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Makassar 2019

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INDONESIAN OPHTHALMOLOGISTS ASSOCIATION

Proceeding Book

15TH NATIONAL CONGRESS &
44TH ANNUAL SCIENTIFIC MEETING OF
INDONESIAN OPHTHALMOLOGISTS ASSOCIATION

"Universal Eye Health, Where are we?"

September
26th-28th 2019

at Claro Hotel and Convention
Makassar, South Sulawesi

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Proceeding Book

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&
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underlying diseases. Best corrected visual acuity was 6/6 in both eyes. Anterior segment examination revealed diffuse scleral injection,round shapes scleral nodule and scleral edema at 3 and 6 o'clock, round shape corneal epithelial defect at the limbus on 3 and 6 o'clock. Laboratory examination showed increased uric acid level. Systemic and topical corticosteroid,artificial tears and allopurinol tablet from the internist was given. Resolution was noted with disappearance of scleral injection and nodule after 1 week, resolution of corneal lesion,no complications and no recurrency at 1 year follow up.

Conclusion: Non-necrotizing Anterior scleritis as ocular manifestation of hyperuricemia condition were rare. Steroid as the first line therapy is considered beneficial combined with xanthine oxidase inhibitor medication. The holistic management of anterior scleritis patient may preserve the vision, eliminate complications and prevent recurrency.

Keywords: Anterior Scleritis, Non Necrotizing Scleritis, Peripheral Keratitis, Hyperuricemia, Non Infectious Scleritis, Corticosteroid

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POS-IIM-095

OUTCOME INJECTION TRIAMCINOLONE SUBCONJUNCTIVA IN PATIENT WITH VOGT KOYANAGI HARADA (VKH) SYNDROME

EKA ALPASRA, GETRY SUKMAWATI, HAVRIZA VITRESIA

Andalas University/ Dr M Djamil Hospital Padang

Introduction: Vogt Koyanagi Harada (VKH) syndome is rarely case, caused by an autoimmune reaction and characterized by diffuse, chronic and bilateral granulomatous panuveitis, accompanied by abnormalities in the integumentary, neurologic and auditory.

Objective: To report a case with VKH syndrome.

Case Presentation: Woman, 39 y.o, came to M Djamil Hospital, with one month hystory of fever, headache, nausea, meningismus, tinnitus, dysacusia, eye redness, pain, photophobia, and vision loss at both eyes. No hystory and complain systemic disease or trauma. VODS 1/~ incorrect light perception, injection conjunctiva and ciliar, KPs(+), VH2, Flare(+2), iris bombe, posterior synechiae, not detecable lens and vitreous, IOP was normal. Funduscopy couldn't be evaluated. USG: heazy vitreous, exudative retinal detachment. Laboratory leukocytosis. Normal thorax X-ray. Patient was hospitalize, treated with methylprednisolone 1 mg/kg/day, Posop pulse therapy, Sulfate Atropine and vitreolenta ed. Three days later, injection triamcinolone subconjuctiva. 1 week later: VOD 20/80, VOS 1/2/60, 1 month later: VOD 20/40, VOS 20/100. USG orbita: vitreous almost clear, improve exudative retinal detachment. Two months later, reinjection triamcinolone but after three months: IOP OD 54 mmHg, OS 34 mmHg. Consul glaucoma subdivision for oral antiglaucoma and trabeculectomy. After 7 months, IOP OD 16 mmHg, OS 16 mmHg.

Result: Methylprednisolone oral and triamcinolone subconjunctiva injection make clinical sign and visual improvement.

Conclusion: At condition of retinal detachment that triamcinolone intravitreal injection couldn't be done, subconjuctiva injection given good result.

Keywords: VKH, panuveitis, triamcinolone

POS-IIM-096

ENDOPHTHALMITIS ENDOGENOUS ET CAUSA SUSPECT BACTERIAL RELATED TO DENTAL INFECTION - A CASE REPORT

VENNIE MAYULU, HERNY POLUAN

Department of Ophthalmology, Faculty of Medicine Sam Ratulangi University Prof Dr.R.D.Kandou General Hospital, Manado, North Sulawesi.

Introduction and Objectives: Endogenous endophthalmitis results from hematogenous seeding of the eye by bacteria or fungi.

to report a case of endogenous endophthalmitis related to dental infection and treated by intravitreal antibiotics.

Case Presentation: A 6-years boy with chief complaint redness and mild eyelid swelling in his right eye since 5 days ago and followed by blurred vision. He also felt slightly pain, discomfort and photophobia. No history of trauma or systemic disease, but he complained of toothache and teeth decay. On oral examination there is caries and mild abcess in second molar. His visual acuity was 2/60, slightly cloudy cornea with conjunctival injection, cell and flare grade 1, hypopion and fibrin in anterior lens capsule. Vitreus was hazed and blunted red reflex. Ultrasound showed hyperechoic. White cell count was 11.500/mm3. patient wad diagnosed with endogenous endophthalmitis et causa suspect bacterial related to dental infection. patient was treated with intravitreal antibiotics vancomycin 1 mg and ceftazidime 2,25 mg, Ceftazidime + dexamethasone injection subconjunctival, vancomycin and ceftazidime fortified 1 drop/hour, tobramycin ED 1 drop/hour, ofloxacin 1 drop/2 hour, prednisolone acetate 6x1 drop/hour, and cefixime syrup 8 mg/kg/day. Cultured from anterior chamber paracintesis and vitreus tap was negative. 5 days after treatment, visual acuity was 6/15. patient was consulted to dental and oral health division for further treatment.

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