in all of the patients.

CONCLUSION Vitreoretinal surgery is suitable to be performed in an ambulatory setting with locoregional setting in most of the clinical presentations. The complication rate was not higher than the average standards. The patient comfort was high and avoiding hospital admission lowers the surgical threshold and the overall costs of these procedures.

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Efficacy of Placental growth factor Inhibition in AMD

VAN DE VEIRE S (1), VAN BERGEN T (2), MOONS L (2), CARMELIET P (2), STALMANS I (1)
(1) UZL, Leuven
(2) KUL, Leuven

PURPOSE We previously showed that an anti-PlGF antibody (5D11D4) inhibits choroidal neovascularization (CNV) in a mouse model of AMD. An additive effect was shown in combination therapy with an anti-VEGFR antibody. Specificity of 5D11D4 was assessed in this study.

METHODS CNV was induced in mice by placing 3 laser burns on the choroid. Mice with a genetic loss of PlGF; a lacking tyrosin kinase domain of the Flt-1R or a knock-down of the monocyte chemoattractive protein were generated. The optimal dose of 25mg/kg of 5D11D4 was injected in all mice ip. 3 times a week.

RESULTS In a first experiment loss of PlGF inhibited CNV. However, administration of 5D11D4 to PlGF-/- mice did not inhibit CNV further than in control-treated PlGF-/- mice. Second, CNV lesions in Ccl2-/- mice were slightly larger than in WT mice within 14 days after laser-injury. Notably, 5D11D4 was able to inhibit CNV again by 53%. Third, CNV lesions were reduced by 70% in Flt1-TK-/- mice, comparably as observed in PlGF-/- mice. 5D11D4 was unable to inhibit CNV in Flt1-TK-/- mice any further, suggesting that PlGF works specifically via Flt1. Fourth, we also tested the murine anti-human PlGF mAb 16D3 in humanized PlGF-/- mice. Human PlGF-2 increased laser-induced CNV after 5 days, but this increase was again blocked by 16D3. And finally, of two other anti-mPlGF mAbs, 3C7A8 and 12H6B6, the first one inhibited CNV, while 12H6B6 was ineffective, showing that anti-PlGF mAb clones with proven efficacy in vitro are not necessarily effective in blocking PlGF-driven processes in vivo.

CONCLUSION We have proven that 5D11D4 specifically inhibits laser-induced CNV formation, in different transgenic models and that this effect is mediated via the Flt1 receptor.

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Functional and structural ophthalmological outcome in cryo- or lasertreated premature babies with retinopathy of prematurity (ROP) between 1989 and 2008

CASSIMAN C, STALMANS P, VAN CALSTER J, ALLEGAERT K, CASTEELS I

PURPOSE To assess the evolution in postmenstrual age (PMA) at birth, birth weight, PMA at treatment, visual outcome, ophthalmoscopic appearance, refractive errors and strabismus in infants treated for ROP between 1989 and 2008 at the University Hospitals of Leuven, Belgium.

METHODS Retrospective analysis of the medical records of premature infants with ROP who were treated with cryotherapy or lasertherapy. The study population is divided into three groups. In group 1 (1989-1995) 26 cryo treated infants and in group 2 (1996-1999) 32 cryo treated infants are included. Group 1 was treated at the threshold stage whereas group 2 was treated at the prethreshold stage. Group 3 consists of 37 laser treated infants (2002-2008). Infants treated during the transition time from cryotherapy to lasertherapy (1999 - 2001) were excluded.

RESULTS Between the three groups differences in mean PMA at birth, mean birth weight and mean PMA at treatment were evaluated. Visual and refractive outcome, ophthalmoscopic appearance were compared. The presence of strabismus within the three groups, and involvement of the central nervous system were evaluated.

CONCLUSION There is a tendency to better ophthalmological functional and structural outcome in infants treated with cryotherapy at the prethreshold stage (group 2) compared to those who were treated at the threshold stage (group 1). Ophthalmological functional and structural outcome is better in infants treated with lasertherapy (group 3) compared to those treated with cryotherapy (group 1 and 2). Subanalysis of the more recently laser treated group shows that poor visual outcome can mainly be attributed to central nervous system involvement. High myopia is mainly present in children who were diagnosed with ROP rush disease.

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Intravitreal bevacizumab for myopic choroidal neovascularization: 1-year and 2-year results

COPPENS G, SPIELBERG L, LEYS A
UZ, Leuven

PURPOSE To report safety and efficacy results after 1 and 2 years of intravitreal bevacizumab injection (IVB) for active choroidal neovascularization associated with pathological myopia (mCNV).

METHODS For this retrospective interventional case series of 29 eyes, charts were reviewed of all patients who received IVB for active mCNV and who had a follow-up of at least 12 months after the first injection. Injections were repeated as needed, based on a decrease in best corrected visual acuity (BCVA), an increase in central macular thickness (CMT) of > 100 µm on optical coherence tomography (OCT), the recurrence of macular edema on OCT and/or leakage on fluorescein angiography. Patients were divided into 3 groups based on length of follow-up: patients in Group 1 had a follow-up of ≥12 months, in Group 2 of ≥18 months and in Group 3 of ≥24 months. Changes in visual acuity and CMT were analyzed, as were safety considerations.

RESULTS Twenty nine patients with a mean age of 62.2 years were included and 83 injections were administered. No ocular or systemic side effects were noted. Mean BCVA at baseline for all patients (n=29) was 20/100, at three months 20/80+ and at one year 20/63. At 18 months, Group 2 and 3 (n=19) had a mean BCVA of 20/80+. At 2 years, Group 3 (n=8) had a mean BCVA of 20/63. The BCVA had improved significantly at 3 months (p=0.0035) and one year (p=0.0042). Although BCVA gains were maintained at 18 and 24 months, these were not statistically significant (p=0.11 and p=0.19, respectively). The mean CMT decreased significantly at one year.

CONCLUSION This study confirms that administration of intravitreal bevacizumab is a safe and effective treatment modality for mCNV. Statistically significant visual improvement can be obtained.

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Dépistage de la rétinopathie diabétique chez les patients admis en hospitalisation d'un jour

FORTUNATI M, HAUTENAUVEN F, GUAGNINI AP
Cliniques universitaires Saint Luc- UCL, Brussels

PURPOSE évaluer les résultats du dépistage de la rétinopathie diabétique par photographies couleur dans le cadre d'hospitalisation de mise au point de courtes durées dans le service d'endocrinologie

METHODS étude transversale avec mesure de l'acuité visuelle de loin et réalisation de photographies couleur analysées de manière différée

RESULTS sur 108 patients randomisés en 18 mois, 74,1% ne présentaient pas de rétinopathie diabétique (RD), 15,7% présentaient une RD minime ou modérée et 10,2% une RD sévère ou proliférante ou associée à une maculopathie et/ou hypertensive nécessitant une prise en charge à court terme. Chez les patients ne présentant pas de RD, l' hypertension artérielle était présente dans 62,5% des cas, l'hypercholestérolémie dans 65% des cas, l'hémoglobine glyquée moyenne était de 8,55%et la créatinine moyenne de 0,93 mg/dL. Chez les patients présentant une RD nécessitant une prise en charge à court terme, l'hypertension artérielle était présente dans 91% des cas, l'hypercholestérolémie dans 76% des cas, l'hémoglobine glyquée moyenne était de 8,85% et la créatinine moyenne de 0,90 mg/dL

CONCLUSION l'examen seul de photographies couleur du fond d'oeil lors de bilans endocrinologiques permet le dépistage de la rétinopathie diabétique ainsi que la prise en charge rapide des formes sévères. Dans notre série, l'hypertension artérielle et l'hypercholestérolémie étaient plus prédictifs que l'hémoglobine glyquée et la créatinine d'une association à une forme de rétinopathie nécessitant une prise en charge rapide

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Ischemic Optic Neuropathies

ANDRIS C, SPRYNGER M
Liège

Dr C. ANDRIS How do you differentiate A-AION from Non-Arteritic? Is a fluo-angiography mandatory? Unilateral or bilateral temporal artery biopsy? Is there a place for temporal artery ultrasound? Whith treatment for GCA? How do you evaluate NA-AION? Is there a treatment ?What to do with carotid stenosis and cardiac disesases? Which hypercoagulable work-up to ask?All these questions will be debated.

Dr M. SPRYNGER There are two varieties of ischemic optic neuropathy, NA and arteritic. Even though diagnosis is mainly based on a clinical evaluation, ancillary exams may be needed urgently.In case of temporal arteritis, corticotherapy must be started quickly in order to preserve the other eye. Transient or permanent ischemia can also be due to cardiac or arterial emboli requiring undelayed treatment. Secondary prevention is a main issue too.What kind of information can cardiovascular ultrasounds give to the ophthalmologist? Is it worth doing carotid or temporal ultrasounds, transthoracic or transesophageal echocardiography? What is the reliability of these techniques and what are the up-to-date recommendations for medical treatment, surgery or endovascular procedures ?This “question-answer session” will try to confront the ophthalmologist’s, the cardiologist’s and the angiologist’s points of view.

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Chronic Optic disc cupping. Is it Glaucoma? Or Not?

COLLIGNON N
CHU de Liège, Liège

PURPOSE Pathological optic disc cupping associated with normal intraocular pressure (IOP) is most often caused by open-angle glaucoma but may represent a diagnostic challenge when caused by many less-common neuro-ophthalmic conditions.

