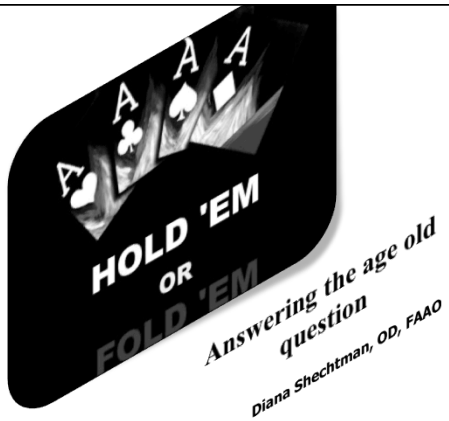


Answering the age old question

Diana Shechtman, OD, FAAO

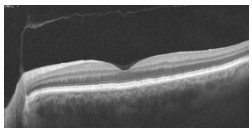
Financial disclosure

- **I have received lecture honoraria or served on an advisory boards or speaker's bureaus for the following companies:**
  - **Arctic Dx, Alcon, Allergan, CZ, Reichert & Zeavision**
- **I have no direct financial interest in any of the products or instrumentation mentioned in this presentation.**

Anomalous PVD

Vitreoschisis (split within the vitreous)
- ERM
- MH

Partial PVD
- Posterior separation
  - RRD
  - Operculated hole/flap tear
- Peripheral separation
  - Vitreopapillary traction
  - VMT



VR adhesion is like STRONG velcro & thus can produce tight traction

It is all about the dynamics of VR adhesion

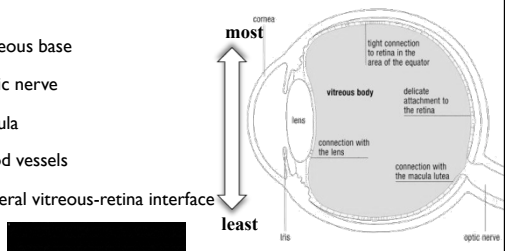
Vitreous base

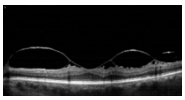
Optic nerve

Macula

Blood vessels

General vitreous-retina interface





VR conditions associated with PVD process

Complications likely associated with accelerated liquefaction occurs before weakening of VR adhesion

VR traction site	Retinal condition
Retinal vasculature	Retinal or vitreous hemes Avulse retinal vessel
Macula	VMT syndrome &/or MH
Periphery	Retinal Breaks RRD

Atrophic retinal holes are NOT associated with vitreoretinal traction

So how to managed the ACUTE PVD?

- **Dilated fundus exam is a MOST! (also consider SD)**
- **Close Follow-Up**
  - **f/u in 1-6 wks…until photopsia resolves**
    - **Then 3-6month →yrly**
    - **Highest threat is within 1st 3M**
  - **PRINT→PRACTICE:**
    - **15% of symptomatic PVDs have a RB**
      - **JAMA 2009, Linder 1966, Jaffe '79, Brodley '83, Novak 1984, Byer 1994**
  - **Educate about onset of news si/s**