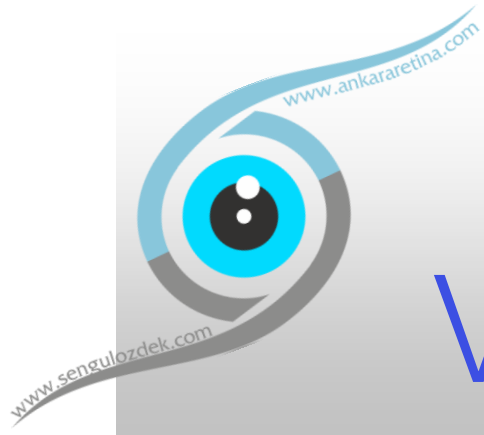


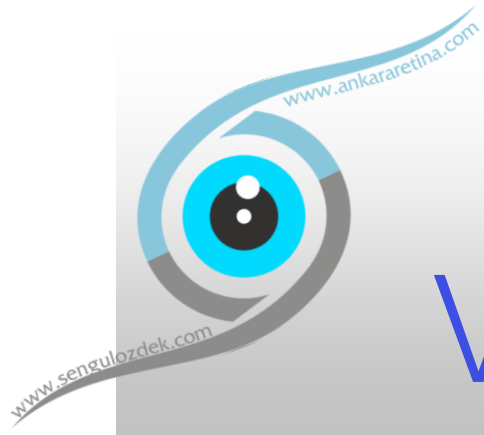
PEDİATRİK VİTREORETİNAL CERRAHİDE NEREDEYİZ?





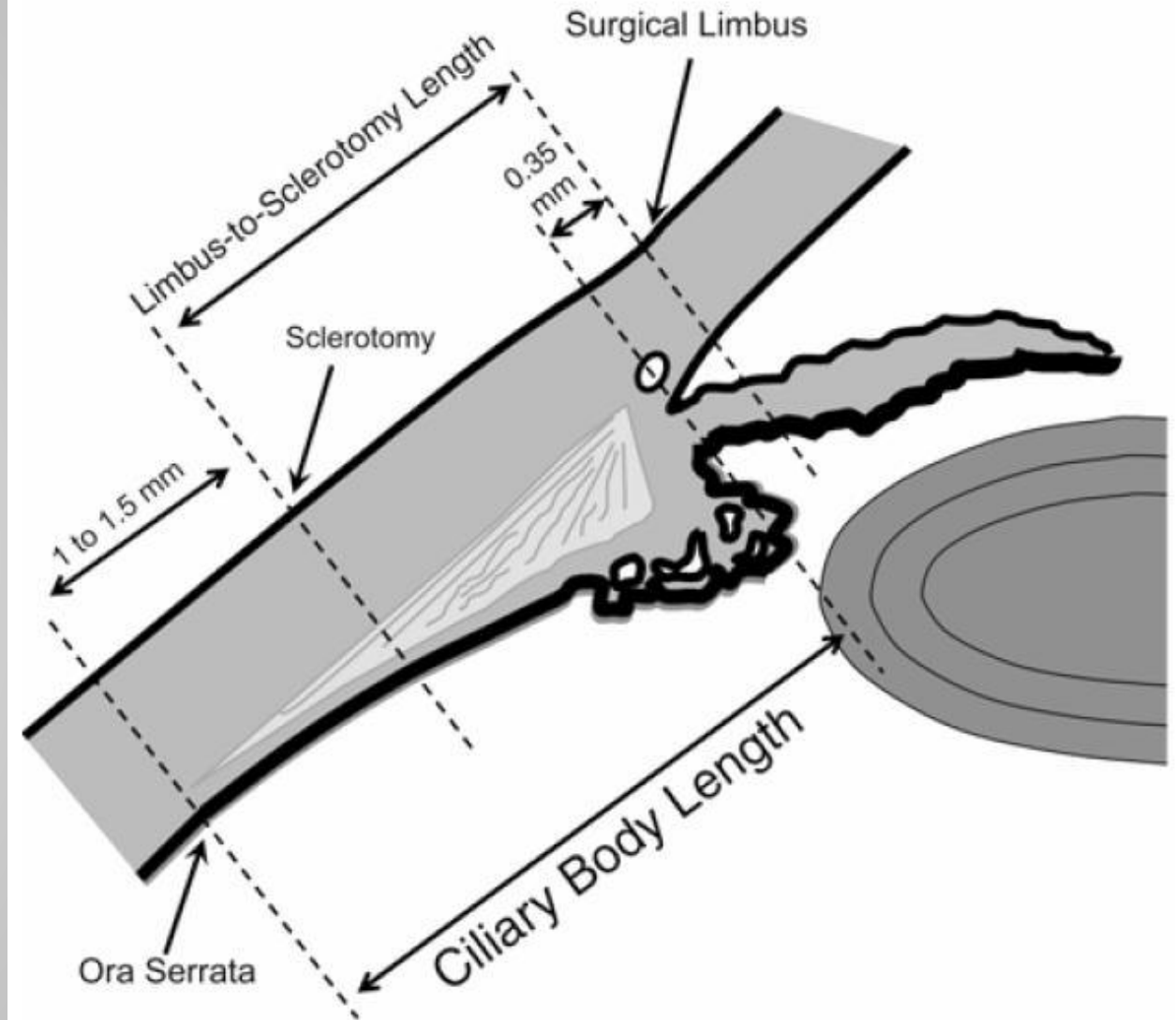
PEDIATRİK VITREORETINAL CERRAHİ

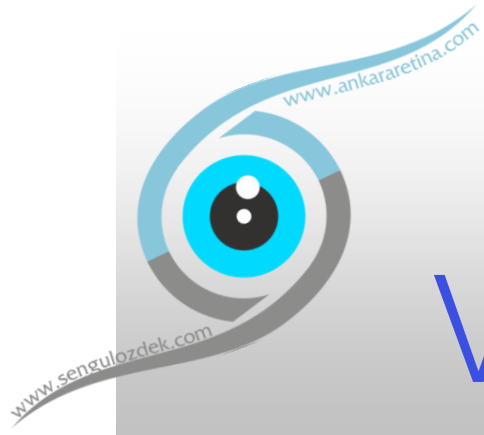
- Kendi kuralları var
- Kendine özel komplikasyonları var
- Hataları affetmez
- Özür kabul etmez



PEDİATRİK VİTREORETİNAL CERRAHİ

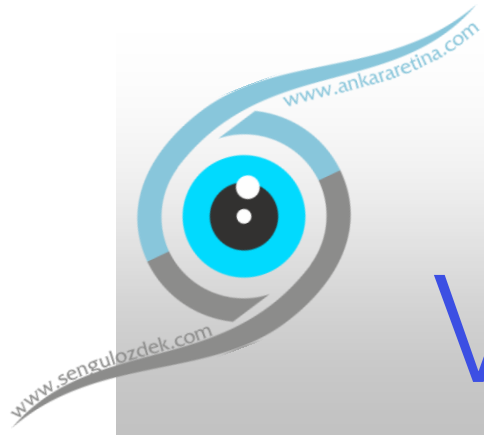
- Göz çok küçük, manevralar için alan dar (15-19mm)
- Lens nisbeten daha büyük
- Vitreous-Retina ilişkisi farklı!
- Pars plana gelişmemiş.
- Sklera ince ve elastik





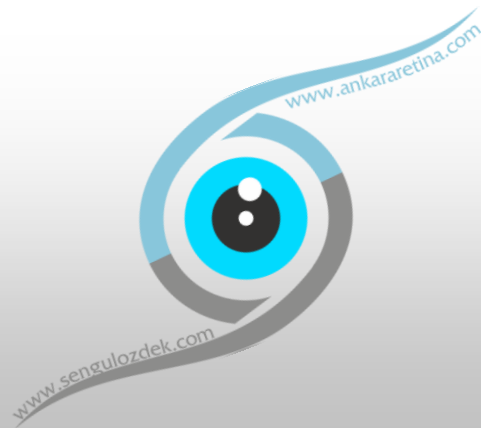
PEDİATRİK VİTREORETİNAL CERRAHİ

- Arka hyaloid sıkı yapışık.
- PFCL ve Silikon yağı kullanımı seyrek.
- Baş pozisyonuna uymazlar!
- Retinal yırtıklar çoğunlukla başarısızlıkla sonuçlanır.
- PVR sık ve şiddetlidir!
- Ambliyopi!



PEDİATRİK VİTREORETİNAL CERRAHİ

- Pars plikata
- 2-3 girişli
- 19G-20G-23G-25G-27G cerrahi
- Lens koruyucu vitrektomi (LKV): mümkün olduğunca!
- Lensektomi-Vitrektomi



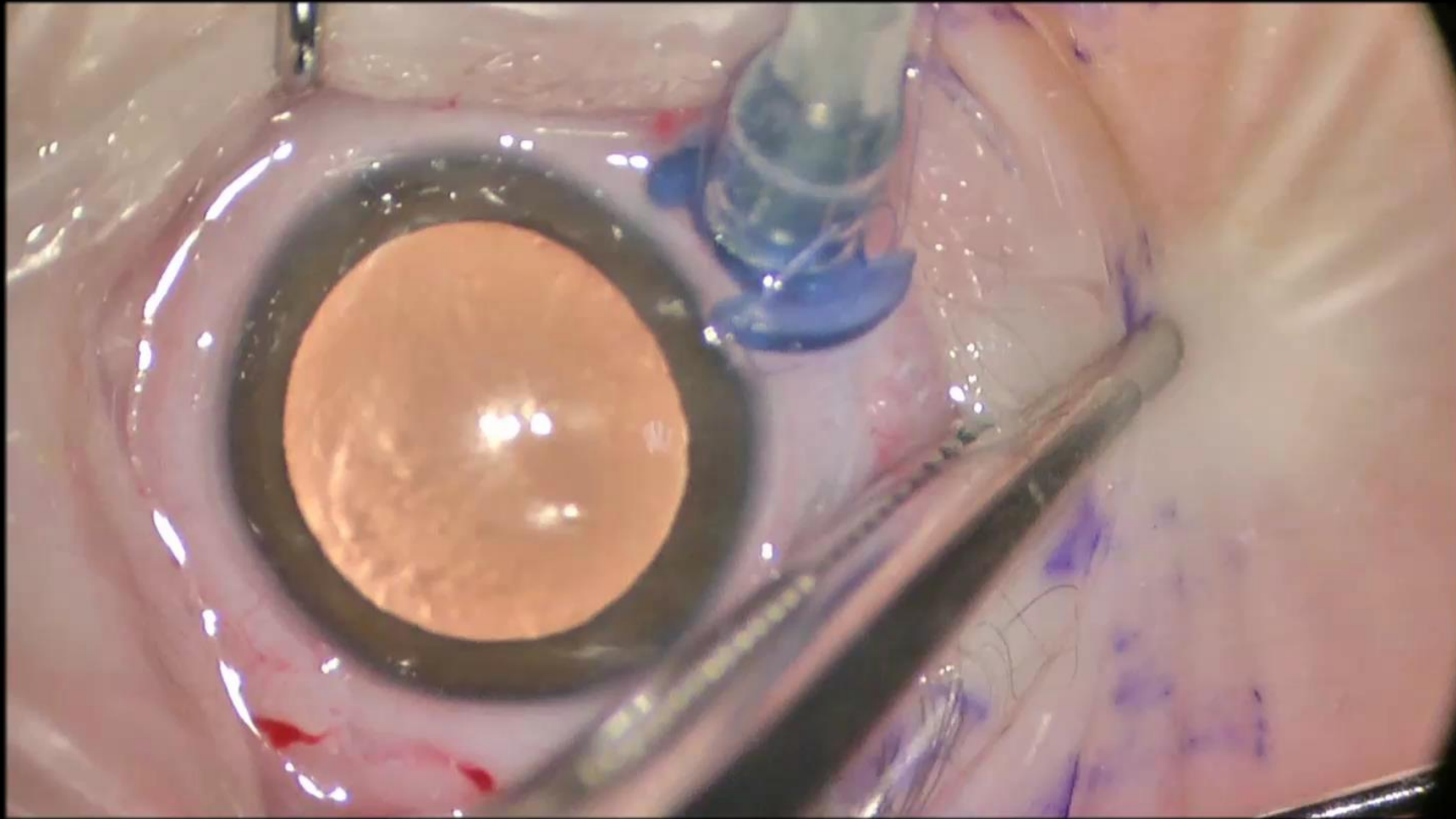
Sklerotomi

DATA USED TO PLAN SCLEROTOMY LOCATION

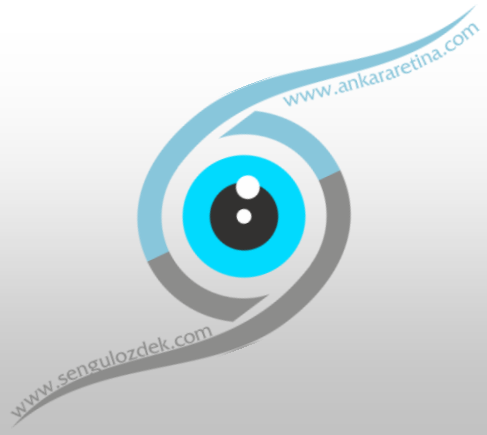
AGE	MINIMUM CILIARY BODY LENGTH (AIELLO ET AL ¹)	MINIMUM LIMBUS- TO-ORA SERRATA DISTANCE	LIMBUS-TO- SCLEROTOMY DISTANCE	
			CALCULATED	APPLIED [*]
0–6 mo	2.60 mm	2.95 mm	1.45 mm	1.5 mm [†]
6–12 mo	2.86 mm	3.21 mm	1.71 mm	2.0 mm
1–2 yr	3.28 mm	3.63 mm	2.13 mm	2.5 mm
2–3 yr	3.75 mm	4.10 mm	2.60 mm	3.0 mm [‡]
Adult	4.60 mm	4.95 mm	3.45 mm	3.5 mm [§]

Aiello AL, Tran VT, Rao NA. Postnatal development of the ciliary body and pars plana: a morphometric study in childhood. Arch Ophthalmol 1992;110:802-805.

YENİDOĞANDA VRC Başlarken....

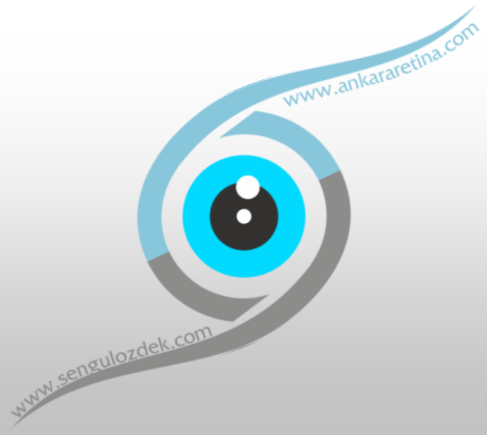


Dar alan kantotomi ile genişletilebilir



Girişler

- **Pars plikata:** LKV (Evre 4, posterior)
- **Trans-iris root:** Lensektomi planlanmışsa (anterior evre 4, evre 5)
- **Limbal giriş:** Lensektomi ile birlikte (anterior evre 4-5)