METHODS This article reviews the clinical differentiation between physiologic cupping and pathologic cupping, and the subclassification of eyes with glaucomatous and nonglaucomatous optic disc cupping.

RESULTS Up to 10-20% of patients may be misdiagnosed and treated for glaucoma due to misinterpretation of the optic-disc cupping.

CONCLUSION A careful interpretation of the history, optic disc characteristics and visual fields are quintessential to the diagnosis of glaucomatous versus non-glaucomatous optic disc cupping, avoiding misinterpretation or inappropriate neuroimaging examinations.

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Transient visual loss

ANDRIS C
Liège

How do I manage a Transient Monocular Visual Loss in a young patient? The differential diagnosis of TMVL in young patient includes a number of entities . “Vasospasm” (retinal migraine), a frequent condition, often affects the same eye every time, has a very stereotypic pattern, no scintillations, no neurological anomalies. This is a diagnosis of exclusion. Selected patients will have specific testing to exclude heart disease, carotid dissection or dysplasia, hypercoagulable/hyperviscosity syndromes. Historical clues are important, and complete examination is necessary.How do I manage a Transient Monocular Visual Loss in an older patient? An aggressive work-up is mandatory. Ischemia is the main problem: carotid artery stenosis, carotid or cardiac emboles and Horton disease. The patient is at risk for stroke. Mortality is increased resulting more likely from myocardial infarction than from stroke. Carotid endarterectomy is warranted for symptomatic patients with greater than 50% stenosis, and asymptomatic patients with greater than 60%. Newer surgical alternatives (angioplasty and stenting) are proposed. Medical treatments include anti-platelets such as aspirin and clopidogrel (Plavix) are used.

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Topographical signs of astigmatism

SALLET G
Ooginstituut, Aalst

PURPOSE Analysis of astigmatism using different measuring devices and learn how to make a correct analysis

METHODS Different devices for analysis of astigmatism will be highlighted: manual and automatic keratometry, corneal topography, Scheimpflug images of the cornea and internal ocular astigmatism as well as wavefront images of the whole eye.

RESULTS Each of these devices help us to have a clearer image of degree and origin of the astigmatism. This might influence our therapeutic approach in cataract, refractive surgery or in prescribing corrective lenses. Classic astigmatism as well as pitfalls in diagnosis of astigmatism will be shown.

CONCLUSION Different measurement techniques help us to grade the astigmatism and help us in our therapeutic approach.

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FRO - Can peroperative bevacizumab (Avastin) improve trabeculectomy outcome? A prospective, randomized, placebo-controlled study

VANDEWALLE E (1), ZEYEN T (2), SPIELBERG I (3), STALMANS I (2)
(1) ULZ, Leuven
(2) UZL, Leuven
(3) Dep of ophthalmology, Rotterdam

PURPOSE Glaucoma surgery fails in 30% due to excessive scar formation of the constructed channel. Our group found that vascular endothelial growth factor (VEGF) is upregulated in the aqueous humor of glaucoma patients and postoperatively in a rabbit model for trabeculectomy, that VEGF stimulates fibroblast proliferation in vitro whereas bevacizumab can inhibit their growth, and that a single peroperative intracameral injection of bevacizumab improves the surgical outcome of trabeculectomy in a rabbit model. Based on these findings, we set up a clinical trial to study the potential of bevacizumab as an anti-scarring agent after trabeculectomy.

METHODS This is a prospective, randomized, placebo-controlled, double-blinded experimental study. The effect of peroperative administration of 50 µl of bevacizumab (25mg/ml) on intraocular pressure, bleb characteristics, as well as number of postoperative IOP-lowering medications and surgical interventions is investigated. Patients with primary open-angle glaucoma (POAG) and normal tension glaucoma (NTG) who are scheduled for primary trabeculectomy are included.

RESULTS Inclusions started on April 2009. Based on a priori calculations we need to include 124 patients. The inclusions will be accomplished in September 2010.

CONCLUSION This study will provide evidence on effectiveness and safety of single administration of bevacizumab during trabeculectomy to reduce the risk of surgical failure, avoiding or reducing the need for long-term medication use or secondary surgical intervention.

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The role of LOX and LOXL2 in wound healing after glaucoma filtration surgery

VAN BERGEN T, VAN DE VEIRE S, VANDEWALLE E, MOONS L, HERMAN J, STALMANS I
KUL, Leuven

PURPOSE Lysyl oxidase (LOX) and lysyl oxidase-like protein 2 (LOXL2) are involved in the crosslinking of collagen and elastin. We showed that LOX and LOXL2 were upregulated after trabeculectomy. The aim of this study was to investigate the efficacy of anti-LOX (M64) and anti-LOXL2 (M20) antibodies (Arresto Biosciences) in a rabbit model.

METHODS Treatment with the antibodies or control (PBS) was initiated on day 0 after surgery by giving an intracameral injection (0.6 mg) and a subconjunctival (SC) injection (0.3 mg). Thereafter the antibodies were injected twice a week SC (0.3 mg) until 30 days after the surgery. The outcome of the treatment was studied by clinical investigation (IOP, bleb area and bleb survival) and by analysis of angiogenesis (CD31), inflammation (CD45) and collagen deposition (Sirius Red).

RESULTS Both antibodies were able to significantly improve surgical outcome by increasing bleb area and bleb survival compared to control ($p<0.001$). Analyses of the different stainings showed a significant reduction in angiogenesis (47%; $p=0.01$), inflammation (34%; $p=0.0003$) and fibrosis (16%; $p=0.01$), respectively, in the anti-LOXL2 treated group compared to control. Anti-LOX antibody resulted in a significant reduction only in collagen deposition (22%; $p=0.0009$ compared to control).

CONCLUSION These results showed that LOX and LOXL2 are important in ocular wound healing. We also provide evidence on effectiveness of repeated anti-LOXL2 injections after trabeculectomy. The anti-LOXL2 antibody was able to improve surgical outcome by reducing angiogenesis, as well as inflammation and collagen deposition. These new insights may have important therapeutic implications for glaucoma surgery.

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FRO - Evaluation of cerebrospinal fluid pressure in patients with Alzheimer's disease as a possible cause of glaucoma

KIEKENS S
Antwerp

There is some evidence that cerebrospinal fluid pressure and trans lamina cribrosa pressure gradient play a role in the pathogenesis of glaucoma. Alzheimer patients, in which glaucoma is more frequent, have a lower CFP. Since they recieve a lumbar punction in their neurological work up, they are an easy group to investigate the hypothesis that correlates a low cerebrospinal fluid pressure with the presence of glaucoma. However this hypothesis was recently confirmed in a prospective interventional study in glaucoma patients and normal patients undergoing a lumbar puncture. We now evaluate the role of cerebrospinal fluid in a non invasive way with 3T MRI imaging. We are developing a new imaging protocol to calculate optic nerve volume and optic nerve sheath volume. This wil be performed in several groups of patients. Data will be analysed and conclusions will follow.

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Correlation between visual field index and ganglion cell complex parameter, global loss volume and focal loss volume, measured by RTVue OCT

HAUTENAUVEN F (1), JANSSEN X (2), POURJAVAN S (1)
(1) Cliniques Universitaires St. Luc, Brussels
(2) CHU St. Pierre, Brussels

PURPOSE To evaluate the correlation between visual field index (VFI%) and ganglion cell complex (GCC) parameters: global loss volume (GLV%) and focal loss volume (FLV%) in glaucomatous patients.

METHODS Prospective study including both eyes of 31 glaucomatous patients with a repeatable abnormal Standard Automated Perimetry (SAP) and a local visual field defect in at least one eye.Visual field (VF) examination was performed using Humphrey SAP. OCT imaging was obtained by an experienced technician and using RTVue Spectral Domain OCT.VFI% from VF examination and GLV% and FLV% from RTVue OCT were taken into account for further statistical analysis. Pearson correlation coefficient was used to assess the correlation between different parameter.

RESULTS The mean age was 56 ± 14 yrs. Only 49 of the total 62 visual fields showed reliable and repeatable defect with an abnormal GHT (Abn VF). These VF were taken into account for the correlation test. The remainders (NL VF) were used as controls. The mean VFI% in Abn VF was 79.8 ± 21%. The mean of GLV% was 6.0 ±4.1 and the mean of FLV % was 19.6±11. The Pearson correlation showed no correlation between VFI% and GLV% ($p=0.07$). There was a correlation between VFI% and FLV% ($p<0.01$).

CONCLUSION To date, in this interim analysis, we found only a correlation between VFI% and FLV%. One might conclude that FVL parameter is more influenced by the focal defect in the VF.

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FRO - The effect of microplamin on wound healing after glaucoma filtration surgery

VAN BERGEN T
Leuven

PURPOSE This study was designed to study the efficacy and safety of Microplasmin as an anti-scarring agent in a rabbit model of trabeculectomy.

METHODS The effect of Microplasmin was investigated in vivo in a rabbit model for glaucoma surgery. Clinical outcome measures were intra-ocular pressure, bleb area, and side effects on slit lamp examination. Moreover, (immuno-) histochemical analysis of the eyes was performed, with quantification of inflammation (CD 45) and collagen deposition (Trichrome and Sirius Red). In the first experiment (n=3), topical Microplasmin drops were compared to placebo drops. In the second experiment (n=5), subconjunctival Microplasmin injection was compared to placebo injection. In the third experiment (n=10), intracameral Microplasmin injection was compared to placebo injection. In the last experiment a combination of intracameral Microplasmin and topical drops was compared to placebo injection and drops. All experiments were conducted by a masked observer. The aqueous solution of microplasmin used in all experiments was not optimized for use as drops or in subconjunctival injection.

