PROGRAMME BOOK

Brussels EXPO
November 23-25, 2011
www.ophthalmologia.be

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Annual Congress of the Belgian Ophthalmological Societies

Ophthalmologica Belgica

Brussels Expo

November 23 - 25, 2011

www.ophthalmologia.be

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Advertisements

Message from the president

Beste Collega,

Het jaarlijkse oftalmologisch congres Ophthalmologica Belgica is ondertussen uitgegroeid tot een vaste waarde op de agenda van iedere oogarts en oftalmologisch medewerker in België.

Opnieuw bouwt OB 2011 verder op deze traditie, met een fascinerende mix van hoogstaande wetenschap, onder vorm van leerrijke interactieve cursussen, vrije mededelingen en wetlabs, maar ook professionele en sociale interactie met de vertegenwoordigers van de industrie, en het vrolijke weerzien van bekenden en vrienden.

Alle deelorganisaties in de Belgische oftalmologie bieden opnieuw een fascinerend en specifiek programma, opgeluisterd door nationale en internationale sprekers, met een waaier van zeer diverse onderwerpen die zonder enige twijfel eenieder op één of andere wijze zullen weten te boeien.

Voor het eerst worden aanwezigheden electronisch geregistreerd met een scansysteem. Aanwezigheidsformulieren zullen nadien electronisch worden opgestuurd naar uw emailadres.

Het sociale luik omvat de "Ophthalmology Meets Industry" receptie op woensdagavond. Op donderdagavond is er de eerste editie van "Pearls in Ophthalmology", een aperitiefvoordracht in een relaxe sfeer met een glas Champagne. Daarna volgt het exquise congresdiner in het prestigieuze restaurant Belga Queen te Brussel.

Ik ben zeer verheugd en vereerd om u terug te zien op onze jaarlijkse afspraak op de Heizel!

Bart P LEROY
Voorzitter OB2011

Message from the president

Chère Consoeur, Cher Confrère,

Le congrès annuel d'ophtalmologie Ophthalmologica Belgica est désormais devenu un rendez-vous incontournable dans l'agenda de chaque ophtalmologue et professionel de l'ophtalmologie en Belgique.

A nouveau OB2011 contribue à confirmer cette tradition de qualité, avec un mélange fascinant d'apport scientifique remarkable, sous forme de cours interactifs enrichissants, de communications libres et de wetlabs, mais également de contacts professionnels et sociaux avec les représentants de l'industrie, ainsi que la rencontre de vos connaissances et amis.

Toutes les sociétés de l'ophthalmologie belge offrent cette année aussi un programme fascinant et spécifique grâce à des orateurs nationaux et internationaux, avec un large éventail de sujets qui captiveront sans nul doute tout le monde d'une façon ou d'une autre.

Vos présences seront enregistrées de façon électronique pour la première fois, avec un système scanner. Par après, les formulaires de présence vous seront ensuite envoyés à votre adresse courriel.

Le volet social comprend la réception "Ophthalmology Meets Industry" le mercredi soir. La première édition de "Pearls in Ophthalmology", un exposé-apéro informel, accompagné d'un verre de Champagne, aura lieu le jeudi soir. Ensuite, le diner officiel du congrès, exquis, aura lieu dans le restaurant prestigieux Belga Queen à Bruxelles.

Je me réjouis tout particulièrement d'avoir l'honneur de vous revoir lors de notre rendez-vous annuel au Heysel!

Bart P LEROY
Président d'OB2011

Nov 2011

Organizing committee

Bart Leroy
President

Antonella Boschi
Past / Vice-president

Werner Spileers
Treasurer

Philippe Kestelyn
Programme Secretary

Sabine Bonnet
ICC - ISC

Bernard Heintz
Wetlab

Joachim Van Calster
Audio-visual

Marlene Verlaeckt
Organization

Organizing societies

AOB	Academia Ophthalmologica Belgica
BBO-UPBMO	Belgische Beroepsvereniging van Oogheelkundigen Union Professionnelle Belge des Médecins Spécialistes en Ophtalmologie et Chirurgie Oculaire
BGS	Belgian Glaucoma Society
BIO	Belgian Immuno Ophthalmology Club
BOG	Belgisch Oftalmologisch Gezelschap
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

Scientific committee

Programme secretary	**Philippe Kestelyn**
AOB	Patrick De Potter - Werner Spileers
BBO-UPBMO	Peter Van Bladel - Philippe Huyghe
BGS	Adèle Ehongo - Roberte Herzeel
BIO	Philippe Kestelyn
BOG	Joachim Van Calster - Bart Leroy
BOV-ABO	Hilde Janssens - Alain Bauwens
BSA	Lieve Van Eeckhoutte
BSCRS	Guy Sallet - René Trau
BSONT	Caroline Timmerman
BSOPRS	Veva De Groot - Paul Jonckheere
BVVB-OBPC	Philippe Kestelyn - Marie-José Tassignon
FAB	Anne Dewachter
NOC	Werner Spileers - Ingele Casteels
OBAO	Luc Van Os - Julie Barbry
PED & LOW	Ann Debackere - Ingele Casteels
SBO	Sabine Bonnet - Bernadette Snyers
Free papers / Posters	Antonella Boschi
Wetlabs	Bernard Heintz
Courses	Sabine Bonnet

General information

OB Office
AOB vzw - asbl
OB 2011: Werkgroep - Groupe de travail
Kapucijnenvoer 33, 3000 Leuven
OB2011@ophthalmologia.be
BE 0862.155.596

Venue and dates
The congress will take place from
Wednesday 23 to Friday 25, November 2011
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. The final programme will be sent to the preregistered participants in order of payments before November 15, 2011. 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.

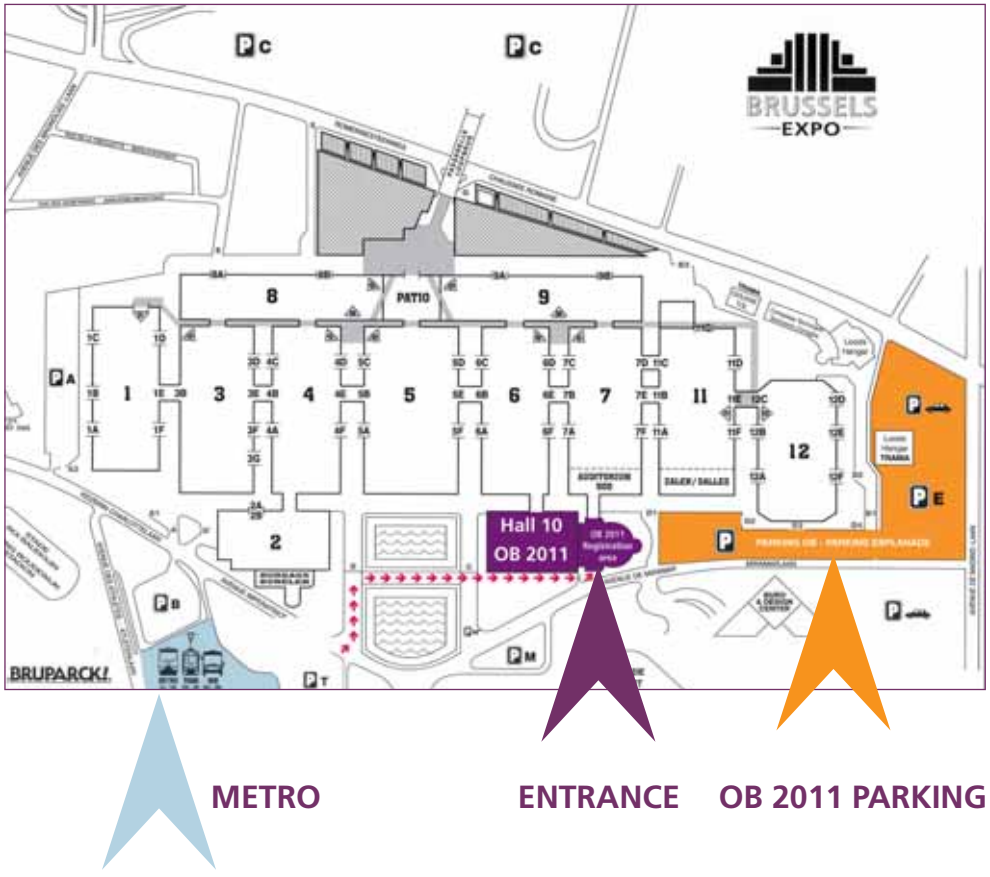
Accreditation
New! Badge scanning
More details on page 17.

The OB 2011 congress has been awarded 15 CP. Wednesday am, 3 CP, Thursday 6 CP and Friday 6 CP.
The session Ethics and Economics on Wednesday pm has been awarded 3 CP.
All accreditation certificates will be available online from November 26 on.

Cancellation and refunds
Refunds up to 75% of the advance registration fee will be granted for cancellation received in writing prior to November 10, 2011. Refund will not be granted for later cancellations or no-shows.

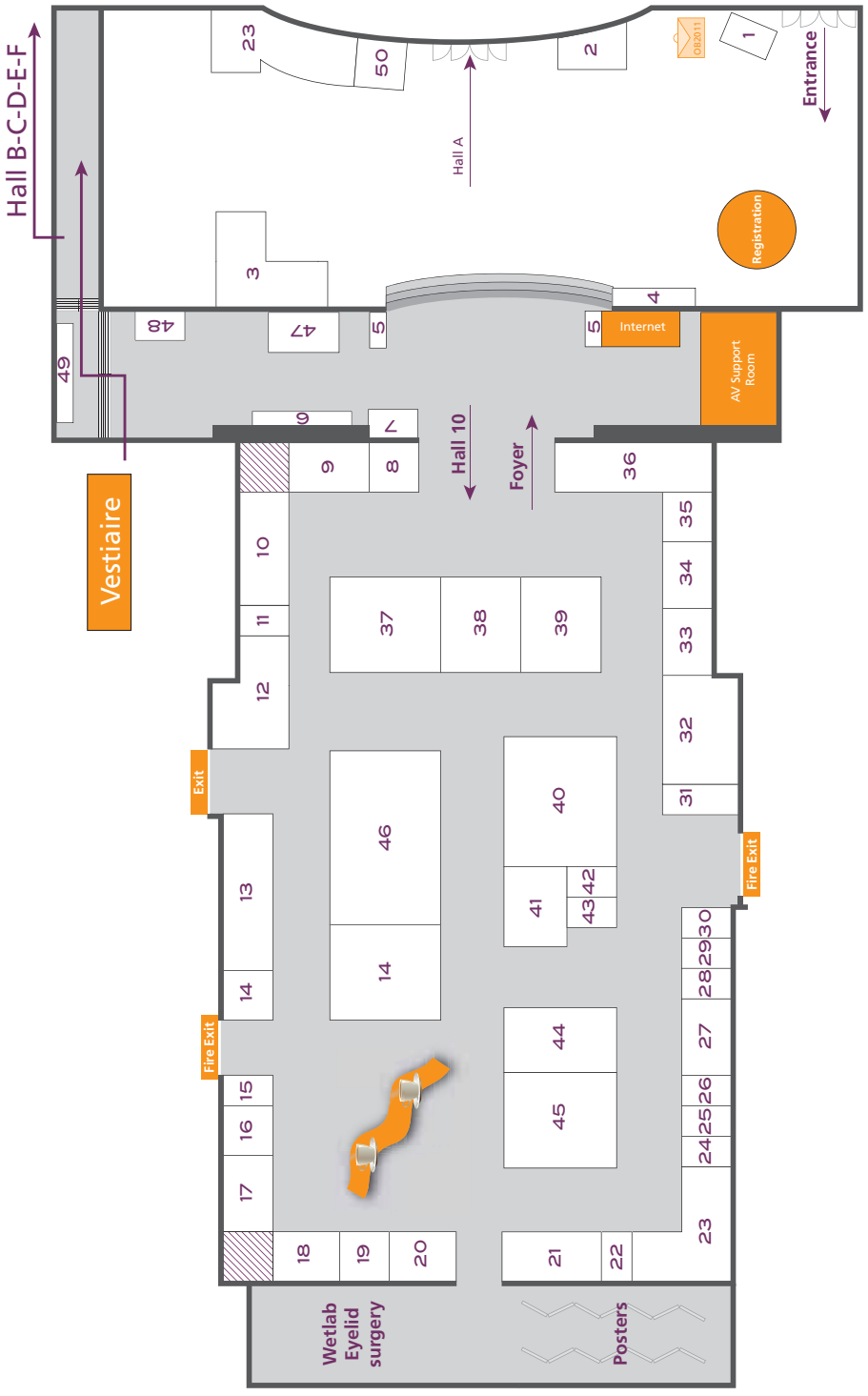
Convention Center

Brussels EXPO, Hall 10
Place de Belgique - Belgiëplein - 1020 Brussels



Brussels Expo, located in the heart of Europe, has the major advantage of being centrally located. The site is easily reached by car, train or airplane.
For more info: www.bruexpo.be

Exhibition


Hall B-C-D-E-F
Hall A
Entrance
Registration
Internet
AV Support Room
Vestiaire
Hall 10
Foyer
Exit
Fire Exit
Fire Exit
Wetlab Eyelid surgery
Posters

Exhibitors

By company

46 ALCON
44 ALLERGAN
37 BAUSCH + LOMB
22 BERENBRINKER
49 BRAILLIGA
23 CARL ZEISS
12 CORILUS
7 DE CEUNYNCK & Co
40 DE CEUNYNCK Medical
41 DORC
18 ERGRA-ENGELEN
20 ESSILOR
5 FABRILENS & SONKES
36 HOSPITHERA / LENSITA
2 HOYA LENS BELGIUM
19 KRYS
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24 LENS OPTICAL TECHNOLOGY
21 MEDA Pharma
11 MEDIBRUGGE
34 MEDICAL WORKSHOP
29 MEDICARE-HTM
11 MENICON
27 MERCK SHARP & DOHME
28 METROVISION
35 MMI Informatique Médicale
16 MORIA
26 NOOTENS
46 NOVARTIS Pharma
6 OBOS
30 OPHTALMO SERVICE
17 OPHTEC
43 OPS Eyewear
47 OPTOS
32 PFIZER
13 PHYSIOL
9 PRO-VISION INSTRUMENTS
42 REVOGAN
38 ROCKMED
48 RODENSTOCK BENELUX
45 SIMOVISION
9 SONICO
4 STORY - SCIENTIA
25 SYNGA MEDICAL
3 TECHNOP
39 THEA Pharma
1 TRB CHEMEDICA
31 TRUSETAL VERBANDSTOFFWERK
10 URSAPHARM Benelux
8 VAASSEN
14 VAN HOPPLYNUS Ophtalm
33 VISIONTech

By booth number

1 TRB CHEMEDICA
2 HOYA LENS BELGIUM
3 TECHNOP
4 STORY - SCIENTIA
5 FABRILENS & SONKES
6 OBOS
7 DE CEUNYNCK & Co
8 VAASSEN
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49 BRAILLIGA
50 LEICA MICROSISTEMAS

Guidelines for speakers

Language

All audiovisual material should be presented in English (slides, movies, ...). For oral presentations either one of the three national languages (French, Dutch and German) or English are acceptable.
However, the Organising Committee of OB 2011 strongly recommends English for oral presentations in order to maximize the international appeal of the meeting.

Technical instructions

Speakers are kindly requested to strictly respect the allocated time to guarantee smooth running of the sessions.

- A single computerized system will be used to manage all slide projections. All presentations will be sent to the assigned Meeting Room from the central server at the Slide Room, by the staff. This procedure ensures efficient management and higher quality of projection. The use of personal laptops for presentations is actively discouraged.

- Speakers are invited to prepare their presentations in Microsoft PowerPoint either 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 start of the session.

- Presentations loaded on a personal laptop must be downloaded and copied at the Slide Room at least two hours before the beginning of the session.

- Should this be the case, please inform the Meeting Administrator's Desk about any particular requests well in advance.

Some suggestions to make a PowerPoint presentation:

- Write the title of the presentation and the speaker's name on 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 embedded in the file name + the date in order to avoid that all presentations are called OB 2011 or Brussels 2011.

- 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. Alternatively, use the option "Pack and go" or "Package to CD/DVD/USB" in the PowerPoint software.

- It is recommended that embedded movies start automatically after slide transmission rather than by mouse click.

- We suggest putting a maximum of one movie per slide.

- Reduce the size of your presentation by choosing the option "Reduce File Size..." and then "Best for viewing on screen" under the "File" dropdown menu in PowerPoint. Images with either .png or .jpg extensions are recommended in order to obtain a smaller size presentation (other kinds of extensions - recognizable by PowerPoint – are also acceptable).

Guidelines for speakers

Procedure: All presenters must read the following instructions

Slide Room opening hours

- The Slide Room is open on November 22 between 17:00 - 20:00 and during the congress between 7:30 - 17:30.

- The OB 2011 Organising Committee ensures that all presentations are erased from computers used by the audiovisual team. In addition, no one other than the presenter will be allowed to copy PowerPoint files from the AV system.

Session Moderators

Session moderators should ensure that speakers remain within the allocated time for their presentation, and that the session finishes within the allocated timeframe. It is actively discouraged to switch the order of talks, as meeting participants may have planned their itinerary in advance, and may move between Meeting Rooms during the Sessions to attend specific talks.

Guidelines for posters

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 22 November 2011, from 16:00 hrs onwards through 19:00 hrs, or at the latest on Wednesday morning 23 November 2011 from 7:30 hrs and before 8:30 hrs.
- Poster boards are located in the poster area in Hall 10 in 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 Book, page 30 - 31.
- Posters must remain on display until Friday, November 25, 15:30. Posters not removed by Friday, November 25, 19:00 hrs 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 in poster area, sandwiches will be served. During this time the jury will be circulating for the poster award.
- All posters are eligible for a Poster Award.
  - Best case: 300 EUR
  - AOB best resident's poster prize: 500 EUR Travel grant EVER 2012 congress.
- An independent panel appointed by the Board of OB 2011 decides on the Poster Awards through voting. Their decision is final.

The poster awards ceremony will be held on Friday 25 November 2011 at 12:30 to 13:30 in Hall A. In order to receive the prize the presence of poster presenters who are awarded a poster prize is mandatory.

Badge scanning

Beste collega's,

Om het voor iedereen van ons wat gemakkelijker te maken en ellenlange wachtrijen voor het ophalen van uw aanwezigheidspapieren aan de accrediteringsdesk te vermijden, wordt voor het registreren van de aanwezigheden vanaf OB 2011 het principe van badge scanning ingevoerd. Hierbij wordt de streepjescode op de naambadge gescand bij binnen- en buitenkomen. Het accrediteringspapier op naam zal nadien electronisch ter beschikking zijn op uw persoonlijk webpagina van uw account op de Academia Ophthalmologica Belgica website. Aanschuiven is dus verleden tijd. Voor de sessie ethiek en economie zal de badge scanning gebeuren bij het binnenkomen van de zaal. Op woensdag zijn zo een halve dag Ethiek en een halve dag congres beschikbaar. Een halve of volledige dag congres zijn ter beschikking op donderdag en vrijdag.

Met vriendelijke groet,
Joachim Van Calster, Verantwoordelijke Audio-Visueel OB 2011

Chers Collègues,

Pour simplifier les choses pour chacun de nous et pour éviter les interminables files d'attente lors de la prise des attestations de présence au guichet d'accréditation, le principe de scannage par badge est introduit pour enregistrer les présences, et ce dès OB 2011. Le code-barre est scanné sur le badge nominatif à l'entrée et à la sortie. Le document d'accréditation nominatif sera désormais disponible sur votre page personnelle Web sur l'account de l'Academia Ophthalmologica Belgica Website. Faire la file appartient au temps passé. Pour la session Ethique et Economie, le badge sera scanné à l'entrée dans la salle. Le mercredi une demi-journée Ethique et une demi-journée de Congrès sont ainsi à disposition. Un demi-jour ou une journée complète de Congrès sont à disposition le jeudi et le vendredi.

Amicalement,
Joachim Van Calster, Responsable Audio-Visuel OB 2011

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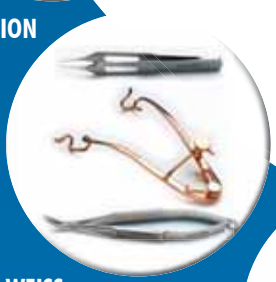

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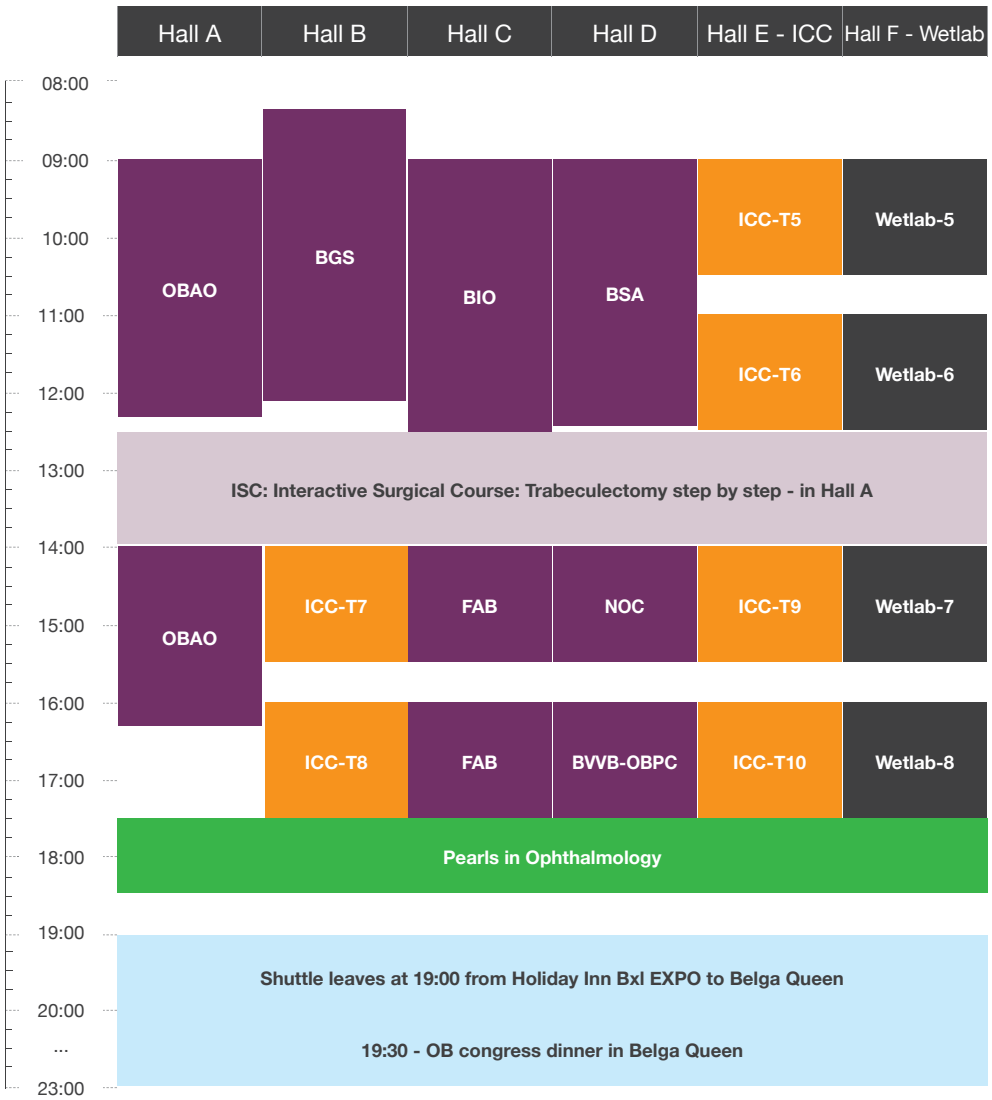
info@lensita.com | WWW.LENSITA.COM

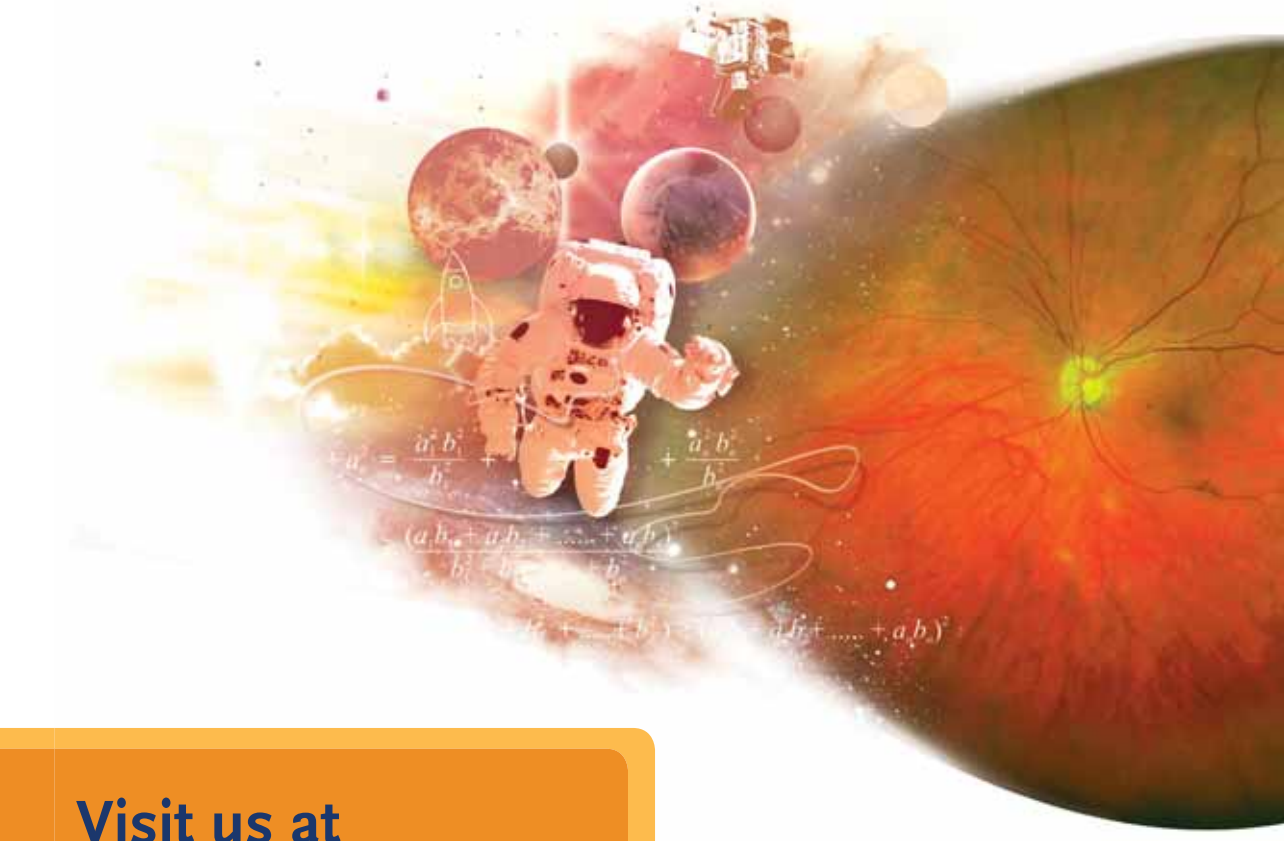
WEDNESDAY, 23 NOVEMBER 2011

THURSDAY, 24 NOVEMBER 2011



FRIDAY, 25 NOVEMBER 2011

Some of the greatest discoveries are farther than the eye can see.