Lensektomi Planlanmıřsa

1. İris kökünden giriş: Iris sorunları

2. Limbal giriş:

Korneal distorsiyon problemleri,

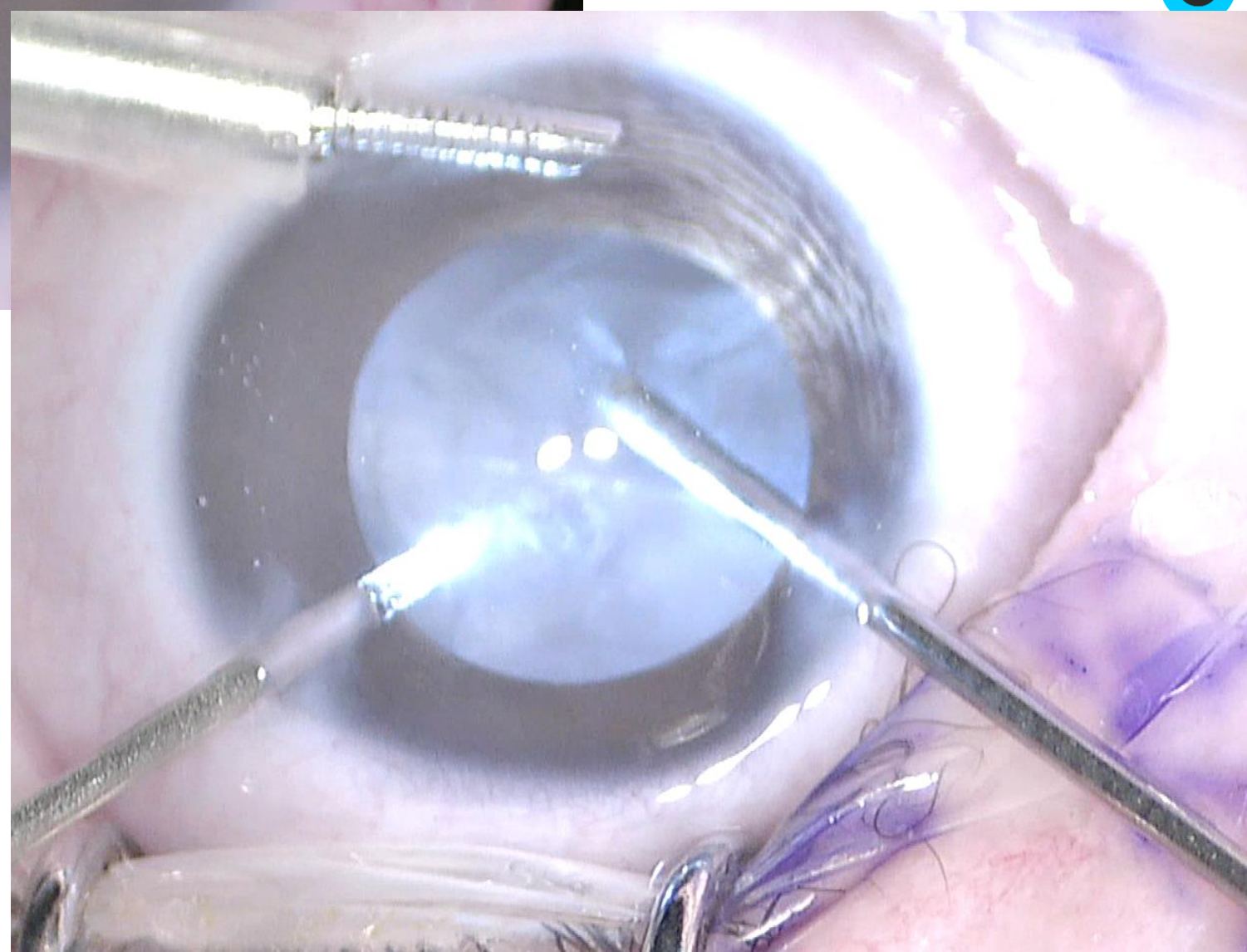
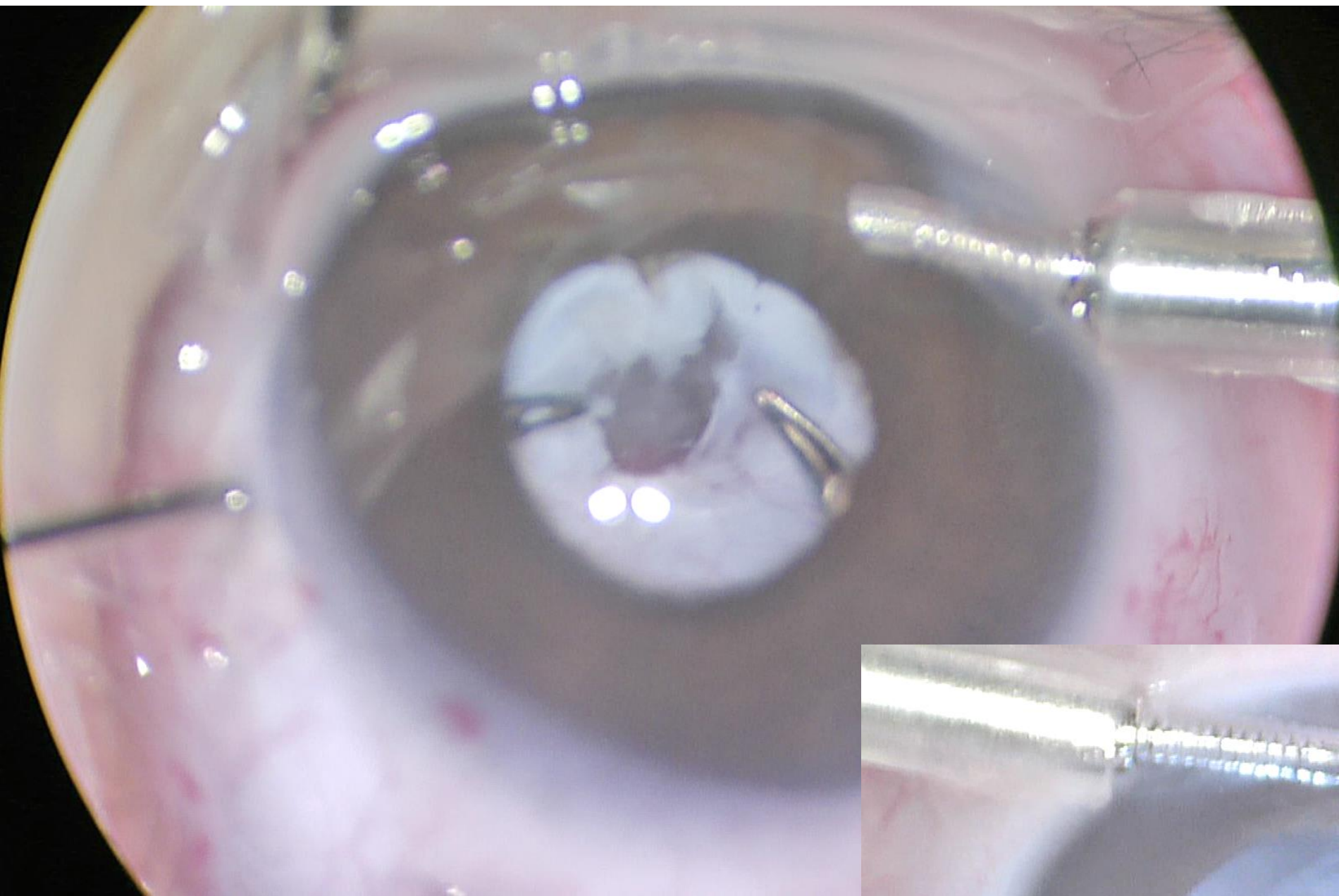
10/0 sütün gerekli (GAA alınması gerekli)

Avantajları:

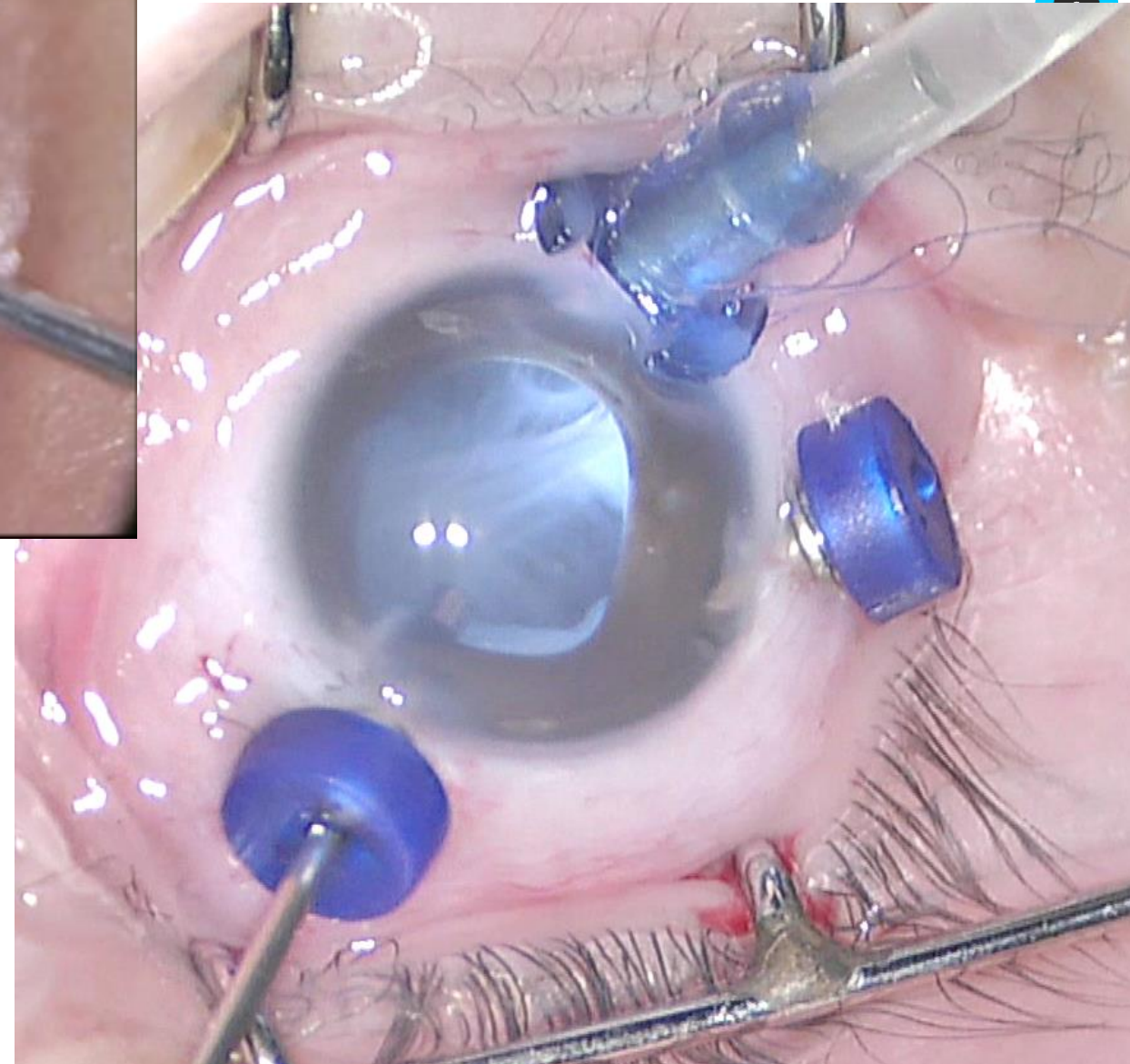
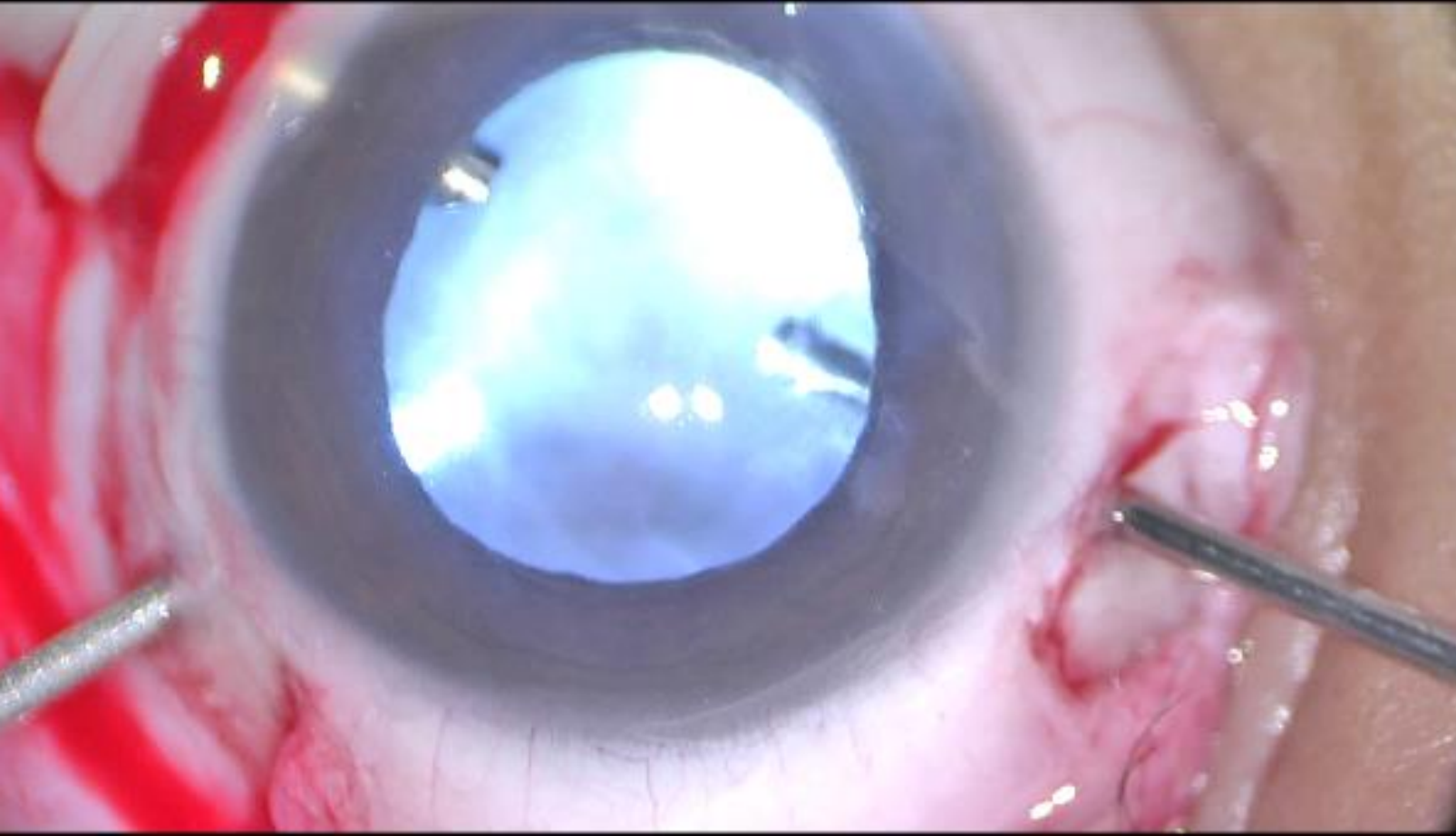
Kantotomiye gerek yok