RESULTS Microplasmin combination therapy significantly augmented the bleb area over the 30 days of follow-up (p=0.05). There was a trend that the single anterior chamber injection augmented the bleb area in the first week compared to control (p= 0.08). In contrast the beneficial effects of microplasmin after topical administration alone or subconjunctival Microplasmin trabeculectomy were absent (p=0.73, 0.90 respectively). No significant changes in collagen deposition and inflammation in the anterior chamber or in the conjunctiva were noticed.

CONCLUSION The combination of anterior chamber injection and topical drops improved surgical outcome of trabeculectomy in a rabbit model, despite the fact that the formulation of Microplasmin was not optimized for use as drops or injections. Our proposed research project will optimize the formulation of Microplasmin for extended drug delivery and determine the optimal administration route and regimen.

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The range of Waveform score of ocular response analyzer (ORA) in healthy subjects: Interim analysis

VANTOMME M, POURJAVAN S
Cliniques Univ. St-Luc, UCL, Woluwe-St-Lambert

PURPOSE To assess the range of waveform score in IOP measurements with ocular response analyzer (ORA, Reichert) in healthy subjects.

METHODS Prospective study including both eyes of healthy subjects with no ocular pathology or previous refractive surgeryThe IOP measurements with ORA were performed. The inclusion criteria of the measurements were based on good waveforms. The waveform score (W.S.) of 3 measurements were included for statistical analysis. Other parameters including age, central corneal thickness (CCT) and axis length were also analysed to evaluate possible correlations. Spearman correlation coefficient was used to assess the correlation.The Anova test was used to assess the variance in repeated measurements.

RESULTS To date, right eyes of 53 healthy subjects are included (Mean age: 46.6 ± 14.3 yrs, Axial length: 23.7 ± 1.1, CCT: 554 ± 34 µm).The mean W.S. from the first IOP measurement were 5.1±2.3 and for the 2de and 3th respectively 5.2±1.9 and 5.±2.1 (p= 0.74, not significantly different). The mean W.S. of 159 signals (one eye and 3 measurements) was 4.2±2.1 and ranged from 1.2 to 9.6. Considering the best signal value per patient, the mean of all best signal values was 5.5±2.0 and it ranged from 1.9 to 9.5. The lowest 10% of all the best signal value was 3.35.

CONCLUSION The waveform score is a new parameter indicating the reliability of each measurement signal. The best signal value indicates the best measurements of each session (Not the mean of the measurements). To date, results show that the lower 10% percentile is 3.35. This could suggest that the measurements with waveform score lower than 3 should be discarded.

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Relationship between central corneal thickness and visual field loss in a glaucomatous cohort

SCHAUWVLIEGHE P (1), SCHAUWVLIEGHE AS (2)
(1) AZ Sint Lucas, Ghent
(2) Ghent

PURPOSE To emphasize the importance of measuring central corneal thickness (CCT) in glaucoma screening.

METHODS In a cohort of 92 patients with ocular hypertension or chronic open angle glaucoma, CCT, intraocular pressure (IOP), cup disc ratio and Octopus Loss of Variance (LV) of all right eyes were measured. IOP and CCT was measured in a control group of 165 right eyes. The glaucoma group was divided in a group with thin cornea (<508 µ), a normal corneal thickness group (509 -588µ), and a thick cornea group (>589µ).

RESULTS In the control group mean CCT was 543µ (s.dev 35 µ). In the glaucomatous group with thin cornea mean LV was 36, with 6 out of 16 patients with loss of LV >30. In the normal CCT glaucoma group mean LV was 12.7 with 3 out of 60 with loss of LV >30. In the thick cornea glaucoma group mean LV was 5.6 with no patient out of 12 having a loss of LV > 20. The difference in LV was significant between the thin cornea group and the normal and thick cornea groups. The difference in LV was not significant between normal and thick cornea group.

CONCLUSION Patients with thin corneas are much more at risk to develop visual field defects. Patients with thick corneas rarely develop visual field defects. Follow up of patients with thin corneas is more mandatory than for patients with thick corneas. The necessity to treat patients with thick corneas is often questionable. Including pachymetry in glaucoma screening will lead to earlier detection of patients at risk.

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Patient reported outcomes in glaucoma: associations between the NEI VFQ-25 and the GQL-15 and clinical measures of visual function

POURJAVAN S (1), SPRATT A (2), KOTECHA A (3)
(1) Cliniques universitaires St.Luc, Brussels
(2) Moorfields Eye Hospital, London
(3) Optometry and Visual science, NIHR BRC for Ophthalmology, London

PURPOSE To examine associations between visual function measurements and patient-reported outcomes as assessed by vision-specific National Eye Institute Visual Function Questionnaire(NEI-VFQ25) and glaucoma-specific Glaucoma Quality of Life 15(GQL-15)

METHODS NEI-VFQ25 & GQL-15 were self administered. LogMAR visual acuity (VA), contrast sensitivity (CS), stereoacuity and visual field (VF) testing with Humphrey Field Analyzer were performed. To estimate the binocular VF defect severity, 2 scores were generated: the average Visual Field Index (mVFI) and the binocular integrated visual field (IVF). Correlations were examined using Spearman's correlation coefficient.

RESULTS 63 glaucoma patients were included(mean age 68.1±12.4 yrs). The group mean mVFI index was 78.6 ±26 % and IVF score was 9 ±18.3. NEI VFQ composite scores were strongly associated with VF defect severity (mVFI $p < 0.001$; IVF $p < 0.001$), worse VA and CS (VA worse eye $p = 0.01$; CS worse eye rho = 0.55, $p < 0.001$) and poorer stereoacuity ($p = 0.01$). GQL scores were also associated with VF defect severity, worse eye VA, worse eye CS and stereoacuity, but to a lesser extent (mVFI: $p < 0.01$; IVF: $p < 0.01$; VA worse eye = 0.36, $p = 0.05$; CS worse eye rho = -0.42, $p<0.01$; stereoacuity rho = 0.3, $p < 0.05$).

CONCLUSION The perceived difficulties experienced by glaucoma patients appear to be related to many aspects of visual function. This interim analysis shows that clinical measures of visual ability are better correlated with the NEI VFQ than the GQL-15. This suggests the former maybe more sensitive to the experiences reported by glaucoma patients.

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24 hour-intraocular pressure fluctuation monitoring using an ocular telemetry Sensor: functionality and tolerability in healthy subjects

DE SMEDT S (1), MERMOUD A (1), SCHNYDER C (2)
(1) Glaucoma Center at the Montchoisi Clinic, Lausanne
(2) Jules Gonin Eye Hospital, Lausanne

PURPOSE To evaluate the precision of the signal transmission, the tolerability and comfort of an ocular Sensor used for 24-hour intraocular pressure fluctuation monitoring in humans.

METHODS In this uncontrolled open trial involving 10 healthy volunteers an 8.7 mm radius prototype ocular telemetry Sensor (SENSIMED Triggerfish®, Lausanne, Switzerland) and an orbital bandage containing a loop antenna were applied and connected to a portable recorder after full eye examination. Best corrected visual acuity and position, surface wetting ability and mobility of the Sensor were assessed after 5 and 30 minutes, 4, 12 and 24 hours. Subjective wearing comfort was scored and activities documented in a logbook. After Sensor removal a full eye examination was repeated and the recorded signal analyzed.

RESULTS The comfort score was high and did not fluctuate significantly over time. The mobility of the Sensor was limited across follow-up visits and its surface wetting ability remained good. Best corrected visual acuity was significantly reduced during Sensor wear and immediately after its removal (from 1.07 before, to 0.85 after, P-value 0.008). Three subjects developed a mild, transient corneal abrasion. In all but one participant we obtained usable data of a telemetric signal recording with sufficient sensitivity to depict ocular pulsation.

CONCLUSION This 24 hour-trial confirmed the functionality and tolerability of the ocular telemetric Sensor for intraocular pressure fluctuation monitoring in human volunteers. Further studies conducted with different Sensor radii as well as trials to improve the interpretation of the telemetric signal are indicated.