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Wednesday
November 23, 2011

Wednesday
09:00 - 12:10
Hall A

BSOPRS

Moderators:

Veva DE GROOT
Peerooz SAEED

BELGIAN SOCIETY OF OCULOPLASTIC AND RECONSTRUCTIVE SURGERY

A practical view on Graves Orbitopathy

09:00 Introduction. What a general ophthalmologist may not miss

09:10 Systematic clinical evaluation
101 *VANDELANOTTE S - Bruges - Leuven*

09:30 Medical treatment options
102 *SAEED P - Amsterdam*

09:50 Orbital decompression - The swinging eyelid technique
103 *DE GROOT V - Antwerp*

10:00 Orbital decompression - Occasionally coronal decompression?
104 *XHAUFLAIRE G - Liège*

10:10 Upper eyelid retraction - Graded full-thickness anterior blepharotomy
105 *MOMBAERTS I - Leuven*

10:20 Upper eyelid retraction - Z-myotomy of the levator muscle, or Müllerectomy
106 *LEMAGNE JM - Brussels*

10:30 Pause

Wednesday
09:00 - 12:10
Hall A

Interesting oculoplastic cases

Moderators:

Paul JONCKHEERE
Veva DE GROOT

11:00 Three uncommon congenital orbital tumors
107 *JONCKHEERE P, BABUSIAUX B - Deurne*

11:15 Surgical options to treat ocular manifestations of facial nerve palsy
108 *DE WILDE F - St. Martens Latem*

11:30 In office correction of punctal ectropium with the Raus clamp
109 *RAUS P - Mol*

11:40 Nobel prize 1905
110 *LASUDRY J - Brussels*

11:50 Giant fornix syndrome
111 *DECOCK C - Ghent*

12:00 Surgical treatment of blepharospasm
112 *FINCK S - Stembert*

12:10 End of session

BELGIAN SOCIETY OF OCULOPLASTIC AND RECONSTRUCTIVE SURGERY

Wednesday
09:00 - 12:30
Hall B

BOG

Moderators:

Philippe KESTELYN
Ingeborg STALMANS
Joachim VAN CALSTER

Drugs and the eye: Facts and Future

09:00 Medication delivery systems for the eye: an overview
113 *ZEYEN T - Leuven*

09:15 Enzymatic vitreolysis with microplasmin
114 *STALMANS P - Leuven*

09:30 Off-label use: Avastin versus Lucentis
115 *DE ZAEYTIJD J - Gent*

09:45 The future in treatment of diabetic retinopathy and retinal vein occlusion
116 *VAN CALSTER J - Leuven*

10:00 The future in AMD treatment
117 *LEYS A - Leuven*

10:15 Discussion
10:30 Break

11:00 Off-label use in uveitis treatment: what's available?
118 *DE SCHRYVER I - Gent*

11:15 The future in uveitis treatment
119 *ZIERHUT M - Tübingen*

11:30 Off-label use in glaucoma treatment
120 *STALMANS I - Leuven*

11:45 The future in glaucoma treatment
121 *HONDEGHEM K - Antwerpen*

12:00 Off-label use of medication: will we be successful or in jail?
122 *CALLENS S - Antwerpen*

12:20 Discussion
12:30 End of session

BELGISCH OFTALMOLOGISCH GEZELSCHAP

SBO

Wednesday
09:00 - 12:30
Hall C

Controverses à propos des traitements cornéens

Moderator:

Bernard DUCHESNE

09:00 Les greffes endothélio-descemetiques
123 *SCHROOYEN M - Brussels*

09:30 Les anneaux intra-cornéens
124 *CHAVES A - Waterloo*

10:00 Le cross-linking
125 *HICK S - Liège*

10:30 Break

11:00 Les cellules souches en surface oculaire, controverses
126 *HUA M - Liège*

11:30 Est-ce aberrant de traiter des aberrations ?
127 *DUCHESNE B - Liège*

12:00 Utiliser un nouvel antibiotique, une hérésie ?
128 *GIOT JB*

12:30 End of session

SOCIÉTÉ BELGE D'OPHTALMOLOG

Poster session
Wednesday
12:30 - 14:00
O'Bistro

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 overview on page 30-31. Poster abstracts on pages 83 - 87.

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

Wednesday
12:30 - 14:00
O'Bistro

Poster session

Moderator:

Antonella BOSCHI

133 A diagnostic challenge: Chronic myelomonocytic leukaemia and recurrent ischaemic optic neuropathy
DE SMIT E, O'SULLIVAN E - London

134 Acute choroidal ischemia as a result of pre-eclampsia associated with PRES and HELLP syndromes: a clinical case.
DELAHAUT A, VERTES D, BOSCHI A - Brussels

135 Additional diagnostic clue in Multiple Evanescent White Dot Syndrome : Fundus autofluorescence
GERARD P, CORDONNIER M, RASQUIN F - Bruxelles

136 Atypical inflammatory myofibroblastic pseudotumor of the etmoidal sinus extending into the orbit
LAUWERS N, DE GROOT V, LEYSEN I, CLAES J, DE KEIZER R - Edegem

137 Correction of the lower eyelid malpositioning in the blepharophimosis, ptosis and epicanthus inversus syndrome (BPES).
DECOCK CE, CLAERHOUT I, KESTELYN PH, LEROY BP, DEBAERE E - Ghent

138 Frequency of metastatic disease and survival of 716 consecutive patients with uveal melanoma: a retrospective monocentric reviewmelanoma
DE POTTER P, HAMMOUCH F, FRANCART D, BAURAIN JF - Bruxelles

139 Insights into Levator muscle dysfunction in a cohort of molecularly confirmed BPES patients using high-resolution imaging, anatomical examination and histopathology
DECOCK CE, KESTELYN P, LEROY BP, CLAERHOUT I, DEBAERE E - Ghent

140 Levator muscle function is increased by supra-maximal resection in BPES patients
DECOCK CE, KESTELYN P, DEBAERE E, LEROY BP, CLAERHOUT I - Ghent

141 Mechanism of lens subluxation in Goltz syndrome
KASMI I, DELBEKE P - Ghent

142 Not all choroidal tumors are melanomas or metastases, and rare cases are challenging for treatment
VAN GINDERDEUREN R, MISSOTTEN G, VAN DEN OORD J - Leuven

Poster session

Wednesday
12:30 - 14:00
O'Bistro

Moderator:

Antonella BOSCHI

143 Orbital lymphangioma treated with intralesional injection of sodium morrhuate

DE GROOT V., DE KEYZER RJW, JONCKHEER P, GODTS D, TASSIGNON MJ - Antwerp

144 Original diagnosis of Central Cloudy Dystrophy of François revisited as corneal opacities in a F216Y/L444P variant of Gaucher disease

GEENS S, CLAERHOUT I - Ghent

145 Phenotype of RDH12-related Early-Onset Retinal Dystrophy

DE ZAEYTIJD J, VISSER L, COPPIETERS F, MUNIER FL, WALRAEDT S, CASTEELS I, DE RAVEL T, COLLIN R, DE BAERE E, HAMEL C, VAN DEN BORN LI, LEROY BP - Ghent, Rotterdam, Ghent, Lausanne, Ghent, Leuven, Leuven, Nijmegen, Ghent, Montpellier, Rotterdam, Ghent

146 Preserved Visual Acuity in Diabetic Macular Ischaemia

PLATTEAU E, PETO T, EGAN C, DOWLER J - London

147 Prevalence of glaucoma in patients with Graves' orbitopathy

FRANCART D, POURJAVAN S, BOSCHI A - Brussels

148 Subconjunctival epidermoid cysts in Gorlin-Goltz syndrome

DE CRAENE S, BATTEAUW A, HASPESLAGH M, DECOCK C - Ghent

149 Sudden bilateral visual loss related to a Cancer-Associated Retinopathy (CAR): An atypical presentation

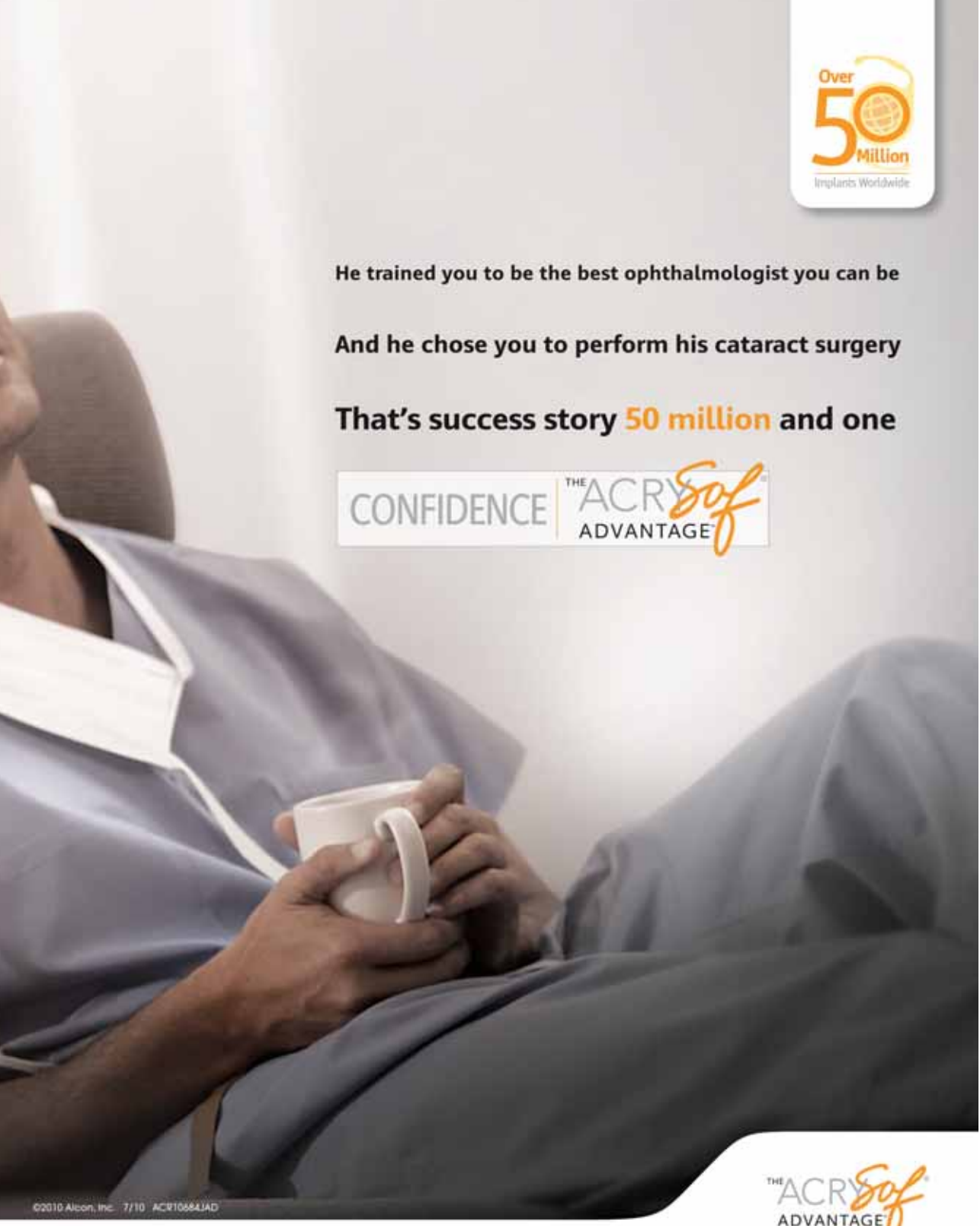
NOEL A, BOSCHI A, DE POTTER P - Bruxelles

150 The continuing quest to perform accurate IOL calculations in cataract surgery

DEBROUWERE V, BLANCKAERT J, MULLIEZ E - Leuven, Ieper

151 Torticollis, photophobia and epiphora secondary to fossa posterior tumour: a case report

DAUWE C, VERLOOY J, DELBEKE P - Ghent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BBO-UPBMO

Wednesday
14:00 - 17:30
Hall A

De oogheelkunde in een veranderende wereld
L'ophtalmologie dans un monde changeant

Moderators:

Edgard MAES
Ludo GEERTS

14:00 Het nieuwe " No Fault" systeem
129 VANSWEEVELT T - Antwerpen

14:45 De nieuwe normen voor de visuele functies van chauffeurs
130 TANT M - Brussel

15:30 Break

16:00 L'optométrie: une menace ou une aide bienvenue?
131 FRANSMAN I - Wemmel

16:45 L'organisation des soins oculaires dans les différents pays européens. L'optometrie: une menace ou une aide bienvenue?
132 AFLALO G - Saint Raphaël

17:30 End of session

BELGISCHE BEROEPSVERENIGING VAN OOGHEELKUNDIGEN
UNION PROFESSIONNELLE BELGE DES MÉDECINS SPÉCIALISTES EN OPHTALMOLOGIE ET CHIRURGIE OCULAIRE

Faculty meets Industry
Wednesday
17:30 - 20:00

in exhibition area

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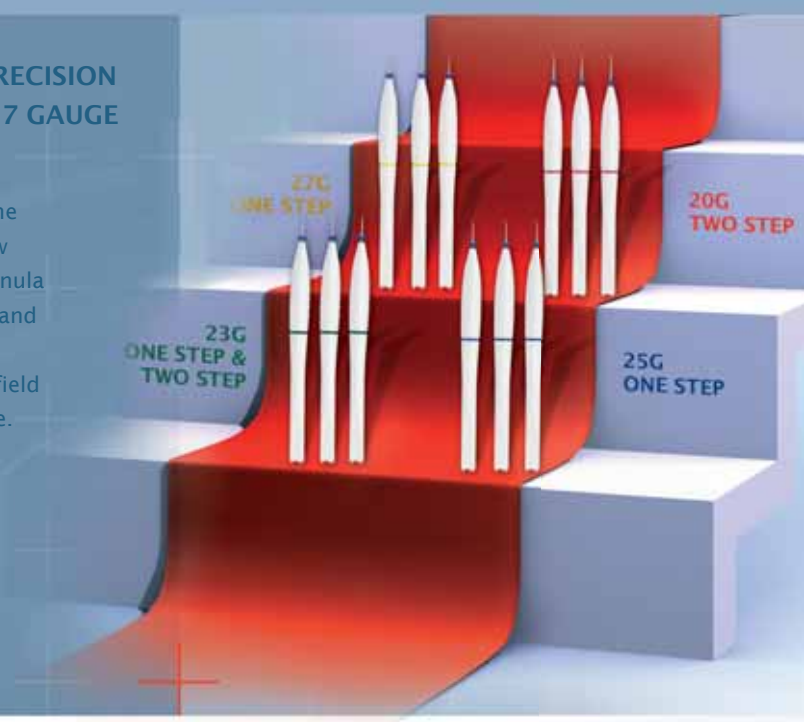

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Thursday
November 24, 2011

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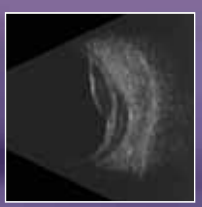

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OBAO

Thursday
09:00 - 16:20
Hall A

Cataract, let's make it clear

Moderator:

Luc VAN OS

09:00 Congenitaal Cataract
201 *CASTEELS I, FOETS B - Leuven*

09:30 Cataract and systemic disease, lensluxation, ectopia lentis
202 *HUA M - Liège*

09:50 5 tips for a happy phako patient: avoid complications and optimize your results
203 *TERMOTE H - Ottignies*

10:10 Optics of the IOL/ pick the right lens for right eye
204 *TASSIGNON MJ - Antwerpen*

10:45 Break

11:15 Cataract surgery in endothelial dystrophy
205 *CHEEMA D - Montreal*

11:45 Biocompatibility of IOL's: How will the IOL behave in the eye?
206 *WERNER L - Salt Lake City*

12:20 Break

14:00 Tips & tricks in Phaco surgery : techniques and machines
239 *BLANCKAERT J - Ieper*

14:20 Combined surgery: anterior & posterior segment
240 *VAN CAUWENBERGE F, RAKIC JM - Liège*

14:40 Break

15:10 Zonular dehiscence during cataract surgery: how to manage it?
241 *CHEEMA D - Montreal*

15:40 Clinical Cases: common complications and how to solve them
242 *FIGUEIREDO C - Sao Paulo*

16:20 End of session

ORGANISATIE VAN BELGISCHE ASSISTENTEN IN OFTALMOLOGIE
ORGANISATION BELGE DES ASSISTANTS EN OPHTALMOLOGIE

Thursday
08:25 - 12:05
Hall B

BGS

Moderators:

Michèle DETRY
Marc GOETHALS

BELGIAN GLAUCOMA SOCIETY

Visual field / Free papers

08:25 Welcome

08:30 Correlation of the rate of progression of visual field loss between Guided Progression Analysis (GPA II) and PeriDataTM program in glaucoma patients: Pilot study

207 *PEETERS H, DETRY- MOREL M, POURJAVAN S - Brussels*

08:40 Differential effects of various VEGF isoforms on endothelial cells and Tenon fibroblasts

208 *VAN BERGEN T, VANDEWALLE E, VAN DE VEIRE S, MOONS L, STALMANS I - Leuven*

08:50 The effect of a single, preoperative, intracameral administration of bevacizumab (Avastin®) on trabeculectomy outcome: A prospective, randomized, double-blinded, placebo-controlled trial

209 *VANDEWALLE E, ZEYEN T, VAN BERGEN T, SPIELBERG L, STALMANS I - Leuven, Rotterdam*

09:00 FRO: Identity-by-descent mapping reveals a new locus for primary congenital glaucoma, GLC3E, on chromosome 19p13.2.

210 *VERDIN H, D'HAENE B, COPPIETERS F, LEFEVER S, KESTELYN P, LEROY B, DE BAERE E - Ghent*

09:10 FRO: Microplasmin as an antiscarring agent for glaucoma surgery: Translation into clinical application

211 *VANDEWALLE E, VAN BERGEN T, MOONS L, STALMANS I - Leuven*

09:20 FRO: Role of placental growth factor (PIGF) in wound healing after glaucoma filtration surgery

212 *VAN BERGEN T, MOONS L, STASSEN JM, STALMANS I - Leuven*

09:30 Topical application of AMA0076, a locally acting rho kinase (ROCK) inhibitor, results in a robust IOP control in a hypertensive rabbit model

213 *VAN DE VELDE S, MOONS L, STALMANS I - Leuven*

BGS

Thursday
08:25 - 12:05
Hall B

Moderators:

Michèle DETRY
Marc GOETHALS

09:40	Pfizer Research Award 2011	
09:50	Basic principles of automated perimetry	
214	*KESTELYN P - Gent*	
10:00	Tips for the perimetrist	
215	*VAN MALDEREN L - Leuven*	
10:10	Interpretation of the results	
216	*COLLIGNON N - Liège*	
10:30	Break	
11:00	Pitfalls	
217	*HOSTE A - Antwerpen*	
11:10	Detecting progression	
218	*ZEYEN T - Leuven*	
11:20	Linking function to structure	
219	*STALMANS I - Leuven*	
11:30	Driver licence: how to apply the new rules	
220	*STEVENS AM - Gent*	
11:40	Challenging clinical cases	
12:05	End of session	

BELGIAN GLAUCOMA SOCIETY

Thursday
09:00 - 12:30
Hall C

BIO

Moderator:

Philippe KESTELYN

BELGIAN IMMUNO OPHTHALMOLOGY CLUB

SUN classification of uveitis
Case reports / Free papers

08:40 FRO: Development of a next-generation sequencing platform for retinal dystrophies, with LCA and RP as proof of concept
221 *COPPIETERS F - Ghent*

08:50 Colour Vision in Stargardt Disease
222 *VANDENBROUCKE T, BUYL R, DE ZAEYTIJD J, UVIJLS A, DE BAERE E, LEROY BP - Ghent, Brussels*

09:00 New classification of uveitis
223 *KESTELYN P - Gent*

09:30 **Case reports**

10:30 Break

11:00 Retinal drug toxicity: state of the art in monitoring - part 1
224 *SPILEERS W - Leuven*

11:20 Retinal drug toxicity: state of the art in monitoring - part 2
225 *DE ZAEYTIJD J - Gent*

11:40 Retinal drug toxicity: state of the art in monitoring - part 3
226 *LEROY BP - Gent*

12:00 FRO: Analysis of the utility of QuantiFERON-TB Gold in tube and measurement of IFNγ release by peripheral mononuclear cells in response to different mycobacterium antigen in the work-up of patients with uveitis
227 *MAKHOUL D - Brussels*

12:10 FRO: Study of the role of P2Y receptors in the development of experimental autoimmune uveitis
228 *JUDICE DE MENEZES RELVAS L, WILLERMAIN F - Brussels*

12:20 Les uvéites chez l'enfant congolais
229 *KAIMBO WA KAIMBO D - Kinshasa*

12:30 Break

BSA

Thursday
09:00 - 12:25
Hall D

Doctor, I have double vision

Moderator:

Annie PUTTEMAN

09:00 Introduction

09:15 Diplopia with normal covertest
230 *PARIS V - Marche-en-Famenne*

09:30 Diplopia in children
231 *DECONINCK H - Brussels*

09:45 A cerebral and an optical cause of diplopia
232 *DE NIJS E - Aalter*

10:00 Progressive impairment of the third nerve
233 *VAN EECKHOUTTE L - Waregem*

10:15 Decompensation of the fourth cranial nerve: surgical and prismatical treatment
234 *GOBIN C - Antwerpen*

10:30 Break

11:00 Diplopia after an iatrogenic event
235 *YUKSEL D - Brussels*

11:15 Diplopia caused by convergence insufficiency
236 *DE TEMMERMAN S - La Louvière*

11:30 Age-related distance esotropia
237 *PRINSEN S - Deurne*

11:45 How do I manage the neurological work-up of diplopia?
238 *ANDRIS C - Liège*

12:25 End of session

BELGIAN STRABISMOLOGICAL ASSOCIATION

Interactive Surgical Course
Thursday
12:30 - 14:00
Hall A

Trabeculectomy step by step

ISC

Thursday
12:30 - 14:00
Hall A

Trabeculectomy step by step

Moderator:

Sabine BONNET

12:30 Introduction of the ISC

12:40 Draping, traction suture, incision of conjunctiva, diathermy
ZEYEN T - Leuven

12:50 Dissection of the scleral flap, flap sutures, paracenthesis and filling of the anterior chamber
HUA M - Liège