Konjonktiva ilerde olası glokom cerrahileri için korunur

Periferik retinal hasardan kaçınılmıř olur



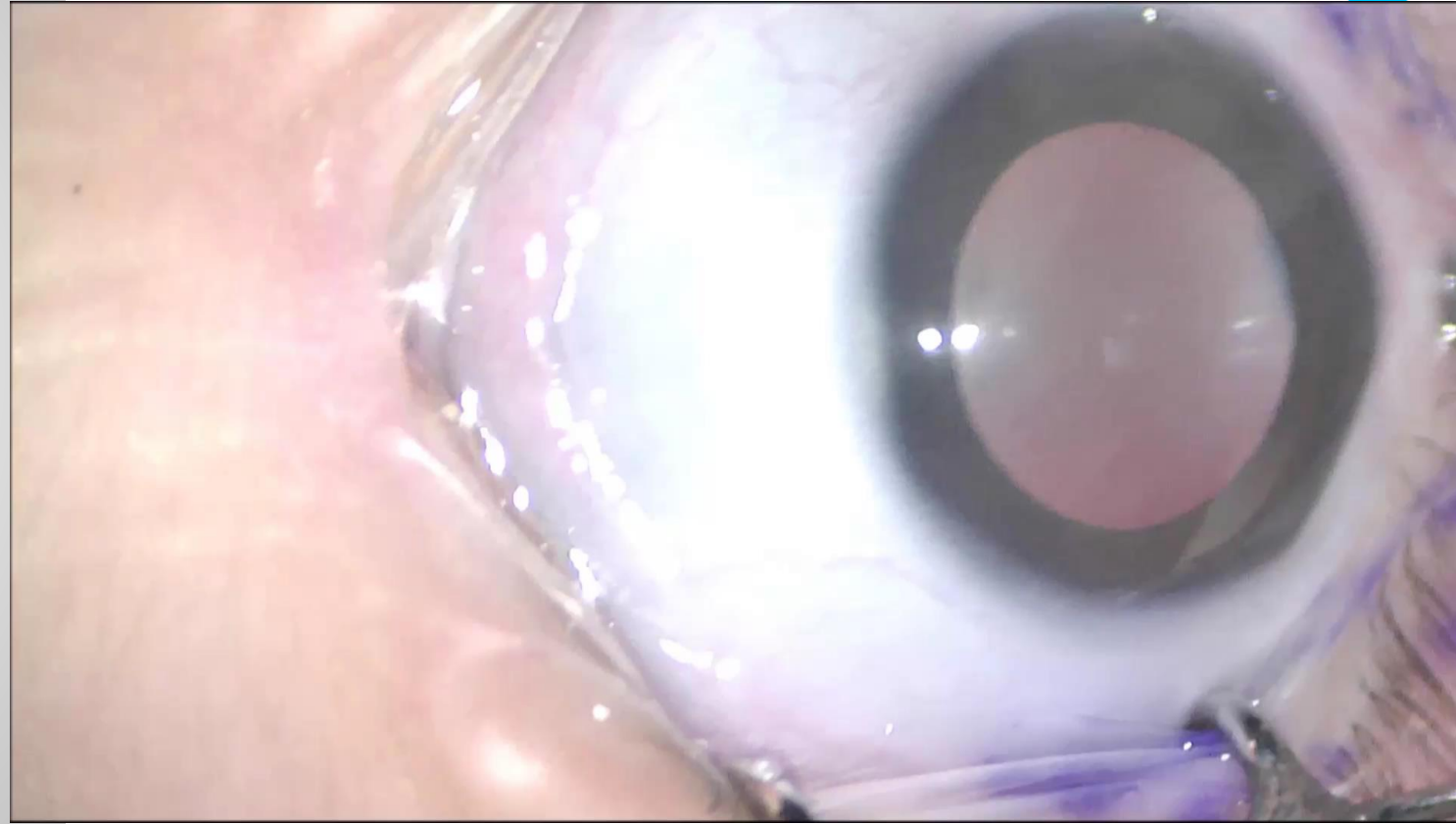
Kanüllü veya kanülsüz

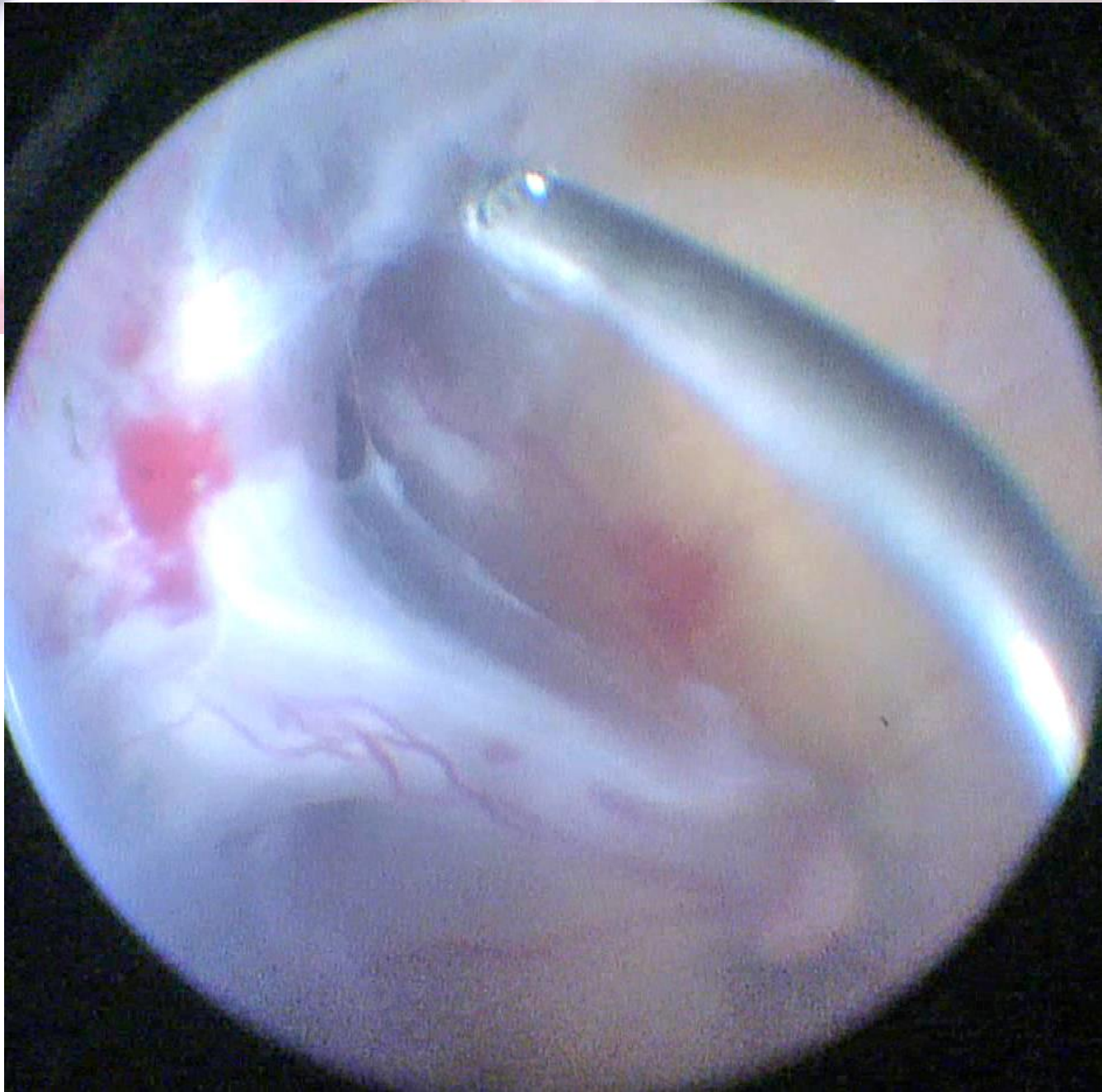
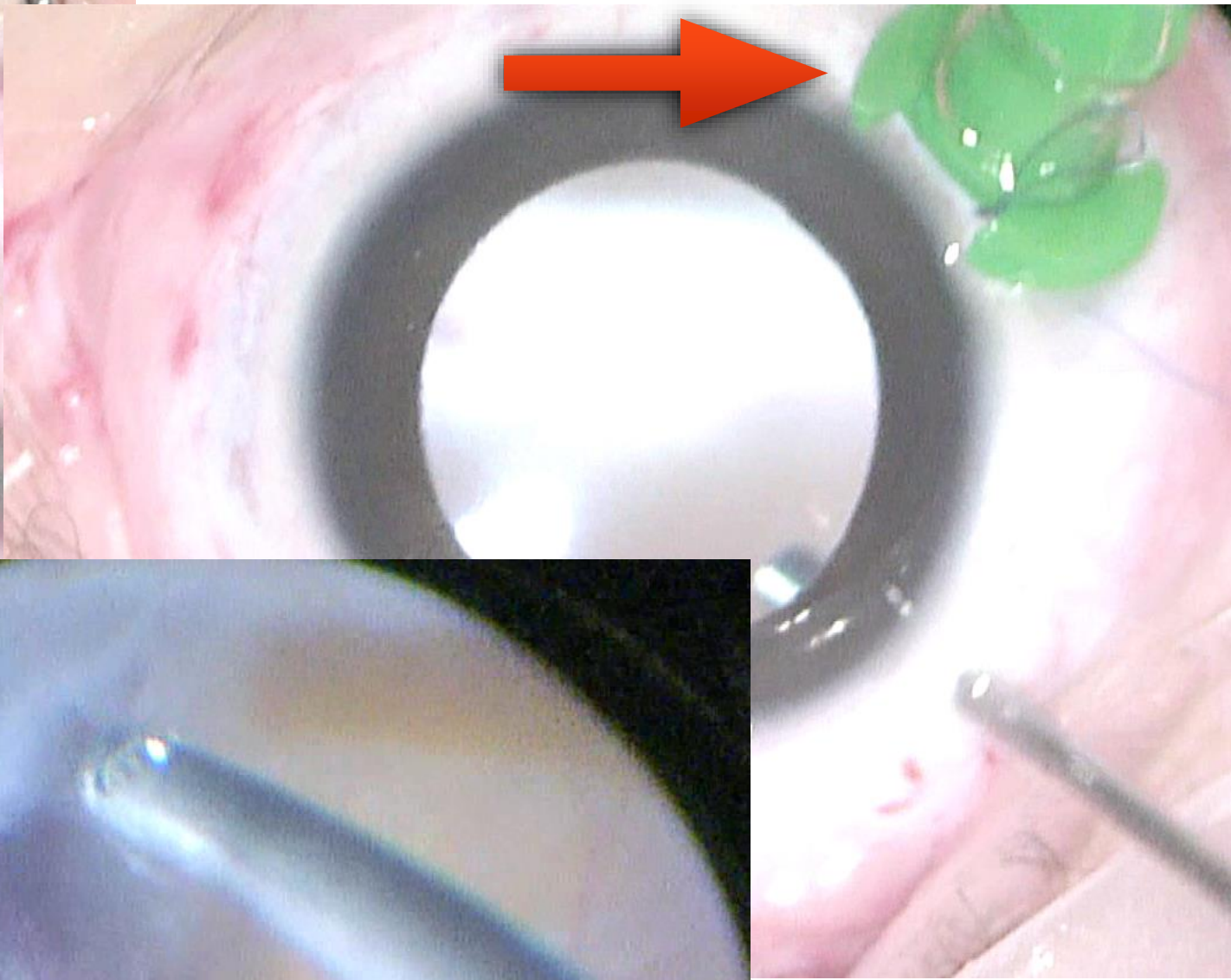
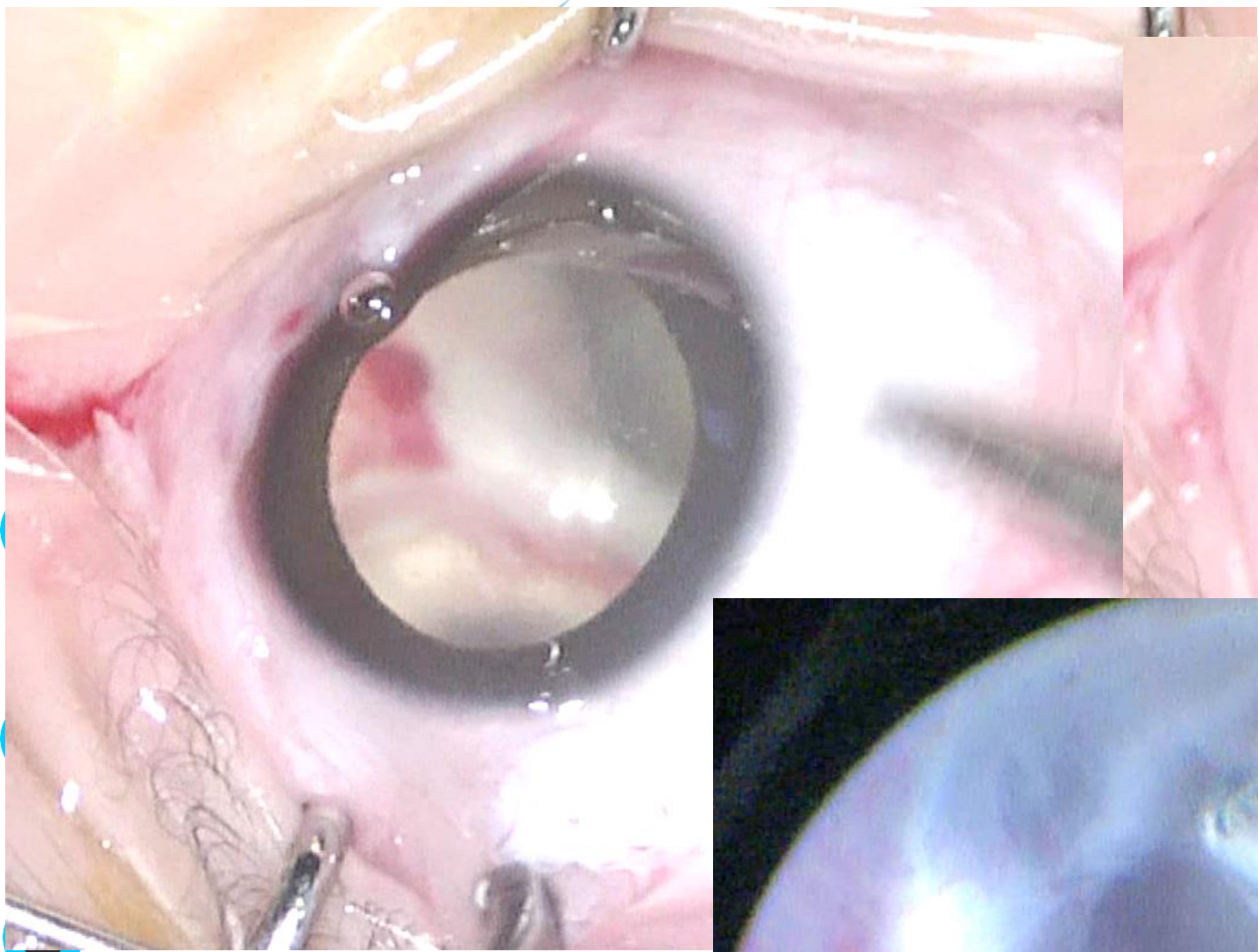




Sklerotomi Yeri Seçimi

- Konj Açılır
- Anterior fibrovasküler doku ve retina hasarından kaçınmak için her hastada yeri ayrı belirlenir.
- Tüm sklerotomiler sütürlenir.

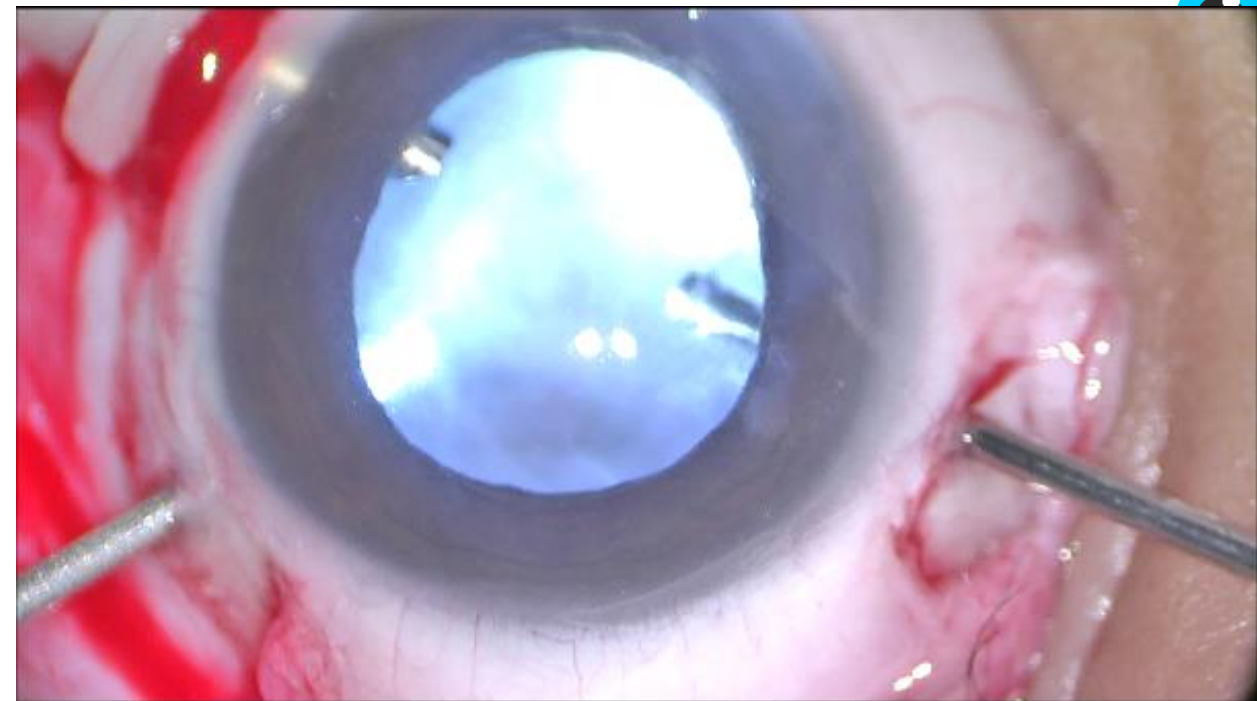
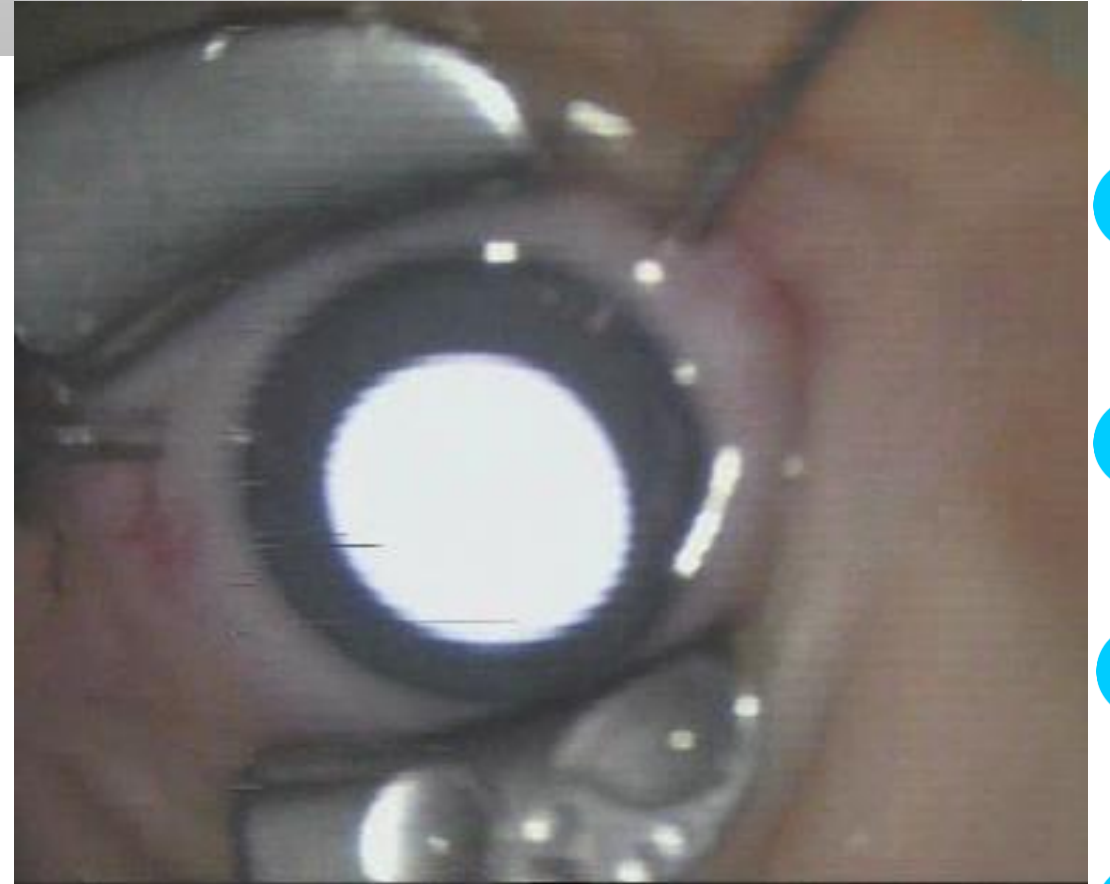


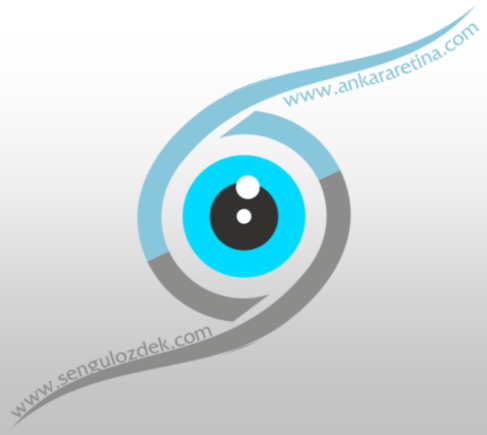




Sklerotomi sayısı

- 2 port
- 3 port





2 li giriş

- **Avantajları:**

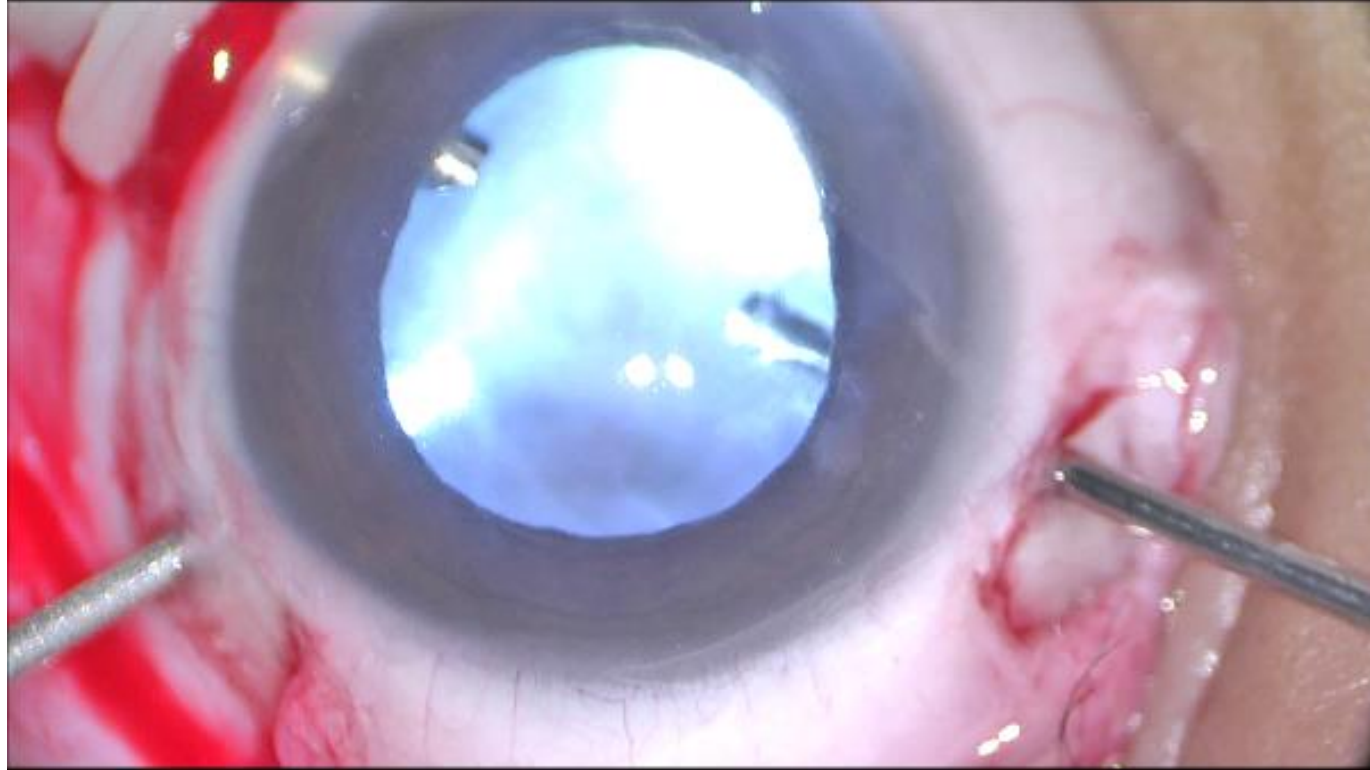
- Kantotomiye gerek yok.
- 3. girişin neden olabileceği sorunlardan kaçınılmış olur

- **Dezavantajları:**

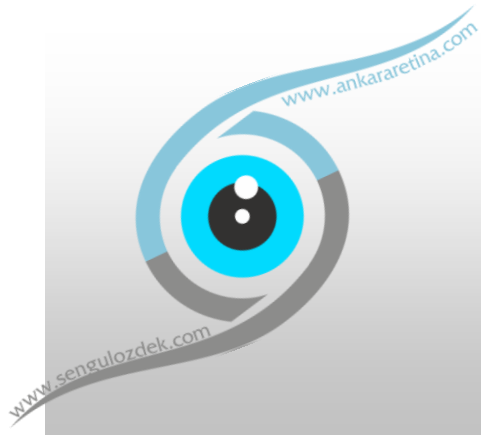
- İlave enstrumanlar gerektirir (forsepsler, endoillüminasyonlar irrigasyonlu olmalı)
- 19-20G cerrahi!
- Hipotoni riski! (Bir el sürekli göz içinde olmalı)



3'lü giriş



- 20G-23G-25G-27G mümkün
- Yetişkin tipi enstrümantasyon mümkün
- Sütürlü infuzyon kanülü: 23G (4mm)



PEDİATRİK VRC

ROP

FEVR

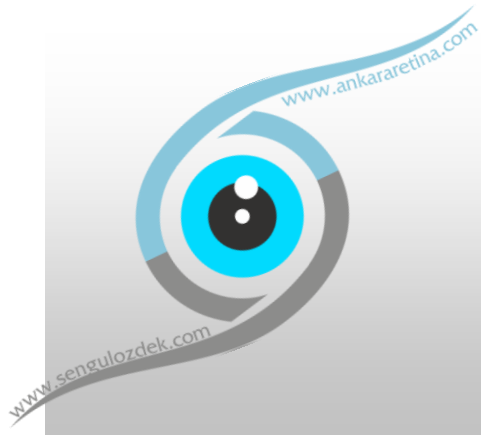
DİĞER (INKONTINENTIA PIGMENTI)

COATS

PFV

SHAKEN BABY

CXLR...