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Le syndrome de pseudoexfoliation capsulaire chez les patients Congolais

KAIMBO WA KAIMBO D
Université de Kinshasa, Kinshasa

PURPOSE Déterminer la fréquence relative ainsi que les caractéristiques cliniques du syndrome de pseudoexfoliation capsulaire (SPE) chez les patients Congolais

METHODS Une étude transversale et descriptive des patients avec le diagnostic de SPE dans une clinique d'ophtalmologie générale durant la période allant de janvier 2005 à août 2008. Tous les patients d'âge égal ou supérieur à 50 ans ont été inclus dans la présente étude. Chaque patient a subi un examen ophtalmologique de routine comprenant l'acuité visuelle, la réfraction, la biomicroscopie, l'aplanation, la gonioscopie ainsi que le fond d'œil dilaté. Le diagnostic de SPE a été basé sur la biomicroscopie

RESULTS Durant la période d'étude, 2142 patients âgés de 50 ans ou plus ont été examinés et 37 patients (60 yeux) ont présenté un diagnostic de SPE ; ce qui donne une fréquence relative de 1,64%. L'âge moyen des patients a été de 70,4 ans±8 (limites, 57 à 84 ans). La répartition en fonction du sexe a été la suivante ; 15 patients (40,5%) de sexe masculin et 22 patients (59,5%) de sexe féminin. La fréquence du SPE a montré une tendance à augmenter avec l'âge passant de 0,50% dans le groupe d'âge de 50 à 59 ans à 7,29% dans le groupe de plus de 80 ans. La fréquence du syndrome a été plus élevée dans le sexe féminin (2,18%) que dans le sexe masculin (1,22%). L'atteinte a été surtout bilatérale (80%). La cataracte a été présente dans 78% et le glaucome dans 37% d'yeux

CONCLUSION Cette étude bien qu'hospitalière, donne la fréquence de ce syndrome dans cette partie du monde et confirme les données de la littérature quant à la fréquence et aux caractéristiques cliniques

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Long-term results of primary transpupillary thermotherapy of posterior uveal melanoma in 88 consecutive cases

DE POTTER P, JAMART J, DE CLERCQ C
Ocular Oncology Unit, Brussels

PURPOSE To evaluate long term ocular and systemic outcomes after primary transpupillary thermotherapy (TTT) for posterior choroidal melanoma.

METHODS Noncomparative interventional case series wit 88 patients newly diagnosed selected posterior choroidal melanoma. All tumors had either documentation of growth or substantial clinical risks factors for future growth.

RESULTS The mean tumor size before treatment was 7.1 mm in base and 2.9 mm in thickness. 30 tumors (34%) were touching the optic disc. After a mean follow-up of 90 months and an average of 3 TTT sessions, tumor recurrence was found in 28 eyes (32%) with an intraocular location in 24 cases (27%) and an extrascleral location in 4 cases (5%). Other complications included branch retinal vein and/or artery occlusion in 31 eyes (35%), retinal neovascularisation in 8 eyes (9%), and vitreous hemorrhage in 9 eyes (10%). Late enucleation was performed in 5 patients (6%) at a mean interval of 84 months as management of tumor recurrence and melanoma-specific metastatic disease developed in 4 patients (5%) at a mean interval of 68 months. The only risk factor for tumor recurrence was a total number of TTT sessions greater than 3 sessions (P=0,02). The risk factors for vascular occlusion were the proximity to the disc (P=0,04) and to fovea (P=0.09). Greater tumor thickness was the most significant factor predictive of retinal neovascularisation (P=0,05). Kaplan Meier estimates revealed that 2% showed intraocular recurrence at 1 year, 20% at 3 years, 25% at 5 years and 27% at 7 years follow-up.

CONCLUSION Our results showed the increasing number of tumor recurrence and vascular complications with long-term observation. Tumors that required more than 3 sessions of TTT are more likely to develop recurrence.

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Vaccination for prevention of metastases of uveal melanoma

MISSOTTEN GS (1), PARIDAENS AD (2), SPILEERS W (3)
(1) Katholieke Universiteit Leuven, Leuven
(2) Rotterdam Oogziekenhuis, Rotterdam - NL
(3) Katholieken Universiteit Leuven, Leuven

PURPOSE To introduce a study for the prevention of uveal melanoma metastases by vaccination.

methods Patients who underwent enucleation for uveal melanoma with monosomy of chromosome 3, and with HLA type A201 are eligible for vaccination against melanoma metastases. The purpose is to include 30 patients, at this moment 16 patients are included.

RESULTS The aim is to prevent metastases in high-risk uveal melanoma patients.

CONCLUSION Randomised studies of vaccination for uveal melanoma are not available. This study wants to investigate the usefulness of vaccination against uveal melanoma metastases

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FRO - Investigating the influence of light intensity and wavelength on retinal straylight

ROZEMA J
Antwerp

PURPOSE To study the influence of macular pigmentation and yellow intraocular lenses (IOLs), promoted with the argument that by blocking blue and ultraviolet light the retina would be protected. Moreover the influence of the yellow lenses on color vision is studied as well.

METHODS For this study a cohort of 100 patients diagnosed with bilateral cataract, is divided into four subgroups of 25 patients each. The patients in these groups will be bilaterally implanted with respectively two colorless Bag-in-the-Lens IOLs (BiL), two yellow BiL IOLs, two colorless AcrySof SA60AT IOLs or two yellow AcrySof SN60AT IOLs . Patients with prior ocular surgery, retinal defects or glaucoma will be excluded from this study. Three months after surgery of both eyes patients perform a straylight test using the Oculus C-Quant straylight meter, a color vision test with the City Occupational CAD test and the macular pigment test with the Tinsley QuantifEYE (MPOD) device.

RESULTS This project has recently started the recruitment phase and so far a number of subjects have agreed to participate. These patients will soon be bilaterally implanted with the IOL type of their respective group. The first follow-up tests on these patients will be performed shortly.

CONCLUSION This study is progress and we hope to present the results at the 2011 OB congress.

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FRO - Study of the immune response in patients with uveitis and latent tuberculosis

MAKHOUL D
Brussels

PURPOSE In this work, we would like to investigate the usefulness of different methods of tuberculosis immunity testing in a series of patients with intraocular inflammation.The production of IFN- by mononuclear cells in response to purified proteins derivatives and other mycobacterium antigen like native heparin-binding hemagglutinin (nHBHA) has been measured by ELISA.

METHODS In this prospective study, patients with uveitis of unknown origin suspected to be related to tuberculosis or to autoimmune disease have been recruited and underwent a standard diagnosis procedure, including TST, chest Xray and a QuantiFERON-Gold. The production of IFN- by mononuclear cells in response to purified proteins derivatives and the other mycobacterium antigen heparin-binding hemagglutinin (nHBHA) has also been measured by ELISA.

RESULTS With the help of the FRO 2009, we recruited 46 patients. Twenty six patients were TST and QuantiFERON- TB negative. When we analyse the IFN gamma release in response to PPD in this concordant negative group, 88,5 % did not, as expected, respond to PPD. Similarly, IFN gamma's response to HBHA was negative in 92 % of the cases. In 15 patients QuantiFERON-TB Gold and TST were positive. In this positive group, IFN response to PPD and nHBHA stimulation was found in respectively, 80 and 47 % of the cases. Discordant results between QuantiFERON-TB Gold and TST were observed in 5 patients (13%). Among them, only one had a positive QuantiFERON-TB Gold and a negative TST. Four patients had thus a positive TST and a negative QuantiFERON-TB Gold. In this discordant group, no patients had any release of IFN in response to PPD or HBHA, which strongly argue in favour of false positive.

CONCLUSION Analysis of the IFN production in response to PPD and nHBHA seem to add important information in both concordant and discordant group. However, more patients need to be included in order to make definitive conclusions.

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Toxic optic neuropathy secondary to disulfiram: a case series

LUCAS RS (1), LEROY BP (2)
(1) Dept of Ophthalmology, Ghent University Hospital, Ghent, Belgium, Ghent
(2) Dept of Ophthalmology & Ctr for Medical Genetics, Ghent University Hospital, Ghent, Belgium, Ghent

PURPOSE To describe the presentation, ophthalmic features and electrophysiological findings in 4 patients with disulfiram (Antabuse) related optic neuropathy.

METHODS Observational case series involving 4 patients. All underwent an extensive ophthalmological work-up, including psychophysical and electrophysiological testing.

RESULTS All patients took disulfiram (Antabuse) tablets in varying doses and length of time before developing profound, bilateral visual loss. Three patients were smokers and one patient suffered from schizophrenia. Ophthalmic examination in combination with automated and manual perimetry showed reduction of visual acuity, disturbed colour vision and visual field defects consistent with bilateral optic neuropathy. Electrophysiological testing revealed delayed and reduced amplitudes on pVEP. After cessation of disulfiram, visual acuity, perimetry and electrophysiological testing gradually returned to normal or near-normal levels.

CONCLUSION Disulfiram is a rare cause of reversible toxic optic neuropathy. Patients who take disulfiram are more likely to abuse tobacco and possibly other drugs or have psychiatric or psychological comorbidity. These patients may also be labelled as cases of malingering. Careful history and examination should alert the clinician to the possibility of disulfiram optic neuropathy.

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FRO - The effect of upregulated LOX and LOXL2 on inflammation and fibrosis in a laser induced CNV model

VAN DE VEIRE S
Leuven

PURPOSE Lysyl oxidase (LOX) and lysyl oxidase-like protein 2 (LOXL2) are involved in the cross-linking of collagen and elastin in the extracellular space. Therefore, these proteins play a major role in the process of fibrosis. This study was designed to elucidate the role of LOX and LOXL2 in inflammation and fibrosis after choroidal neovascularization (CNV).

METHODS CNV was induced in 8 to 10 weeks old C75Bl/6 mice (n = 5 per timepoint), by placing 3 laser spots at 9, 12 and 3 o'clock position (50µm, 0.05 s and 400mW). Mice were sacrificed 2, 4, 7, 14, 28 and 35 days after lasering. LOX and LOXL2 expression in choroid and retina was analyzed by using quantitative real time RT-PCR. Inflammation was studied by an immunohistochemical staining for CD45; fibrosis was evaluated by a Sirius Red and Trichrome staining.