13:00 Trabeculectomy and iridectomy
COLLIGNON N - Liège

13:10 Iridenflip technique
DE GROOT V - Antwerpen

13:20 Closure of the conjunctiva
STALMANS I - Leuven

13:30 Combined phaco and deep sclerectomy
KESTELYN P - Gent

13:40 Discussion

14:00 End of session

INTERACTIVE SURGICAL COURSE

Thursday
14:00 - 15:30
Hall C

FAB

Moderator:

Anne DEWACHTER

FLUORESCEIN ANGIOGRAPHY CLUB BELGIUM

Free papers

14:00 Contribution of intravitreal bevacizumab in macular edema due to central retinal vein occlusion (CRVO)

243 *ASSOULINE JA, CORDONNIER MC, RASQUIN F - Bruxelles*

14:10 Intravitreal injections of bevacizumab for macular edema due to retinal branch and central vein occlusion

244 *DE FAYS A, GUAGNINI AP - Namur, Brussels*

Presentation of case reports

14:20 Clinical Cases Medical Retina

15:30 Break

FAB

Thursday
16:00 - 17:30
Hall C

Free papers

16:00 Idiopathic macular hole surgery: what are the results now?
245 *FORTUNATI M, GRIBOMONT AC - Brussels*

16:10 FRO: Role of VEGF-isoforms in pathological retinal & choroidal angiogenesis
246 *VAN DE VEIRE S, VAN BERGEN T, MOONS I, CARMELIET P, STALMANS I - Leuven*

16:20 FRO: Safety of the anterior vitreous detachment induced by microplasmin, pharmacologic vitreolysus to separate the posterior capsule from the anterior hyaloid
247 *VAN LOOVEREN J - Antwerpen*

16:30 Emulsification-resistant silicone oil and F4H5 to capture oil droplets
248 *STALMANS P - Leuven*

16:40 Subretinal tissue plasminogen activator injection to treat submacular hemorrhages in age related macula degeneration
249 *DELAERE L, VANINBROUKX I, VAN CALSTER J, STALMANS P - Leuven*

16:50 The Clinical Use of Ultrasound in the Evaluation of Posterior Hyaloid Detachment
250 *STALMANS P - Leuven*

17:00 The EVRS Retinal Detachment Study
251 *JACOB J, STALMANS P ON BEHALF OF THE EVRS STUDY GROUP - Leuven*

17:10 The importance of gas injection in idiopathic epiretinal membrane peeling recovery
252 *KOCH P, BENCHEKROUN S, LIBERT J - Brussels*

17:20 Treatment of Symptomatic Vitreomacular Adhesions (VMA) With Ocriplasmin: A Subgroup Analysis of the Phase III MIVI-TRUST Program
253 *STALMANS P - Leuven*

17:30 End of session

Moderators:

Sabine BONNET
Christophe DELAEY

FLUORESCEIN ANGIOGRAPHY CLUB BELGIUM

Thursday
14:00 - 15:30
Hall D

NOC

Moderator:

Ingele CASTEELS

NEURO OPHTHALMOLOGY CLUB

Clinical Neuro-ophthalmology and orbital lesions

14:00 Technical investigations in neuro-ophthalmological problems
254 *SPILEERS W - Leuven*

14:25 Orbital lymphocytic lesions
255 *MOMBAERTS I - Leuven*

14:50 Meningioma
256 *SAEED P - Amsterdam*

15:25 Discussie

15:30 End of session

BVVB-OBPC

Thursday
16:00 - 17:30
Hall D

Visual aids in- or outside the eye

Moderators:

Philippe KESTELYN
Marie-José TASSIGNON

16:00 Visuele revalidatie bij patiënten met homonieme hemianopsie
257 *COECKELBERGH T - Antwerp*

16:18 The need of Low Vision in Central Africa
258 *NOË P - Rwanda*

16:36 Spectacle mounted mirror telescopic device
259 *VARGAS F - Murcia, Spain*

16:54 Intra-ocular mirror telescope as additive IOL
260 *LIPSHITZ I - Tel Aviv, Israel*

17:12 Indication and surgical procedure of intraocular additional mirror telescope
261 *TASSIGNON MJ - Antwerp*

17:30 End of session

BELGISCHE VERENIGING TER VOORKOMING VAN BLINDHEID
ORGANISATION BELGE POUR LA PRÉVENTION DE LA CÉCITÉ

Thursday
17:30 - 18:05
Hall A

OB SESSION

Pearls in Ophthalmology

A Champagne aperitif lecture on a topic of interest to a wide audience by an eminent ophthalmologist in an informal atmosphere. Join us for a mix of delights for both mind and body in Hall A!

17:30 Introduction by Prof. Jean-Jacques De Laey

17:35 The EYE in history
262 *GOES FJ sr - Brasschaat*

18:05 End of session

OB Congress Dinner
Belga Queen
Thursday
19:30 - 23:00

Shuttle leaves at 19:00 from Holiday Inn Brussels EXPO

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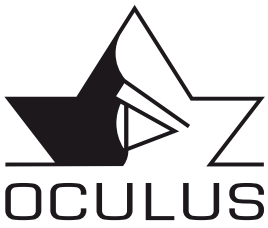

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Friday
November 25, 2011

Friday
09:00 - 17:45
Hall A

BSCRS

Moderators:

Guy SALLET
Jérôme C. VRYGHEM

BELGIAN SOCIETIES OF CATARACT AND REFRACTIVE SURGERY

Comprehensive Ophthalmology

Treating the difficult cataract patient

09:00 Introduction

09:05 The pre-op examination: visual acuity (distance, near), macular function, astigmatism
301 *VRYGHEM J - Brussels*

09:20 Ocular surface disorders
302 *KOPPEN C - Antwerp*

09:35 Complementary examinations: OCT - Fluo-angiography
303 *DELAEY C - Gent*

09:50 Biometry: A-scan/Immersion/Interference
304 *BLANCKAERT J - Ieper*

10:05 Cataract & Intraocular Lens Choice
305 *GOLENVAUX B - Brussels*

10:20 Cataract & ARMD
306 *RAKIC JM - Liège*

10:35 Break

11:00 Cataract & diabetic retinopathy
307 *VAN CALSTER J - Leuven*

11:15 Cataract & High myopia
308 *VAN LOOVEREN J - Antwerp*

11:30 Cataract & corneal dystrophies
309 *KESTELYN P - Gent*

11:45 Cataract & glaucoma
310 *KIEKENS S, DE GROOT V - Antwerp*

12:00 Aberrometry
311 *MATHYS B - Brussels*

12:15 Discussion

12:30 Break

BSCRS

Friday
09:00 - 17:45
Hall A

Comprehensive Ophthalmology

Treating the difficult cataract patient

Moderators:

René TRAU
Bernard MATHYS

14:00 Cataract & post-operative surprises
344 *TASSIGNON MJ - Antwerp*

14:15 Cataract and postoperative refractive surprises
345 *VAN HORENBEECK RJ - Antwerp*

14:30 Cataract & presbyopic issues
346 *VRYGHEM J - Brussels*

14:45 Prevention of lawsuits after cataract surgery
347 *TRAU R - Antwerp*

15:00 Break

Treating the unhappy patient after refractive surgery

15:30 Refractive Lasersurgery - Aberrometry
348 *MATHYS B - Brussels*

15:45 Phakic intra-ocular lens / Glare & Halo's
349 *SALLET - Aalst*

16:00 Refractive lensexchange / Waxy vision / Brain adaptation
350 *EVENS P - Brussels*

BELGIAN SOCIETIES OF CATARACT AND REFRACTIVE SURGERY

BSCRS

Friday
09:00 - 17:45
Hall A

Free papers

16:15 Cataract surgery in Fuchs endothelial dystrophy
351 *VAN CLEYNENBREUGEL H, REMEIJER L, HILLENAAR T - Rotterdam*

16:25 Corneal collagen crosslinking using riboflavin and ultraviolet-A light for keratoconus: analysis of effectiveness using Scheimpflug imaging
352 *GOES F jr - Antwerp*

16:35 Femtolasik flap thickness accuracy of the Zeiss 500 kHz Visumax femtosecond laser
353 *GOES F jr - Antwerp*

16:45 First Clinical Experience with a New 1-Piece Multifocal IOL
354 *GOES FJ sr - Antwerp*

16:55 FRO: The Slug Mucosal Irritation (SMI) assay: A tool to predict ocular stinging, itching and burning sensations
355 *LENOIR J, CLAERHOUT I, KESTELYN P, REMON JP, ADRIAENS E - Gent*

17:05 FRO: Tear film biomarkers as prognostic indicators for recurrent pterygium
356 *ZAKARIA N - Antwerp*

17:15 Intracorneal ring segment (ICRS) implantation in Keratoconus patients in tunnels made by the Ziemer femtosecond laser
357 *VRYGHEM JC, HEIREMAN S - Brussels*

17:25 IOL calculation in vitrectomy patients that underwent previous refractive surgery
358 *LEQUEU I, STALMANS P - Leuven*

17:35 Optimized A-constant for a particular lens (XL-Stabi ZO, Carl Zeiss Meditec) and general advice for optimization and IOL calculations formulas
359 *MATHYS B, ALIO J, MORBELLI H, LEBRUN T, KHAITRINE L, RIECK P, DEWILDE F, TRABUCCHI T - Brussels, Alicante, Albacete, Saint Ouen, Reims, Berlin, Sint Martens Latem, Legnano*

17:45 End of session

Moderators:

René TRAU
Bernard MATHYS

BELGIAN SOCIETIES OF CATARACT AND REFRACTIVE SURGERY

Friday
08:30 - 15:40
Hall B

Nederlandstalig

BSONT

Moderator:

Peter VAN ELDEREN

BSONT

BELGIAN SOCIETY OF OPHTHALMIC NURSES & TECHNICIANS

Contactlenzen
Esthetische, plastische chirurgie van het oog
Botuline toepassingen: klinisch en esthetisch

08:30	Inschrijving
09:20	Openingswoord door de president OB 2011, Bart LEROY en door de peter, Philippe KESTELYN
09:30	Visus meting bij volwassenen
312	*WIRIX M - Sint Truiden*
09:50	Visus meting bij kinderen
313	*PRINSEN S - Deurne*
10:10	Oculo plastische chirurgie
314	*DECOCK C - Gent*
10:55	Break
11:30	Contactlenzen: toepassingen van de verschillende contactlenzen
315	*DE JONG S - Leuven*
12:00	Contactlenzen: gebruik en aandachtspunten
316	*DE VRIES V - Brussel*
12:30	Klinische gevolgen van slechte hygiëne bij het gebruik van contactlenzen
317	*BEIRNAERT V - Gent*
13:00	Lunch
14:30	Botulinum toxine: klinisch gebruik in Leuven
360	*GOBIN C - Deurne*
14:50	De stralende blik: meer dan rimpel vrij - Focusverandering bij veroudering in de faciale regio
361	*KNAPEN H - Antwerpen*
15:20	Questions & answers
15:30	Prijsuitreiking
15:40	End of session

BSONT

Friday
09:00 - 15:30
Hall C

Les paupières

Moderator:

Carine VERBIEST

BSONT

BELGIAN SOCIETY OF OPHTHALMIC NURSES & TECHNICIANS

09:00 Inscription et accueil des participants

09:30 Ouverture par le président OB 2011, Bart LEROY

09:40 Anatomie des paupières
318 BETZ P - Liège

10:10 Les tumeurs
319 LASUDRY J - Bruxelles

10:40 Break

11:10 Ectropion et entropion
320 CARRETTE S - Liège

11:40 Les traumatismes
321 SOHNGEN A - Verviers

12:10 Lunch

14:00 Blepharochalazis
362 DELBRASSINNE N - Ottignies

14:30 Ptosis
363 LEMAGNE JM - Bruxelles

15:00 Dystonie et botox
364 BETZ P - Liège

15:30 End of session

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OMEGA 3 (375 mg DHA)

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1 comprimé + 1 capsule par jour pendant le repas

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BOV-ABO

Friday
09:00 - 12:30
Hall D

Orbit & strabismus: congenital and acquired orbital pathology

Moderators:

Hilde DECONINCK
Demet YUKSEL

09:00 Welcome

09:05 Anatomy of the orbit
322 *BETZ P - Liège*

09:25 Craniosynostosis and Non-Synostotic Plagiocephaly
323 *ROCHE NA - Gent*

09:55 Eyemovement disorders associated with abnormal orbital growth
324 *NISCHAL KK - London*

10:25 Break

10:55 Orbital biomechanics
325 *SCHUTTE S - Delft*

11:30 Specific forms of slow progressive strabismus
326 *DIELTIËNS M, BEELEN L, DE CLIPPELEIR L, VAN LAMMEREN M, BAEKELAND L, JANSSENS H, GOOVAERTS L - Leuven*

12:00 Orbital traumata
327 *DE GROOT V, GODTS D - Antwerpen*

12:30 End of session

BELGISCHE ORTHOPTISCHE VERENIGING
ASSOCIATION BELGE D'ORTHOPTIE

Friday
12:30 - 14:00
Hall A

AWARD CEREMONY

Moderator:

Philippe KESTELYN

Poster Awards

All posters are eligible for a Poster Award.

- Best case report: 300 EUR
- AOB best resident's poster prize: 500 EUR – Travel grant EVER 2012

An independent panel appointed by the Board of OB 2011 decides on the Poster Awards through voting. Their decision is final.

FRO awards

Prizes of the Société Royale de Philanthropie
Stichting Brailleliga / Ligue Braille Foundation

EBO Diploma

AL-SABAI Nashwan
BARTHOLOMEEUSEN Ellen
COPPENS Greet
DE KEYSER Christophe
DE KEYZER Tomas
DUPONT Géraldine
GOLUB Olena
HAUTENAUVEN Frédéric
HOORNAERT Kristien
JANSSENS Sarah
KAES Karen
KESTELYN Philippe-Adriaan
LAMBRECHT Noémia
LENFANT Thibaut
LEPIECE Gwendoline
MEUNIER Audrey
NELIS Stephanie
NYST Benjamin
VANINBROUKX Isaline
YEH Ru-Yin

Award Ceremony
Friday
12:30 - 14:00
Hall A

Friday
14:00 - 17:30
Hall D

PED & LOW

Moderators:

Ingele CASTEELS
Ann DEBACKERE

PEDIATRIC OPHTHALMOLOGY & LOW VISION REHABILITATION

Congenital infections

14:00 Algemene tekens van congenitale infecties bij baby en kind
365 *SMETS K - Gent*

14:45 Oftalmologische bevindingen bij congenitale CMV infectie
366 *CASTEELS I - Leuven*

15:30 Break

16:00 Epidemiologie en diagnostiek van CMV infecties
367 *NAESSENS A - Brussel*

16:45 Oeil et toxoplasmose congénitale
368 *BREZIN AP - Paris*

17:30 End of session

Interactive Clinical Courses

WEDNESDAY, 23 NOVEMBER 2011

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

Basis pediatrisch oogonderzoek

Erica SMETS, Ilse DE VEUSTER, Margriet BARTIER

Typical pediatric clinical cases will be presented. Strategies for eye examination will be discussed.
The comprehensive ophthalmologist will be provided with simple tools to perform an efficient eye examination.
The hand-outs will contain general accepted guidelines regarding pediatric ophthalmology.

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

OCT-course: an update

Eric FERON, Ine COSEMANS, Joke RUYS, Jozef DEPLA

This course is intended for ophthalmologists who have already experience with OCT, but who like to learn more about the state-of-the-art of the instrument.
Interpretation of OCT in macular pathology will systematically include vitreomacular interface disorders, different types of macular edema and diseases affecing the deeper retinal layers, RPE and choroid. The course will include OCT-based guidelines for vitreoretinal surgery and for anti-VEGF and steroid intravitreal injections.

WEDNESDAY, 23 NOVEMBER 2011

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

La maculopathie diabétique : en théorie et en pratique

Anne BORLON, Astrid BOURGUIGNONT

Nous proposons de revoir la sémiologie de la maculopathie diabétique à travers l'examen du FO, de l'O.C.T, de l'angiographie en fluorescence ,des facteurs de risque généraux et locaux . Une classification ainsi que les indications thérapeutiques actuelles seront redéfinies . Une mise en application à partir de cas cliniques permettra de passer de la théorie à la pratique.

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

Panorama des uvéites les plus fréquentes : pratique et prise en charge

Alexandra KOZYREFF, Pierre LEFEBVRE, Nacima KISMA, Dorine MAKHOUL

Les uvéites antérieures, intermédiaires et postérieures les plus fréquentes seront abordées de façon pratique et illustrée. Des lignes de conduite à tenir seront exposées pour les bilanter, les prendre en charge ou les référer.

THURSDAY, 24 NOVEMBER 2011

09:00 - 10:30 ICC - T5 | Intermediate **Hall E**

Astigmatism correction during phacoemulsification

Benoît GOLENVAUX, Guy SALLET, Emmanuel VAN ACKER

The ICC will introduce technics that will be further elaborated in the WETLAB

This course aims to provide pragmatic information regarding surgical correction of corneal astigmatism during phaco. The course will cover selection of candidates, determination of axis and surgical correction of astigmatism, either by incisional surgery or with toric IOL's. Several models of toric IOL's will be presented, together with their calculating method and alignement process. Finally, several clinical cases on astigmatism management will be presented for discussion with the audience. Additionnally, this course constitues also a theoretical counterpart to the wetlab organized on the same subject.

THURSDAY, 24 NOVEMBER 2011

11:00 - 12:30 ICC - T6 **Hall E**

Presbyopia correction: Cornea and Lens

Frank GOES sr, Jean-Marie HENRY, Werner HÜTZ & Erik MERTENS, Johan BLANCKAERT, Bernard HEINTZ

Frank GOES / Jean-Marie HENRY / Werner HÜTZ
Course will discuss the options of presbyopia correction with special emphasis on lens surgery.
Patient selection-IOL power calculation-the Surgery itself-IOL selection Clinical outcomes- and future developments will be analyzed and discussed.
Panel will review more than 1.000 cases and will propose guidelines in order to have more HAPPY PATIENTS.

Erik MERTENS / Johan BLANCKAERT / Bernard HEINTZ
Attendees will recognize advantages and disadvantages of the different types of presbyopia correction and be able to describe selection criteria for this procedures. They will understand patient selection, surgical technique, and how to prevent and manage complications. Case studies will also be presented by each speaker to increase learning experience.

Course will describe the possible options in correcting presbyopia (corneal inlays, accommodative and multifocal IOLs, presbyLASIK and INTRACOR laser treatment). Patient selection, surgical technique, management of complications, patient satisfaction and refractive and ocular outcomes will be reviewed.

THURSDAY, 24 NOVEMBER 2011

14:00 - 15:30 ICC - T7 | Intermediate **Hall B**

Management van complicaties tijdens cataractchirurgie

Peter STALMANS

Elke cataractchirurg komt vroeg of laat te staan voor complicaties die tijdens of kort na een ingreep kunnen ontstaan: lenskapselscheur, glasvochtprolaps, dropped nucleus, subchoroidaal hematoom en endoftalmitis.
Vaak moeten deze patiënten verwezen worden voor vitreoretinale chirurgie. Het is dan ook belangrijk de aanpak van deze problemen ook te bekijken vanuit het standpunt van de vitreoretinale chirurg.
Deze ICC toont een aantal praktische tips voor de beginnende én meer ervaren chirurg.

16:00 - 17:30 ICC - T8 | Basic **Hall B**

Rôle de l'ophtalmologue et de l'orthoptiste dans le traitement de la dyslexie

Colette BRASSEUR

On pense actuellement qu'une dysfonction proprioceptive interviendrait dans la genèse de la dyslexie.
La rééducation logopédique est souvent insuffisante ; la piste proposée est un traitement de la proprioception en multidisciplinarité.
Un bilan postural et un bilan orthoptique permettent d'évaluer cette dysfonction.
Le but du cours est d'exposer les bases théoriques et pratiques de cette nouvelle approche, accessibles à tout intervenant ayant suivi une formation adéquate.

THURSDAY, 24 NOVEMBER 2011

14:00 - 15:30 ICC - T9 | Basic **Hall E**

Corneal Grafts: What's new?

Alessandra CHAVES

In the last years many new surgical techniques have been proposed for corneal transplantation. The surgical approach can vary depending on the corneal layer that is affected. Let's discuss about these surgical options, their advantages and disadvantages.

16:00 - 17:30 ICC - T10 | Basic **Hall E**

Glaucoma: how to use rate of visual field progression in clinical practice?

Ingeborg STALMANS, Tania BARLET

The European Glaucoma Society promotes in their guidelines the use of the rate of visual field progression in the management of glaucoma patients. During this course, the concept of rate of progression, as well as its clinical importance will be highlighted. Using patient examples, a clinical situation will be simulated, in which the participants will be able to translate this knowledge into daily clinical practice.

FRIDAY, 25 NOVEMBER 2011

09:00 - 10:30 ICC - F11 | Intermediate **Hall E**

La gonioscopie: un examen irremplaçable. Gonioscopie is onmisbaar

Michèle DETRY, Sayeh POURJAVAN

La gonioscopie représente la pièce clé du puzzle que constitue le bilan d'un suspect de glaucome ou d'un glaucome confirmé.En son absence, le clinicien s'expose à poser des diagnostics erronés et à instaurer des traitements inappropriés. Après un rappel théorique, plusieurs cas cliniques exposés en français et néerlandais seront discutés avec les particpants pour illustrer l'importance de la gonioscopie.
De gonioscopie is een onmisbaar onderdeel van het globale onderzoek van mogelijke glaucoompatiënten en patiënten waarbij effectief glaucoom werd vastgesteld.Het niet uitvoeren van dit onderzoek is één van de meest voorkomende oorzaken van verkeerde diagnoses en niet geschikte behandelingen. Na een korte theoretische uiteenzetting van de gonioscopie, worden acht klinische casussen die om beurt worden uiteengezet in het Frans en in het Nederlands en die het belang van de gonioscopie onderstrepen, besproken met de deelnemers.

11:00 - 12:30 ICC - F12 | Intermediate **Hall E**

Syndromes de l'interface vitréo-maculaire: Comment évaluer? Quand opérer? Pour quel résultat?

Anne - Catherine GRIBOMONT, Sabine BONNET

Après une brève introduction descriptive des syndromes de l'interface vitréo-maculaire et des résultats habituels du traitement chirurgical, la présentation illustrée de cas cliniques variés permettra de discuter, en se basant notamment sur l'examen OCT, la manière de diagnostiquer avec précision la nature de la maculopathie, ainsi que le bien-fondé et le pronostic d'une intervention chirurgicale au cas par cas, en particulier pour les cas rares, ou atypiques.

FRIDAY, 25 NOVEMBER 2011

14:00 - 15:30 ICC - F13 | Basic **Hall E**

Difficult cases in cataract surgery

Camille BUDO, Johan BLANCKAERT, Albert GALAND

Purpose: Show some cases we experienced and discuss how we managed these.
Methods: Through videos of complication and challenging cases we have experienced.
Results: How we manage a complication or a challenging case is of utmost importance for the patient and determines the success of a surgery.
Conclusion: Every surgeon encounters complications or challenging cases, it is important to learn how to deal with these case through own experience but also though other surgeon's experience.

16:00 - 17:30 ICC - F14 | Basic **Hall E**

Tumors of the eyelid, conjunctiva and anterior segment

Guy MISSOTTEN, Ilse MOMBAERTS, Rita VAN GINDERDEUREN

This course will emphasize the different oncologic pathologies of the anterior segment, conjunctiva and eyelid. Starting from the iris up to the eyelid, the differential diagnosis, the treatment options and choices and the prognosis will be discussed. The differences and implications of pathology examinations will be discussed. The different treatment options with excision, brachytherapy (Strontium, iridium needles), external radiotherapy and chemotherapeutic drops will be illustrated and their different complications will be shown. For basocellular carcinoma the options of surgery, cryotherapy or radiotherapy will be discussed. The focus will be on frequently occurring pathologies.