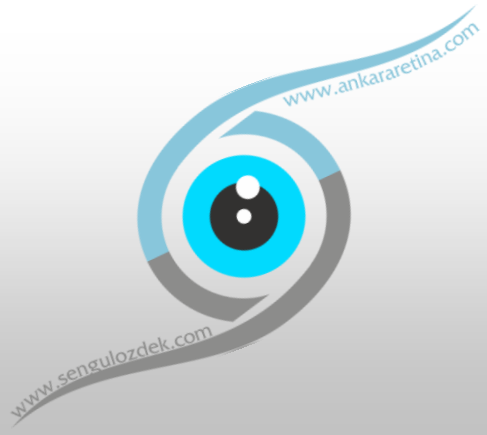
PEDIATRİK VRC

ROP

FEVR

INKONTINENTIA PIGMENTI

COATS



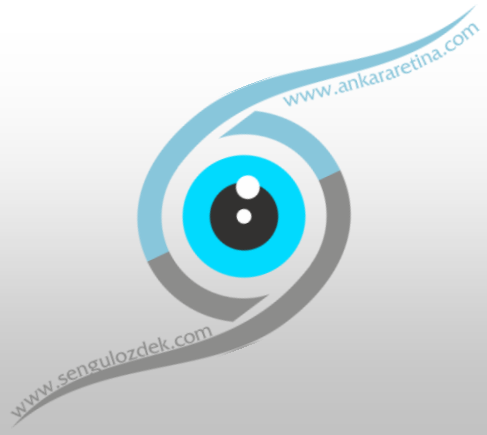
ROP

EVRE 4A

EVRE 4B

EVRE 5?

SKATRİSYEL

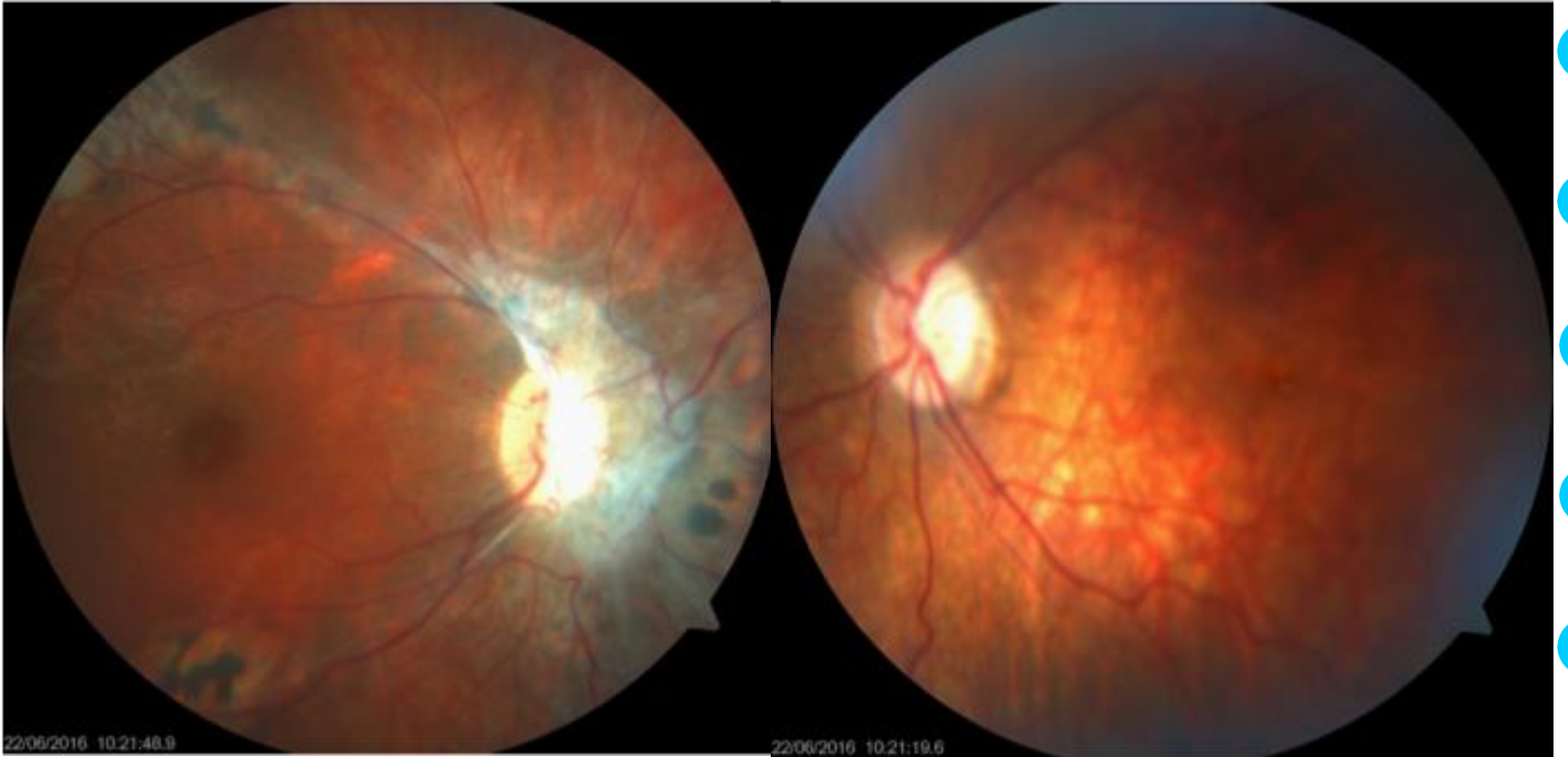


Evre 4A ROP Trokarlı giriş

Prof. Dr. Şengül Özdek

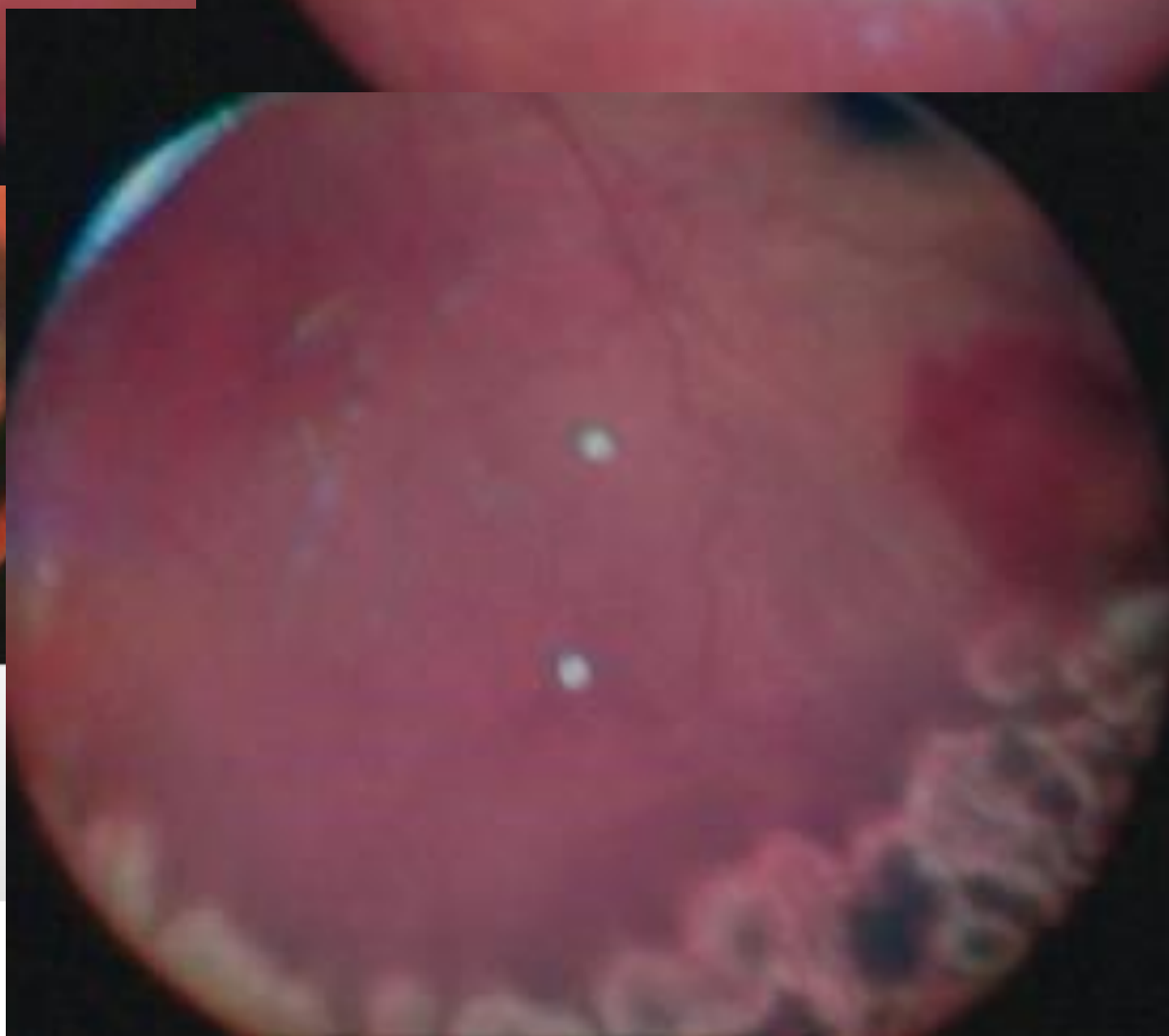
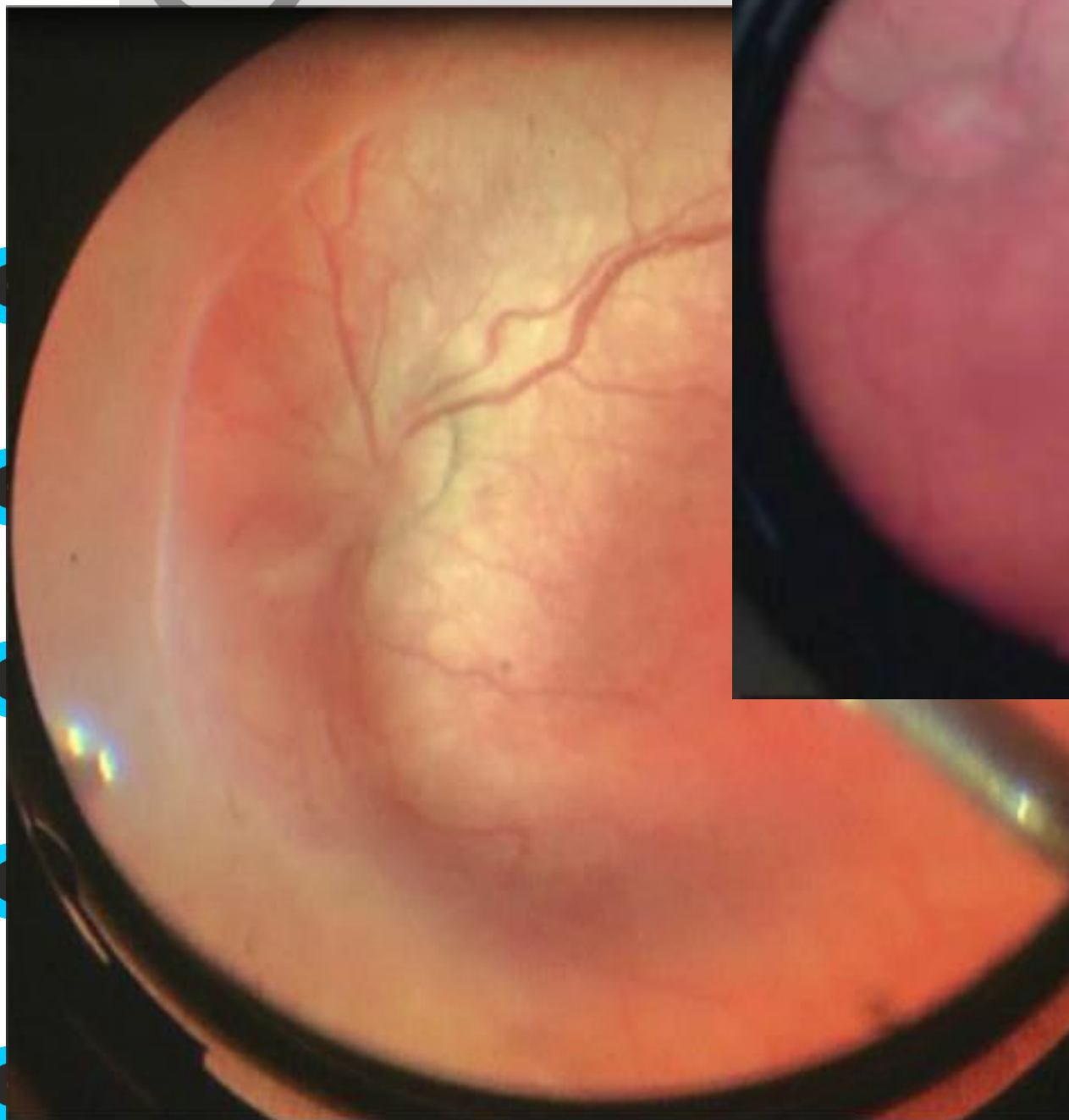