RESULTS Both LOX and LOXL2 were significantly increased over time in the choroid and retina of lasered mice. LOX was 2.1, 3.2, 1.75, 1.3, 2 and 1.3 times upregulated on day 2, 4, 7, 14, 28 and 35 after laser, respectively, compared to the expression of LOX in non-lasered eyes. LOXL2 was 1.1, 1.6, 1.3, 1.1, 1.5 and 1.2 times upregulated on day 2, 4, 7, 14, 28 and 35 after laser, respectively, versus LOXL2 expression in non-lasered eyes. On day 2 and 4 after laser, the number of inflammatory cells was increased by 16% compared to control. Both Sirius Red and Thrichrome staining showed a significant increase of collagen deposition in the choroid on day 14 (43%), day 28 (44%) and day 35 (40%) after laser compared to non-lasered eyes.

CONCLUSION A biphasic upregulation of LOX and LOXL2 was observed after CNV induction, which was associated with the inflammatory and fibrotic phase, respectively. Our data suggests that LOX and LOXL2 play a role in the process of inflammation and fibrosis after the induction of CNV. Our proposed research will elucidate the efficacy of anti-LOX and/or anti-LOXL therapy in CNV and will highlight any anti-angiogenic, anti-inflammatory, and/or anti-fibrotic effects.

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Transient-recurrent diplopia gaze evoked

CORDONNIER M
CUB Hôpital Erasme, ULB, Brussels

PURPOSE To describe the adequate work-up and differential diagnosis in the presence of transient diplopia.

METHODS Anamnesis is most important to avoid unnecessary investigations. If patient's informations are sparse or doubtful, and if anamnestic clues are not consistent with a matter of urgency, homework questionnaire and a new appointment may be given to the patient.

RESULTS Transient or intermittent binocular diplopia occurs in decompensated phoria, myasthenia, convergence spasm, neuromyotonia, dysthyroïd ophthalmopathy, multiple sclerosis, transient ischemic attack and giant cell arteritis.MIGRAINE

CONCLUSION True urgencies to be worked up without delay consist in giant cell arteritis, vertebral artery dissection and myasthenia. Some delay in the work-up is acceptable when transient binocular diplopia comes from other causes.

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Persistent diplopia-workup for acute oculomotor palsies

BOSCHI A
Cliniques Universitaires St Luc, Brussels

PURPOSE To discuss the most appropriate work-up for acute oculomotor nerve palsies in children and adult patients.

METHODS Through the presentation of different clinical cases, the diagnostic approach for oculomotor palsies will be discuss.

RESULTS In children, the most common cause for the III and IV nerve is congenital followed by trauma. For the acquired VI nerve palsy the major diagnostic criteria are trauma, benign recurrent nerve palsy, elevated intracranial pressure, and pontine glioma. In adult, the VI nerve palsy is the most common ocular motor palsy. If the abducens nerve palsy is isolated in a vasculopathic pat > 50yo, usually it resolve within 3 mo. In this case neuroimaging is not required. A cranial MRI will be mandatory if no recovery is observed after 3mo.But VI nerve palsy in a patient less then 50yo require careful scrutinity, and should undergo cranial MRI.An isolated IV nerve palsy in a pat >50yo is typically caused by microvascular disease. In case of lack of recovery after 3 mo an MRI should be performed. The IV nerve is particularly vulnerable to head trauma, and bilateral IV nerve palsy should be always considered. Partial III nerve palsy is more common. A III nerve palsy with pupillary involvement or evidence of progression to papillary involvement must be assumed to be secondary to an aneurysm until proven otherwise. Anevrysms are uncommon before 20yo, but may be present already in the first decade of age. Pupil-sparing third nerve palsy is almost always benign and secondary to a microvascular disease, especially related to diabetes.

CONCLUSION Differential diagnosis and practical guidelines will be presented for each of the oculomotor nerve palsies.

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Oculentis M-plus: a new concept of multifocal intraocular lens technology: 6 months results

VRYGHEM JC
Brussels Eye Doctors / Clinique St-Jean, Brussels

PURPOSE Clinical evaluation of a new intraocular lens (IOL) with an innovative multifocal optic design and near addition of +3.0 D up to 6 months after surgery.

METHODS The Oculentis M-plus IOL was implanted in 50 eyes of 25 patients with a mean age of 67.1 ± 6.7 years. This IOL is a single piece, multifocal acrylic lens with a distinct near sector in the lower IOL segment. Six months after surgery, functional results, defocus curves as well as contrast sensitivity were evaluated.

RESULTS Mean implanted IOL sphere was 21.1 ± 1.4 D. Six months postoperatively, mean spherical equivalent was -0.22 ± 0.75 D resulting in a BCDVA of 0.09 ± 0.09 logMAR. The UCNVA was 0.22 ± 0.20 logMAR, DCNVA was 0.24 ± 0.20 logMAR and BCNVA was 0.1 ± 0.1 logMAR with 0.82 ± 0.77 D near addition in average. The defocus curve showed clearly two peaks at 0 and about -2.5 D which are explained by the two foci. Halo and glare effects were rarely reported

CONCLUSION This new innovative multifocal IOL concept showed very good and stable functional results as well as high patient satisfaction.

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Physiol FineVision, a new trifocal diffractive intraocular lens: early results

VRYGHEM JC, HEIREMAN S
Brussels Eye Doctors / Clinique St-Jean, Brussels

PURPOSE To evaluate the clinical results in cataract surgery when implanting a new diffractive intraocular lens (IOL) producing three useful focal points

METHODS A new trifocal diffractive pattern was designed by combining two superimposed diffractive profiles. Incident light could be focused toward three useful foci: distant, mid-range (intermediate), and near. The 1st order diffractive power of the 2nd diffractive profile (1.75D) was half as that of the 1st diffractive profile (3.50 D), providing the intermediate foci. The fraction of light lost in non-useful orders was reduced compared to bifocal designs. 20 eyes of 10 patients were included in the study. Functional results, defocus curves as well as contrast sensitivity were evaluated. Mean follow-up was 3 months.

RESULTS The mean monocular uncorrected visual acuity was 20/25 while the binocular UCVA was 20/20 . The monocular and binocular uncorrected acuity for near vision at 40 cm was 20/25 , At 30 cm the monocular (20/40) and the binocular (20/32) was worse than at 40 cm. In contrast the uncorrected intermediate visual acuity (60 cm) was 20/25 monocular and 20/20 binocular. The defocus curve showed clearly two peaks at 0 and about -2.5 D with at the intermediate focus a dramatic improvement compared to the defocus curve of other bifocal IOLs. Contrast sensitivity was within the normal range. Halo and glare effects were rarely reported.

CONCLUSION Implanting a trifocal diffractive IOL results in very good functional results as well as high patient satisfaction. The design of the FineVision adds intermediate vision with no significant decrease in near and far vision as compared by currently available bifocal IOLs.

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Mid-term results with the butterfly mini-incision intraocular lens

GOLENVAUX B, RACZKO A
Clinique Ste Anne St Rémi et Institut Médical Edith Cavell, Brussels

PURPOSE To evaluate a new mini-incision single-piece acrylic intraocular lens (IOL).

METHODS In this single-surgeon prospective clinical trial, eyes from consecutive eligible patients planned for cataract surgery were included. Preoperative axial length measurements were performed with laser interferometry (IOL Master, Carl Zeiss). IOL power and target ametropia were calculated with SRKT and Haigis formulae. Torsional phacoemulsification was performed in a standardized fashion with implantation of the Butterfly (97B) IOL (Morcher, GmbH) through either 2.2 or 1.8 mm clear corneal incisions. Measures included uncorrected (UCVA), best spectacle corrected visual acuities (BSCVA), and postoperative deviation from target ametropia. Satisfaction rate, occurrence of dysphotopsia, YAG laser capsulotomy rate and IOL-related complications were also recorded.

RESULTS 263 eyes were included in the study, with a mean follow of 13.7 months. The mean deviations from target ametropia were 0.33 (SD 0.3) and 0.45 diopters (SD 0.37) after IOL power calculation with SRKT and Haigis formulae respectively. The mean deviation from subjective refraction recorded one month and twelve months after the operation was +0.11 diopters. YAG laser capsulotomies were performed in 8 eyes (3%), and dysphotopsia was reported by 6 patients (3.6%). To date, there was no report of IOL-related complication.

CONCLUSION Mid-term results of this new mini-incision IOL suggest that this lens is safe, and achieve predictible and stable postoperative refraction. Posterior capsule opacification is low, but should be evaluated in the long term.