Wetlabs

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WEDNESDAY, 23 NOVEMBER 2011

09:00 - 10:30 Wetlab 1 - FR **Hall F**

Phakic IOL's
Hervé TERMOTE

11:00 - 12:30 Wetlab 2 - NL **Hall F**

Learning phaco-chop
Ann Haustermans

14:00 - 15:30 Wetlab 3 - ENG **Hall F**

Small incision manual cataract surgery
Piet Noë

16:00 - 17:30 Wetlab 4 - FR **Hall F**

La chirurgie non perforante du trabéculum
Nathalie COLLIGNON

14:00 - 15:30 Wetlab eyelid surgery 1 **Hall G**

Paul JONCKHEERE, Philippe BETZ

16:00 - 17:30 Wetlab eyelid surgery 2 **Hall G**

Paul JONCKHEERE, Philippe BETZ

THURSDAY, 24 NOVEMBER 2011

09:00 - 10:30 Wetlab 5 - NL **Hall F**

Cataractchirurgie: phaco for beginners
Ivo NIJS

11:00 - 12:30 Wetlab 6 - FR **Hall F**

Astigmatism correction during phacoemulsification
Benoît Golenvaux

14:00 - 15:30 Wetlab 7 - NL **Hall F**

Trabeculectomie
Ingeborg Stalmans

16:00 - 17:30 Wetlab 8 - FR **Hall F**

Cataractchirurgie: phaco pour débutants
Michel Hoebeke

FRIDAY, 25 NOVEMBER 2011

09:00 - 10:30 Wetlab 9 - ENG **Hall F**

Glaucoma: non perfo sclerectomy for beginners
Philippe Kestelyn

11:00 - 12:30 Wetlab 10 - ENG **Hall F**

Small incision manual cataract surgery
Piet Noë

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nov 2011

DUOTRAV®

Naam van het geneesmiddel: DuoTrav 40 microgram/ml + 5 mg/ml oogdruppels, oplossing
Kwalitatieve en kwantitatieve samenstelling: Iedere ml oplossing bevat 40 microgram travoprost en 5 mg timolol (als timololmaleaat). Lijst van hulpstoffen: polyquaternium-1, mannitol (E421), propyleenglycol (E1520), polyoxyethyleen gehydrogeneerde castorolie 40 (HCO-40), boorzuur, natriumchloride, natriumhydroxide en/of zoutzuur (om de pH in te stellen), gezuiverd water.
Farmaceutische vorm: Oogdruppel, oplossing (oogdruppel). Heldere, kleurloze oplossing.
Therapeutische indicaties: Verlaging van de intraoculaire druk (IOD) bij volwassen patiënten met openkamerhoekglaucoom of oculaire hypertensie die onvoldoende reageren op topische bètablokkers of prostaglandine-analogen.
Dosering en wijze van toediening:
Dosering: Gebruik bij volwassenen, inclusief ouderen: De dosis is één druppel DuoTrav eenmaal daags, 's morgens of 's avonds, in de conjunctivale zak van het (de) aangedane oog (ogen). Het moet iedere dag op hetzelfde tijdstip 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).
Bijzondere patiëntengroepen: Lever- en nierfunctiestoornissen: Er is geen onderzoek verricht met DuoTrav of met timolol 5 mg/ml oogdruppels bij patiënten met lever- of nierfunctiestoornissen. Travoprost is onderzocht bij patiënten met lichte tot ernstige leverfunctiestoornissen en bij patiënten met lichte tot ernstige nierfunctiestoornissen (creatinineklaring zo laag als 14 ml/min). Bij deze patiënten was aanpassing van de dosis niet nodig. Het is onwaarschijnlijk dat de dosis DuoTrav aangepast moet worden bij patiënten met lever- of nierfunctiestoornissen. Pediatrische patiënten: De veiligheid en werkzaamheid van DuoTrav bij kinderen en jongeren onder de 18 jaar werden niet vastgesteld. Er zijn geen gegevens beschikbaar. Wijze van toediening: Voor oculair gebruik. 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. Nasolacrimale occlusie of het zachtjes sluiten van het ooglid na instillatie wordt aanbevolen. Dit kan de systemische absorptie van oculair toegediende geneesmiddelen reduceren en daarmee de systemische bijwerkingen verminderen. Indien meer dan één topisch oftalmisch geneesmiddel wordt gebruikt, moeten deze geneesmiddelen met een tussenperiode van minimaal 5 minuten worden toegediend. Wanneer een ander oftalmisch antiglaucoommiddel wordt vervangen door DuoTrav, moet het gebruik van het andere middel worden stopgezet en moet de volgende dag met DuoTrav worden begonnen. Patiënten moeten geïnstrueerd worden hun zachte contactlenzen te verwijderen vóór toediening van DuoTrav en 15 minuten te wachten na indruppeling van de dosis voordat zij hun contactlenzen weer kunnen inzetten.
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 atrioventriculair blok, manifest hartfalen of cardiogene shock. Ernstige allergische rhinitis en bronchiale hyperreactiviteit; corneale dystrofie; overgevoeligheid voor andere bètablokkers.
Bijwerkingen: In klinisch onderzoek bij 938 patiënten werd DuoTrav (met benzalkoniumchloride als conserveermiddel) eenmaal daags toegediend. De meest gemelde bijwerking die met de behandeling in verband kon worden gebracht was oculaire hyperemie (15,0%). Bijna alle patiënten (96%) beëindigden de behandeling als gevolg van deze reactie niet.
De volgende bijwerkingen, hieronder opgesomd, zijn waargenomen in klinische studies of zijn door postmarketing-ervaringen vastgesteld. Zij zijn gerangschikt naar systeem/orgaanklasse en ingedeeld 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 < 1/1.000), zeer zelden (< 1/10.000), of niet bekend (kan met de beschikbare gegevens niet worden bepaald). Binnen iedere frequentiegroep worden bijwerkingen gerangschikt naar afnemende ernst.
DuoTrav (met benzalkoniumchloride als conserveermiddel)Psychische stoornissen: Vaak: zenuwachtigheid. Niet bekend: depressie. /
Zenuwstelselaandoeningen: Vaak: duizeligheid, hoofdpijn. Niet bekend: cerebrovasculair accident, syncope, paresthesie. /
Oogaandoeningen: Zeer vaak: ongemak in het oog, oculaire hyperemie. Vaak: keratitis punctata, voorste oogkamerontsteking, oogpijn, fotofobie, oogzwelling, conjunctiva hemorragie, scherpzien gereduceerd, visuele stoornis, gezichtsvermogen wazig, droog oog, oogpruritus, conjunctivitis, traanproductie verhoogd, erytheem van het ooglid, blefaritis, asthenopie, groei van de wimpers. Soms: cornea-erosie, keratitis, oogallergie, conjunctivaal oedeem, ooglidoedeem. Zelden: iritis. Niet bekend: macula-oedeem, ooglidptose, cornea-aandoening. /
Hartaandoeningen: Vaak: hartfrequentie onregelmatig, hartfrequentie verlaagd. Soms: aritmie. Niet bekend: hartfalen, tachycardie. /
Bloedvataandoeningen: Vaak: bloeddruk verhoogd, bloeddruk verlaagd. /
Ademhalingsstelsel-, borstkas- en mediastinumaandoeningen: Vaak: bronchospasme. Soms: dyspnoea, hoesten, orofaryngeale pijn, keelirritatie, neusongemak, postnasale drip. Niet bekend: astma. /
Lever- en galaandoeningen: Soms: alanine-aminotransferase verhoogd, aspartaataminotransferase verhoogd. /
Huid- en onderhuidaandoeningen: Vaak: urticaria, huidhyperpigmentatie (periocular). Soms: contactdermatitis. Zelden: alopecia. Niet bekend: rash. /
Skeletspierstelsel- en bindweefselaandoeningen: Vaak: pijn in extremiteit. /
Nier- en urinewegaandoeningen: Soms: chromaturie. /
Algemene aandoeningen en toedieningsplaatsstoornissen: Soms: dorst. Niet bekend: borstkaspijn.
Tijdens de ontwikkeling van DuoTrav (met polyquaternium-1 als conserveermiddel) werden in 3 klinische studies 372 patiënten/proefpersonen tot 12 maanden blootgesteld. De meest gemelde bijwerking die in verband kon worden gebracht met de behandeling met DuoTrav (met polyquaternium-1 als conserveermiddel) was hyperemie van het oog (11,8%), waaronder oculaire of conjunctiva hyperemie. De meeste patienten (91%) die hyperemie van het oog ondervonden, stopten niet met de therapie vanwege deze reactie.
De volgende bijwerkingen, hieronder opgesomd, zijn waargenomen in de klinische studies:
DuoTrav (met polyquaternium-1 als conserveermiddel)
Immuunsysteemaandoeningen: Soms: overgevoeligheid. / Zenuwstelselaandoeningen: Soms: hoofdpijn. / Oogaandoeningen: Vaak: oogpijn, ongemak in het oog, droog oog, oogpruritus, oculaire hyperemie. Soms: keratitis punctata, iritis, fotofobie, gezichtsvermogen wazig, conjunctivitis, meibom-ontsteking, schilferige ooglidrand, asthenopie, traanproductie verhoogd, groei van de wimpers. / Hartaandoeningen: Soms: bradycardie. / Bloedvataandoeningen: Soms: hypotensie. / Huid- en onderhuidaandoeningen: Soms: huidverkleuring, haargroei abnormaal. / Algemene aandoeningen en toedieningsplaatsstoornissen: Soms: vermoeidheid. / Onderzoeken: Soms: hartfrequentie verlaagd.
Aanvullende bijwerkingen die voor één van de werkzame bestanddelen werden vastgesteld en die mogelijk kunnen voorkomen met DuoTrav:
Travoprost:
Oogaandoeningen: uveïtis, conjunctiva-aandoening, conjunctivale follikels, irishyperpigmentatie. / Huid- en onderhuidaandoeningen: huidexfoliatie.

Timolol:
Voedings- en stofwisselingsstoornissen: hypoglykemie. /
Zenuwstelselaandoeningen: cerebrale ischemie, myasthenia gravis. /
Oogaandoeningen: diplopie. /
Hartaandoeningen: hartstilstand, atrioventriculair blok, hartkloppingen. /
Ademhalingsstelsel-, borstkas- en mediastinumaandoeningen: respiratoir falen, neusverstopping. /
Maagdarmstelselaandoeningen: diarree, nausea. /
Algemene aandoeningen en toedieningsplaatsstoornissen: asthenie.
Publieksprijs inclusief BTW: DuoTrav 1 x 2,5 ml: 33,61 € ; 3 x 2,5 ml: 71,68 €.
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Registratienummer: EU/1/06/338/001-002.
Aflevering: Geneesmiddel op medisch voorschrift.
Datum van herziening van de tekst: 24 maart 2011.Mar 2011

DUOTRAV®

Dénomination du médicament: DuoTrav 40 microgrammes/ml + 5 mg/ml collyre en solution
Composition qualitative et quantitative: Chaque ml de solution contient 40 microgrammes de travoprost et 5 mg de timolol (sous forme de maléate de timolol). Liste des excipients: polyquaternium-1, mannitol (E421), propylène glycol (E1520), huile de ricin hydrogénée polyoxyéthylénée 40 (HCO-40), acide borique, chlorure de sodium, hydroxyde de sodium et/ou acide chlorhydrique (ajustement du pH), eau purifiée.
Forme pharmaceutique: Collyre en solution (collyre). Solution incolore et limpide.
Indications thérapeutiques: Réduction de la pression intraoculaire (PIO) chez les patients adultes atteints de glaucome à angle ouvert ou d'hypertonie intraoculaire et qui présentent une réponse insuffisante aux bêta-bloquants ou aux analogues des prostaglandines administrés localement.
Posologie et mode d'administration:
Posologie: Utilisation chez les adultes et les sujets âgés: La posologie est d'une goutte de DuoTrav dans le cul de sac conjonctival de l'œil ou des yeux atteint(s), une fois par jour, le matin ou le soir. Il doit être administré tous les jours à la même heure. Si une instillation est oubliée, le traitement doit être poursuivi avec l'instillation suivante. La posologie ne doit pas dépasser une goutte par jour dans l'œil ou les yeux atteint(s).
Population particulières: Insuffisants hépatiques et rénaux: Aucune étude n'a été effectuée avec DuoTrav ou avec timolol 5 mg/ml collyre chez les insuffisants hépatiques ou rénaux. Travoprost 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 adaption de la posologie n'est nécessaire chez ces patients. Les patients insuffisants hépatiques ou rénaux ne nécessitent pas d'adaption de la posologie avec DuoTrav. Population pédiatrique: La sécurité et l'efficacité de DuoTrav chez les enfants et adolescents de moins de 18 ans n'ont pas été établies. Aucune donnée n'est disponible. Mode d'administration: Voie oculaire. Le patient doit retirer le sachet protecteur juste avant la première utilisation. Pour éviter le 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. Une occlusion nasolacrymale ou une fermeture douce des paupières après l'administration est recommandée. Ceci peut réduire l'absorption systémique des traitements administrés par voie oculaire et conduire à une diminution des réactions indésirables systémiques. En cas d'utilisation de plusieurs collyres, les instillations doivent être espacées d'au moins 5 minutes. En cas de remplacement d'un autre médicament antiglaucomateux ophtalmique par DuoTrav, interrompre l'autre médicament et commencer DuoTrav le jour suivant. Les patients doivent enlever leurs lentilles de contact avant instillation de DuoTrav et attendre 15 minutes après l'instillation avant de poser des lentilles de contact.
Contre-indications: Hypersensibilité aux substances actives 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; dystrophies cornéennes; hypersensibilité aux autres bêta-bloquants.
Effets indésirables: Au cours des études cliniques incluant 938 patients, DuoTrav (conservé avec du chlorure de benzalkonium) a été administré une fois par jour. L'effet indésirable le plus fréquent lié au traitement était l'hyperhémie oculaire (15,0%). La plupart des patients atteints d'hyperhémie (96%) n'a pas arrêté le traitement pour cette raison.
Les effets indésirables recensés ci-dessous ont été observés lors des essais cliniques ou après commercialisation. Ils sont présentés par classe de systèmes d'organes et listés ciaprès de la façon suivante: très fréquents (≥ 1/10), fréquents (≥ 1/100 à < 1/10), peu fréquents (≥ 1/1.000 à ≤ 1/100), rares (≥ 1/10.000 à < 1/1.000), très rares (< 1/10.000) ou fréquence indéterminée (ne peut être estimée sur la base des données disponibles). Au sein de chaque fréquence de groupe, les effets indésirables sont présentés suivant un ordre décroissant de gravité.
DuoTrav (conservé avec du chlorure de benzalkonium)
Affections psychiatriques: Fréquente: nervosité. Indéterminée: dépression. /
Affections du système nerveux: Fréquentes: étourdissement, maux de tête. Indéterminée: accident cérébrovasculaire, syncope, paresthésie. /
Affections oculaires: Très fréquentes: gêne oculaire, hyperhémie oculaire. Fréquentes: kératite ponctuée, inflammation de la chambre antérieure (effet Tyndall cellulaire et protéique), douleur oculaire, photophobie, gonflement oculaire, hémorragie conjonctivale, acuité visuelle réduite, trouble visuel, vision floue, sécheresse oculaire, prurit oculaire, conjonctivite, larmoiement augmenté, érythème des paupières, blépharite, asthénopie, croissance des cils. Peu fréquentes: érosion cornéenne, kératite, allergie oculaire, œdème conjonctival, œdème des paupières. Rare: iritis. Indéterminées: œdème maculaire, ptosis des paupières, affection cornéenne. /
Affections cardiaques: Fréquentes: rythme cardiaque irrégulier, diminution du rythme cardiaque. Peu fréquente: arythmie. Indéterminées: insuffisance cardiaque, tachycardie. /
Affections vasculaires: Fréquentes: augmentation de la pression artérielle, diminution de la pression artérielle.
/ Affections respiratoires, thoraciques et médiastinales: Fréquente: bronchospasme. Peu fréquentes: dyspnée, toux, douleur oro-pharyngée, irritation de la gorge, gêne nasale, rhinopharyngite. Indéterminée: asthme. /
Affections hépatobiliaires: Peu fréquentes: augmentation des alanine-aminotransférases, augmentation des aspartate-aminotransféases. /
Affections de la peau et du tissu souscutané: Fréquentes: urticaire, hyperpigmentation de la peau (périoculaire). Peu fréquente: dermatite de contact. Rare: alopécie. Indéterminées: éruption cutanée. /
Affections musculo-squelettiques et systémiques: Fréquentes: douleurs aux extrémités. /
Affections du rein et des voies urinaires: Peu fréquente: chromaturie.
Troubles généraux et anomalies au site d'administration: Peu fréquente: soif. Indéterminée: douleur thoracique.

Dans 3 études cliniques réalisées pour le développement de DuoTrav (conservé avec du polyquaternium-1), 372 patients/sujets ont été traités sur une période allant jusqu'à 12 mois. L'effet indésirable le plus fréquemment rapporté comme lié à DuoTrav (conservé avec du polyquaternium-1) était une hyperhémie oculaire (11,8 %) incluant hyperhémie oculaire ou conjonctivale. Chez la plupart des patients qui présentaient une hyperhémie (91%), le traitement n'a pas été arrêté pour cette raison.
Les effets indésirables listés ci-dessous ont été rapportés lors des essais cliniques.
DuoTrav (conservé avec du polyquaternium-1)
Affections du système immunitaire: Peu fréquentes: hypersensibilité. / Affections du système nerveux: Peu fréquentes: maux de tête. / Affections oculaires: Fréquentes: douleur oculaire, gêne oculaire, sécheresse oculaire, prurit oculaire, hyperhémie oculaire. Peu fréquentes: kératite ponctuée, iritis, photophobie, vision floue, conjonctivite, meibomite, croûtes sur le bord de la paupière, asthénopie, larmoiement augmenté, croissance des cils. / Affections cardiaques: Peu fréquentes: bradycardie. / Affections vasculaires: Peu fréquentes: hypotension. / Affections de la peau et du tissu souscutané: Peu fréquentes: dyschromie cutanée, croissance des cheveux anormale. / Troubles généraux et anomalies au site d'administration: Peu fréquentes: fatigue. / Examens: Peu fréquentes: fréquence cardiaque diminuée.
Effets indésirables supplémentaires qui ont été observés avec l'un des principes actifs et peuvent éventuellement survenir avec DuoTrav:
Travoprost:
Affections oculaires: uvéite, affection conjonctivale, follicules conjonctivaux, hyperpigmentation de l'iris. /
Affections de la peau et du tissu souscutané: exfoliation cutanée.
Timolol:
Troubles du métabolisme et de la nutrition: hypoglycémie. /
Affections du système nerveux: ischémie cérébrale, myasthénie gravis.
/ Affections oculaires: diplopie. /
Affections cardiaques: arrêt cardiaque, bloc auriculoventriculaire, palpitations.
Affections respiratoires, thoraciques et médiastinales: insuffisance respiratoire, congestion nasale. /
Affections gastro-intestinales: diarrhée, nausée.
/ Troubles généraux et anomalie au site d'administration: asthénie.

Prix public incl. TVA: DuoTrav 1 x 2,5 ml: 33,61 € ; 3 x 2,5 ml: 71,68 €.
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/1/06/338/001-002.
Délivrance: Médicament soumis à prescription médicale.
Date de mise à jour du texte: 24 mars 2011.Mar 2011

TRAVATAN®

Naam van het geneesmiddel : TRAVATAN 40 microgram/ml oogdruppels, oplossing
Kwalitatieve en kwantitatieve samenstelling : Iedere ml oplossing bevat 40 microgram travoprost. Lijst van hulpstoffen: polyquaternium-1, polyoxyethyleen gehydrogeneerde castorolie 40 (HCO-40), boorzuur (E284), mannitol (E421), natriumchloride, propyleenglycol (E1520), natriumhydroxide en/of zoutzuur (voor het instellen van de pH), gezuiverd water.
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
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.
Pediatrische patiënten
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.
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.
Wijze van toediening
Voor oculair gebruik.
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 4400 patiënten werd TRAVATAN (met benzalkoniumchloride als conserveermiddel) 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 het product gemeld. De meest gemelde bijwerking die met de behandeling van TRAVATAN (met benzalkoniumchloride als conserveermiddel) als monotherapie in verband kon worden gebracht, was hyperemie van het oog (22,0%), waaronder oculaire, conjunctiva of sclerale hyperemie. De hyperemie was mild bij 83,6% 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.
In een 5 jaar-durende post-autorisatie klinische studie waarbij bij 502 patiënten eenmaal daags TRAVATAN werd toegediend, werden geen ernstige oftalmische of systemische bijwerkingen die in verband konden worden gebracht met TRAVATAN gemeld. De meest voorkomende bijwerking die in verband kon worden gebracht met de behandeling met TRAVATAN was hyperpigmentatie van de iris (29,5%). Hyperemie van het oog dat in verband werd gebracht met het gebruik van TRAVATAN werd gemeld met een incidentie van 10,0%, waarbij 2% van de patiënten die hyperemie van het oog meldden hun deelname aan de studie stopzette als gevolg van de bijwerking.
De volgende bijwerkingen konden in verband worden gebracht met de behandeling met TRAVATAN (met benzalkoniumchloride als conserveermiddel) als monotherapie. Zij zijn volgens de volgende conventie 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.
TRAVATAN (met benzalkoniumchloride als conserveermiddel)
Infecties en parasitaire aandoeningen : Soms: herpes simplex, keratitis herpetisch
Immuunsysteemaandoeningen : Soms: overgevoeligheid, geneesmiddelenovergevoeligheid, seizoensgebonden allergie
Zenuwstelselaandoeningen : Vaak: hoofdpijn. Soms: dysgeusie, duizeligheid, gezichtsvelduitval
Oogaandoeningen : Zeer vaak: oculaire hyperemie, iris hyperpigmentatie. Vaak: keratitis punctata, voorste oogkamerontsteking, oogpijn, fotofobie, oogafscheiding, ongemak in het oog, scherpzien gereduceerd, gezichtsvermogen wazig, droog oog, oog pruritis, traanproductie verhoogd, erytheem van het ooglid, ooglidoedeem, groei van de wimpers, wimperverkleuring. Soms: cornea-erosie, uveïtis, keratitis, oogontsteking, fotopsie, blefaritis, conjunctivaal oedeem, halogezicht, conjunctivitis, conjunctivale follikels, ooghypo-esthesie, meibom-ontsteking, ectropion, voorste oogkamer pigmentatie, mydriase, cataract, schilferige ooglidrand, asthenopie
Hartaandoeningen : Soms: hartfrequentie onregelmatig, hartkloppingen, hartfrequentie verlaagd
Bloedvataandoeningen : Soms: bloeddruk verlaagd, bloeddruk verhoogd, hypotensie, hypertensie
Ademhalingssysteem-, borstkas- en mediastinumaandoeningen : Soms: dyspnoea, astma, luchtwegaandoening, orofaryngeale pijn, hoesten, dysfonie, neusverstopping, keelirritatie
Maagdarmstelselaandoeningen : Soms: peptisch ulcus gereactiveerd, maagdarmstelselaandoening, constipatie
Huid- en onderhuidaandoeningen : Vaak: huidhyperpigmentatie (periocular). Soms: dermatitis allergisch, periorbitaal oedeem, contactdermatitis, erytheem, rash, haarkleurveranderingen, haartextuur abnormaal, hypertrichose, madarose
Skeletspierstelsel- en bindweefselaandoeningen : Soms: skeletspierstelselpijn
Algemene aandoeningen en toedieningsplaatsstoornissen : Soms: asthenie, malaise
Tijdens de ontwikkeling van TRAVATAN (met polyquaternium als conserveermiddel) werden in 2 klinische studies 201 patiënten tot 3 maanden blootgesteld. In geen van de klinische studies werden ernstige oftalmische of systemische bijwerkingen gemeld die in verband konden worden gebracht met het product. De meest gemelde bijwerking die in verband kon worden gebracht met TRAVATAN (met polyquaternium als conserveermiddel) was hyperemie van het oog (18,9%), waaronder oculaire of conjunctiva hyperemie. Eén patient (0,5%) zette de deelname aan de studie stop vanwege hyperemie van het oog.
De volgende bijwerkingen konden in verband worden gebracht met de behandeling (met TRAVATAN (met polyquaternium-1 als conserveermiddel) als monotherapie) en zijn ingedeeld 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 ≤1/1.000), of zeer zelden (≤1/10.000). Binnen iedere frequentiegroep worden bijwerkingen gerangschikt naar afnemende ernst.
TRAVATAN (met polyquaternium-1 als conserveermiddel)
Zenuwstelselaandoeningen: Soms: hoofdpijn.
Oogaandoeningen: Zeer vaak: oculaire hyperemie. Vaak: keratitis punctata, oogpijn, fotofobie, ongemak in het oog, droog oog, oog pruritus. Soms: scherpzien gereduceerd, traanproductie verhoogd, erytheem van het ooglid, schilferige ooglidrand.
Maagdarmstelselaandoeningen: Soms: droge mond.
Huid- en onderhuidaandoeningen: Vaak: huidhyperpigmentatie, huidverkleuring.
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, astma verergerd, vertigo, tinnitus, PSA verhoogd, haargroei abnormaal.
Publiekprijs inclusief BTW: Travatan 2,5 ml : 28,75 €; 3 x 2,5 ml : 54,08 €.
Registratiehouder: Alcon Laboratories (UK), Ltd. Boundary Way, Hemel Hempstead, Herts HP2 7UD, Verenigd Koninkrijk.
Fabrikant: SA ALCON-COUVREUR NV, Rijksweg 14, 2870 Puurs, België.
Registratienummer: EU/1/01/199/001-002.
Aflevering: Geneesmiddel op medisch voorschrift.
Datum van herziening van de tekst: 14 april 2011.
Apr 2011