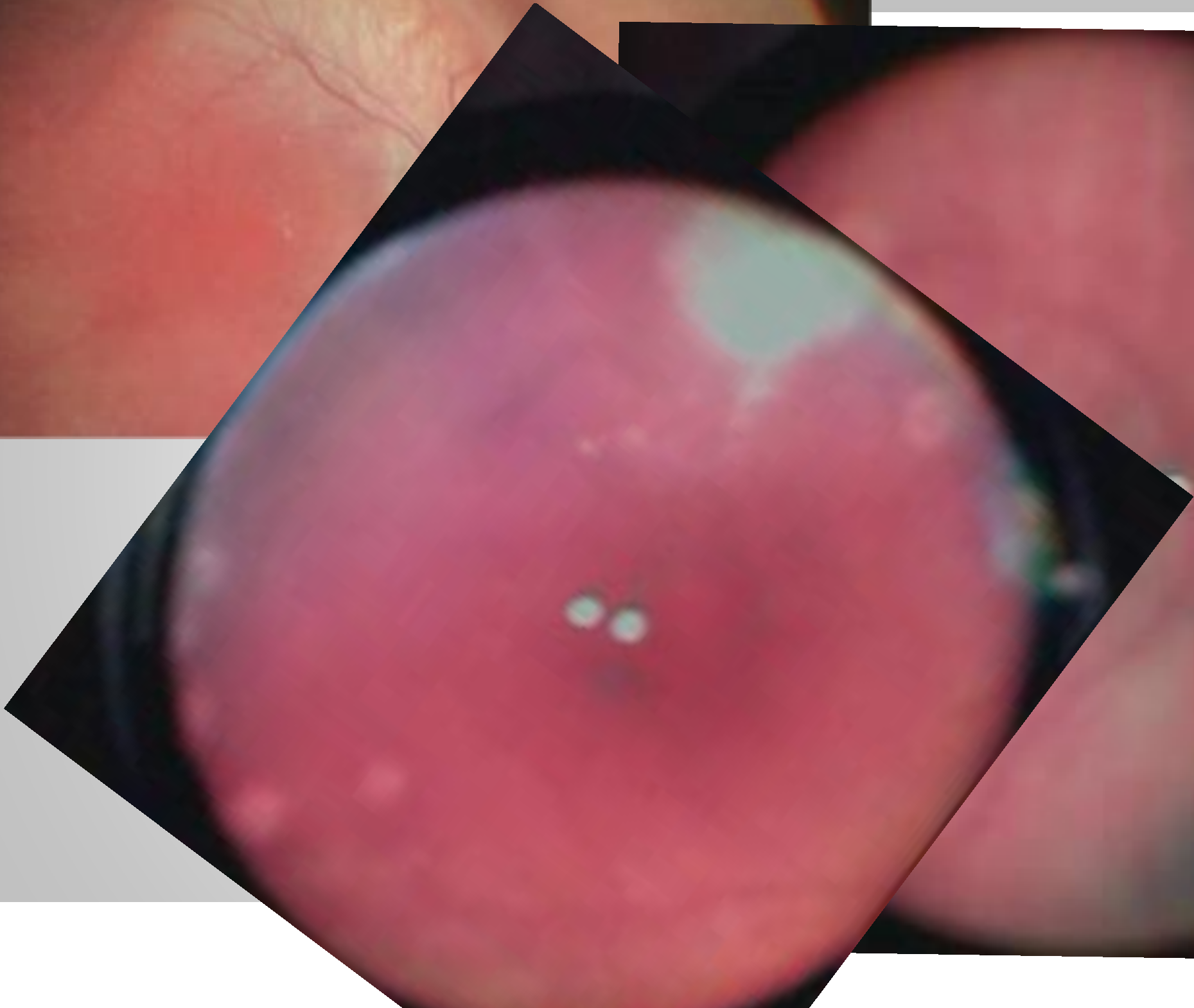
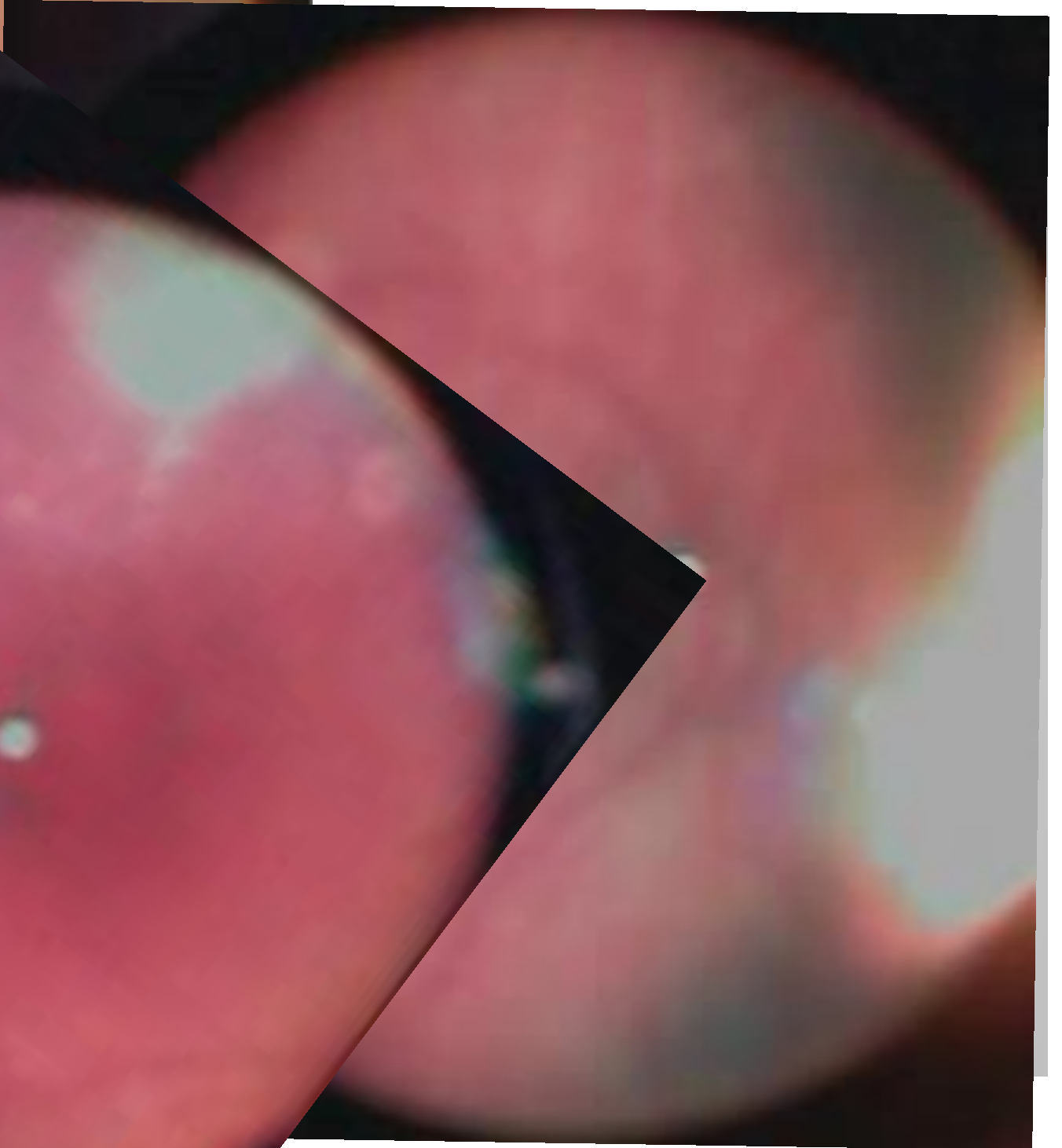
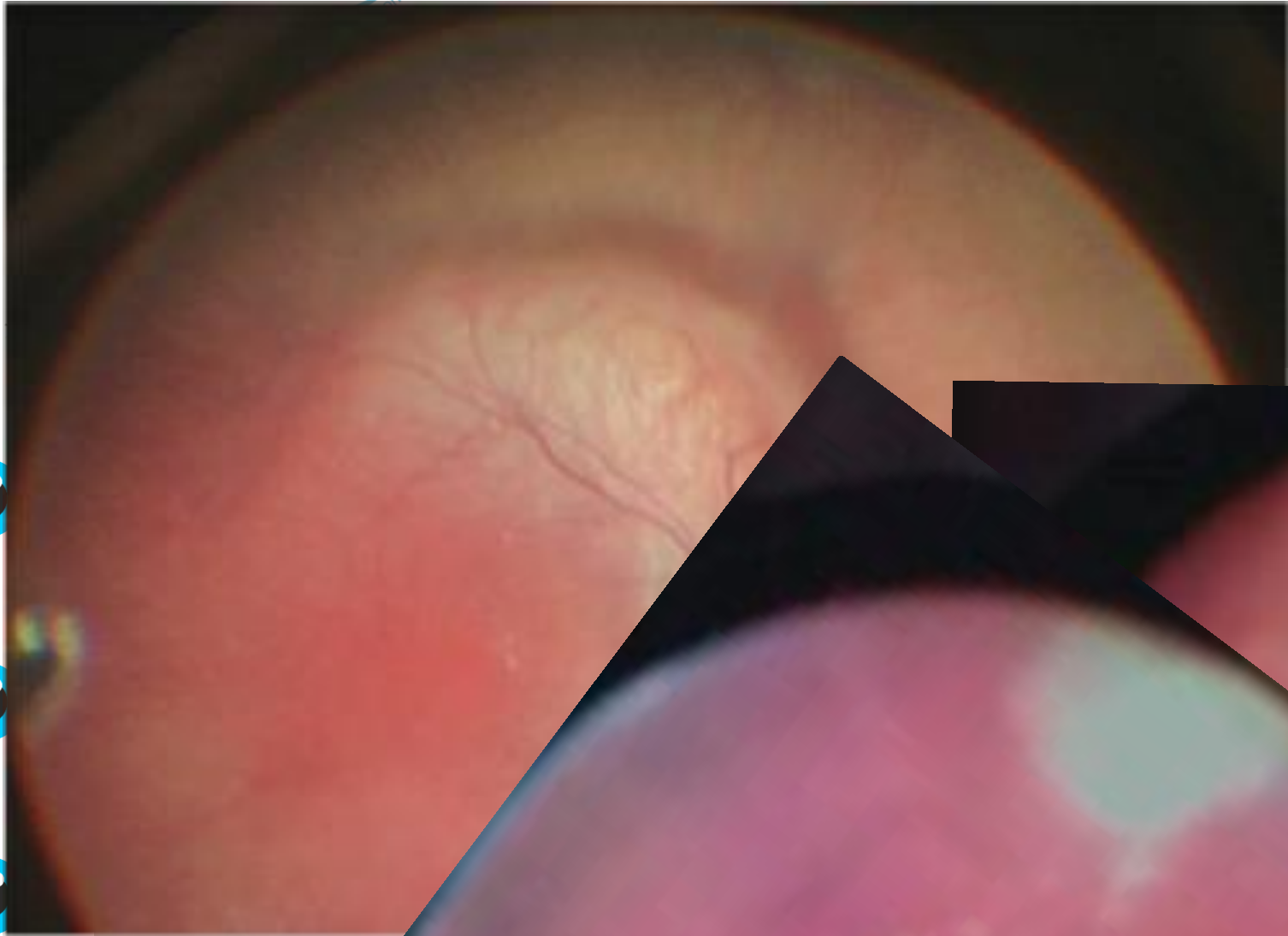
Bilateral cerrahi Postop: 50 ay



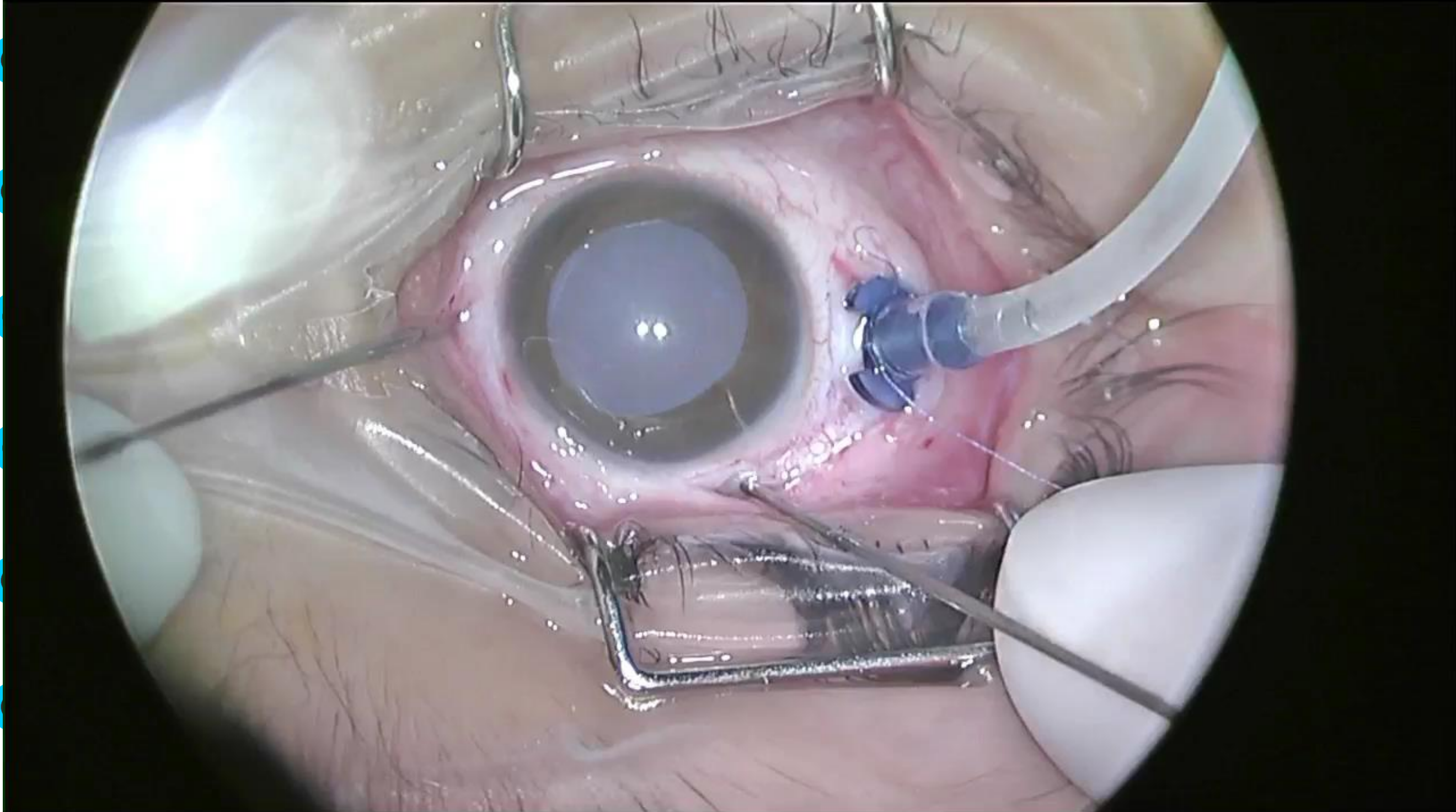
RE: **0.2** (-3.25 -1.50 180)

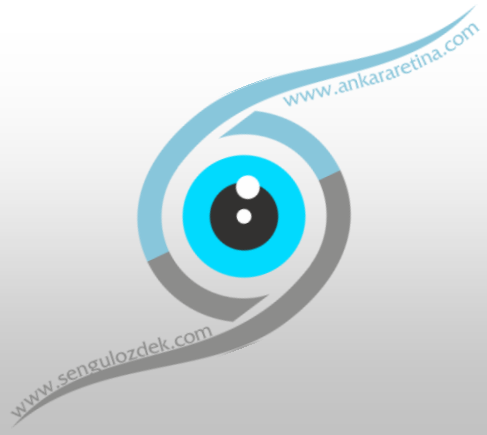
LE: **0.3** (-8.50 -3.25 180)