Notes

Future OB congresses

OB 2011	Brussels Expo	Nov 23 - 25, 2011
OB 2012	Brussels Expo	Nov 28 - 30, 2012
OB 2013	Brussels Expo	Nov 27 - 29, 2013

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References: Mundorf TK, Rauchman SH, Williams RD, et al. A patient preference comparison of AZARGA™ (brinzolamide/timolol fixed combination) vs. COSOPT® (dorzolamide/timolol fixed combination) in patients with open-angle glaucoma or ocular hypertension. Clin Ophtalmol. 2008:2;623-628.

juli 2010

Alcon®

AZARGA® Oogdruppels, suspensie / Collyre en suspension

Naam van het geneesmiddel: AZARGA 10 mg/ml + 5 mg/ml oogdruppels, suspensie. **Kwalitatieve en kwantitatieve samenstelling:** Eén ml suspensie bevat 10 mg brinzolamide en 5 mg timolol (als timololmaleaat). Lijst van hulpstoffen: benzalkoniumchloride, mannitol (E421), carbopol 974P, tyloxapol, dinatriumedetaat, natriumchloride, zoutzuur en/of natriumhydroxide (voor het instellen van de pH), gezuiverd water. **Farmaceutische vorm:** Oogdruppels, suspensie – Witte tot gebroken witte egale suspensie, pH 7.2 (bij benadering). **Therapeutische indicaties:** Verlaging van de intraoculaire druk (IOD) bij volwassenen met open-kamerhoekglaucoom of oculaire hypertensie waarbij monotherapie onvoldoende daling van de intraoculaire druk geeft. **Dosering en wijze van toediening:** Gebruik bij volwassenen, inclusief ouderen: De dosis is één druppel AZARGA in de conjunctivale zak van het (de) aangedane oog (ogen) tweemaal daags. Nasolacrimale occlusie of het zachtjes sluiten van het ooglid na indruppeling wordt aanbevolen. Dit kan de systemische absorptie van oculair toegediende geneesmiddelen en daarmee systemische bijwerkingen verminderen. Indien meer dan één topisch oftalmisch geneesmiddel wordt gebruikt, moeten deze geneesmiddelen met een tussenperiode van minimaal 5 minuten worden toegediend. Als een dosis wordt vergeten, dient de behandeling volgens schema voortgezet te worden met de volgende dosis. De dosis mag niet hoger zijn dan tweemaal daags één druppel in het (de) aangedane oog (ogen). Wanneer een ander oftalmisch antiglaucoommiddel wordt vervangen door AZARGA, moet het gebruik van het andere middel worden stopgezet en de volgende dag met AZARGA worden begonnen. Kinderen: AZARGA wordt niet aanbevolen voor gebruik bij kinderen jonger dan 18 jaar vanwege een gebrek aan gegevens over veiligheid en werkzaamheid. Gebruik bij lever- en nierfunctiestoornissen: Er is geen onderzoek verricht met AZARGA of timolol 5 mg/ml oogdruppels bij patiënten met lever-of nierfunctiestoornissen. Een dosisaanpassing is niet nodig bij patiënten met leverfunctiestoornissen of bij patiënten met lichte tot matige nierfunctiestoornissen. AZARGA is niet onderzocht bij patiënten met ernstige nierfunctiestoornissen (creatinineklaring < 30 ml/min) of bij patiënten met hyperchloremische acidose. Aangezien brinzolamide en zijn belangrijkste metabolieten voornamelijk via de nieren worden uitgescheiden, is AZARGA gecontraïndiceerd bij patiënten met ernstige nierfunctiestoornissen. Wijze van toediening: voor oculair gebruik. Instrueer patiënten het flesje vóór gebruik goed te schudden. Om besmetting van de druppelteller en de suspensie te voorkomen, moet er op gelet worden dat de druppelteller niet in contact komt met de oogleden, het omringende gedeelte of andere oppervlakken. Instrueer patiënten het flesje goed te sluiten wanneer het niet wordt gebruikt. **Contra-indicaties:** Overgevoeligheid voor de werkzame bestanddelen of voor één van de hulpstoffen. Astma bronchiale, een anamnese van astma bronchiale of ernstige chronische obstructieve longziekte. Sinus bradycardie, tweede-of derdegraads atrioventricullair blok, manifest hartfalen of cardiogene shock. Ernstige allergische rhinitis en bronchiale hyperreactiviteit; overgevoeligheid voor andere bèta-blokkers. Hyperchloremische acidose. Ernstige nierfunctiestoornissen. Overgevoeligheid voor sulfonamiden. **Bijwerkingen:** Samenvatting van het veiligheidsprofiel: In twee klinische studies van 6 respectievelijk 12 maanden, waarbij 394 patiënten werden behandeld met AZARGA, was de meest gerapporteerde bijwerking voorbijgaand wazig zicht na indruppeling (3,6%), variërend van een paar seconden tot een paar minuten. Samenvatting van de bijwerkingen: De volgende bijwerkingen zijn gerangschikt volgens de volgende conventie: zeer vaak (≥1/10), vaak (≥1/100 tot <1/10), soms (≥1/1.000 tot <1/100), zelden (≥1/10.000 tot <1/1000), of zeer zelden (<1/10.000). Binnen iedere frequentiegroep worden bijwerkingen gerangschikt naar afnemende ernst. Psychische stoornissen: Soms: insomnia. Zenuwstelsaandoeningen: Vaak dysgeusia. Oogaandoeningen: Vaak: wazig zicht, oogpijn, oogirritatie, corpus alienum gevoel in de ogen; Soms: corneale erosie, keratitis punctate, droog oog, oogafscheiding, pruritus aan het oog, oculaire hyperemie, blefaritis, allergische conjunctivitis, aandoening van de cornea, flare in de voorste oogkamer, conjunctivale hyperemie, korstvorming op de ooglidrand, astenopie, abnormaal gevoel in het oog, pruritis van de oogleden, allergische blefaritis, erytheem aan het ooglid. Bloedvataandoenigen: Soms: verlaagde bloeddruk. Ademhalingsstelsel-, borstkas- en mediastinumaandoeningen: Soms: chronisch obstructieve pulmonaire aandoening, faryngolaryngale pijn, rhinorrhoea, hoesten. Huid- en onderhuidaandoeningen: Soms: aandoening van het haar, lichen planus. Beschrijving van geselecteerde bijwerkingen: Dysgeusie (bittere of vreemde smaak in de mond na indruppeling) was een frequent gerapporteerde systemische bijwerking die in verband werd gebracht met het gebruik van AZARGA tijdens klinische studies. Het wordt waarschijnlijk veroorzaakt door de passage van de oogdruppels in de nasofarynx via het nasolacrimale kanaal en is toe te schrijven aan brinzolamide. Nasolacrimale occlusie of het zachtjes sluiten van het ooglid na indruppeling kan helpen om de incidentie van dit effect te beperken. AZARGA bevat brinzolamide, een sulfonamideremmer van koolzuuranhydrase, die systemisch wordt geabsorbeerd. Effecten op het maagdarmstelsel, op het zenuwstelsel en hematologische, renale en metabole effecten worden gewoonlijk in verband gebracht met systemische koolzuuranhydraseremmers. Gelijksoortige bijwerkingen als die worden toegeschreven aan orale koolzuuranhydraseremmers kunnen voorkomen bij topische toediening. AZARGA bevat brinzolamide en timolol (als timololmaleaat). Bijkomende bijwerkingen die in verband worden gebracht met het gebruik van de individuele bestanddelen die waargenomen zijn tijdens klinische studies en postmarketing ervaring en die mogelijk kunnen voorkomen met AZARGA: Infecties en parasitaire aandoeningen: Brinzolamide 10 mg/ml: nasofaryngitis, faryngitis, sinusitis, rinitis. Bloed- en lymfestelselaandoeningen: Brinzolamide 10 mg/ml: verminderde hoeveelheid rode bloedcellen, verhoogde hoeveelheid chloride in het bloed. Immuunsysteemaandoeningen: Brinzolamide 10 mg/ml overgevoeligheid. Voedings- en stofwisselingsstoornissen: Timolol 5 mg/ml: hypoglykemie. Psychische stoornissen: Brinzolamide 10 mg/ml: apathie, depressie, depressieve stemming, verminderd libido, nachtmerries, nervositeit - Timolol 5 mg/ml: Depressie. Zenuwstelselaandoeningen: Brinzolamide 10 mg/ml: slaperigheid, motorische disfunctie, amnesie, geheugenstoornis, duizeligheid, paresthesie, tremor, hoofdpijn, hypoesthesie, ageusie - Timolol 5 mg/ml: cerebrale ischemie, cerebrovasculair accident, syncope, myasthenia gravis, paresthesie, hoofdpijn, duizeligheid. Oogaandoeningen: Brinzolamide 10 mg/ml: keratitis, keratopathie, verhoogde cup/disc ratio van de oogzenuw, defect van het cornea-epitheel, aandoening van het cornea-epitheel, verhoogde intraoculaire druk, afzetting op het oog, verkleuring van de cornea, cornea-oedeem, conjunctivitis, meibomianitis, diplopie, glare, fotofobie, fotopsie, verminderde gezichtsscherpte, pterygium, oculair ongemak, keratoconjunctivitis sicca, hypoesthesie van het oog, sclerale pigmentatie, subconjunctivale cyste, toegenomen lacrimatie, visuele stoornissen, zwelling van het oog, oogallergie, madarosis, ooglidstoornis, ooglidoedeem - Timolol 5 mg/ml: conjunctivitis, diplopie, ooglidptosis, keratitis, visuele stoornis. Evenwichtsorgaan- en ooraandoeningen: Brinzolamide 10 mg/ml: tinnitus, vertigo. Hartaandoeningen: Brinzolamide 10 mg/ml: cardio-respiratoire uitputting, angina pectoris, bradycardie, onregelmatige hartslag, arrythmie, palpitaties, tachycardie, versnelde hartslag - Timolol 5 mg/ml: hartstilstand, hartfalen, arrythmie, atrioventricullair blok, bradycardie, palpitaties. Bloedvataandoeningen: Brinzolamide 10 mg/ml:verhoogde bloeddruk, hypertensie - Timolol 5 mg/ml: hypotensie. Ademhalingsstelsel-, borstkas-, en mediastinumaandoeningen: Brinzolamide 10 mg/ml: dyspneu, astma, bronchiale hyperactiviteit, epistaxis, irritatie van de keel, nasale congestie, congestie van de bovenste luchtwegen, postnasale drip, niezen, nasale droogte - Timolol 5 mg/ml: respiratoir falen, bronchospasme, dyspneu, nasale congestie. Maagdarmstelselaandoeningen: Brinzolamide 10 mg/ml: droge mond, oesofagitis, braken, diarree, misselijkheid, dyspepsie, pijn in de bovenbuik, abdominaal ongemak, maagklachten, frequente bewegingen van de darm, gastrointestinale aandoening, orale hypoesthesie, orale paresthesie, flatulentie - Timolol 5 mg/ml: diarree, nausea. Lever- en galaandoeningen: Brinzolamide 10 mg/ml; abnormale leverwaarden. Huid- en onderhuidaandoeningen Brinzolamide 10 mg/ml: urticaria, maculo-papulaire uitslag, uitslag, algemene pruritis, alopecia, strakke huid, dermatitis, erytheem - Timolol 5 mg/ml: alopecia, uitslag. Skeletspierstelsel-en bindweefselaandoeningen: Brinzolamide 10 mg/ml: rugpijn, spierkrampen, myalgie, arthralgie, pijn in de extremiteiten Nier- en urinewegaandoeningen**:** Brinzolamide 10 mg/ml: nierpijn, pollakiurie Voortplantingsstelstel en borstkasaandoeningen: Brinzolamide 10 mg/ml: erectiele dysfunctie. Algemene aandoeningen en toedieningsplaatsstoornissen: Brinzolamide 10 mg/ml: pijn, asthenie, ongemak ter hoogte van de borst, vermoeidheid, abnormaal gevoel, zenuwachtig gevoel, geïrriteerdheid, pijn op de borst, perifeer oedeem, malaise, medicatieresidu Timolol 5 mg/ml: asthenie, pijn op de borst. Letsels, intoxicaties en verrichtingscomplicaties: Brinzolamide 10 mg/ml: corpus-alienum in het oog. Kinderen: AZARGA wordt niet aanbevolen voor gebruik bij kinderen jonger dan 18 jaar vanwege een gebrek aan gegevens over veiligheid en werkzaamheid. **Publieksprijs inclusief BTW:** 51,38 €. **Registratiehouder:** Alcon Laboratories (UK) Ltd., Pentagon Park, Boundary Way, Hemel Hempstead, Herts, HP2 7UD, Verenigd Koninkrijk. **Fabrikant:** SA Alcon-Couvreur NV, Rijksweg 14, 2870 Puurs, België. **Registratienummer:** EU/1/08/482/002. **Aflevering:** Geneesmiddel op medisch voorschrift. **Datum van herziening van de tekst:** 21 december 2009.