TRAVATAN®

Dénomination du médicament : TRAVATAN 40 microgrammes/ml collyre en solution.
Composition qualitative et quantitative : Chaque ml de solution contient 40 microgrammes de travoprost. Liste des excipients: polyquaternium-1, huile de ricin hydrogénée polyoxyéthylénée 40 (HCO-40), acide borique (E284), mannitol (E421), chlorure de sodium, propylène glycol (E1520), 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
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.
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.
Mode d'administration
Voie oculaire
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 4400 patients, TRAVATAN (conservé avec du chlorure de benzalkonium) 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 au produit n'a été rapporté dans aucune des études cliniques. L'effet indésirable, lié à TRAVATAN (conservé avec du chlorure de benzalkonium) en monothérapie, le plus fréquemment rapporté était une hyperémie oculaire (22,0 %) incluant hyperémie oculaire, conjonctivale ou sclérale. L'hyperémie était légère chez 83,6 % 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'hyperémie a diminué avec le temps.
Lors d'une étude clinique post-AMM à long terme d'une durée de 5 ans incluant 502 patients, TRAVATAN a été administré une fois par jour. Aucun effet indésirable grave, ophtalmique ou systémique, lié à TRAVATAN n'a été rapporté au cours de l'étude clinique. L'effet indésirable lié au traitement avec TRAVATAN le plus fréquemment rapporté était une hyperpigmentation de l'iris (29,5 %). L'hyperémie oculaire considérée comme liée à l'utilisation de TRAVATAN a été rapportée avec une incidence de 10,0 %, et 2 % des patients rapportant une hyperémie oculaire ont interrompu leur participation à l'étude en raison de cet effet indésirable.Les effets indésirables suivants ont été considérés comme liés au traitement avec TRAVATAN (conservé avec du chlorure de benzalkonium) 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.
TRAVATAN (conservé avec du chlorure de benzalkonium)
Infections et infestations: Peu fréquentes : herpès simplex, kératite herpétique
Affections du système immunitaire : Peu fréquentes : hypersensibilité, hypersensibilité médicamenteuse, allergie saisonnière
Affections du système nerveux: Fréquentes : céphalées. Peu fréquentes : dysgueusie, sensation vertigineuse, anomalie du champ visuel
Affections oculaires : Très fréquentes : hyperémie oculaire, hyperpigmentation de l'iris. Fréquentes : kératite ponctuée, inflammation de la chambre antérieure, douleur oculaire, photophobie, sécrétions oculaires anormales, gêne oculaire, baisse d'acuité visuelle, vision trouble, sécheresse oculaire, prurit oculaire, augmentation de la sécrétion lacrymale, érythème des paupières, œdème des paupières, croissance des cils, coloration des cils. Peu fréquentes : érosion de la cornée, uvéite, kératite, inflammation oculaire, photopsie, blépharite, œdème conjonctival, effet de halo, conjonctivite, follicules conjonctivaux, hypo-esthésie oculaire, meibomite, ectropion, pigmentation de la chambre antérieure, mydriase, cataracte, bord de la paupière croûteux, asthénopie
Affections cardiaques : Peu fréquentes : fréquence cardiaque irrégulière, palpitations, fréquence cardiaque diminuée
Affections vasculaires : Peu fréquentes : diminution ou augmentation de la pression artérielle, hypotension, hypertension
Affections respiratoires, thoraciques et médiastinales :Peu fréquentes : dyspnée, asthme, trouble respiratoire, douleur oro-pharyngée, toux, dysphonie, congestion nasale, irritation de la gorge.
Affections gastro-intestinales : Peu fréquentes : réactivation d'ulcère gastro-duodénal, affection gastro-intestinale, constipation
Affections de la peau et du tissus sous-cutané : Fréquentes : hyperpigmentation cutanée (péri-oculaire). Peu fréquentes : dermatite allergique, œdème péri-orbital, dermatite de contact, érythème, rash, modification de la couleur des cheveux, texture anormale des cheveux, hypertrichose, madarose
Affections musculo-squelettiques et systémiques :Peu fréquentes : douleur musculo-squelettique
Troubles généraux et anomalies au site d'administration : Peu fréquentes : asthénie, malaise
Dans 2 études cliniques réalisées pour le développement de TRAVATAN (conservé avec du polyquaternium), 201 patients ont été traitées sur une période allant jusqu'à 3 mois. Aucun effet indésirable grave, ophtalmique ou systémique, lié au produit n'a été rapporté dans ces études cliniques. L'effet indésirable lié à TRAVATAN (conservé avec du polyquaternium) le plus fréquemment rapporté était une hyperémie oculaire (18,9 %) incluant hyperémie oculaire ou conjonctivale. Un patient (0,5%) a interrompu sa participation à l'essai pour hyperémie oculaire.
Les effets indésirables suivants ont été considérés comme liés au traitement (avec TRAVATAN (conservé avec du polyquaternium-1) 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, ≤1/1 000) ou très rares (≤1/10 000). Dans chaque groupe de fréquence, les effets indésirables sont présentés dans l'ordre décroissant de gravité.
TRAVATAN (conservé avec du polyquaternium-1)
Affections du système nerveux : Peu fréquentes : céphalées
Affections oculaires : Très fréquentes : hyperémie oculaire. Fréquentes : kératite ponctuée, douleur oculaire, photophobie, gêne oculaire, sécheresse oculaire, prurit oculaire. Peu fréquentes : baisse d'acuité visuelle, augmentation de la sécrétion lacrymale, érythème des paupières, bord de la paupière croûteux
Affections gastro-intestinales : Peu fréquentes : bouche sèche
Affections de la peau et du tissu sous-cutané : Fréquentes : hyperpigmentation cutanée, dyschromie cutanée
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 : 54,08€.
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.
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Abstracts

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Orbital decompression - The swinging eyelid technique

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Basic principles of orbital decompression will be explained. The anatomy of the bony orbit, the degree of proptosis and the presence of optic nerve compression will influence the number of walls that will be removed. The surgical technique will be illustrated to give the audience a nice overview.

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A diagnostic challenge: Chronic myelomonocytic leukaemia and recurrent ischaemic optic neuropathy

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PURPOSE Ischaemic optic neuropathy (ION) is usually anterior and either arteritic (AAION), or non-arteritic (NAAION). Distinguishing between these two categories is not always simple, but crucial as they are associated with different underlying systemic conditions. Here we describe a rare and diagnostically challenging case and highlight the importance of diagnosis in atypical presentations.

METHODS A 66 year old Caucasian man presented with acute visual loss and a swollen right optic disc. He had risk factors and clinical features suggesting NAAION but a blood profile more consistent with an inflammatory process. He was started on steroids which were tapered after a negative temporal artery biopsy and symptomatic improvement. Over the next 5 months he suffered 2 more episodes of visual loss affecting both eyes. Re-introduction of steroids improved vision. Investigations revealed mildly raised inflammatory markers and thrombocytopenia. A rash was noted. Autoimmune tests showed a weakly positive ANCA. A raised white cell count was initially thought to be steroid induced, but further review showed an underlying monocytosis. A bone marrow biopsy demonstrated chronic myelomonocytic leukaemia (CMML). A skin biopsy revealed lymphocytic vasculitis.

CONCLUSION We report for the first time ION linked to CMML and its associated vasculitis. We highlight the difficulty and delay in diagnosis due to the use of steroids masking an underlying systemic process. Recurrent ION and raised inflammatory markers should raise suspicion of vasculitis. Together with an elevated monocyte count, CMML should be considered.

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Acute choroidal ischemia as a result of pre-eclampsia associated with PRES and HELLP syndromes: a clinical case

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PURPOSE To describe the case of a patient who developed choroidal ischemia and retinal detachment as late manifestation of eclampsia associated in post-partum time with mild PRES (Posterior Reversible Encephalopathy Syndrome) and severe, prolonged HELLP syndrome (Haemolysis, Elevated Liver enzymes and Low Platelets).

METHODS Review of a clinical case.

RESULTS After an early delivery at 35 weeks caused by pre-eclampsia, the patient developed a severe eclampsia associated with HELLP syndrome. Despite subjective bilateral decreased vision, the ophthalmological examination at the intensive care unit was unremarkable. The brain MRI showed left parietal PRE Syndrome. Six days later, bilateral macular oedema was confirmed by fundus examination. Parietal lesions improved on MR imaging but bilateral choroidal thickening appeared associated with visual acuity of 0.1 RE and 0.2 LE. Fluorescein angiography and OCT confirmed both choroidal ischemia and serous neuroretinal macular detachment. The patient was treated with 1g IV methylprednisolone, 30 mg nifedipine and 500 mg acetazolamide 3 times per day for eight days. Visual acuity progressively improved while the corticosteroids were tapered for four weeks. Six months later, ocular examination confirmed almost full functional recovery.

CONCLUSION Visual loss due to choroidal ischemia might be a late complication of eclampsia and HELLP syndrome. Visual recovery is usually complete with a prompt management of the aetiology. As corticosteroids and acetazolamide have been recommended in the literature, our case showed an almost complete recovery of visual function.

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Additional diagnostic clue in Multiple Evanescent White Dot Syndrome: Fundus autofluorescence

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PURPOSE Multiple Evanescent White Dot Syndrome (MEWDS) affects young adults and is characterized by sudden visual alterations in one eye, paracentral scotomas and photopsia. The fundus lesions demonstrate flat, small, multifocal, whitish, well defined spots located predominantly in the paramacular area, and a characteristic foveal granularity. Other findings may include mild vitritis, mild disc swelling and a relative afferent pupillary defect. We describe the evolution of fundus autofluorescence (FAF) in two patients, one with a typical and the other with an uncommon presentation of MEWDS.

METHODS Two patients with MEWDS were evaluated by angiography and FAF.

RESULTS For both patients, FAF in the acute phase showed hyperautofluorescent spots that precisely corresponded to the areas of hypofluorescent spots seen on indocyanine green angiography. In one patient who had no white spots on the fundus, but only foveal granularity, FAF findings allowed a faster diagnosis.

CONCLUSION FAF is a useful non invasive imaging technique to identify MEWDS and should be added to the workup of MEWDS.

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Atypical inflammatory myofibroblastic pseudotumor of the etmoidal sinus extending into the orbit

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PURPOSE To report a case of an atypical inflammatory pseudotumor of the paranasal sinuses with bony invasion extending into the orbit .

METHODS Case-report.

RESULTS A 71-year old man presented with slowly progressive painless diplopia followed by unilateral proptosis of the left eye with a slight edema of the upper eyelid. Visual acuity was 0.4 with a relative afferent pupillary defect . Abduction and depression of the left eye were limited. Imaging showed an orbital tumor around the obliquus superior with lateral displacement, possible infiltration of the superior and medial rectus, involvement of fossa pterygopalatinum , sinus etmoidalis, sphenoidalis and maxillaris , intracranial extension through the fissura orbitalis superior, bone erosion and sclerotic bone reaction. Endoscopic ethmoïdal, maxillary and orbital biopsies discovered a inflammatory myofibroblastic tumor. Blood parameters showed eosinophily. ANCA and CRP were negative. Discussion: In the literature three cases of orbital myofibroblastic tumors have been described but never with bone invasion. Only a few sinus inflammatory pseudotumors with bony erosion have been reported. Central nervous system myofibroblastic tumors give a dura based mass-forming an en plaque pattern. Two cases with orbital involvement have been described.

CONCLUSION This eroding sino-orbital inflammatory myofibroblastic tumor is a new finding mimicking a malignant tumor.

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Correction of the lower eyelid malpositioning in the blepharophimosis, ptosis and epicanthus inversus syndrome (BPES)

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PURPOSE Blepharophimosis, ptosis, epicanthus inversus syndrome (BPES) is an autosomal dominant complex eyelid malformation. We aim to offer an explanation for the lower eyelid malformation and propose a novel surgical approach to correct it.

METHODS An observational and interventional case series of ten consecutive, molecularly proven, BPES patients who underwent surgical repair of the lower eyelid malformation. During surgery detailed anatomical examination and surgical repositioning of the medial canthal tendon was performed.

RESULTS All patients exhibited a marked asymmetry in the attachment of the lower and upper eyelid to the medial canthal tendon, with the lower eyelid being much less attached. This resulted in an abnormal downward concavity with a temporal ectropion and a temporally displaced lower eyelid. Consequently, the inferior punctum was displaced temporally. All patients underwent a novel surgical technique to remediate this, namely inserting 4.0 nylon suture between the tarsal plate of the lower eyelid and the medial canthal tendon during telecanthus surgery. This simple additional surgical step not only corrected the position of the lower eyelid, but also its abnormal downward concavity, the temporal ectropion and the lateral displacement of the inferior punctum. None of our patients had lasting epifora.

CONCLUSION Lateral displacement of the inferior punctum is an important hallmark in the diagnosis of BPES. We demonstrate an anatomical explanation for the complex lower eyelid malformation and also propose a novel surgical technique to correct this.

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Frequency of metastatic disease and survival of 716 consecutive patients with uveal melanoma: a retrospective monocentric reviewmelanoma

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PURPOSE To determine the frequency, location, time to systemic metastases and survival in patients with uveal melanoma managed at one cancer center

METHODS A retrospective review on 716 consecutive patients, referred and managed at the Centre du Cancer, Brussels for uveal melanoma between 1/1998 and 12/2010. Patient survival was assessed by Kaplan-Meier method and the impact of metastatic diesase–related symptoms on survival by the Log-Rank test. A multivariate Cox regression was performed to identify risk factors for metastatic disease.

RESULTS The median age at diagnosis was 63 years. According to the COMS classification, there were 43 (6%) small tumors, 379 (53%) medium tumors, 232 (32%) large tumors and 62 (9%) tumors were unclassified. Enucleation, radiotherapy+/-thermotherapy and thermotherapy alone was performed in 24%, 66% and 10% of patients, respectively. The median time between tumor diagnosis and treatment was 9 days. After a median follow-up of 36 months 100 patients (13.9%) developed metastases (71% exclusively liver localisation, 19% extraliver and liver localisations and 5% only extraliver localisation) with a median time to relapse of 32 months. The relapse free survival from diagnosis at 5 and 10 years was 81% and 74,6%, respectively. Fourty patients (40%) died from their melanoma with a median survival time of 17 months. No difference in survival was observed between those patients with metastasis-related symptoms and those without (p> 0.05).

CONCLUSION Our study showed a lower frequency (14%) of metastatic disease with a higher median survival time than those previously reported. The potential impact of the treatment(s) on survival prognosis among our patients with metastatic disease is under investigation

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Insights into Levator muscle dysfunction in a cohort of molecularly confirmed BPES patients using high-resolution imaging, anatomical examination and histopathology

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PURPOSE Blepharophimosis syndrome (BPES) is an autosomal dominant eyelid malformation associated or not with ovarian dysfunction. The pathophysiology underlying this eyelid malformation remained unexplored. It was our aim to study the basis of defective Levator Palpebrae Superioris (LPS) function in BPES.

METHODS Eight molecularly proven BPES patients underwent high-resolution surface coil three tesla MRI prior to surgery. The features of LPS muscle and adjoining connective tissue were compared with an age comparable control. During levator resection for ptosis repair, detailed anatomical examination of the LPS was performed. Histopathology was compared with a normal control and a sample from a patient with simple congenital ptosis.

RESULTS The most striking feature obtained by MRI was the thin and long anterior part of LPS. During surgery this consisted of a disorganized, long and thin aponeurosis.However in the posterior part there was presence of an organized thick structure assuming a muscle belly. Histopathology revealed posteriorly well formed striated muscle fibers in all BPES patients, but not in the control sample from the patient with severe congenital ptosis. These striated muscle fibers were comparable to the normal control but are more intermixed with collagenous tissue and little fatty degeneration.

CONCLUSION The presence of striated muscle fibers in LPS of BPES patients contrasts with the fatty degeneration in patients with severe congenital ptosis. This is the first study providing novel insights into the pathogenesis of the eyelid malformation in BPES through exhaustive imaging, anatomic study and histopathology in a unique cohort of molecularly proven BPES.

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Levator muscle function is increased by supra-maximal resection in BPES patients

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PURPOSE To study the efficacy, clinical and anatomical results of supra-maximal levator resection in BPES patients with severe congenital ptosis with poor levator function (LF).

METHODS Eleven molecularly proven BPES patients underwent (supra-) maximal levator resection. Palpebral fissure (PF) height and LF was measured pre- and postoperatively.

RESULTS All patients showed an excellent reduction in ptosis with a single intervention resulting in a clear visual axis. PF height improved from 3.3 ± 0.7 mm preoperatively to 7.1 ± 0.9 mm postoperatively (p value < 0.0001). Four patients underwent additional surgery because of cosmetic issues with eyelid height asymmetry. All patients showed a marked, consistent and lasting improvement in LF, going from 1.9 ± 0.9 mm preoperatively to a value of 7.4 ± 1.1 mm postoperatively (p value < 0.0001). This improvement could be attributed to the presence of a very long and thin tendon, as well as a striated muscle belly. This elongated aponeurosis inhibits the levator muscle from having sufficient impact on the vertical eyelid excursion.

CONCLUSION We demonstrated that (supra)-maximal levator resection performed in BPES patients not only results in good cosmesis in terms of ptosis reduction in the majority of cases, but also in a significant increase of the levator palpebrae superioris (LPS) function. An anatomical substrate was found to explain these findings. This is the first study to provide evidence of a marked increase in LF in BPES due to resection of the elongated tendon with reinsertion of the muscle belly.

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Mechanism of lens subluxation in Goltz syndrome

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PURPOSE With this case we want to enlighten the ophthalmic features in Goltz syndrome or Focal dermal hypoplasia.Goltz syndrome is a rare mesoectodermal disorder inherited by an X-linked dominant gene with abnormal ophthalmic features in 40% of the patients. Here we report a unique mechanism of lens subluxation.

METHODS We present the case of a 4-year-old girl who presented at birth with the typical clinical features of Focal dermal hypoplasia. Diagnosis was confirmed by molecular analyses.

RESULTS The girl had mild facial dysmorphism with hypertelorism. There was a horizontal nystagmus with a moderate esotropia of the right eye. The best corrected visual acquity was 1/60 at both eyes. Slitlamp examination showed a bilateral iriscoloboma with an inferior lens subluxation due to stretched ciliary processes. In the fundus there was a chorioretinal coloboma involving the optic discs at both sides. Furthermore she had the typical linear dermal aplasie on the chest, hypoplasia of the nails, clinodactyly of the 5th finger of right hand, syndactyly of the 4th and 5th finger of the left hand and bilateral hypoplastic kidneys. Molecular analysis showed a missense mutation in the PORCN gen.

CONCLUSION Lensluxation normally presents because of stretched or broken lens zonula. This case illustrates the unusual mechanism of lens subluxation due to stretched ciliary processes in a patient with Goltz syndrome

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Not all choroidal tumors are melanomas or metastases, and rare cases are challenging for treatment

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PURPOSE Description of a case report. A monophthalmic patient was referred with different choroidal tumors in his only left eye for advise about the diagnosis and different treatment options

METHODS In 2006 the right eye was enucleated for melanoma. In 2009 a skin melanoma on the head was resected, and in 2010 a neuroendocrine adenocarcinoma (NEAC) of the prostate was diagnosed with a liver metastasis of NEAC. Multiple metastatic lesions were detected by ct on liver, spine and abdomen without any complains. The different treatment options and correlations between these 4 tumors were investigated

RESULTS After review of the 4 biopsies the final diagnosis was: 2 different tumors: a paraganglioma in the left eye with skin metastasis (and not melanoma) and NEAD in the prostate with hepatic metastasis. The tumors in the left eye are presumed to be metastases of one of the originals or a new location of one. Both type of tumors have common clinical and pathologic characteristics and a genetic predisposition is suggested. In most cases there is a favorable prognosis. The vision of the left eye was 7/10 with diffuse metamorphopsia, because of subretinal fluid around the tumors. The treatment options were discussed with multiple experts and external beam radiation to the left eye was performed to stabilize the tumors. He was in general good health, although multiple detected metastases on imaging

CONCLUSION This case shows a very rare paraganglioma in one eye in a patient with multiple NEAD and metastates in the other eye; this demonstrates the possible genetic link between both rare entities

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Orbital lymphangioma treated with intralesional injection of sodium morrhuate.

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PURPOSE To describe the efficacy of the injection of the sclerosing agent sodium morrhuate in orbital lymphangioma.Orbital lymphangiomas often cause disfiguring proptosis with recurrent painfull hemorrhages and risk of vision loss. Surgical removal is almost always incomplete and associated with considerable risks. Other sclerosing agents have been described with variable success, but also with serious orbital inflammation and even blindness. Sodium morrhuate has only been described once.

METHODS Case report. A 6 year old boy presented with a sudden unilateral painless proptosis of 8 mm compared to the other eye. VA was 0.8 bilaterally. Imaging revealed an intraconal lymphangioma with internal hemorraghe. The following 3 months proptosis increased slowly to 10 mm, with diplopia and VA decreased to 0.6. One month later he presented with a swollen caruncula. Proptosis had increased to 15 mm, VA was 0.5 with moderate optic disc swelling en retinal venous dilatation. The largest orbital cyst was punctured under CT guidance. Yellow clear fluid was aspirated, followed by injection of water soluble contrast, which remained confined to the orbit and did not enter the cavernous sinus. Finally 0,8 mm of sodium morrhuate was injected in the orbital lesion.

RESULTS There was no postoperative inflammation and proptosis was unchanged. Proptosis reduced to 5 mm after one month, 4 mm after 3 months and remained stable since.

CONCLUSION The intralesional injection of sodium morrhuate in orbital lymfangioma did not induce any visible external orbital inflammatorion and was efficient in reducing proptosis.

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Original diagnosis of Central Cloudy Dystrophy of François revisited as corneal opacities in a F216Y/L444P variant of Gaucher disease

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PURPOSE To report a case of corneal opacities in a patient with Gaucher disease.

METHODS Case Report with slit-lamp photography and molecular analysis of the glucocerebrosidase gene.

RESULTS Ophthalmic evaluation in a 57-year-old Caucasian patient ruled out corneal opacities. Analysis of the glucocerebrosidase gene disclosed a heterozygous F216Y/L444P mutation. His two siblings known with the same disorder and mutations also show subnormal visual acuity, slightly hazy corneas and increased central corneal thickness. The corneal abnormalities were already seen at the age of 16, years before diagnosis of Gaucher disease was made. Professor François originally classified the corneal densities in this patient as central cloudy dystrophy. Corneal opacities are a rare but early sign of Gaucher disease.

CONCLUSION Corneal involvement in Gaucher disease is unique and limited to anecdotal case-reports. This is the first case to describe corneal deposits in a rare F216Y/L444P non neurogenic variant of Gaucher disease. The initial diagnosis of Central Cloudy Dystrophy of François was revisited after diagnosis of Gaucher disease was made.

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Phenotype of RDH12-related Early-Onset Retinal Dystrophy

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PURPOSE To describe the phenotype in Early-Onset Retinal Dystrophy (EORD) related to RDH12 mutations.

METHODS Twenty-eight affected individuals from nineteen families with proven RDH12 mutations underwent a detailed ophthalmological examination including fundus photography using white, autofluorescent, near-infrared and red-free light and optical coherence tomography (OCT). In addition, psychophysical and electrophysiological testing (ISCEV-standard ERG) was performed.

RESULTS All twenty-eight affected individuals had a history of poor vision from the first few years of life. Fundoscopy showed marked atrophy and yellow discolouration of the macula. Spicular intraretinal pigmentation was present in the (mid)periphery of all fundi. In addition, a remarkable aspect of patchy preservation of functional retina in the retinal periphery was present until relatively late in the disease with additional significant sparing of the peripapillary area in all individuals. OCT confirmed the conservation of the peripapillary retinal structure. ERG revealed very reduced to absent responses under both scotopic and photopic conditions.

CONCLUSION The phenotype of RDH12-related EORD includes an early macular atrophy with yellow discolouration, and patchy preservation of peripheral and peripapillary retina as a specific pathognomonic feature.

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Prevalence of glaucoma in patients with Graves' orbitopathy

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PURPOSE 1.To determine whether the elevation of IOP in patients with Graves' orbitopathy (GO) has an impact on onset of glaucomatous damage.2.To assess the effects of orbital decompressing surgery on IOP.

METHODS Retrospective study including 153 eyes of 78 patients with GO. The records were studied and the patients were divided in the following groups: 1.GO with normal IOPs lower than 21 mmHg. 2.GO with OHT (IOP> 21 mmHg) without topical antiglaucomatouse meds. 3.GO with hypertension and topical treatment. Each patient underwent a complete examination on each visit including IOP in primary and up-gaze position, optic nerve examination and VF examination 30-2 using Humphrey sita-fast program.

RESULTS 56 female and 22 male were in total included in the study. The mean age was 51.9 ± 13.9 years (range 15 to 86 years). The mean Follow-up was 51.6 ± 13.2 months. 58,4% of the total GO had normal IOPs at baseline (16.6±3.6mmHg). 8.4% had raised IOP at baseline where no treatment was required (23.1± 1.3 mmHg). 31.8 % had raised IOP requiring topical meds (26.2 ±4.2 mmHg). In total, 27% of the included eyes had orbital decompression. De mean IOP preop was 20.9± 3.8 mmHg. The IOP on 1 month and 4 month Follow-up was respectively 18.8± 3.9 mmHg and 17.7± 3.4 mmHg. The mean IOP on the last follow-up was 16.1± 2.7. The drop in the IOP was statistically significant (p=0.001).