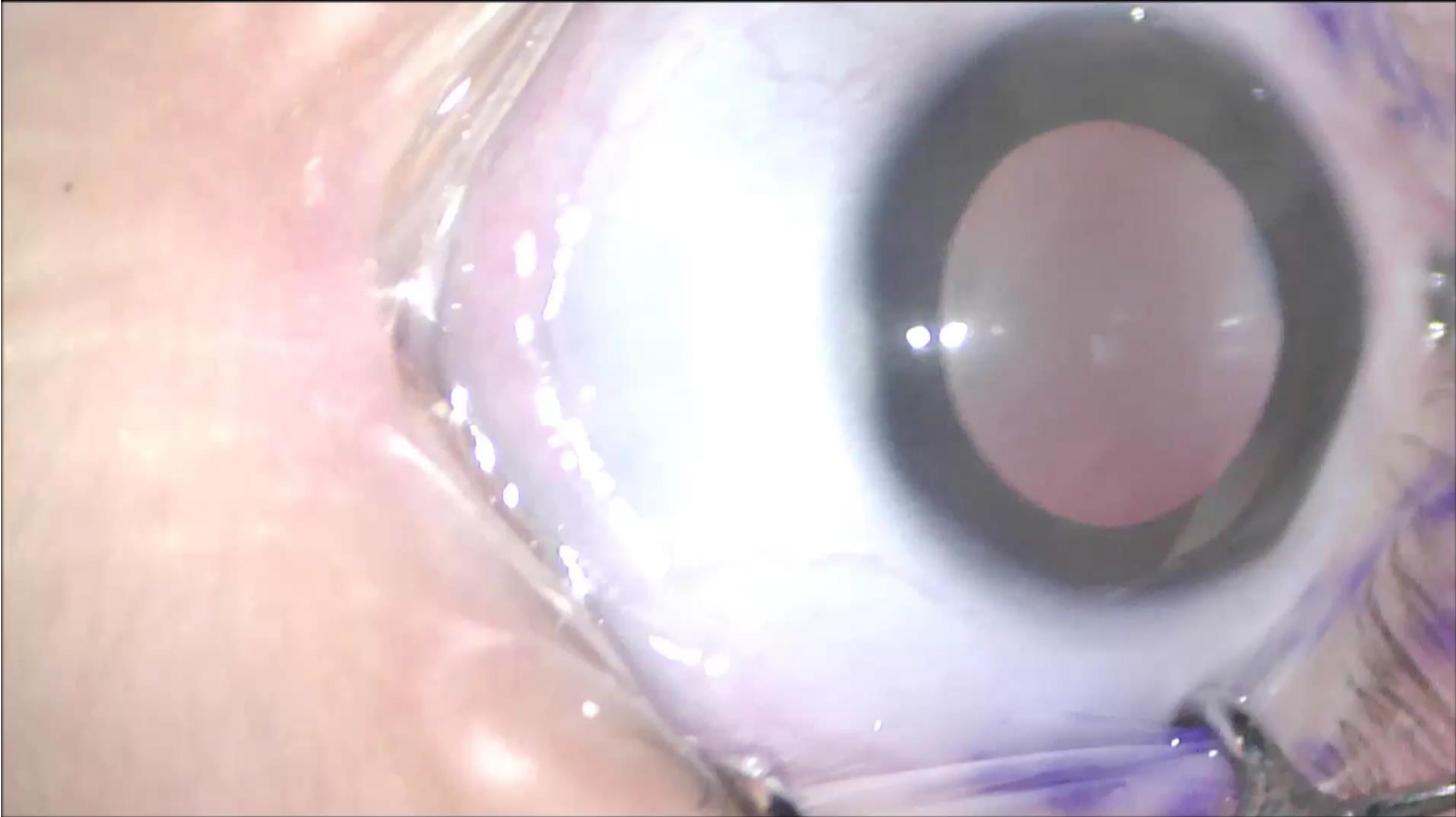


Şiddetli Evre 4A Trokarsız girişler

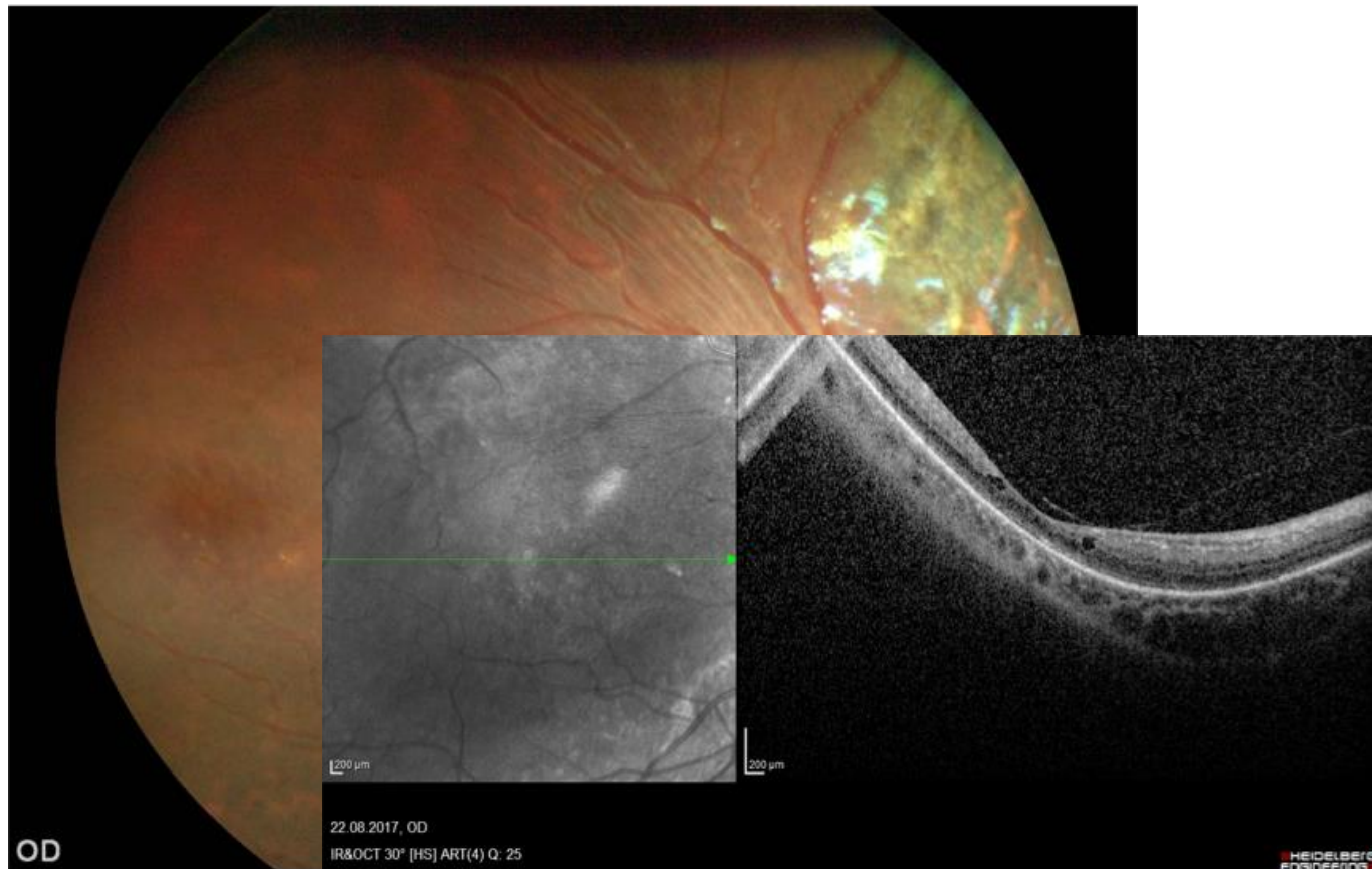




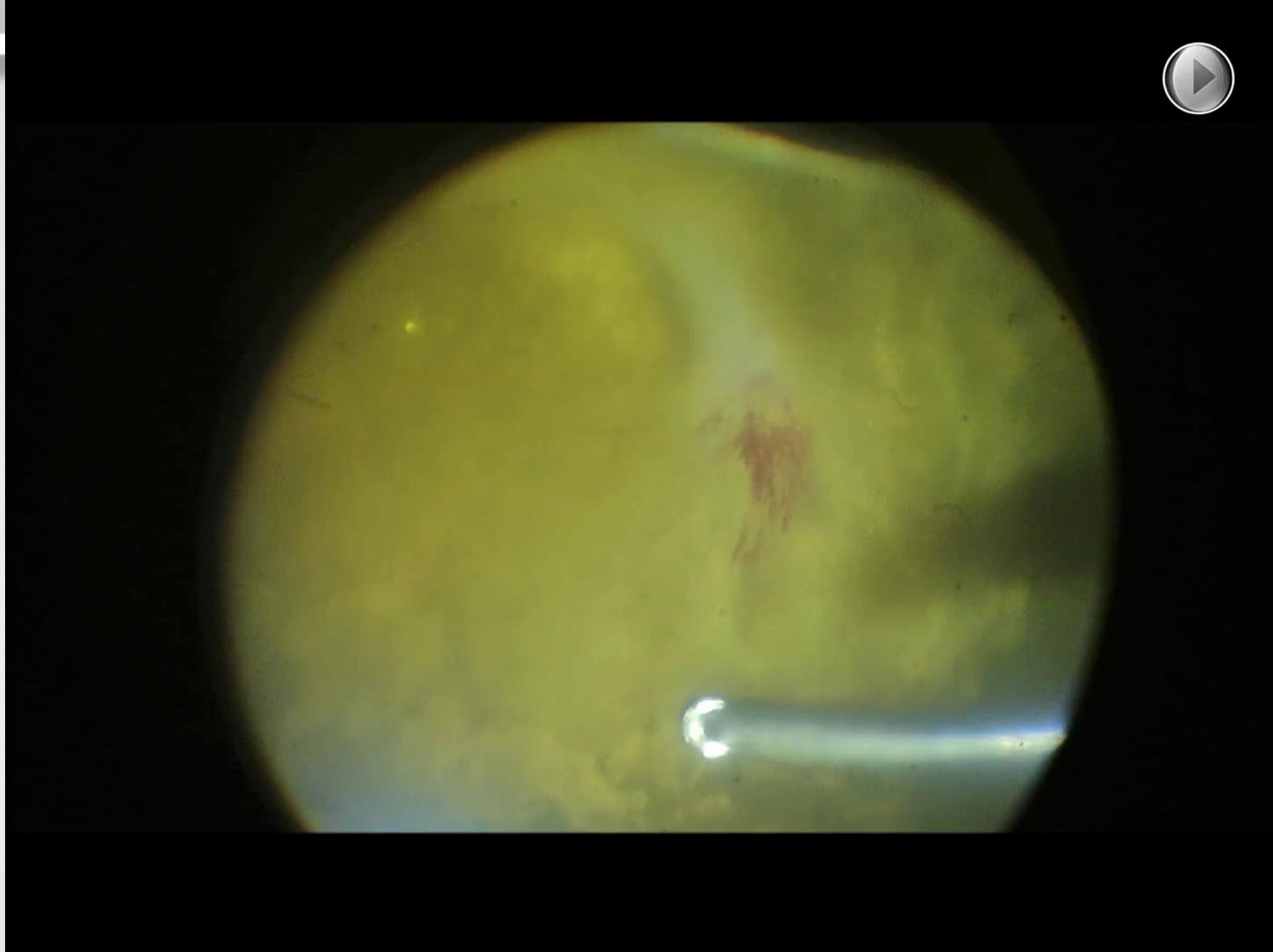
Evre 4B (Diğer göz Evre 5)

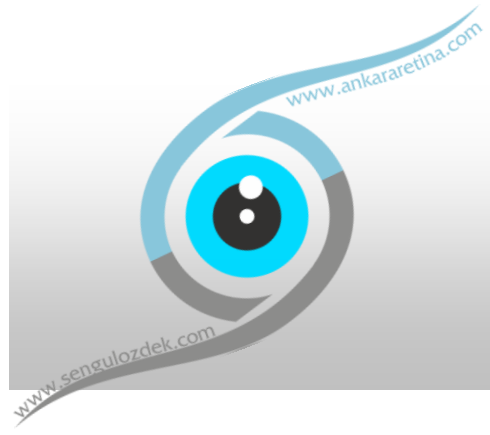


5y, GK: 0.05 (20/400)



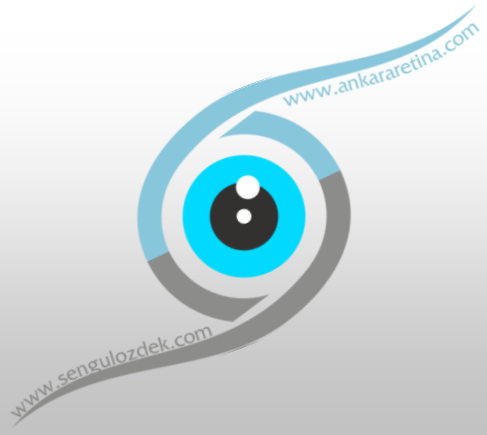
YETERSİZ LAZER!



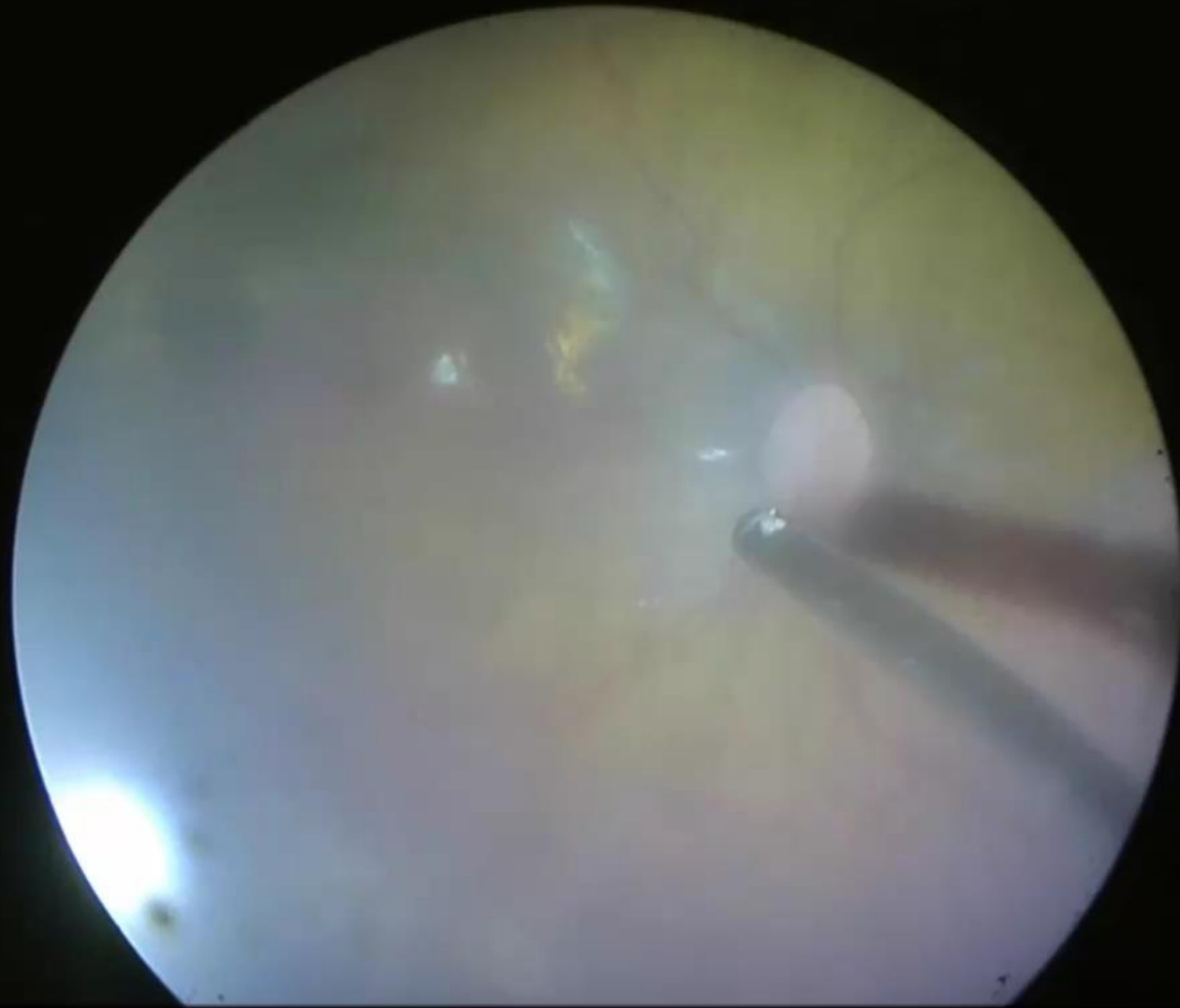


ROP Cerrahisi

- Cerrahin nerede durması gerektiğini bilmesi gereken en tipik cerrahi!
- “Mükemmel iyinin düşmanıdır”
- Retinada yırtık oluşmasına izin verme!

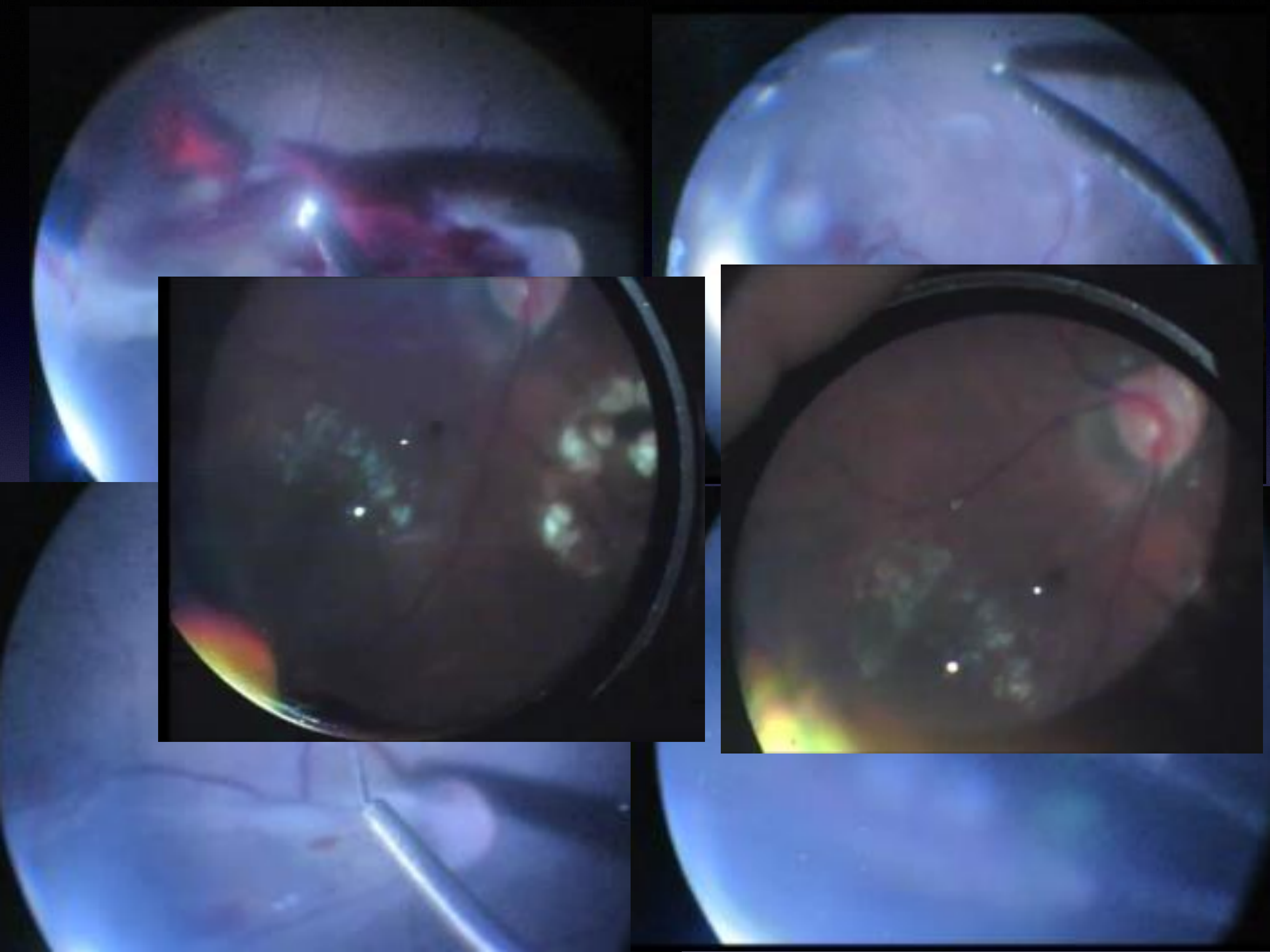


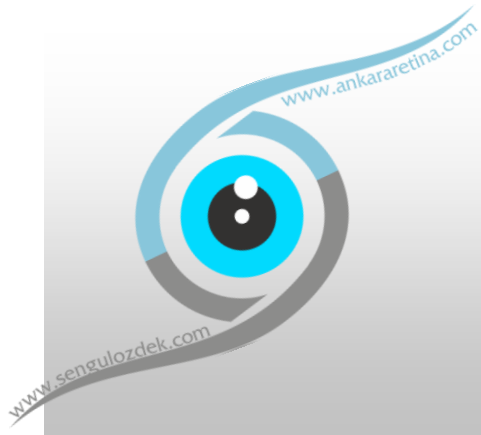
ROP Cerrahi Yırtık Gelişimi



Triamcinolone-assisted vitrectomy







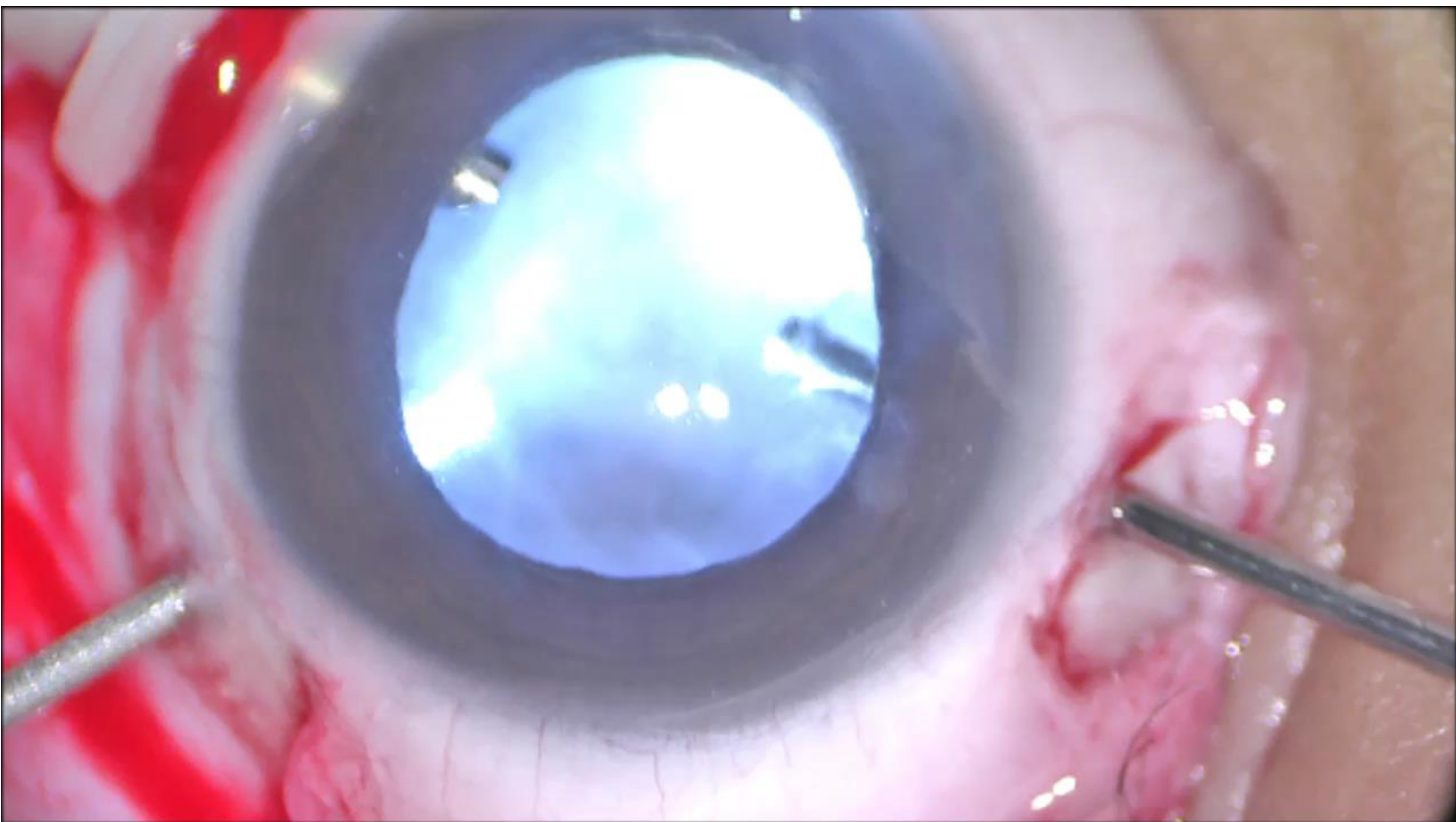
CERRAHİDE YIRTIK GELİŞİRSE...

- Yırtık sakin bir alanda ise: Devam...
- Çok proliferasyon olan bölgede ise: Cerrahiye son...