AZARGA® Collyre en suspension

Dénomination du médicament: AZARGA 10 mg/ml + 5 mg/ml, collyre en suspension. **Composition qualitative et quantitative:** Un ml de suspension contient 10 mg de brinzolamide et 5 mg de timolol (sous forme de maléate de timolol). Liste des excipients: chlorure de benzalkonium, mannitol (E421), carbopol 974P, tyloxapol, édétate disodique, chlorure de sodium, acide chlorhydrique et/ou hydroxyde de sodium (ajustement du pH), eau purifiée. **Forme pharmaceutique:** Collyre en suspension – Suspension uniforme blanche à blanchâtre, pH 7,2 (environ). **Indications thérapeutiques:** Réduction de la pression intraoculaire (PIO) chez les patients adultes atteints de glaucome à angle ouvert ou d'hypertonie intraoculaire, pour lesquels la réduction de PIO sous monothérapie est insuffisante. **Posologie et mode d'administration:** Utilisation chez les adultes et les sujets âgés: La posologie est d'une goutte d'AZARGA dans le cul de sac conjonctival de l'œil ou des yeux atteint(s) deux fois par jour. Une occlusion nasolacrymale ou une fermeture douce des paupières après l'instillation est recommandée. Ceci peut réduire l'absorption systémique des médicaments administrés par voie oculaire et conduire à une diminution des effets indésirables systémiques. En cas d'utilisation de plusieurs médicaments administrés par voie oculaire, les instillations doivent être espacées d'au moins 5 minutes. Si une instillation est oubliée, le traitement doit être poursuivi avec l'instillation suivante comme prévu. La posologie ne doit pas excéder une goutte deux fois par jour dans l'œil (les yeux) atteint(s). En cas de remplacement d'un autre traitement antiglaucomateux ophtalmique par AZARGA, interrompre l'autre médicament et commencer AZARGA le jour suivant. Sujets pédiatriques: AZARGA n'est pas recommandé chez les enfants de moins de 18 ans en raison de l'absence de données de tolérance et d'efficacité. Utilisation chez les insuffisants hépatiques et rénaux: Aucune étude n'a été effectuée avec AZARGA ou avec timolol 5 mg/ml collyre chez les insuffisants hépatiques ou rénaux. Aucune adaptation posologique n'est nécessaire chez les insuffisants hépatiques ou chez les insuffisants rénaux légers à modérés. AZARGA n'a pas été étudié chez les patients présentant une insuffisance rénale sévère (clairance de la créatinine <30 ml/min) ou chez les patients présentant une acidose hyperchlorémique. Etant donné que le brinzolamide et son principal métabolite sont excrétés majoritairement par le rein, AZARGA est contre-indiqué chez les insuffisants rénaux sévères. Mode d'administration: voie oculaire. Demander aux patients de bien agiter le flacon avant usage. Pour éviter la contamination de l'embout compte-gouttes et de la solution, il faut faire attention de ne pas toucher les paupières, les surfaces voisines ou d'autres surfaces avec l'embout compte-gouttes du flacon. Indiquer aux patients de conserver le flacon bien fermé quand il n'est pas utilisé. **Contre-indications:** Hypersensibilité aux principes actifs ou à l'un des excipients. Asthme bronchique, antécédent d'asthme bronchique ou bronchopneumopathie chronique obstructive sévère. Bradycardie sinusale, bloc auriculo-ventriculaire du second ou du troisième degré, insuffisance cardiaque confirmée ou choc cardiogénique. Rhinite allergique sévère et hyperréactivité bronchique; hypersensibilité aux autres bêta-bloquants. Acidose hyperchlorémique. Insuffisance rénale sévère. Hypersensibilité aux sulfonamides. **Effets indésirables**: Résumé du profil de tolérance: Dans deux études cliniques de 6 et 12 mois ayant inclus 394 patients traités avec AZARGA, l'effet indésirable le plus fréquemment rapporté était une vision floue transitoire lors de l'instillation (3,6%) persistant de quelques secondes à quelques minutes. Résumé des effets indésirables: Les effets indésirables suivants ont été classés de la façon suivant : très fréquents (≥1/10), fréquents (≥1/100 à < 1/10), peu fréquents (≥1/1000 à <1/100), rares (≥1/10000 à <1/1000), ou très rares (<1/10000). Dans chaque groupe de fréquence, les effets indésirables sont présentés dans l'ordre décroissant de gravité. Affections psychiatrique : Peu fréquente insomnie, Affections du système nerveu : Fréquente: dysgueusi:. Affections oculaires: Fréquentes: vision floue, douleur oculaire, irritation oculaire, sensation de corps étranger dans les yeux ; Peu fréquents: érosion cornéenne, kératite ponctuée, œil sec, écoulement oculaire, prurit oculaire, hyperhémie oculaire, blépharite, conjonctivite allergique, affection de la cornée, inflammation de la chambre antérieure de l'œil, hyperhémie conjonctivale, formation de croûtes sur le bord de la paupière, asthénopie, sensation anormale dans l'œil, prurit des paupières, blépharite allergique, érythème de la paupière. Affections vasculaire : Peu fréquente: diminution de la pression artérielle, Affections respiratoires, thoraciques et médiastinale.: Peu fréquentes: bronchopneumopathie chronique obstructive, douleur pharyngolaryngée, rhinorrhée, toux. Affections de la peau et du tissu sous-cutan : Peu fréquentes: troubles de la pilosité, lichen pla,. Description de certains effets indésirables: Un effet indésirable systémique fréquemment rapporté au cours des études cliniques avec AZARGA a été la dysgueusie (goût amer ou inhabituel dans la bouche après instillation). Il est probablement dû au passage du collyre dans le nasopharynx par le canal nasolacrymal et il est imputable au brinzolamide. L'occlusion nasolacrymale ou la fermeture douce des paupières après l'instillation peut contribuer à réduire la fréquence de cet effet. AZARGA contient du brinzolamide qui est un sulfonamide inhibiteur de 1'anhydrase carbonique absorbé par voie systémique. Les effets gastro-intestinaux, affectant le système nerveux, hématologiques, rénaux et métaboliques sont généralement associés aux inhibiteurs de l'anhydrase carbonique systémiques. Les effets indésirables des inhibiteurs de l'anhydrase carbonique par voie orale peuvent être observés avec la voie locale. AZARGA contient du brinzolamide et du timolol (sous forme de maléate de timolol). D'autres effets indésirables liés à l'utilisation d'un des composants ont été observés au cours d'études cliniques et après la commercialisation. Ils peuvent éventuellement survenir avec AZARGA et incluent: Infections et infestation : Brinzolamide 10 mg/ml rhinopharyngite, pharyngite, sinusite, rhinite, Affections hématologiques et du système lymphatiqu : Brinzolamide 10 mg/m : diminution du nombre de globules rouges, augmentation du taux de chlorure dans le san,. Affections du système immunitair : Brinzolamide 10 mg/m : hypersensibilité. Troubles du métabolisme et de la nutritio : Timolol 5 mg/m : hypoglycémie. Affections psychiatrique : Brinzolamide 10 mg/m : apathie, dépression, troubles de l'humeur, diminution de la libido, cauchemars, nervosit, - Timolol 5 mg/m : dépressio,. Affections du système nerveu : Brinzolamide 10 mg/m : somnolence, troubles de l'appareil locomoteur, amnésie, troubles de la mémoire, vertiges, paresthésie, tremblements, maux de tête, hypoesthésie, agueusie, - Timolol 5 mg/m : ischémie cérébrale, accident cérébrovasculaire, syncope, myasthénie gravis, parésthésie, maux de tête, étourdissemen,. Affections oculaire : Brinzolamide 10 mg/m : kératite, kératopathie, augmentation du ratio cup/disc du nerf optique, anomalie de l'épithélium cornéen, affection de l'épithélium cornéen, augmentation de la pression intraoculaire, dépôt oculaire, coloration cornéenne, œdème cornéen, conjonctivite, meibomite, diplopie, éblouissements, photophobie, photopsie, baisse d'acuité visuelle, ptérygion, gêne oculaire, kératoconjonctivite sèche, hypœsthésie oculaire, pigmentation sclérale, kyste sous-conjonctival, larmoiement augmenté, trouble visuel, gonflement oculaire, allergie oculaire, madarose, troubles de la paupière, œdème de la paupièr, - Timolol 5 mg/m : conjonctivite, diplopie, ptosis de la paupière, kératite, trouble visue . Affections de l'oreille et du labyrinth : Brinzolamide 10 mg/m : tinnitus, vertige,. Affections cardiaque : Brinzolamide 10 mg/m : détresse respiratoire, angine de poitrine, bradycardie, rythme cardiaque irrégulier, arythmie, palpitations, tachycardie, accélération du rythme cardiaque - Timolol 5 mg/ml arrêt cardiaque, insuffisance cardiaque, arythmie, bloc auriculoventriculaire, bradycardie, palpitation,. Affections vasculaire : Brinzolamide 10 mg/m : augmentation de la pression artérielle, hypertensio, - Timolol 5 mg/m : hypotensio,. Affections respiratoires: thoraciques et médiastinales: Brinzolamide 10 mg/m : dyspnée, asthme, hyperactivité bronchique, épistaxis, irritation de la gorge, congestion nasale, congestion des voies respiratoires supérieures, sécrétions rétro-nasales, éternuements, sécheresse nasale - Timolol 5 mg/ml insuffisance respiratoire, bronchospasme, dyspnée, congestion nasale. Affections gastro-intestinale : Brinzolamide 10 mg/ml: bouche sèche, oesophagite, vomissement, diarrhée, nausée, dyspepsie, douleur abdominale haute, gêne abdominale, maux d'estomac, selles fréquentes, troubles gastro-intestinaux, hypoesthésie orale, paresthésie orale, flatulences , Timolot 5 mg/ml: diarrhée, nausé,. Affections hépato-biliaire : Brinzolamide 10 mg/m : bilan hépatique anorma,. Affections de la peau et du tissu sous-cutan : Brinzolamide 10 mg/m : urticaire, rash maculopapuleux, rash, prurit généralisé, alopécie, tiraillements cutanés, dermatite, érythème – Timolol 5 mg/ml: alopécie, éruption cutanée. Affections musculo-squelettiques et systémique : Brinzolamide 10 mg/m : maux de dos, spasmes musculaires, myalgie, arthralgie, douleur des extrémité,. Affections du rein et des voies urinaire : Brinzolamide 10 mg/ml: douleurs rénales, pollakiuri,. Affections des organes de reproduction et du sei : Brinzolamide 10 mg/m : dysfonction érectile. Troubles généraux et anomalies au site d'administratio : Brinzolamide 10 mg/m : douleurs, asthénie, gêne thoracique, fatigue, sensation de mal-être, sensation de nervosité, irritabilité, douleur thoracique, oedème périphérique, malaise, résidu médicamenteux, - Timolot 5 mg/m : asthénie, douleur thoracique. Lésions, intoxications et complications liées aux procédures: Brinzolamide 10 mg/ml: corps étranger dans l'œil, Population pédiatrique: AZARGA n'est pas recommandé chez les enfants de moins de 18 ans en raison de l'absence de données de tolérance et d'efficacité. **Prix public incl. TVA:** 51,38 €. **Titulaire d'enregistrement:** Alcon Laboratories (UK) Ltd., Pentagon Park, Boundary Way, Hemel Hempstead, Herts, HP2 7UD, Royaume-Uni. **Fabricant:** SA Alcon-Couvreur NV, Rijksweg 14, 2870 Puurs, Belgique. **Numéro d'enregistrement:** EU/1/08/482/002. **Délivrance:** Médicament soumis à prescription médicale. **Date de mise à jour du texte:** 51 dévembre 2089.Apr. 2010