CONCLUSION The elevated IOP in GO was found in more than 30% of the patients. It seems to be related to the compression of the eyeball and to the increased intraorbital pressure as result of the proliferation of the orbital adipose tissue and the enlargement as well as swelling of extraocular muscles. We have observed a significant reduction in IOP after decompression in our study sample.

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Preserved Visual Acuity in Diabetic Macular Ischaemia

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PURPOSE To describe three patients with severe diabetic macular ischaemia and bilateral best corrected visual acuity (BCVA) of 6/6.

METHODS Two patients with Type 1 diabetes and one patient with Type 2 diabetes treated with insulin were referred for ophthalmological evaluation. Two patients were diagnosed having proliferative disease at presentation, the third patient presented with severe non proliferative diabetic retinopathy. Foveal avascular zone (FAZ) was graded according to Early Treatment Diabetic Retinopathy Study (ETDRS) grading system.

RESULTS The patients were aged between 26 and 45 and suffered diabetes for more then 10 years each. Spectralis optical coherence tomography (OCT) and fluorescein angiography (FA) were performed in every patient. FA revealed abnormalities of the FAZ including increased FAZ diameter larger than 1000 µm (range 1536 µm-4004 µm), irregular FAZ margins, severe ETDRS capillary dropout grade, enlargement of the perifoveal intercapillary area and precapillary arteriolar occlusions.

CONCLUSION Severe diabetic macular ischaemia can coexist with good visual acuity and good visual acuity does not necessarily exclude diabetic macular ischaemia.

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Subconjunctival epidermoid cysts in Gorlin-Goltz syndrome

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PURPOSE To describe a patient with Gorlin-Goltz syndrome with subconjunctival cysts. Gorlin-Goltz syndrome or nevoid basal cell carcinoma syndrome is an autosomal dominant disorder characterized by a wide range of developmental abnormalities and a predisposition to neoplasms.

METHODS A 24-year old woman with confirmed Gorlin-Goltz syndrome presented with subconjunctival cysts in both upper eyelids. These were removed under local anesthesia and histopathological examination was performed.

RESULTS Slit-lamp examination showed bilateral subconjunctival light-yellow cysts in the palpebral conjunctiva of the upper eyelids. Anterior segment examination and fundoscopy were normal. BVCAs were 10/10. Histological examination of both upper eyelid biopsy specimen revealed multiple epidermoid cysts filled with keratic debris.Our patient is known with de novo Gorlin-Goltz syndrome, confirmed by molecular analysis. She has multiple skin naevi and fibroma (cardiac, overian and tongue). Different odontogenic keratocysts of the mandible were surgically removed that showed epidermoid cysts with keratosis, similar to the subconjunctival cysts.

CONCLUSION Subconjunctival epidermoid cysts are an ocular feature of Gorlin-Goltz syndrome. Until now, only three patients have been described with this ocular sign. Histopathological examination of the subconjunctival cysts showed similarities with the jaw keratocysts found in our patient.

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Sudden bilateral visual loss related to a Cancer-Associated Retinopathy (CAR): An atypical presentation.

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PURPOSE To report the case of a 56-year old woman without any prior history of cancer, who was referred for a rapid bilateral visual loss and ultimately diagnosed with a neuroendocrine tumor of the lung associated to cancer-associated retinopathy (CAR).

METHODS Case-report and review of literature.

RESULTS The patient presented with rapid visual loss in both eyes over ten days. Visual acuity was LP OD, HM OS. Anterior and posterior biomicroscopy revealed anterior uveitis with vitritis in both eyes. Bilateral optic disc pallor, arteriolar attenuation and disappearance of the foveal reflect were documented. OCT demonstrated major photoreceptor layer atrophy. Fluorescein angiography was unremarkable. Blood analyses were normal. ERG showed flat responses on both scotopic and photopic conditions. In order to rule out CAR syndrome, chest CT was ordered and revealed a right lung tumor with mediastinal lymphadenopathy. Histopathogical examination confirmed the diagnosis of large cell neuroendocrine carcinoma of the lung. Dosage of anti-recoverin antibodies was not performed. Despite intensive IV corticosteroid therapy and disappearance of the inflammatory signs, the final vision was LP in both eyes within two weeks.

CONCLUSION The two-week bilateral loss of vision in our patient is atypical for patient diagnosed with CAR syndrome as well as the neuroendocrine characteristics of the primary tumor.

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The continuing quest to perform accurate IOL calculations in cataract surgery.

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PURPOSE Purpose: To evaluate the accuracy of intraocular lens (IOL) calculations with the LENSTAR®

METHODS Methods:Design: Retrospective, case series.Participants: 30 patients who underwent phacoemulsification + intraocular lens implant. Intervention: All patients were evaluated preoperatively with objective refraction(OR), axial length based on ultrasonography(AXL) and LENSTAR®. On the one hand, IOL was calculated based on AXL and OR and on the other hand,the three calculated IOL's of the LENSTAR® were documented. The difference (D) between the chosen IOL and the calculated IOL was noted for all methods. Patients were seen the first postoperative day and one month after surgery. Their best corrected visual acuity (BCVA) and OR were documented on each visit. Finally, we compared the documented D with the OR of the patients.Main outcome measures: BCVA and OR after IOL calculation with LENSTAR® after 1 month of follow up.

RESULTS Results: The preliminary results show that the calculation based on the Haigis method is the most accurate. In most cases the difference between the chosen IOL and the calculated IOL by this method is almost neglectable, whereas in other formulas, the difference is more notable. Statistical analyses will be illustrated on the poster.

CONCLUSION Conclusion: The preliminary results illustrate a very good accuracy of the IOL calculations with LENSTAR®, with the Haigis Formula in particular.

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Torticollis, photophobia and epiphora secondary to fossa posterior tumour: a case report

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PURPOSE To indicate that a pilocytic astrocytoma in the posterior cranial fossa in children is one of the causes of torticollis with epiphora and photophobia. To illustrate the value of an MRI scan of the brain in making this diagnosis.

METHODS Case report

RESULTS We describe the case of an eight-month-old girl who presented with a triad of photophobia and epiphora since birth with a pronounced progressive torticollis with a head turn to the right and a chin tilt downwards. The eye examination was unremarkable with the exception of a slightly paler fundus. There was no nystagmus. Neurological examination revealed a normal, albeit asymmetrical development with reduced unilateral grasping and failure to thrive. A brain CT scan did not show any substantial abnormalities. MRI of the brain revealed a posterior fossa tumour. The tumour is mainly hyperintense on T2, and hypo-intense on T1. Biopsy and debulking of the tumour were performed with subtotal excision. Histopathology was typical of a pilocytic astrocytoma. With more than 95% of the lesion resected without damage to either medulla oblongata or brain stem, and in view of the histopathological findings, no further surgery or chemotherapy was performed. The torticollis improved, the child thrived better, but photophobia remained.

CONCLUSION The triad of photophobia, epiphora and torticollis should suggest a posterior fossa tumour. In infants with these symptoms an MRI rather than a CT brain is the examination of choice.

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Correlation of the rate of progression of visual field loss between Guided Progression Analysis (GPA II) and PeriDataTM program in glaucoma patients: Pilot study

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PURPOSE To assess the correlation of progression rate measured by GPAII using visual field index (VFI%) and PeriDataTM employing functional equivalent score (FES) in glaucoma patients.

METHODS Retrospective, observational study including 54 eyes of 37 medically treated glaucoma patients with at least 5 reliable visual field examinations in minimum 2 years. Only patients with a negative rate of progression with VFI were taken into account to calculate their rate of progression and loss of FES. Patients who underwent filtering surgery or laser trabeculoplasty during the follow-up period were excluded.

RESULTS Mean age was 75.7 ±13.4 yrs. the patients performed their visual field with Humphrey standard automated perimeter (Sita Standard 24-2). The mean follow-up was 7.5 ± 2.5 yrs.The mean of progression by GPA (%/year) and PeriData FES index (%/year) were: -2.0 ± 2.2 (range= -10.6 to -0.2 per year) and -3.18 ± 2.5 (range: -9.3 to 2.8 per year) respectively. There was an excellent correlation between GPAII index VFI% loss per year and PeriData FES loss per year (<0.001) for the total group. In contrary when the group was limited to low- moderate progressors (VFI% loss per year ≥ -2), there was no correlation between the two different indexes.

CONCLUSION In this study we couldn't find any correlation between VFI% and FES% in the clinically low to moderate visual field progression.

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Differential effects of various VEGF isoforms on endothelial cells and Tenon fibroblasts

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PURPOSE To clarify the differential effects elicited by VEGF isoforms in scar formation after glaucoma surgery, we compared the biological responses and signaling pathways activated by the various isoforms on endothelial cells (HUVEC) and Tenon fibroblasts (TF) in vitro.

METHODS VEGF-R2 and neuropilin-1 (NRP-1) expression was analyzed on HUVEC and TF by RT-PCR. The effect of different VEGF isoforms (VEGF189, VEGF165 and VEGF121) on HUVEC and TF proliferation was determined by WST-1 assay. The extracellular signal-regulated kinase (ERK) pathway was evaluated by TransAM c-Myc assay.

RESULTS HUVEC showed a higher expression of VEGF-R2 and NRP-1 mRNA as compared to TF. VEGF189 only significantly increased the growth of TF, whereas VEGF165 only significantly increased HUVEC proliferation. VEGF165 strongly binds VEGF-R2 and NRP-1. As such, the combined reduced expression of VEGF-R2 and NRP-1 on TF explained why VEGF165 was more potent in inducing proliferation of HUVEC as compared to TF. VEGF121 exerted significant proliferative effects on both cell types by binding VEGF-R2. However, similar concentrations of VEGF121 stimulated HUVEC more than TF, due to the lower expression of VEGF-R2 on TF. All these stimulating effects on proliferation were associated with an activation of the ERK pathway.

CONCLUSION Our data indicate that VEGF165 and VEGF121 predominantly affect blood vessel growth, whereas VEGF189 may be more important in fibrosis. Selective inhibition of VEGF165 (pegaptanib) may therefore be less effective to reduce ocular scar formation than non-selective VEGF-inhibition (bevacizumab), presumably due to retained action of VEGF121 and VEGF189.

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The effect of a single, preoperative, intracameral administration of bevacizumab (Avastin®) on trabeculectomy outcome: A prospective, randomized, double-blinded, placebo-controlled trial.

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PURPOSE To investigate the effect of a single, preoperative administration of bevacizumab (Avastin®) in terms of clinical outcome following trabeculectomy in patients with either primary open-angle glaucoma (POAG) or normal tension glaucoma (NTG).

METHODS 141 medically uncontrolled glaucoma patients who were scheduled for primary trabeculectomy were included in this prospective, randomized, double-blinded and placebo-controlled study. Patients were divided into POAG and NTG, which were then randomized to receive 50 µl of either bevacizumab (25 mg/ml) or placebo peroperatively. NTG patients also received mitomycin C. The target intraocular pressure (IOP) range was between 6 and 18 mmHg for POAG and between 6 and 14 mmHg for NTG. Absolute success was defined as meeting the target IOP at 6 month of follow-up without IOP-lowering medications or postoperative interventions. Qualified success was defined as meeting the target IOP at month 6 with or without either IOP-lowering medications and/or postoperative surgical interventions.

RESULTS Absolute success in the bevacizumab group was 83% compared to 59% in the placebo group (p=0.003, Odds Ratio (OR) 3.3, confidence interval (CI) 1.4-7.9). Qualified success was 99% in the bevacizumab group versus 94% in the placebo group (not significant, OR 4, CI 0.3-201). Needlings were significantly less frequent in the bevacizumab group as compared to the placebo group, respectively in 11% versus 32% (p=0.004). Complication rates were comparable in both groups.

CONCLUSION A single preoperative intracameral administration of bevacizumab was associated with increased absolute success rates and reduced need for postoperative interventions.

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FRO: Identity-by-descent mapping reveals a new locus for primary congenital glaucoma, GLC3E, on chromosome 19p13.2.

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PURPOSE Primary congenital glaucoma (PCG) is caused by developmental anomalies of the trabecular meshwork and the anterior chamber angle, resulting in an increased ocular pressure (IOP) and optic nerve damage from birth or early infancy. The prevalence of PCG is estimated to be 1:10.000 in Western populations with higher prevalences in inbred populations. In general PCG displays an autosomal recessive inheritance and is genetically heterogeneous. To date, four PCG loci are known (GLC3A-D), in which two genes have been identified, CYP1B1 and LTBP2. Here, we aimed to map the disease gene in a large, four-generation consanguineous family with PCG, originating from Jordany.

METHODS Mutations in and linkage to the known PCG genes CYP1B1 and LTBP2 were excluded respectively. Homozygosity or identity-by-descent (IBD) mapping was performed in six affected members using genomewide SNP genotyping with 250K arrays (Affymetrix), followed by data analysis with a homemade Perl script.

RESULTS The identified IBD regions did not overlap with any known PCG loci. Filtering on both size of the region and number of consecutive homozygous SNPs revealed a new candidate region on 19p13.2, named GLC3E. This region measures 1,8 Mb and contains 57 genes. Targeted resequencing of this region is ongoing.

CONCLUSION We identified a new PCG locus, named GLC3E, confirming the genetic heterogeneity of PCG, and representing a unique opportunity to identify the third PCG gene.

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FRO: Microplasmin as an antiscarring agent for glaucoma surgery: Translation into clinical application

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PURPOSE Previously the effect of Microplasmin was investigated in vivo in a rabbit model for glaucoma surgery. The combination of anterior chamber injections and topical drops of Microplasmin improved surgical outcome in a rabbit model for trabeculectomy. The aqueous solution of Microplasmin used was not optimized for use as drops or injections. Microplasmin is an autocatalytic enzyme which has a short half life when it is brought in conditions of 37°C and physiological pH. Therefore there is need for a more stable and longer acting formulation of Microplasmin.

METHODS In the first part of the project we did pharmacological experiments to determine the rheological characterization of drug carriers and finally we checked the Microplasmin activity in the new obtained solutions by spectrophotometer.In the second part of the project we performed trabeculectomy in a rabbit model and administered the most qualified and optimized formulations. Postoperative clinical evaluation of intraocular pressure, filtration bleb area, conjunctival vascularity and anterior chamber assessment was performed and the eyes were immunohistological investigated for collagen and inflammation.

RESULTS Our previous data learned that the combination of anterior chamber injections and topical drops of Microplasmin improved surgical outcome in a rabbit model for trabeculectomy, despite the fact that the formulation of Microplasmin was not optimized for use as eye drops or injections.

CONCLUSION In our proposed research project we tried to optimize the formulation of Microplasmin for extended drug delivery and hope to translate this novel antifibrotic adjunctive therapy into clinical application.

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FRO: Role of placental growth factor (PlGF) in wound healing after glaucoma filtration surgery

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PURPOSE The aim of our study was to check the hypothesis that placental growth factor (PlGF) plays a role in scar formation after glaucoma filtration surgery (GFS), and that it may be a target for improvement of the outcome of this surgery.

METHODS Since the rabbit is the most popular animal used for investigating postoperative scar formation, the cross-reactivity to rabbit-PlGF with human and murine PlGF-antibodies (16D3 and 5D11D4; ThromboGenics NV) was tested using ELISA. Murine conjunctival fibroblasts were isolated and cultured. The purity of the cultured cells was verified by an immunostaining for vimentin. Also, a mouse model of GFS was set-up, according to the technique Seet L, et al. (Mol Med 2011).

RESULTS ELISA-experiments demonstrated that none of the PlGF-antibodies showed cross-reactivity to rabbit PlGF. So, these antibodies could not be used in the standard rabbit model of glaucoma filtration surgery. Therefore, a mouse model of GFS was set-up and different immunostainings showed an increase of angiogenesis and inflammation during the initial phase of healing and fibrosis at the later stages. Cultured murine conjunctival fibroblasts were all positive for vimentin, which confirmed the purity of the fibroblast culture.

CONCLUSION Future experiments will elucidate the in vitro and in vivo role of the murine PlGF-antibody (5D11D4; ThromboGenics NV) on cultured fibroblasts and in the mouse model of GFS. This research project will clarify the potential role of PlGF-inhibition in the improvement of filtration surgery outcome, and will highlight any angiostatic, anti-inflammatory, and/or anti-fibrotic effects.

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Topical application of AMA0076, a locally acting rho kinase (ROCK) inhibitor, results in a robust IOP control in a hypertensive rabbit model

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PURPOSE To elucidate the IOP lowering effect of the local ROCK inhibitor, AMA0076, in the rabbit eye.

METHODS An ocular hypertensive rabbit model, based on the intracameral injection of visco-elastic material, has been developed to determine the IOP lowering effect of compounds acting to improve aqueous humor outflow. Using this model, the IOP lowering effect of AMA0076 was tested and compared to Y-39983, Latanoprost and Bimatoprost (5 rabbits/compound).

RESULTS Topical administration (TID) of AMA0076 prevented the IOP rise induced by the injection of visco-elastics in a dose dependent manner (overall $P<0.0001$). Treatment with AMA0076 0.3% completely prevented the rise in IOP (overall $P<0.0001$). Administration of Y-39983 0.3% significantly reduced (but did not completely abolish) IOP rise in the hypertensive model compared to the control eye (overall $P<0.0001$). A more subtle IOP decrease was also observed in the control eye with this non-local ROCK inhibitor, presumably due to the systemic absorption of Y-39983. AMA0076 was significantly more potent in blocking the IOP elevation in the hypertensive model compared to Latanoprost and Bimatoprost (respectively overall $P=0.0004$; $P=0.0003$).

CONCLUSION The local ROCK inhibitor AMA0076 lowers IOP in an efficient manner in an acute rabbit model for ocular hypertension, with a potency exceeding that of the non-local ROCK inhibitor Y-39983, as well as the prostaglandin analogues Latanoprost and Bimatoprost. In summary, the present data indicate that this new class of ROCK inhibitors has potential therapeutic value for the treatment of glaucoma through a novel IOP lowering strategy.

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FRO: Development of a next-generation sequencing platform for retinal dystrophies, with LCA and RP as proof of concept.

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PURPOSE Leber Congenital Amaurosis (LCA) is a rare congenital retinal dystrophy associated with 16 genes. Recent breakthroughs in LCA gene therapy offer the first prospect of treating inherited blindness, which requires an unequivocal and early molecular diagnosis. While present genetic tests do not address this due to a tremendous genetic heterogeneity, massively parallel sequencing (MPS) strategies might bring a solution. Here, we developed a comprehensive molecular test for LCA based on targeted MPS of all exons of 16 known LCA genes.

METHODS We designed a unique and flexible workflow for targeted resequencing of all 236 exons from 16 LCA genes based on qPCR amplicon ligation, shearing and parallel sequencing of multiple patients on a single lane of a short read sequencer. Twenty-two pre-screened LCA patients were included, five of which with known molecular cause.

RESULTS Validation of 107 variations was performed as proof of concept. In addition, the causal genetic defect and a single heterozygous mutation were identified in 3 and 5 out of 17 patients without previously identified mutations, respectively.

CONCLUSION We propose a novel targeted MPS-based approach that is suitable for accurate, fast and cost-effective early molecular testing in LCA, and easily applicable in other genetic disorders.

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Colour Vision in Stargardt Disease

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PURPOSE To investigate the type and severity of colour vision deficiencies (CVDs) in Stargardt disease (STD). And, to establish how the degree of CVD relates to best-corrected visual acuity (BCVA), full field ERG (ffERG) and duration of disease.

METHODS A retrospective, cross-sectional study of 97 patients with a clinical diagnosis of STD included a comprehensive medical history and a full clinical work-up, with extensive colour vision testing. Eight patients underwent anomaloscopy. ABCA4 was screened in 92 patients.

RESULTS Patients were allocated to 5 BCVA groups and to 3 ffERG groups. Normal colour vision was found in almost 30% of patients. R/G CVDs increased as BCVA declined. More than 50% had a deutan type R/G CVD, although protan R/G CVDs became progressively apparent as BCVA decreased. A predominance of pseudoprotanomaly was evident only on anomaloscopy. Additional Blue/Yellow (B/Y) CVDs were noted in 25% of patients. B/Y CVDs and BCVA higher than 0.75 were seen in adult-onset STD. CVDs evolve to scotopization in patients with low BCVA and/or longstanding disease. Duration of disease did not correlate well with CVDs. Also, no statistically significant differences in ERG results were found between groups with or without a CVD.

CONCLUSION Since colour vision function is better correlated to BCVA than either disease duration or ffERG, it is a rather reliable indicator of disease severity. The presence of CVDs may help to establish an early diagnosis of STD.

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FRO: Analysis of the utility of QuantiFERON-TB Gold in tube and measurement of IFN release by peripheral mononuclear cells in response to different mycobacterium antigen in the work-up of patients with uveitis

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PURPOSE To compare the usefulness of tuberculin skin test (TST) and QuantiFERON-TB Gold in tube (QFR) as tuberculosis screening test in patients with uveitis in a low prevalence country with a mixed BCG vaccinated population.

METHODS Patients with uveitis of unknown origin have been recruited and underwent a standard diagnosis procedure including TST. In all patients a QFR was performed. IFN release by mononuclear cells in response to PPD and to the mycobacterium antigen HBHA was also analyzed.

RESULTS Data were analysed in 46 patients. In the TST/QFR negative concordant group (26 patients= 56,5 %), IFN release in response to PPD and HBHA was negative in 88,5% and 92% respectively. In the TST/QFR positive concordant group (15 patients = 32,6%), IFN release was observed in response to PPD in 86,7 % and HBHA in 47 %. In the discordant group TST+/QFR-, no IFN responses to PPD or HBHA were observed.

CONCLUSION Our data from a no endemic country with a mixed BCG vaccinated population, strongly suggest that a negative TST represent a true negative result. On the contrary, a positive TST can be a false positive and has to be confirmed by QFR.

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FRO: Study of the role of P2Y receptors in the development of experimental autoimmune uveitis

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PURPOSE To study the potential role of P2Y2 receptors in the development of experimental autoimmune uveitis (EAU).

METHODS EAU were induced in WT and P2Y2 KO mice receptors by IRBP 1-20 peptide immunisation. Twelve days later, T lymphocytes from spleen and lymph nodes were semi-purified and restimulated by IRBP 1-20 peptide. Lymphocyte proliferation was measured by thymidine incorporation, cytokines secretion by ELISA and surface molecules are detected by FACS. EAU development after adoptive transfer of activated lymphocytes was followed through fundus examination of the eyes and VCAM-1 retinal expression analysed by immunofluorescence.

RESULTS Autoreactive lymphocytes generated in KO mice proliferate less and produce less pro-inflammatory cytokines after IRBP 1-20 peptide restimulation than lymphocytes generated in WT mice. Following adoptive transfer, KO lymphocytes induced less disease as assessed by clinical grading and VCAM1 expression.

CONCLUSION Our data shows that P2Y2 KO mice are less likely to develop an immune response against a retinal antigen than WT. This suggests that P2Y2 receptor might act as danger receptor during EAU development.

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Les uvéites chez l'enfant congolais

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PURPOSE Déterminer la fréquence relative et les conditions associées des uvéites chez les enfants congolais.

METHODS Une étude descriptive et transversale de tous les cas d'uvéites chez les enfants congolais âgés de 0 à 17 ans examinés dans une pratique d'ophtalmologie générale, non spécialisée, durant la période de 1997 à 2010.

RESULTS Sur 18692 patients examinés durant la période d'étude, 40 enfants avaient un diagnostic d'uvéite, ce qui donne une fréquence relative de 0,2%. L'âge moyen des enfants au moment du diagnostic était de 12,4 ans±4. La répartition en fonction du sexe a montré une prédominance masculine (62,5% des cas). Les uvéites ont été bilatérales dans 35% des cas et unilatérales dans 65% des cas. Les uvéites antérieures étaient les plus fréquentes (60%), suivies par les uvéites postérieures (22,5%), et les uvéites totales (17,5%). Les uvéites les plus fréquentes étaient les uvéites dont l'étiologie n'a pu être déterminée (45%), suivies par les uvéites associées au traumatisme (27,5%), à l'arthrite juvénile idiopathique (7,5%), à l'infection virale (5%), à l'infection urinaire (5%), et à d'autres conditions (10%) telles que la tuberculose, la toxoplasmose, un vitiligo, et une transfusion sanguine.

CONCLUSION La fréquence relative des uvéites trouvée dans cette étude montre une faible fréquence des uvéites par rapport aux fréquences rapportées dans d'autres études chez l'enfant et chez l'adulte.

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Progressive impairment of the third nerve

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RESULTS A 38 year old woman noted painless vertical diplopia.Examination revealed limited elevation of her right eye.Multiple diagnosis were considered.The pattern of her motility deficit became worse and she received a diagnosis of a third nerve palsy.Further neurological investigation was needed.

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Diplopia caused by convergence insufficiency

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PURPOSE To describe a more frequent cause of diplopia than it may seem.

METHODS Several clinical cases will be evoked to illustrate the symptoms and the treatment possibilities of convergence insufficiency.