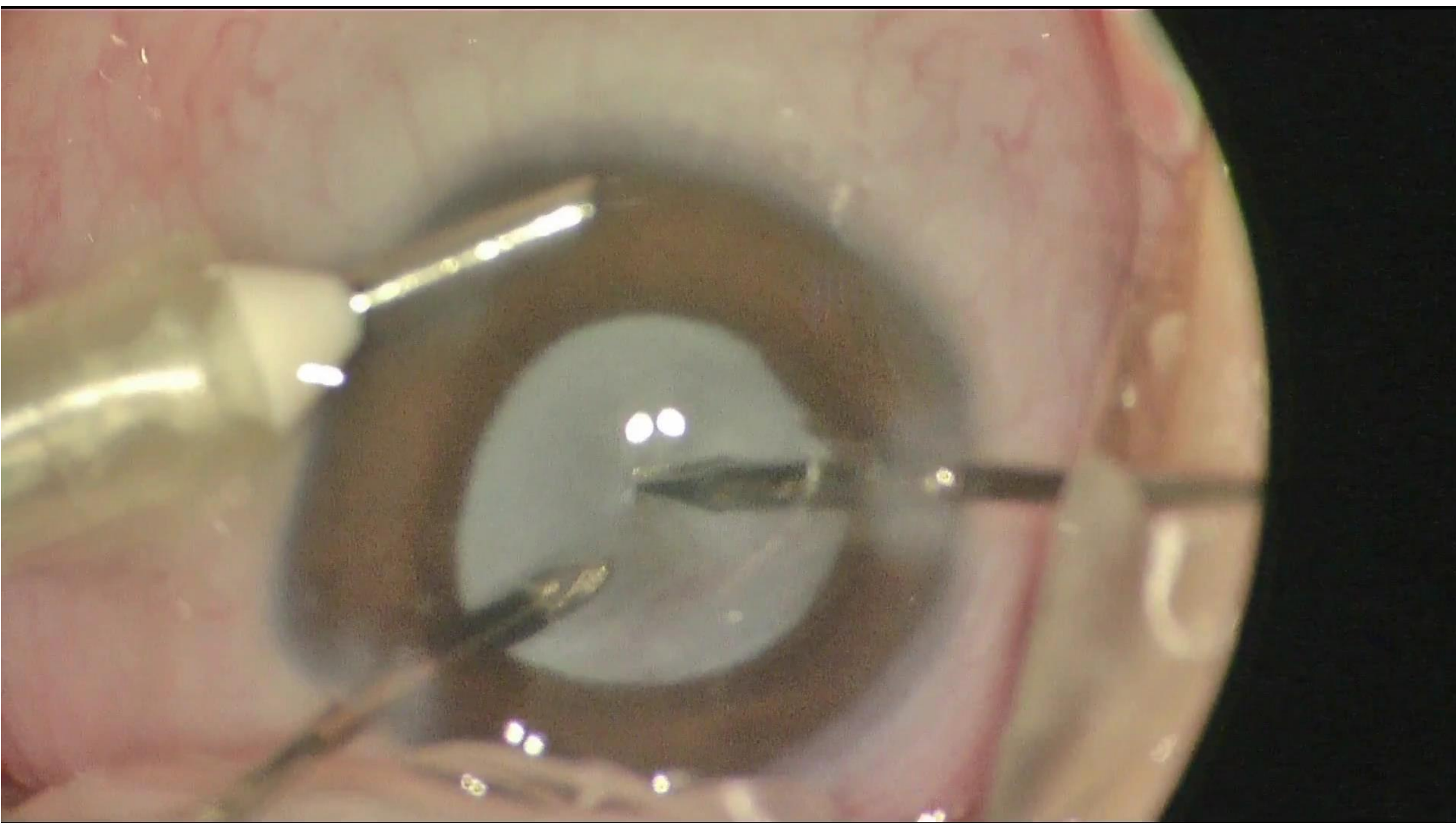
Evre 5 CERRAHİ?

- ÇOĞUNLUKLA INOP
- ÇOK DÜŞÜK GÖRSEL BEKLENTİLER
- PERSEPSİYONUN KORUNMASI - AMBULATUAR GÖRME???
- ANATOMİK/KOZMETİK SONUÇ
- DİĞER GÖZ İYİ İSE.....ÇOĞUNLUKLA OPERE ETMEYİZ

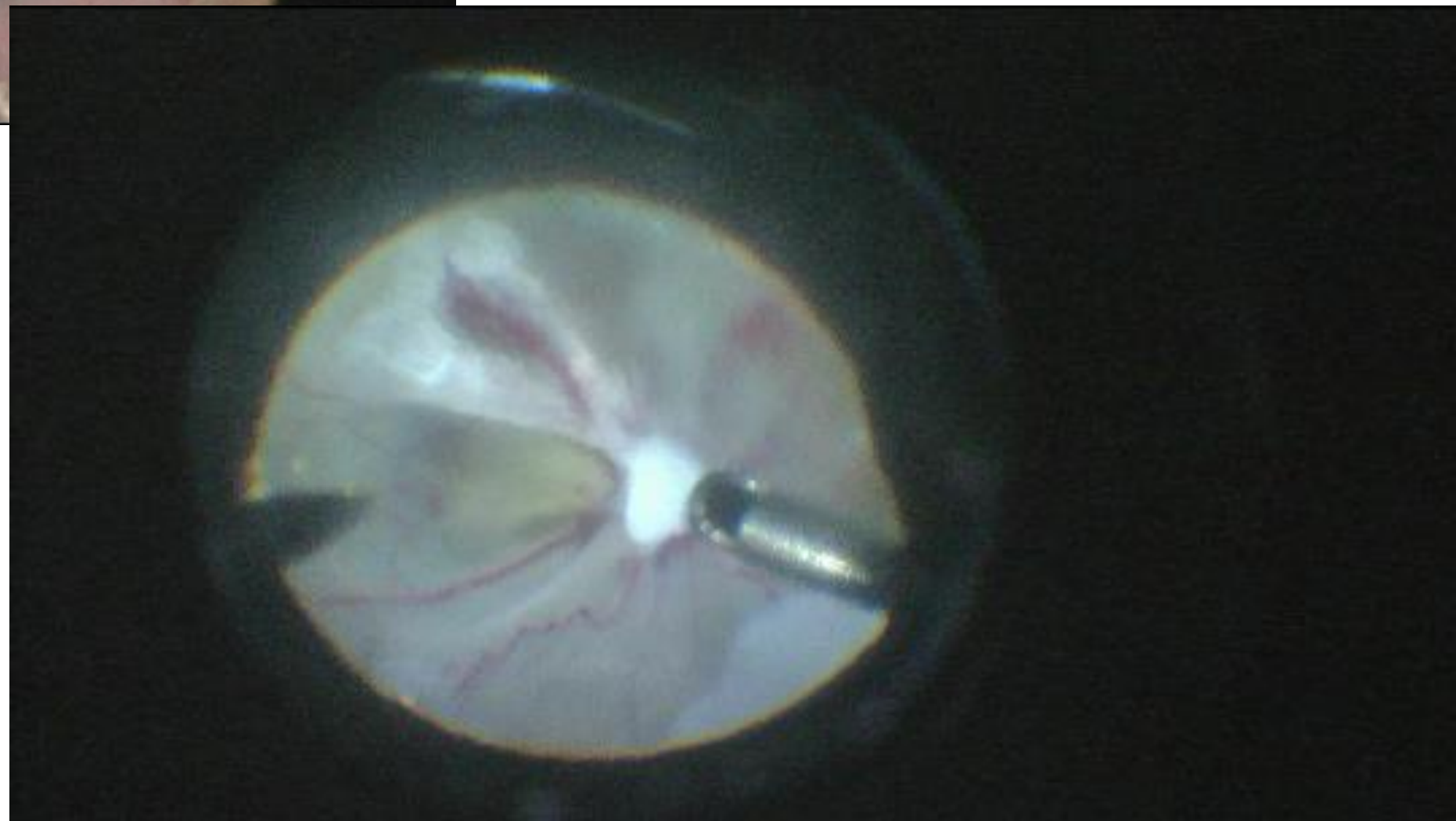
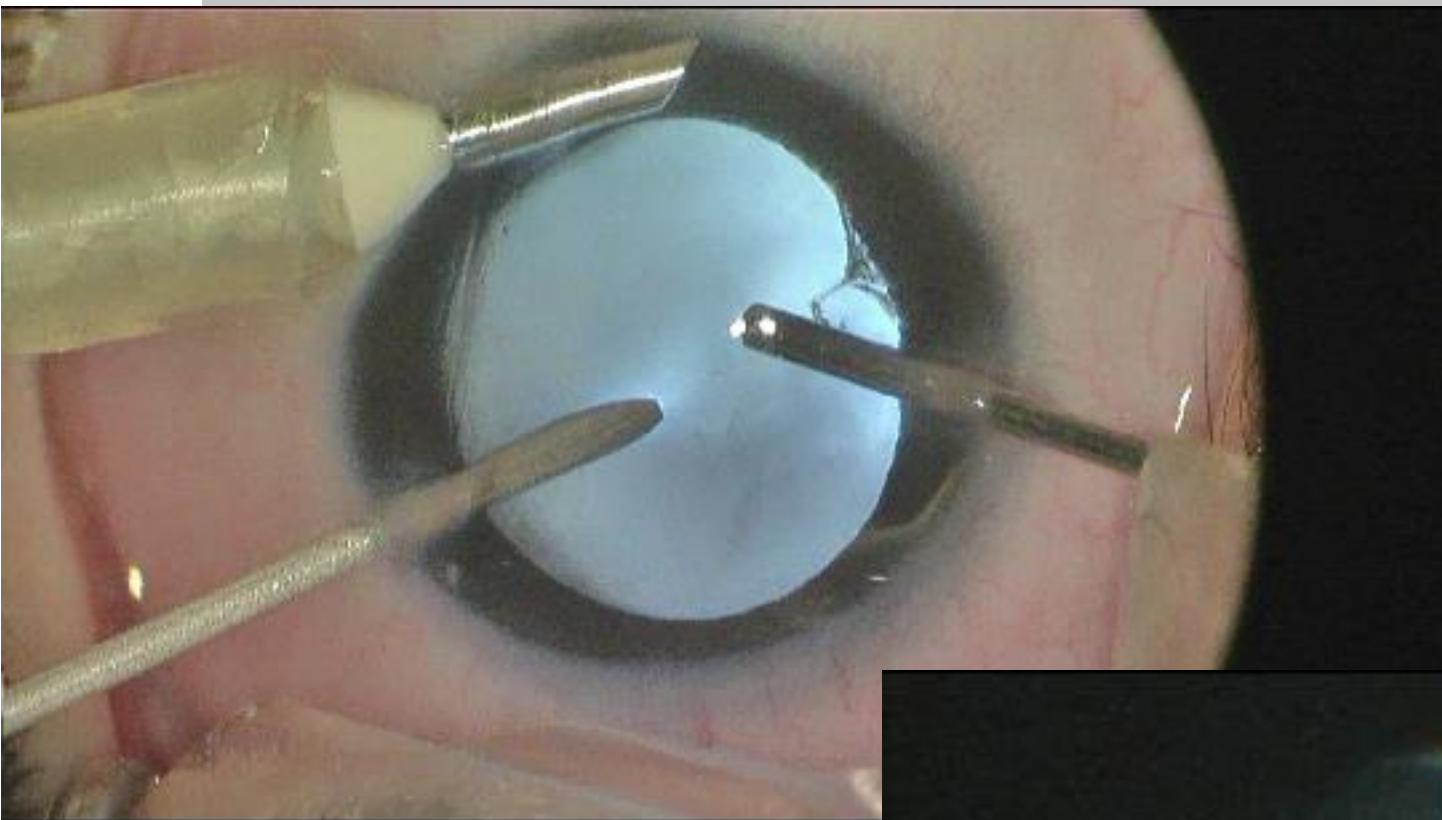
Evre 5

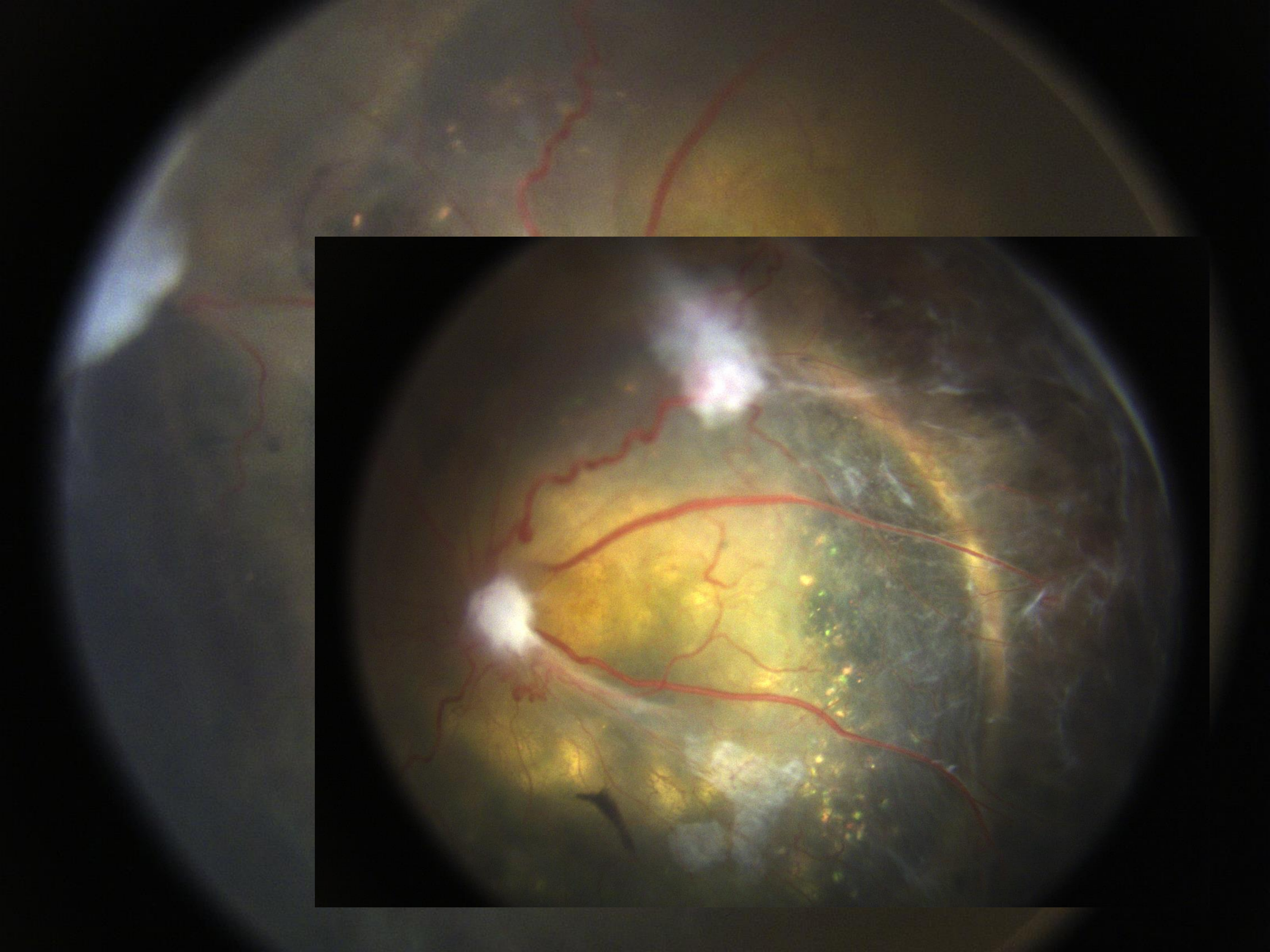


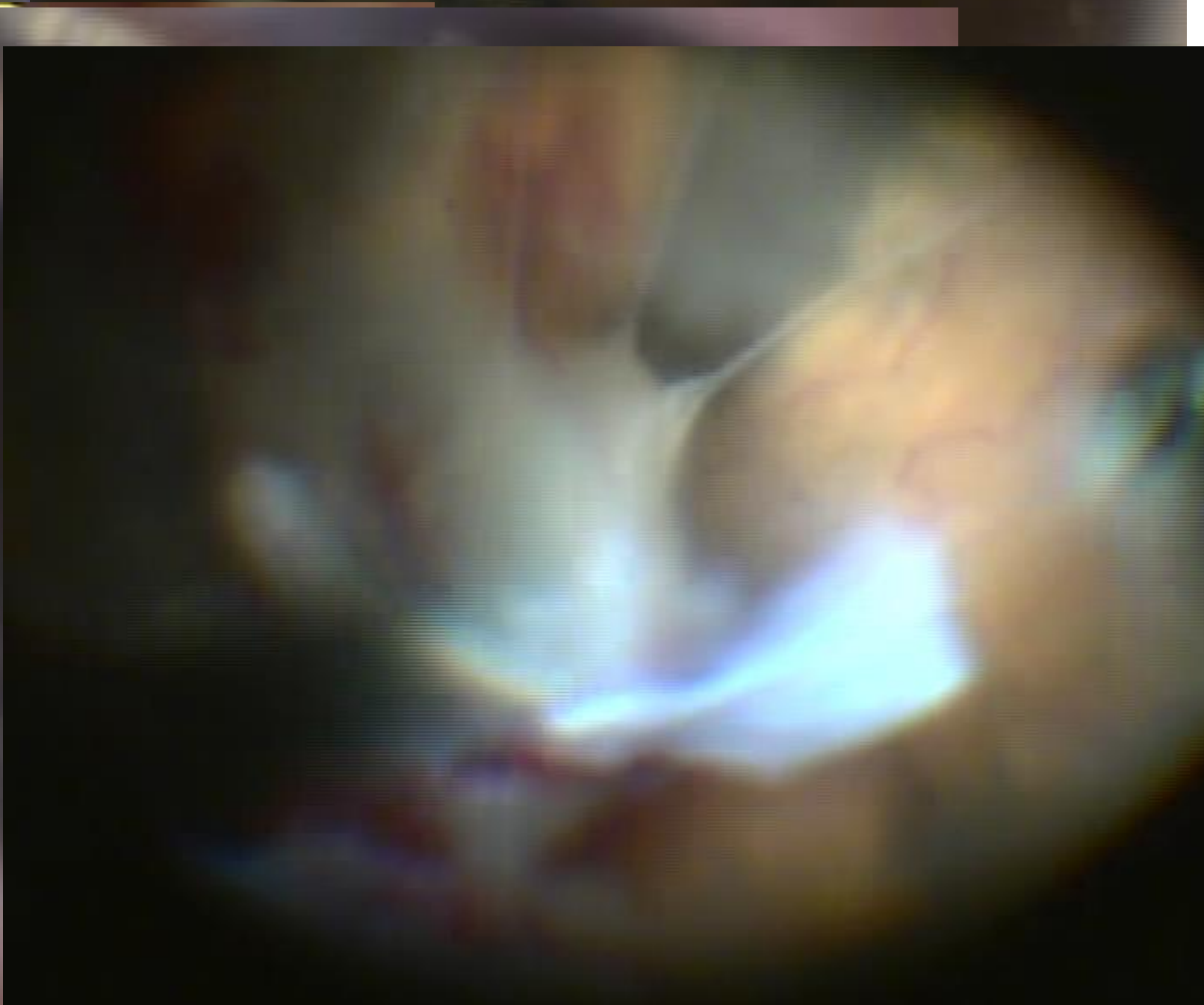
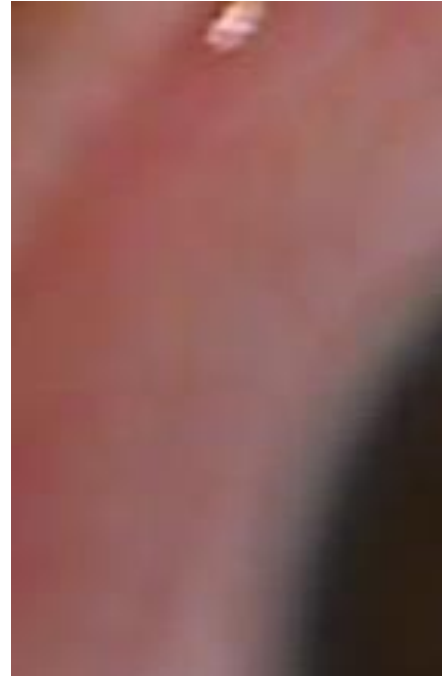
Evre 5