First Author index

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If the author has submitted an abstract, the abstract number is marked red.
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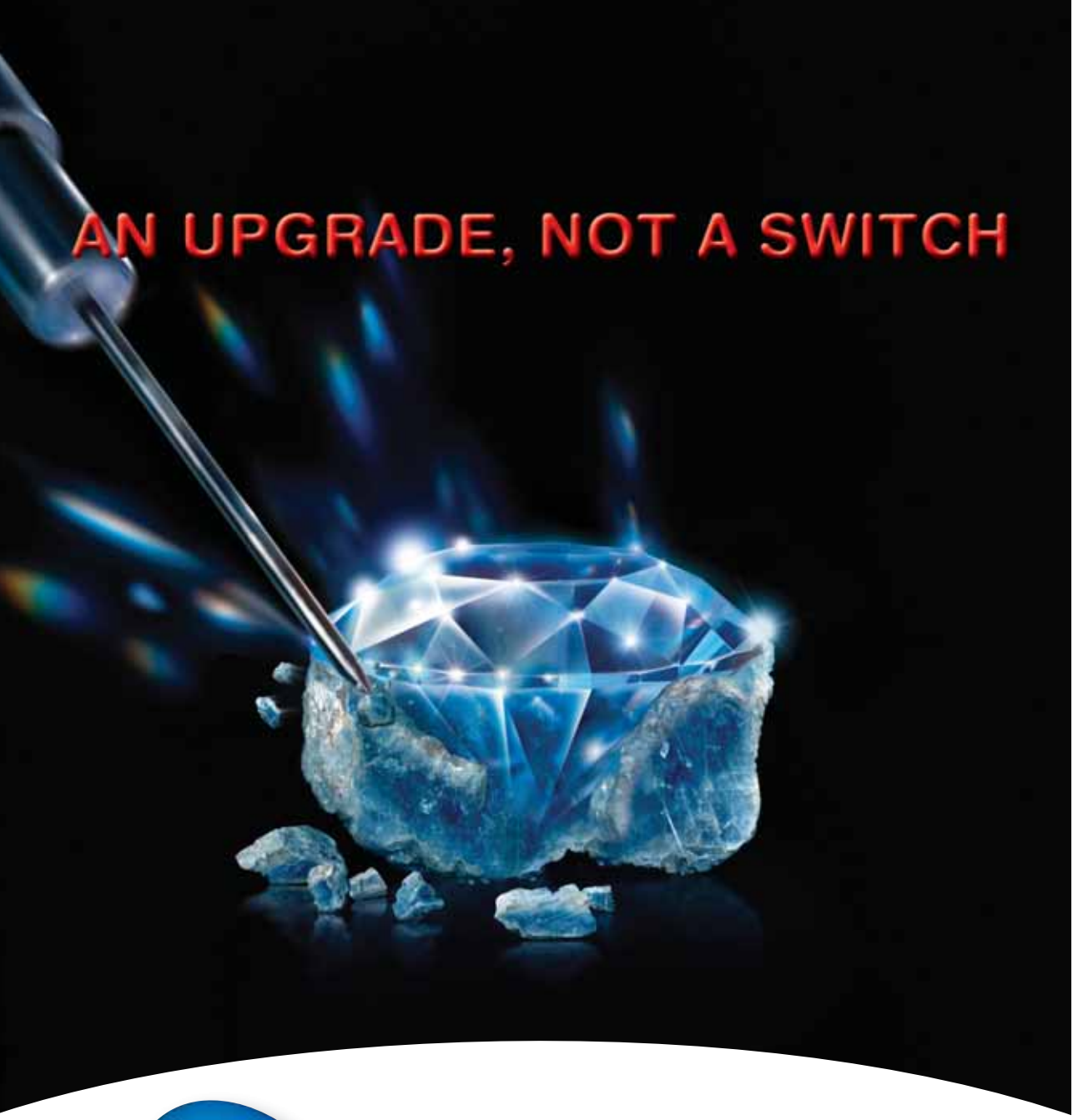

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