RESULTS Convergence insufficiency is generally a progressive decompensated condition. It has nevertheless its place in the work-up of an acute diplopia.

CONCLUSION The stress induced by "seeing double" can lead the patient to an emergency consultation, even in case of convergence insufficiency, an usually progressive condition.

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Contribution of intravitreal bevacizumab in macular edema due to central retinal vein occlusion (CRVO)

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PURPOSE To evaluate the effects of intravitreal bevacizumab on visual acuity and central macular thickness in eyes with macular edema due to central retinal vein occlusions (CRVO).

METHODS This retrospective study was conducted on patients having macular edema due to CRVO and treated with IVT bevacizumab between January 2006 and March 2011, in our hospital. All patients underwent visual acuity measurement, optical coherence tomography imaging, and ophthalmoscopic examination at baseline and follow-up visits.

RESULTS 31 eyes of 31 patients were included in the study (mean age 68 years, follow-up between 5 and 24 months). Initial mean visual acuity was 0.8 LogMAR. At 5, 12, and 18 months of follow-up, mean visual acuity improved respectively to 0.58 LogMAR (n = 31, p = 0.0125), 0.44 LogMAR (n = 18, p = 0.0092), and 0.64 LogMAR (n = 12, p = 0.6407). The mean central macular thickness at baseline was 664 µm. At 5, 12, 18 and 24 months of follow-up, mean central macular thickness had decreased respectively to 423 µm (n = 31, p = 0.0000), 424 µm (n = 18, p = 0.0008), 438 µm (n = 12, p = 0.050) and 420 µm (n = 7, p = 0.0216). No complications were recorded.

CONCLUSION These encouraging results confirm the data of previous studies identifying IVT bevacizumab as a promising therapeutic option for macular edema due to OVCR.

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Intravitreal injections of bevacizumab for macular edema due to retinal branch and central vein occlusion

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PURPOSE To evaluate visual and anatomical outcome of intravitreal bevacizumab (Avastin) as treatment for macular edema due to branch retinal vein occlusion (BRVO) or central retinal vein occlusion (CRVO).

METHODS 8 patients with BRVO and 4 with CRVO developed a macular edema. They were treated with intravitreal injections of bevacizumab (IVB). Visual acuity (Snellen and logarithm of the minimal angle of resolution (LogMAR) units) was evaluated. The decrease of foveal thickness was measured by optical coherence tomography (OCT).

RESULTS The initial mean visual acuity of the 8 patients with BRVO (mean age 72.2 years) was 0.34 (0.47 logMAR). After 3 IVB, it increased to 0.58 (0.24 logMAR). The final mean visual acuity was 0.63 (0.20 logMAR). The patients needed a mean number of 6 IVB to achieve stabilization after a mean follow-up of 12.3 months. The foveal thickness decreased from mean 604µm before treatment to 340.5µm. All patients received a complementary laser treatment. The initial mean visual acuity of the 4 patients with CRVO (mean age 68 years) was 0.31 (0.50 logMAR). After 3 IVB, it increased to 0.46 (0.33 logMAR). The final mean visual acuity was 0.52 (0.28 logMAR). The patients needed a mean number of 5 IVB to achieve stabilization after a mean follow-up of 10 months. The foveal thickness was 655µm and decreased at 257µm. Only 50% received additional laser treatment. No complications were reported in either series.

CONCLUSION Intravitreal injections of bevazicumab appear to be safe and efficient for the treatment of macular edema due to retinal branch and central vein occlusion. The number of injections needed and the need of association with laser photocoagulation for durable stabilization still have to be evaluated.

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Idiopathic macular hole surgery: what are the results now?

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PURPOSE To evaluate the visual results and complications of idiopathic macular hole (IMH) surgery in a consecutive series of eyes operated on by one single surgeon with one single technique in one single facility.

METHODS This retrospective study is dealing with 57 eyes treated for IMH and with a 6-month follow-up visit. During the study period, 65 eyes were operated on, among which 8 were lost for follow-up. The main study parameters are preoperative and 6-month distance and near best-corrected visual acuities (BCVA), and the incidence, nature and consequences of per- and postoperative complications.

RESULTS Mean distance BCVA improves from 0.26 preoperatively to 0.48 at 6 months. At 6 months, distance BCVA improves in 44 eyes and doesn't change in 8 eyes. Cataract increase only is responsible for worsening of distance BCVA in 5 eyes. Mean near BCVA improves from 0.22 to 0.59. Near BCVA is not available at 6 months for 3 eyes, improves in 50 eyes and doesn't change in 2 eyes. Dense cataract is responsible for worsening in 2 eyes. A retinal tear or small retinal detachment is observed ant treated during surgery in 12 eyes. None develops such a complication postoperatively. Except for cataract, none of the complications observed in this study interferes with IMH surgery functional results at 6 months.

CONCLUSION Nowadays, IMH surgery is a safe and efficient treatment with satisfactory functional results in a vast majority of cases.

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FRO: Role of VEGF-isoforms in pathological retinal & choroidal angiogenesis

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PURPOSE The aim of this project was to study the specific role of the VEGF isoforms in pathological angiogenesis, and to investigate the effect of blocking a single isoform on the formation of choroidal neovascularization (CNV).

METHODS To study the in vivo role of the VEGF isoforms in pathological angiogenesis, VEGF isoform specific mice (VEGF 120/+, VEGF 164/164 and VEGF188/188 mice) were bred. After backcrossing these mice strains into a C75Bl/6 background CNV was induced by placing 3 green laser spots (100µm spot size, 0.05 sec spot duration and 400mW power) around the optic nerve. Quantification of the area of newly formed blood vessels was determined by retrobulbar dextran linked FITC-perfusion.

RESULTS Preliminary results showed that the area of neovascularization in the VEGF 120/+ and VEGF 164/164 mice was comparable to the wild type mice, whereas an inhibition in neovascularization was present in the VEGF188/188 isoform specific mice. For the moment, mice colonies are being enlarged to repeat experiments and subsequently, these mice are intercrossed to obtain double transgenic mice. Furthermore, retinal angiogenesis will also be checked using the ROP model.

CONCLUSION VEGF164 and VEGF120 seems to play an important role in the process of pathological neovascularization, whereas VEGF188 not. These new insights in the role of different VEGF isoforms may improve the efficacy of the currently existing anti-VEGF therapy (that differ in their specificity for the different VEGF isoforms). This can open new perspectives for patients with vision threatening eye diseases and may have important therapeutic implications for them.

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FRO: Safety of the anterior vitreous detachment induced by microplasmin, pharmacologic vitreolysus to separate the posterior capsule from the anterior hyaloid

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PURPOSE To investigate the vitreolenticular interface and it's anomalies and to establish the safety of the use of microplasmin to promote the separation of the anterior hyaloids from the posterior capsule

METHODS Pediatric cataract surgery using the bag-in-the-lens implantation technique was performed in 39 eyes of 30 children between September 2010 and August 2011. The age at time of surgery ranged from 1 month to 8 years old. Videoregistration was performed. Alterations in the vitreolenticular interface and the ease to separate the anterior hyaloids from the posterior capsule using viscoelastics were observed.Remnants of posterior lens capsule, extracted out of the eye after performing posterior capsulorhexis, were fixated in Saccomanno's fixative and sent for histologic examination to confirm the presence or indications of previous presence of hyaloidal adhesions to the centre of the posterior lens capsule. Some samples were fixated in gluteraldehyde solution and sent for electron microscopic evaluation, but were unfortunately all lost during processing. New imaging is planned for the end of September.A study on rabbit eyes to establish the safety of the use of microplasmin at the vitreolenticular interface is planned for the near future.

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Emulsification-resistant silicone oil and F4H5 to capture oil droplets

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PURPOSE Emulsification is a well-known problem that occurs when a silicone oil tamponade is used after vitrectomy. This results in the formation of small oil droplets, which can cause inflammation and elevated intra-ocular pressure. Emulsification occurs less extensive in 5000 cs silicone oil than in 1000 cs, but the former is more difficult to handle and has less tamponading effect on the retina. A new silicone oil has been designed (Siluron 2000) which has in vitro properties to combined the advantages of both silicone oil types. A "cleaning liquid" F4H5 has been proposed to capture oil droplets at the time of removal of the silicone oil.

METHODS A prospective, randomized clinical trial was designed whereby 74 patients undergoing vitrectomy for macular hole are treated either with Siluron 2000 or 5000 silicone oil. After 3 months, the silicone oil is removed. The removed silicone oil is analysed to determine the amount of emulsification. During that surgery, in 50% of the patients in each study arm, a wash of the vitreous cavity with F4H5 is performed. After 6 weeks, a B-scan ultrasound examination is performed with automated counting of remaning oil droplets to determine the effect of this F4H5 wash.

RESULTS Presently, 43 patients are included in this trial. In 30 of the included patients, the silicone oil was already removed from the eye.

CONCLUSION Although this is an ongoing study, an interim analysis of the main study endpoints will be provided.

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Subretinal tissue plasminogen activator injection to treat submacular hemorrhages in age related macula degeneration

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PURPOSE To evaluate the efficacy and safety of transconjunctival sutureless vitrectomy subretinal tissue plasminogen activator injection and pneumatic displacement of the hemorrhage with air as a treatment for submacular hemorrhages secondary to neovascular age-related macular degeneration.

METHODS We retrospectively evaluated the records of 58 patients with submacular hemorrhage caused by neovascular age-related macular degeneration, that underwent 23 Gauche transconjunctival sutureless vitrectomy with subretinal tissue plasminogen activator and air tamponade between November 2008 and July 2011. Intravitreal anti-VEGF was administered to the patients postoperatively when indicated

RESULTS The submacular hemorrhage was successfully displaced in most of the cases. The visual acuity improved significantly in 39 patients (67 %), stabilized in 12 patients (21 %) and decreased in 7 patients (12 %). Complications consisted of 5 cases of retinal detachment, 3 vitreous hemorrhages and 2 subchoroidal hemorrhages during the follow-up period. Most of the cases needed further treatment with anti-VEGF after surgery as the choroidal neovascular membrane was still active.

CONCLUSION Subretinal injection of tissue plasminogen activator seems to be an effective treatment in patients with submacular hemorrhage. Moreover, the surgical morbidity of this technique is minimal because the surgery is performed using the 23G sutureless technique, it can be performed under local anesthesia and prolonged postoperative positioning is not necessary. Nevertheless, the underlying disease stays the most important prognostic factor for visual outcome.

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The Clinical Use of Ultrasound in the Evaluation of Posterior Hyaloid Detachment

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PURPOSE The adhesion of the vitreous on the retina plays a major role in several pathologies, such as vitreomacular traction, macular hole formation, diabetes and age related macular degeneration. Moreover, determining the status of the posterior hyaloid by ultrasound imaging is often a key examination in several surgical settings, such as the risk of retinal detachment in e.g. fellow eyes with retinal detachment or in high myopia before cataract surgery, the risk of vitreous hemorrhage in diabetes and the ease of vitrectomy in (young) patients.

METHODS The 10 Mhz ultrasound probe B-Scan Echography was used in all patients to evaluate the status of the posterior hyaloid using the Ellex EyeCubed: a two-dimensional scan of each eye's posterior segment delivered a 6-scan evaluation of the posterior hyaloid, 4 longitudinal sections and 2 transverse sections. Patients without vitreous detachment were treated with an intravitreal microplasmin injection (or placebo) to induce enzymatic detachment of the posterior vitreous in 2 phase 3 randomized prospective trials (in total, 652 patients were included).

RESULTS Using the Ellex EyeCubed 10-Mhz probe, grading of the posterior vitreous detachment was possible in 4 stages, varying from no detachment (stage 0) to complete vitreous detachment (stage 4). In contrast to ultrasound imaging, the status of the posterior hyaloid could be assessed with OCT when the vitreous detachment progressed into stage 2 or higher.

CONCLUSION This study demonstrates that the distinction between various stages of ocular diseases is possible when high-resolution axial and paraxial B-scan ultrasound exams are performed.

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The EVRS Retinal Detachment Study

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PURPOSE To determine the parameters influencing the outcome of surgery for rhegmatogenous retinal detachment.

METHODS Retrospective multi-center European study of 7678 cases of surgery for primary rhegmatogenous retinal detachment with PVR less then stage C2 between April 2010 and May 2011.

RESULTS 4 clinical variables were independently linked to the effective failure rate: PVR stage C1, complete retinal detachment, hypotony with choroidal detachment and a large tear size all increased the failure rate. However, lens status and number of tears were not found to be determining variables of the failure rate.Buckling technique is very relevant for PVR stages 0 and A and most surgeons used segmental buckle. Cryo technique, whether reinforced or not by focal laser led to better outcomes than transpupillary laser alone. Most surgeons use SF6 gas as a tamponade and in 81% of cases an external drainage was performed. However, there is no significant influence of drainage on the failure rate.Machine parameters for vitrectomy were also evaluated. The results show that a peristaltic pump delivers a better surgical result. Small gauge surgery (23G&25G) outperforms 20G systems. Posterior hyaloid removal and avoidance of retinotomy decreased the failure rate. Applying cryoretinopexy provided better results than focal laser coagulation alone. The use of gas tamponade is superior to silicone oil, particularly for PVR stage C1. A scleral buckle combined with vitrectomy offers no advantage.

CONCLUSION A decision tree is proposed for the treatment of different types of rhegmatogenous retinal detachments.

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The importance of gas injection in idiopathic epiretinal membrane peeling recovery

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PURPOSE Inner limiting membrane (ILM) removal has become a standard procedure in idiopathic epiretinal membrane (iERM) peeling since 15 years but some entities still badly respond to surgery, either in their final visual acuity or anatomy.We herein propose to investigate the importance of gas injection as a tamponnade in every iERM peeling and examine the effect on final visual acuity, metamorphopsia, and OCT findings.

METHODS This study is a 4 year prospective study including 56 patients that were operated for ILM peeling under slit lamp microscopic control. Patients were either assigned in group 1 (gas injection at the end of surgery, n=29) or group 2 (no gas, n=27). When gas was injected, patients were asked to respect a prone positioning during 10'/hour for the first 7 days. Best corrected visual acuity (BCVA) was measured in decimals preoperatively and at 1, 3, 6, and 12 months after surgery with OCT reports, and then converted in LogMar.Inclusion criterias were BCVA between 0,5 and 0,2(LogMar) with an iERM (no history of diabetus, retinal vein occlusion, retinal detachment, …).In a next step, iERM were subdivided in different entities based on OCT findings to examine the importance of gas on surgical results.

RESULTS Preoperative BCVA was comparable between groups. Final BCVA and the number of lines gained were measured at one year and revealed an increased recovery with gas (p<0,001). Especially, anatomic results demonstrated by OCT findings are better after gas injection in some iERM entities.

CONCLUSION The injection of gas at the end of surgery represents an important procedure to reach a better final visual acuity and anatomical results at OCT.

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Treatment of Symptomatic Vitreomacular Adhesions (VMA) With Ocriplasmin: A Subgroup Analysis of the Phase III MIVI-TRUST Program

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PURPOSE To evaluate the safety and efficacy of ocriplasmin for the treatment of patients with symptomatic VMA.

METHODS MIVI-006 and MIVI-007 were randomized, placebo-controlled, double-masked, multicenter trials, investigating a single intravitreal injection (125 µg [100 µL]) of ocriplasmin for the treatment of symptomatic VMA compared to 100 µL placebo. Primary end point was pharmacological resolution of VMA at day 28. Patients were followed for 6 months. We present here the visual acuity responder analysis from the subset of patients who had baseline vitreomacular traction (VMT) syndrome and Full Thickness macular hole(FTMH).

RESULTS 188 and 106 of a total 464 ocriplasmin-treated eyes had VMT syndrome and FTMH at baseline, respectively. Of these, 29.8% of eyes with VMT syndrome had resolution of VMA and 40.6% of eyes with FTMH had macular hole closure at day 28. 41.1% and 14.3 % of patients in the VMT syndrome subset achieved ≥2 and ≥3 line improvements in visual acuity, respectively. 76.7% and 51.2% of patients in the FTMH subset achieved ≥2 and ≥3 line improvements in visual acuity, respectively. A majority of the adverse events in all patients occurred within the first 7 days and were either transient or temporary in nature.

CONCLUSION A single intravitreal dose of 125 µg ocriplasmin achieved clinically significant visual acuity results in VMT syndrome and FTMH patients who responded to treatment, defined here as resolution of VMA or FTMH closure. Treatment was well tolerated with a majority of adverse events being transient and occurring within the first 7 days of therapy. Ocriplasmin could provide a minimally invasive pharmacologic option to treat symptomatic VMA including FTMH.

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The EYE in history

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In this "EXPOSE" we will highlight and discuss:the history of the discovery of -the function and the anatomy-of the eye-the discovery-of the nature of light-the discovery of how do we see We will briefly mention the Eye of the Animals.We will discuss the major steps made by a single person in the improvement of eye surgery as well as the evolution of eye surgery in general.We will mention the Giants in Ophthalmology and will Analyse Eye diseases of Saints Kings Queens Rulers-and Artists.We will also look into our crystal ball with a glimpse into the future.

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Complementary examinations: OCT - Fluo-angiography

DELAEY C
Gent

Cataract and macular disease often coexist in an ageing population. In order to prevent disappointment with the surgical outcome, patients with macular disease need to be identified prior to cataract surgery. When there is an important discrepancy between a patients complaints and the lens opacities observed by slit lamp examination, retinal examination should be performed. Fluorescein angiography has long been the preferred tool of the retinal specialist and will easily identify any macular lesions. Yet, an angiography is an invasive examination, which requires time and special equipment. Therefore routine angiography of all patients undergoing cataract surgery is hardly feasible. Optical coherence tomography has not only become a standard tool in any retina clinic, but also has been adopted by a large number of non-retina specialists. It's ease of use and quick examination makes it an ideal screening tool, not only for patients with suspected macular disease but for all patients undergoing cataract surgery.

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Cataract & Intraocular Lens Choice

GOLENVAUX B
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This paper will discuss major issues related to intraocular lenses (IOL's) and pseudophakia. Materials used to manufacture intraocular lenses, types of IOL's and surgery related indications of IOL's will be presented. Special IOL's such as toric, multifocal, aspherical and small incision IOL's will be described. Design considerations and side effects related to pseudophakia, such as posterior capsule opacification, dysphotopsia and quality of vision will also be reported.

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Cataract & High myopia

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Pathologic myopia is an abnormal elongation of the eyeball, associated with degenerative changes that involve sclera, choroid, retina and vitreous. When performing cataract surgery in these myopic eyes, there are a lot of aspects that need special attention. In this presentation we will discuss the preoperative assessment of macular function and retinal detachment risk. We will address the difficulties in biometry and in choosing the correct intraocular lens type and power. We will also give some tips and tricks to minimize surgical hazards.

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Cataract & glaucoma

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The coexistence of cataract and glaucoma is a common condition. However the management is a rather complex issue with several therapeutic options. Depending on the degree of cataract, the extend of the glaucomatous damage, IOP control and the number of IOP lowering medications a certain strategy will be chosen. In certain situations cataract surgery alone is sufficient. Other options include combined cataract and glaucoma surgery or two-phased surgery (cataract surgery followed by glaucoma surgery , or vice versa). With modern phaco-emulsification technique a mild IOP lowering effect can be expected on average. When there is an indication for a combined procedure a phaco trabeculectomy is the gold standard. Nevertheless combining cataract surgery with deep sclerectomy, viscocanalostomy, suprachoroidal drainage devices, trabecular drainage devices, or endosopic cyclophtocoagulation may sometimes provide sufficient IOP lowering with less complications. If maximal IOP lowering is mandatory a single trabeculectomy is preferred. However later cataract surgery may compromise bleb function. Therefore, the impact of each condition on the diagnosis has to be weighted carefully in order to choose the optimal treatment.

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Aberrometry

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PURPOSE To evaluate a new technique in our diagnostic tools.

METHODS The theory of aberrometry will be explained.

RESULTS In cases of visual complaints, aberrometry goes beyond refraction and standard topographical maps: it helps us to understand why some patients remain unhappy after refractive surgery, despite of a perfect procedure and a perfect anatomical result.Some examples will be presented.

CONCLUSION Aberrometry is an invaluable tool for the clinician and the surgeon; however, it is time consuming, requires a perfectly trained technician, and is more difficult to interprete than corneal topography.

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Anatomy of the orbit

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Anatomy of the orbitWe do not describe systematically all structures of the orbit. We highlight essential structures in order to understand the physiopathology of orbital diseases. We further discuss the adjacent structures to the orbit which might also be involved in orbital diseases.

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Craniosynostosis and Non-Synostotic Plagiocephaly

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PURPOSE Review of 2 relatively common craniofacial malformations; give an overview of the pathophysiolygy, diagnosis and surgical/conservative treatment

CONCLUSION Craniosynostosis is a craniofacial malformation in which 1 or more cranial sutures are prematurely fused. It can be syndromic or isolated; syndromic children are generally more severely affected and can have multiple other malformations. Recurrence rate is higher for syndromic craniosynostosis; gene mapping has resulted in defining the mutated gene in many syndromes. Diagnosis is made clinically and based on CT scan (with 3D reconstruction) findings. The child has to be evaluated for other anomalies; review of family history and pedigree are extremely important, including prenatal history. Treatment is surgical before the age of 1,5 years to provide space for the growing brain, to avoid the complications of high intracranial pressure and to obtain the best aesthetic results. In syndromic cases, the rest of the face can be affected and this has to be evaluated and treated separately. Because of associated problems with feeding, breathing, speech development and craniofacial growth, these children are best followed and treated until adulthood by an experienced multidisciplinary craniofacial team.Non-synostotic plagiocephaly is a deformational disorder, where the head has an abnormal shape caused by nondisruptive mechanical forces; it can arise in utero due to head constraint or postnatal due to head preference position of the infant. Diagnosis is made clinically and with plain X-ray. It is seen very frequently due to the "back to sleep" campaign. Treatment is conservative with physiotherapy or helmet molding in severe cases before the age of 1 year.

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Eyemovement disorders associated with abnormal orbital growth

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London

PURPOSE To describe 15 years' experience of eyemovement disorders associated with abnormal orbital growth secondary to craniosynostoses.

METHODS A retrospective review of casenotes, and literature review of studies from our own unit and those from other craniofacial units.

RESULTS Children with craniosynostoses, especially the syndromic variety, display upshoots in adduction and concomitant downshoots in abduction. Orbital imaging reveals excyclorotated rectus muscles in these cases. Surgical management of such cases is best managed with anteriorisation of the inferior oblique with 'J' deformity.Patients with syndromic craniosynostoses also may exhibit missing muscles. Utilisation of a 'Foster suture' in any transposition surgery greatly enhances the end effect of surgical intervention.

CONCLUSION Children with abnormal orbital growth due to craniosynostoses exhibit peculiar eyemovement anomalies which need careful evaluation , orbital imaging and a surgical approach that expects anomalous and or missing muscles.

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Orbital biomechanics

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The human eye is suspended in the orbit. An interaction between pressure and tensile forces in the soft tissues keeps the eye in place, while a large range of rotational motion is enabled. To reach a better understanding of these mechanics, several approaches have been followed, ranging from visualisation of MRI-data to computational modeling based upon finite-element analysis (FEA).This presentation will discuss the current state-of-the-art and the 'hot-topics' in orbital biomechanics. An overview will be given of the factors that play a role in understanding the soft tissue biomechanics and the suspension of the eye in the orbit.

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Specific forms of slow progressive strabismus

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PURPOSE Strabismus population has changed in the past decades with an increasing number of adult strabismus cases. The purpose of this report is to give an overview of slow progressive forms of strabismus that can be successfully treated either by non-surgical means or by strabismus surgery

METHODS Slow progressive strabismus is often related to neurogenic etiologies but mechanical causes have to be considered. Recent advances in the knowledge of the anatomy and physiology of extraocular muscles and their associated connective tissue have stressed the importance of orbital imaging in the study of adult strabismus.

RESULTS Acquired strabismus of mechanical origin can be due to connective tissue degeneration, inflammatory diseases as thyroid eye disease and idiopathic orbital inflammatory disease, infectious pathology with slow progressive necrosis of the orbital wall , orbital tumors and iatrogenic causes. Connective tissue degeneration leading to relative dislocation of ocular muscles can be associated with high myopia, but also nonmyopic patients may develop similar strabismus patterns: age-related distance esotropia and simulated Brown patterns may be due to pulley pathology.Diagnosis and treatment of these specific forms of slow progressive strabismus will be discussed.

CONCLUSION Physiologic as well as pathological alterations of orbital structures may account for a large spectrum of strabismological symptoms. Every clinican should be aware of these pathogenic mechanisms, which have often a favourable prognosis

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Orbital traumata

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Different types of orbital trauma will be discussed : Posttraumatic orbital trauma as blow out fractures and traumatic Brown syndromes; surgical trauma after orbital decompression or sinus surgery. Symptoms and signs, investigations and therapy will be discussed and illustrated by different cases.

345

Cataract and postoperative refractive surprises

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PURPOSE To describe how to avoid and to treat refractive surprises after intraocular lens surgery.

METHODS First the possible causes are described. Then the different treatment options are given.

RESULTS The possible treatment are : waiting, adjusting, correcting or explanting. The special aspects of diffractive intraocular lenses are emphasized.

CONCLUSION Prevention is the best way to avoid refractive surprises. Prior use of an ICR in challenging cases simplifies a possible lensexchange procedure.

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Prevention of law suits after cataract surgery

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PURPOSE To prevent the increasing occurrence of law suits.

METHODS In the preoperative stage: careful selection of patients on objective but also on subjective criteria. In the operative stage: very complete surgical report without omitting any details.In the post-operative stage: following the patient personally (don't "delegate"); listen carefully: don't "brush away" complaints but on the contrary give them attention and care. Never loose contact with the patient.

CONCLUSION Application of these guidelines allowed us to avoid any law suit for the last 30 years.

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Refractive Lasersurgery - Aberrometry

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PURPOSE To evaluate the efficacy of the Formulas for IOL calculations after Refractive Surgery.

METHODS A cohort of 70 eyes were enrolled in this study: 55 eyes after incisional refractive surgery,15 eyes after ablative surgery. Hoffer Q Formula was used in the first series, and compared with other third generation Formulas; Haigis L Formula was used in the other series and also compared with other third generation Formulas.Data were collected at J1,1M,3M,6M. Deviation from intended refraction was calculated in all cases

RESULTS There was a significal improvement in IOL calculations with Hoffer Q and Haigis L Formulas and with the IOL Master device. No complications occured; no lens exchange was performed.Data will be presented.

CONCLUSION These Formulas (Hoffer Q and Haigis L)seem to be very interesting for IOL calculations after refractive surgery; however, the patient must be warned that a "refractive surprise" can occur.

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Phakic intra-ocular lens / Glare & Halo's

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PURPOSE Treating high myopia with excimerlaser correction can result in adverse effects with glare and halo. Phakic intra-ocular lenses (IOL) for high myopia should give better quality of vision with less glare and halo. Better insight in possible adverse effects in the different options for refractive treatment of high myopia was studied.

METHODS Case studies of patients treated for high ametropia with Artisan/Artiflex and Implantable Collamer Lens (ICL) tduring the last year were analysed to look for the incedence and source of possible glare and halo post-operatively. This was compared with patients treated for high myopia above -8 diopters with All-Laser LASIK. A survey was done to thirteen refractive surgeons worldwide about possible options when treating high myopia.

RESULTS Glare and halos were found in both groups. Survey results showed no distinct advantage for any of the phakic IOL's over LASIK. Both treatments are feasible and have their possible adverse effects. Large pupils are a risk factor for post-operative glare and halo's in both groups.

CONCLUSION Treatment of high myopia especially in case of larger pupils might induce glare and halo's in patients treated with phakic IOL's as well as with LASIK.

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Cataract surgery in Fuchs endothelial dystrophy

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PURPOSE To evaluate the use of preoperative parameters in patients with Fuchs' endothelial dystrophy (FED) who are undergoing cataract surgery to predict the need for future endothelial keratoplasty (EK).

METHODS Eighty-nine patients (89 eyes) with FED undergoing cataract extraction were included in this study. Best corrected visual acuity (BCVA), slit lamp examination, ultrasound pachymetry, Pelli-Robson contrast sensitivity chart, C-Quant Straylight Meter and In Vivo Confocal Microscopy (IVCM) were assessed preop and 1, 2 and 12 months postop. All parameters were compared to the eventual progression into EK.

RESULTS LogMAR BCVA improved from a mean of 0,33 (range -0,12 to 0,9) before cataract surgery to 0,26 (range -0,16 to 0,92) at 2 months postop. In 36 (40,5%) eyes, EK was performed between 2 and 12 months postop. Logistic regression analysis of pre- and intraop parameters defined ultrasound pachymetry (p=0,010), Subepithelial peak (p=0,00052) and Epithelial valley (p=0,00056) on the IVCM backscatter profile as the 3 variables related to postop progression into EK.

CONCLUSION According to past publications, pachymetry can be used as a predictor of corneal decompensation after cataract surgery in FED. A preop pachymetry of > 606 microns is predictive of corneal decompensation, and a combined cataract extraction with endothelial keratoplasty may be considered. We defined the Subepithelial peak and Epithelial valley on the IVCM backscatter profile as 2 additional predictors of postop decompensation with a better sensitivity and specificity compared to pachymetry.

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Corneal collagen crosslinking using riboflavin and ultraviolet-A light for keratoconus: analysis of effectiveness using Scheimpflug imaging

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PURPOSE To evaluate changes in corneal keratometry, corneal elevation, and keratoconus indices after corneal collagen crosslinking with riboflavin and ultraviolet-A (UVA) light in eyes with progressive keratoconus.

METHODS 38 eyes underwent corneal crosslinking with riboflavin and UVA irradiation. Scheimpflug imaging was performed preoperatively and at 1 week, 1, 3, and 6 months, and 1 year after crosslinking. Index of Surface Variance (ISV), Index of Vertical Asymmetry (IVA), Keratoconus Index (KI), Central Keratoconus Index (CKI), Index of Height Asymmetry (IHA), Index of Height Decentration (IHD), and Rmin (Smallest Radius of Curvature) were measured at each visit.

RESULTS Mean differences between postoperative and preoperative visits were as follows : K max +0.3 D, ISV +5.3, IVA +0.1, KI +0.1, CKI +0.0, IHA -4.1, IHD 0.0, Rmin 0.0. Mean follow-up was 185 days.

CONCLUSION Stable anterior and posterior corneal curvatures, and stable keratometry indices indicate that keratoconus did not progress : the results indicate a probable long-term stabilization and improvement after collagen crosslinking. Thus, corneal collagen crosslinking is an effective therapeutical option for progressive keratoconus.

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Femtolasik flap thickness accuracy of the Zeiss 500 kHz Visumax femtosecond laser

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PURPOSE To evaluate FEMTOLASIK flap thickness accuracy using Scheimpflug and ultrasound pachymetry.

METHODS A prospective study of 121 consecutive eyes who had flaps created with the 500 kHz VisuMax femtosecond laser (Carl Zeiss Meditec) were included for flap thickness evaluation. Preoperative pachymetry was performed with the Oculus Pentacam HR Scheimpflug imaging system, residual stromal thickness was measured with ultrasound pachymetry. Real flap thickness was calculated and compared to the intended theoretical flap thickness.

RESULTS All eyes underwent eventless femtosecond laser flap creation. No complications occurred. Side cut angle was 90 °, hinge position 0°, hinge angle 50° in all eyes. Scan direction was 'spiral in', energy offset was 29 mJ, track distance and spot distance was 3 µm at the flap and 1.5 µm at the flap side.The intended flap thickness was 110 µm in all eyes. The mean real achieved flap thickness was 109.06 ± 17.14 µm.

CONCLUSION The flap creation with the VisuMax 500 kHz femtosecond laser was found to be highly predictable and accurate.Inaccuracy in measuring residual stromal thickness using ultrasound pachymetry, compared to the accurate preoperative pachymetry measured with the Oculus Pentacam HR Scheimpflug imaging system, may account for the relatively high standard deviation.

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First Clinical Experience with a New 1-Piece Multifocal IOL

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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 15 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), C quant measurements, 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, at 3 month follow-up this improved to 20/20 or better. At that time UCNVA was 20/20 or better in all patients. Preferred reading distance was 34 cm. Four patients reported on slight halos postoperatively, only one patient was disturbed. Straylight measurements revealed that 13 eyes were within the normal range and 2 eyes had higher levels. Patient satisfaction was very high in all these multifocal patients due to complete spectacle independence in all patients.

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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FRO: The Slug Mucosal Irritation (SMI) assay: A tool to predict ocular stinging, itching and burning sensations

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PURPOSE Eyes are very sensitive to stinging, itching and burning (SIB) sensations. A screening method for ocular discomfort would be very helpful in the development and refinement of ocular formulations. The Slug Mucosal Irritation (SMI) test was developed as an alternative for the Draize test (eye irritation test in rabbits). The aim of this study was to investigate whether the SMI-test could also demonstrate a relation between an increased mucus production (MP – expressed as % of initial body weight) in slugs and an elevated incidence of SIB sensations in human eyes by using shampoos as test substance.

METHODS The stinging potency of an artificial tear (ArtTear) and 5 shampoos (A-E) was evaluated with the SMI-test by placing 3 slugs per treatment 3 times on 100µl of the test item. After each 15-min contact period (CP), MP was measured. Evaluation of the results is based upon the total MP during the 3 repeated CPs. Additionally, a human eye irritation test (HEIT) was set up: 24 participants were dripped 10µl of a shampoo dilution in water or an artificial tear in one eye, while in the other eye 10µl of water was instilled (control). Evaluation of the test items was performed both by participants and an ophthalmologist at several time points (30 sec up to 30 min).

RESULTS Analyses reveal that (1) a significant positive association existed between immediate stinging reaction reported by the participants and the mean total mucus produced by the slugs (MTMP) (Spearman's Rank correlation = 0.986, $p<0.001$); (2) ArtTear was best tolerated in both tests; (3) moreover, all shampoos induced higher reactions than ArtTear and water; (4) Shampoo B was the best tolerated shampoo in both tests, while C, D and E resulted in more pronounced reactions; (4) Shampoo A induced the highest MTMP and received higher scores for immediate discomfort; (6) lacrimation might not be a valuable parameter to evaluate the general tolerance of a product.

CONCLUSION These results indicate that the SIB protocol of the SMI-test is a good tool to predict clinical ocular discomfort with reference to non- and mildly irritating formulations in humans.

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Intracorneal ring segment (ICRS) implantation in Keratoconus patients in tunnels made by the Ziemer femtosecond laser

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PURPOSE To assess objective an subjective visual results in keratoconus (KC) patients with a need of surgical visual revalidation using Keraring ICRS, implanted into tunnels made by the Ziemer femtosecond laser

METHODS Prospective study in which 16 keratoconic eyes of 15 patients Keraring ICRS were implanted into tunnels made by the Ziemer femtosecond laser to visually rehabilitate these contact lens intolerant patients. In all patients the KC was assumed to be stable with or without Ulltra-Violet Crosslinking (UV-CXL). Target was near emmetropia. Mean follow-up was 6 months. Pre-and post-op data include UCVA, BCVA, refraction, spherical equivalent, Kmax, placido-based and elevation topography. A questionnaire was submitted to the patients to assess their satisfaction.

RESULTS In all patients the KC was topographically recentered with a significant decrease of the Kmax in all the patients and an improvement of the BCVA of 2 lines or more in 69 % of the eyes No eyes lost 2 lines or more. Spherical Equivalent and astigmatism were reduced significantly in all eyes. In 2 eyes out of 16 the topographical changes did not result in an improvement of the UCVA. Average patient satisfaction was high (87,5 %) despite the presence of halo's.

CONCLUSION In selected stabilized KC eyes the implantation of Keraring ICRS into tunnels made by the Ziemer femtosecond laser resulted in an improvement of most objective parameters in all eyes and a high patient satisfaction rate, even if halo's are present in most patients.

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FRO: Tear film biomarkers as prognostic indicators for recurrent pterygium

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Ophthalmology - Cornea, Antwerp

PURPOSE The aim of this project is to establish the use of IL-6, IL-8 and VEGF as biomarkers in the tear film for early detection of recurrent pterygium.

METHODS Patients with pterygia showing corneal encroachment and requiring surgical excision will be recruited in this study along with a second population of control subjects. Using a corneal bath, 3 drops of normal saline will be applied and 50µl of the diluted epithelial secretions collected and stored at -80°C. A Cytometric Bead Array of the tears will be performed for IL-6, IL-8 and VEGF. Resected pterygial tissue will be stored for immunohistochemical analysis angainst antibodies for CD43, SCD5 and MEFV (antibodies up-regulated in recurrent pterygium).

RESULTS From the results we can determine the baseline levels of IL-6, IL-8 and VEGF present in normal epithelial secretions and correlate it with potentially higher levels in the eyes of patients with pterygia. By collecting post op epithelial secretions at different time points; namely pre-op, 2 weeks, 3 months and 1 year post op; along with regular ocular surface photographs and grading of any recurrent pterygia we will be able to ascertain the role of these cytokines and growth factors as biomarkers for recurrent pterygia.

CONCLUSION By establishing higher tear film levels of IL-6, IL-8 and VEGF in eyes with pterygia compared to normal eyes and the return to baseline levels post excision we can begin to ascertain the role of these key players in the pathogenesis of pterygia. But if we can also show high levels of these cytokines/growth factors in subjects that present with recurrence post excision, we will be able to quantitatively as well as qualitatively justify the role of IL-6, IL-8 and VEGF as prognostic indicators of recurrent pterygium

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IOL calculation in vitrectomy patients that underwent previous refractive surgery

LEQUEU I, STALMANS P
Afdeling Oogheelkunde UZLeuven, Leuven

PURPOSE Some vitrectomy patients underwent previous refractive surgery. In these cases, determining the correct implant lens can be difficult. Frequently, the preoperative K-values are not available, nor the pre-operative refraction. Moreover, the classical instruments to determine the actual keratometry may provide inaccurate K-values. In cases with retinal detachment, the retina is often detached at the macular area, which makes measurement of axial length also difficult. Finally, suturing an encircling band also influences the axial length of the patient.

METHODS In total, 15 patients had K-values measured using different measurement techniques: Javal keratometry, autokeratometer, IOLmaster and Pentacam. In some cases, the K-values measured before the refractive surgery were available, which could be used for calculation of the estimated K-power. Axial length was measured using IOLmaster or A-scan. Two IOL calculation formulas are compared: SRK/T and Holladay.

RESULTS Post-vitrectomy refractive outcome was used to determine which keratometry method or calculation was most accurate

CONCLUSION -Pentacam "True Corneal Power" provided the most accurate K-power to be used for IOL calculation. If available, using a predictive formula with pre-refractive K-values also yielded a good estimation of the K-value.-If the retina is detached at the macular area, the fellow eye was used to determine axial length. If this in unavailable or there is a marked refraction difference between both eyes, A-scan measurement with manual placement of the markers is the best option.-An encircling band increases myopia by approximately 1.5 diopters. This difference is added to the target-refraction for IOL calculation when applicable.

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Optimized A-constant for a particular lens (XL-Stabi ZO, Carl Zeiss Meditec) and general avice for optimization and IOL calculations formulas

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PURPOSE To evaluate the efficacy of the Constant A given by the manufacturer of an aspheric IOL: evaluation of the difference between the subjective spherical equivalent 3 months post surgery and the target refraction.

METHODS 260 eyes from 8 surgical centers were enrolled in this study: 247 eyes received the study lens (XL Stabi ZO, Carl Zeiss Meditec). SRK/T formula was used in 71.7% of the cases.Patients were divided in 3 groups: short eyes (axial length (AL) < 22mm, normal eyes (22mm<AL<25mm) and long eyes (AL>25mm).Data were collected at 1M and 3M.Deviation from intended refraction was calculated in all cases.

RESULTS The main efficacy criterion, the evaluation of the difference between the subjective spherical equivalent at 3M and the target refraction showed a slight undercorrection, with a mean value of -0.30D (SD: 0.61). In the short eyes group, -0.43D (SD: 0.76); in the normal eyes group -0.26D (SD: 0.56); in the long eyes group 0.36D (SD: 0.61).

CONCLUSION The A Constant for the XL Stabi ZO should be adapted for short and long eyes, or another Formula should be used.

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1. enVista™ Directions for Use. **2.** Tetz MR, Werner L, Schwahn-Bendig S, Batlle JF. A prospective clinical study to quantify glistenings in a new hydrophobic acrylic IOL. Paper presented at: American Society of Cataract and Refractive Surgery (ASCRS) Symposium & Congress; April 3-8, 2009; San Francisco, CA.

N° agréation Activiteitsnr.	Date Datum	Type Rubriek	Intitulé Titel	Durée Duur	CP	Organisateur Organisator
11004185	23/11/11	3	OB 2011	3 h/u	3	2080 AOB
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References: *Mundorf TK, Rauchman SH, Williams PD, 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.*

Alcon®

Summary of product characteristics inside publication

Nov 2011

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 suivante: 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 psychiatriques: Peu fréquente insomnie. Affections du système nerveux: Fréquente: dysgueusie. 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 vasculaires: Peu fréquente: diminution de la pression artérielle. Affections respiratoires, thoraciques et médiastinales: Peu fréquentes: bronchopneumopathie chronique obstructive, douleur pharyngolaryngée, rhinorrhée, toux. Affections de la peau et du tissu sous-cutané: Peu fréquentes: troubles de la pilosité, lichen plan. 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 infestations: Brinzolamide 10 mg/ml rhinopharyngite, pharyngite, sinusite, rhinite. Affections hématologiques et du système lymphatique: Brinzolamide 10 mg/ml: diminution du nombre de globules rouges, augmentation du taux de chlorure dans le sang. Affections du système immunitaire: Brinzolamide 10 mg/ml: hypersensibilité. Troubles du métabolisme et de la nutrition: Timolol 5 mg/ml: hypoglycémie. Affections psychiatriques: Brinzolamide 10 mg/ml: apathie, dépression, troubles de l'humeur, diminution de la libido, cauchemars, nervosité - Timolol 5 mg/ml: dépression. Affections du système nerveux: Brinzolamide 10 mg/ml: somnolence, troubles de l'appareil locomoteur, amnésie, troubles de la mémoire, vertiges, paresthésie, tremblements, maux de tête, hypoesthésie, agueusie - Timolol 5 mg/ml: ischémie cérébrale, accident cérébrovasculaire, syncope, myasthénie gravis, parésthésie, maux de tête, étourdissement. Affections oculaires: Brinzolamide 10 mg/ml: 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 paupière - Timolol 5 mg/ml: conjonctivite, diplopie, ptosis de la paupière, kératite, trouble visuel. Affections de l'oreille et du labyrinthe: Brinzolamide 10 mg/ml: tinnitus, vertiges. Affections cardiaques: Brinzolamide 10 mg/ml: 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, palpitations. Affections vasculaires: Brinzolamide 10 mg/ml: augmentation de la pression artérielle, hypertension - Timolol 5 mg/ml: hypotension. Affections respiratoires: thoraciques et médiastinales: Brinzolamide 10 mg/ml: 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-intestinales: 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 - Timolol 5 mg/ml: diarrhée, nausée. Affections hépato-biliaires: Brinzolamide 10 mg/ml: bilan hépatique anormal. Affections de la peau et du tissu sous-cutané: Brinzolamide 10 mg/ml: urticaire, rash maculopapuleux**,** rash, prurit généralisé, alopécie, tiraillements cutanés, dermatite, érythème – Timolol 5 mg/ml: alopécie, éruption cutanée. Affections musculo-squelettiques et systémiques: Brinzolamide 10 mg/ml: maux de dos, spasmes musculaires, myalgie, arthralgie, douleur des extrémités. Affections du rein et des voies urinaires: Brinzolamide 10 mg/ml: douleurs rénales, pollakiurie. Affections des organes de reproduction et du sein: Brinzolamide 10 mg/ml: dysfonction érectile. Troubles généraux et anomalies au site d'administration: Brinzolamide 10 mg/ml: douleurs, asthénie, gêne thoracique, fatigue, sensation de mal-être, sensation de nervosité, irritabilité, douleur thoracique, oedème périphérique, malaise, résidu médicamenteux - Timolol 5 mg/ml: 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:** 51,44 €. **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:** 21 décembre 2009.
May 2011

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 atrioventriculair 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, atrioventriculair 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:** 51,44 €. **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.

Notes

Notes

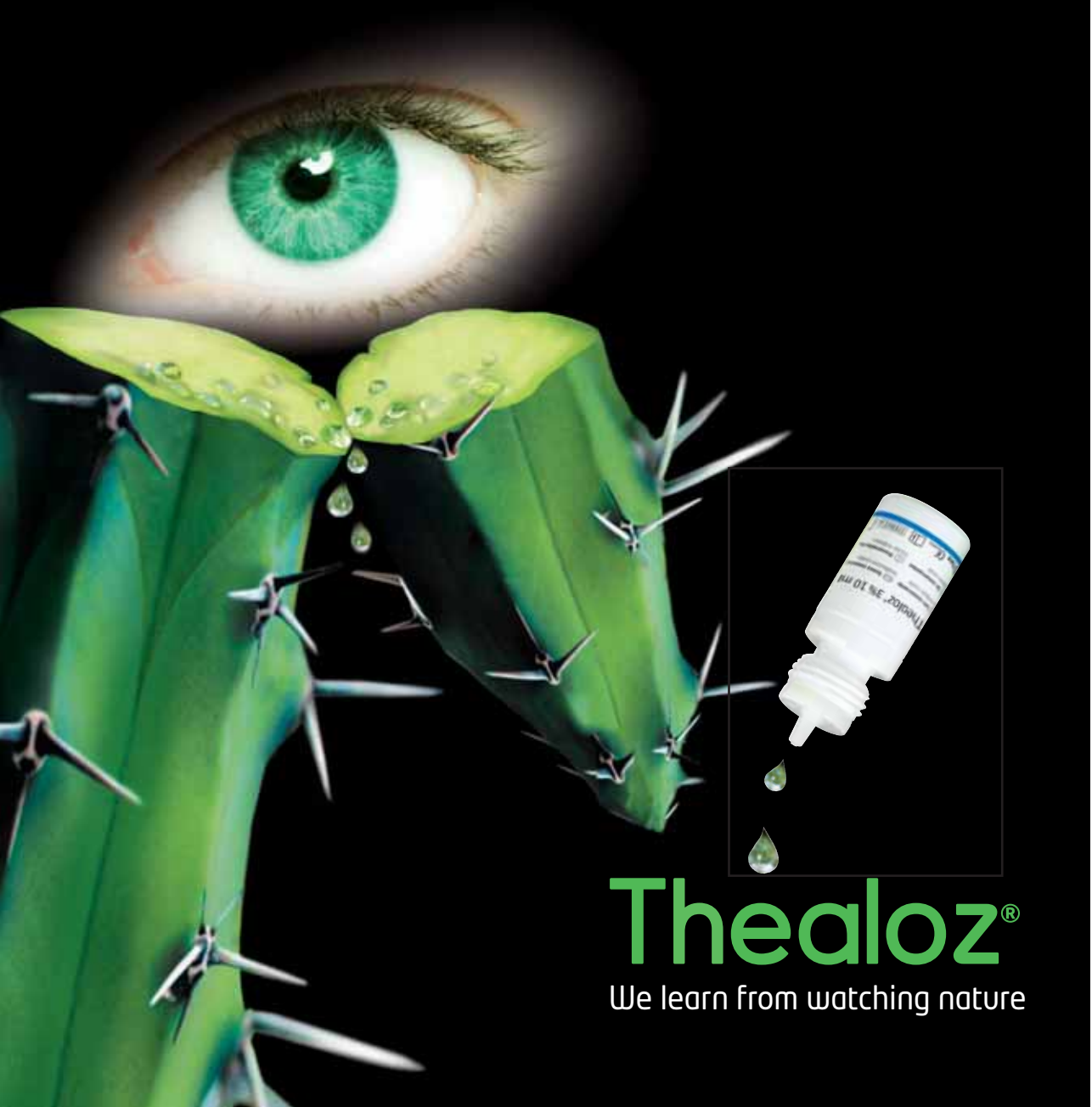
First author index

All first authors are listed alphabetically.
If the author has submitted an abstract, the abstract number is marked **orange**.
If there is no abstract submitted, the abstract number is marked *grey italic*.

Théa

DRY EYES

The natural defense



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OB 2011
Hall A
Hall B
Hall C
Hall D
Hall E - ICC
Hall F - Wetlab
Hall G - Eyelid
WEDNESDAY
Nov. 23, 2011
BSOPRS
BOG
SBO
ICC-W1
ICC-W2
ICC-W3
ICC-W4
Wetlab - 1
Wetlab - 2
Wetlab - 3
Wetlab - 4
Wetlab - Eyelid 1
Wetlab - Eyelid 2
Poster session - in O'Bistro
BBO-UPBMO
Faculty meets Industry - in exhibition area
THURSDAY
Nov. 24, 2011
OBAO
BGS
BIO
BSA
ICC-T5
ICC-T6
Wetlab - 5
Wetlab - 6
ISC: Interactive Surgical Course: Trabeculectomy step by step - in Hall A
OBAO
ICC-T7
ICC-T8
FAB
FAB
NOC
BVVB-OBPC
ICC-T9
ICC-T10
Wetlab - 7
Wetlab - 8
Pearls in Ophthalmology
19:00 Shuttle leaves from Holiday Inn Bxl EXPO
20:00 Congress Dinner in Belga Queen
FRIDAY
Nov. 25, 2011
BSCRS
BSONT NL
BSONT FR
BOV-ABO
ICC-F11
ICC-F12
Wetlab - 9
Wetlab - 10
Award ceremony - in Hall A
BSCRS
BSONT NL
BSONT FR
PED & LOW
ICC-F13
ICC-F14