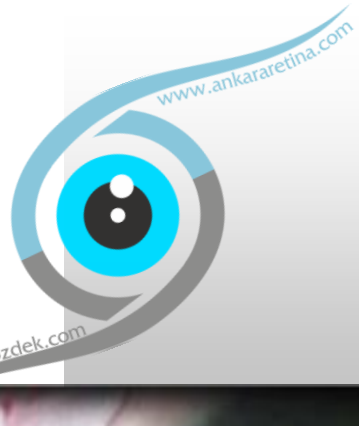


Evre 5

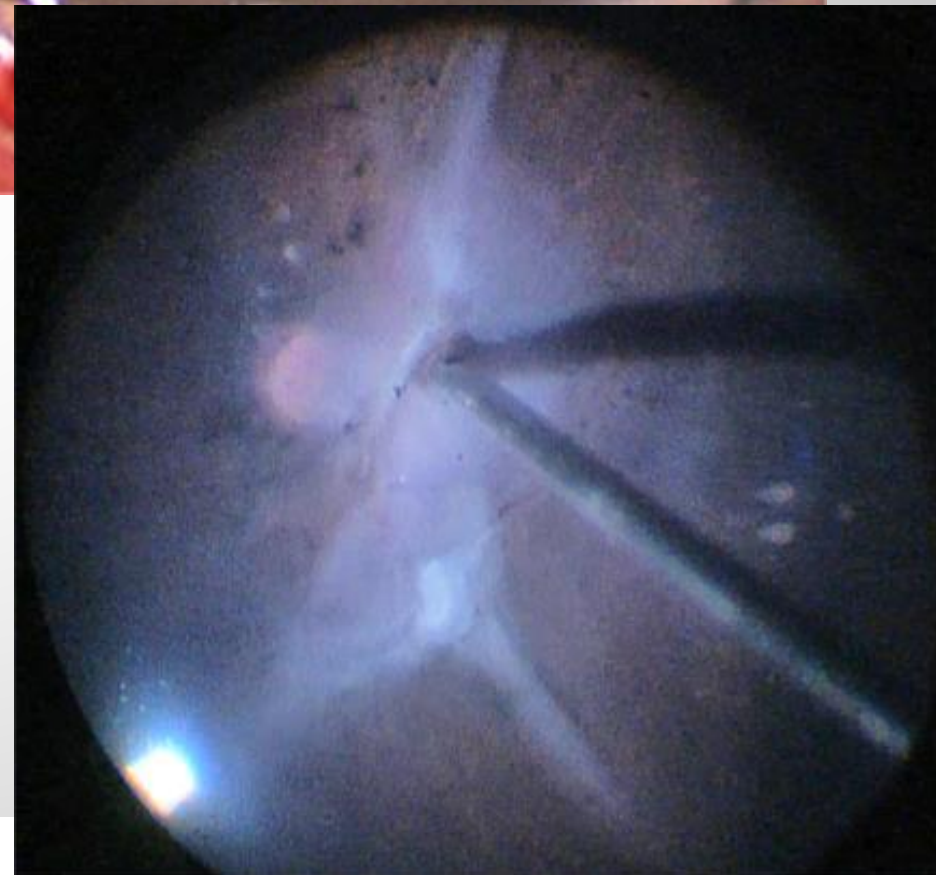
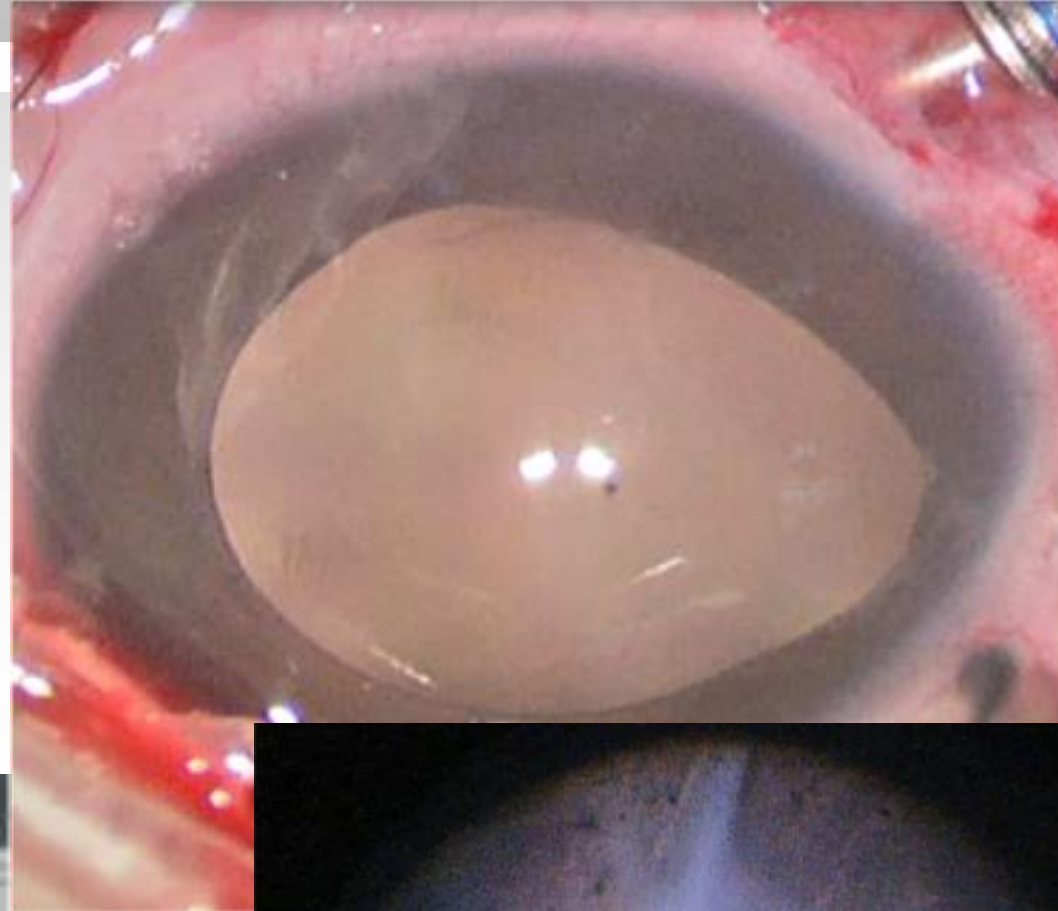
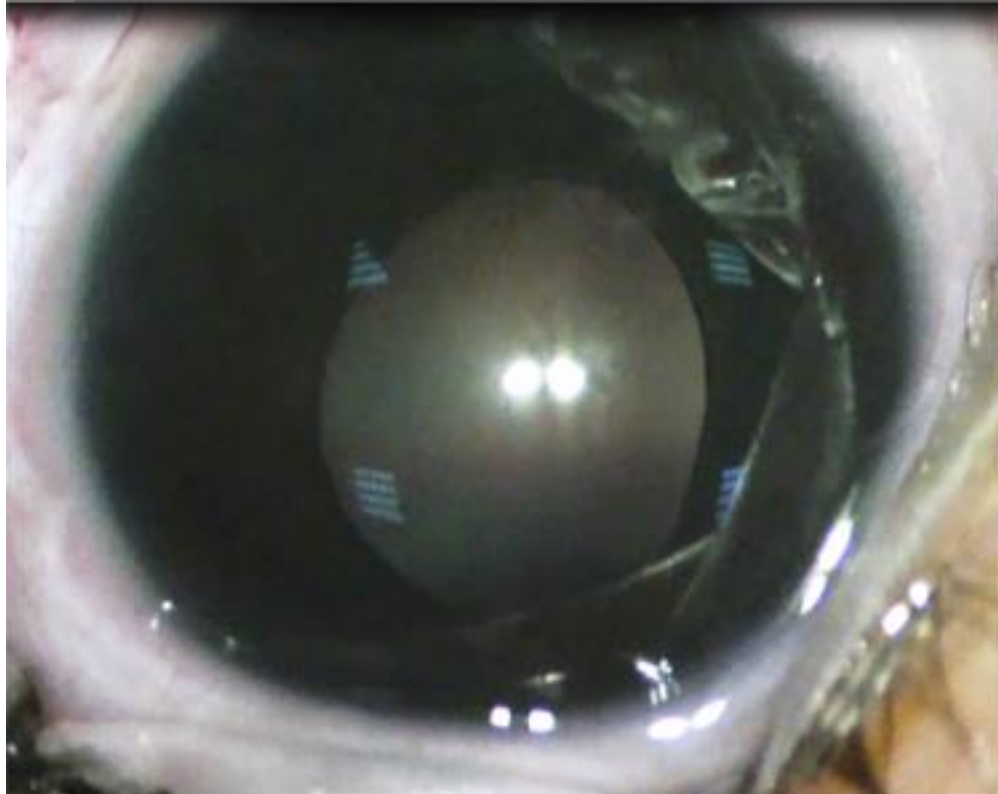


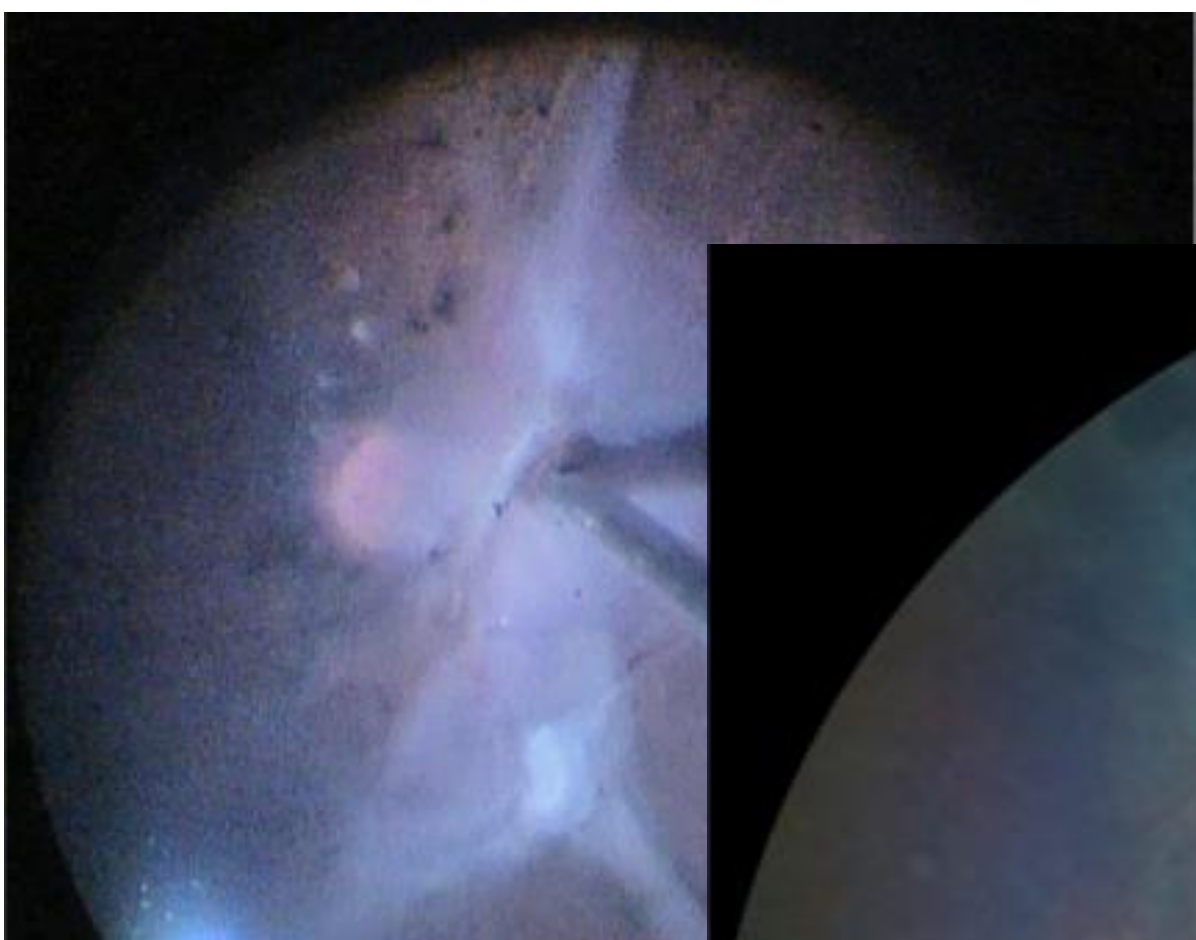




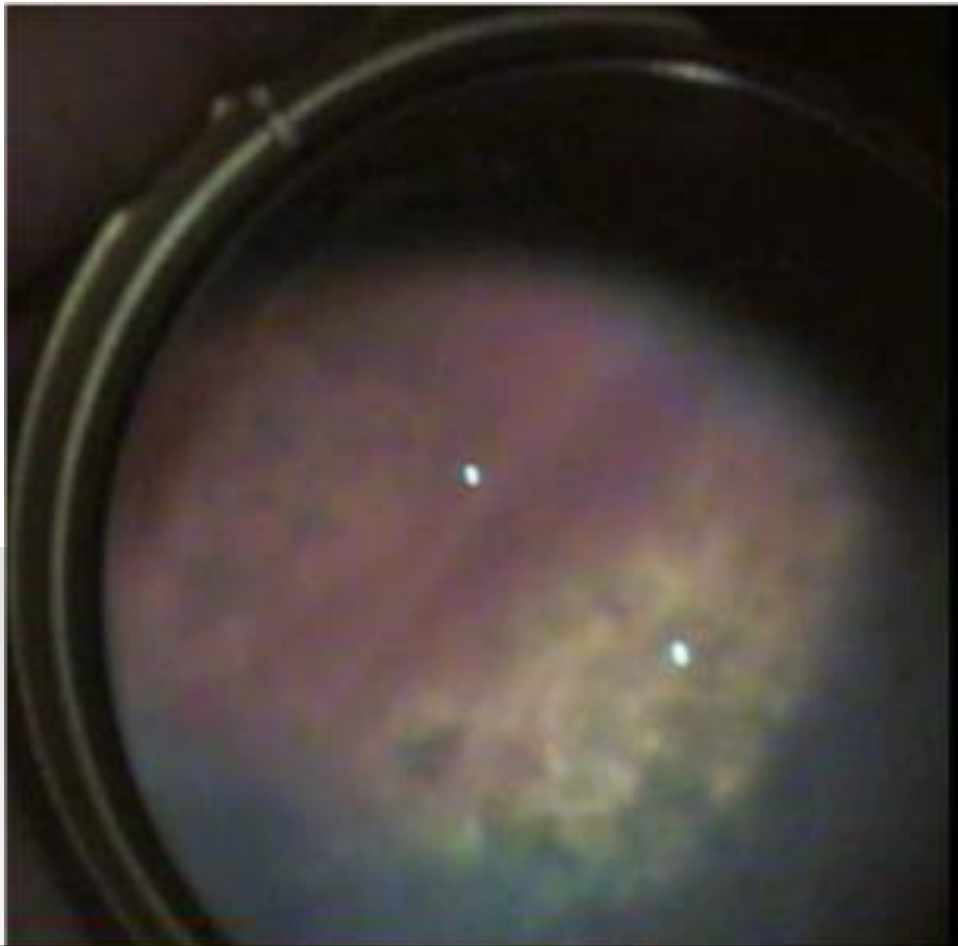
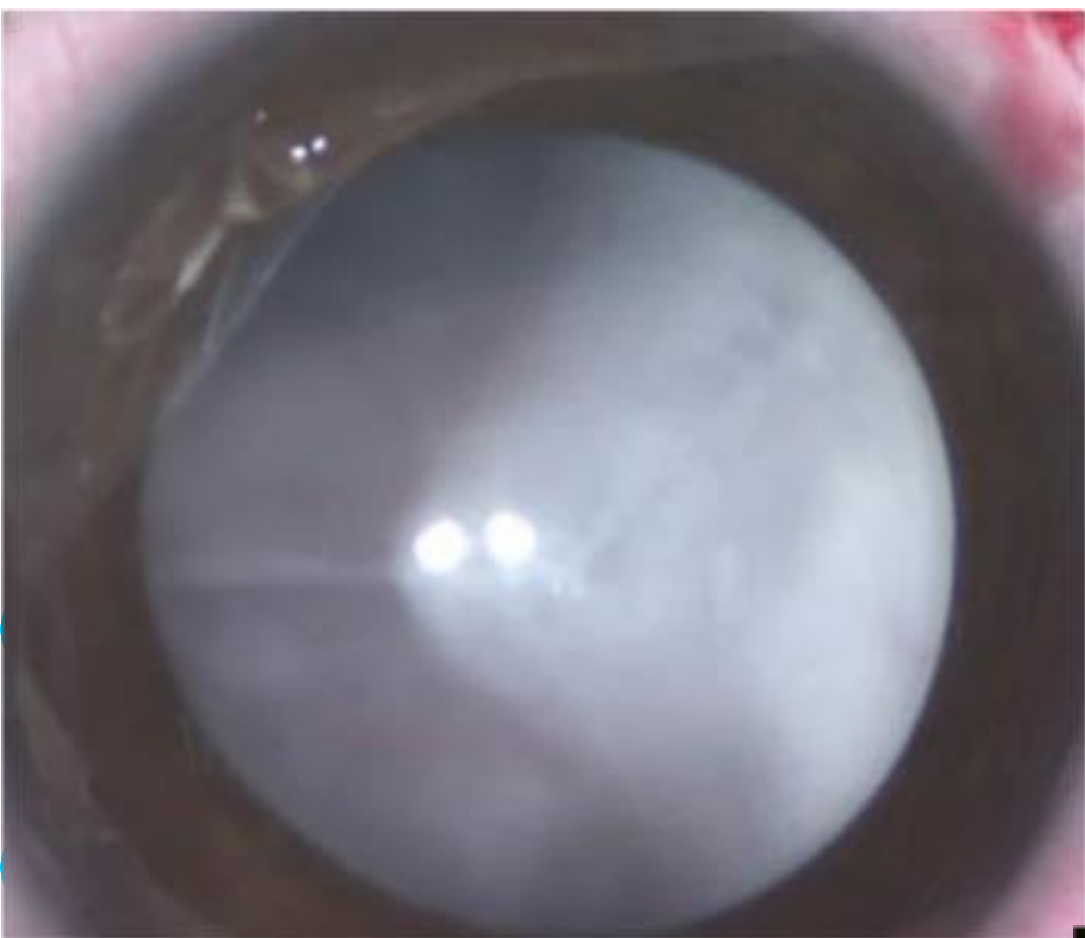


28hf, 950gr, Tedavisiz, Evre 5

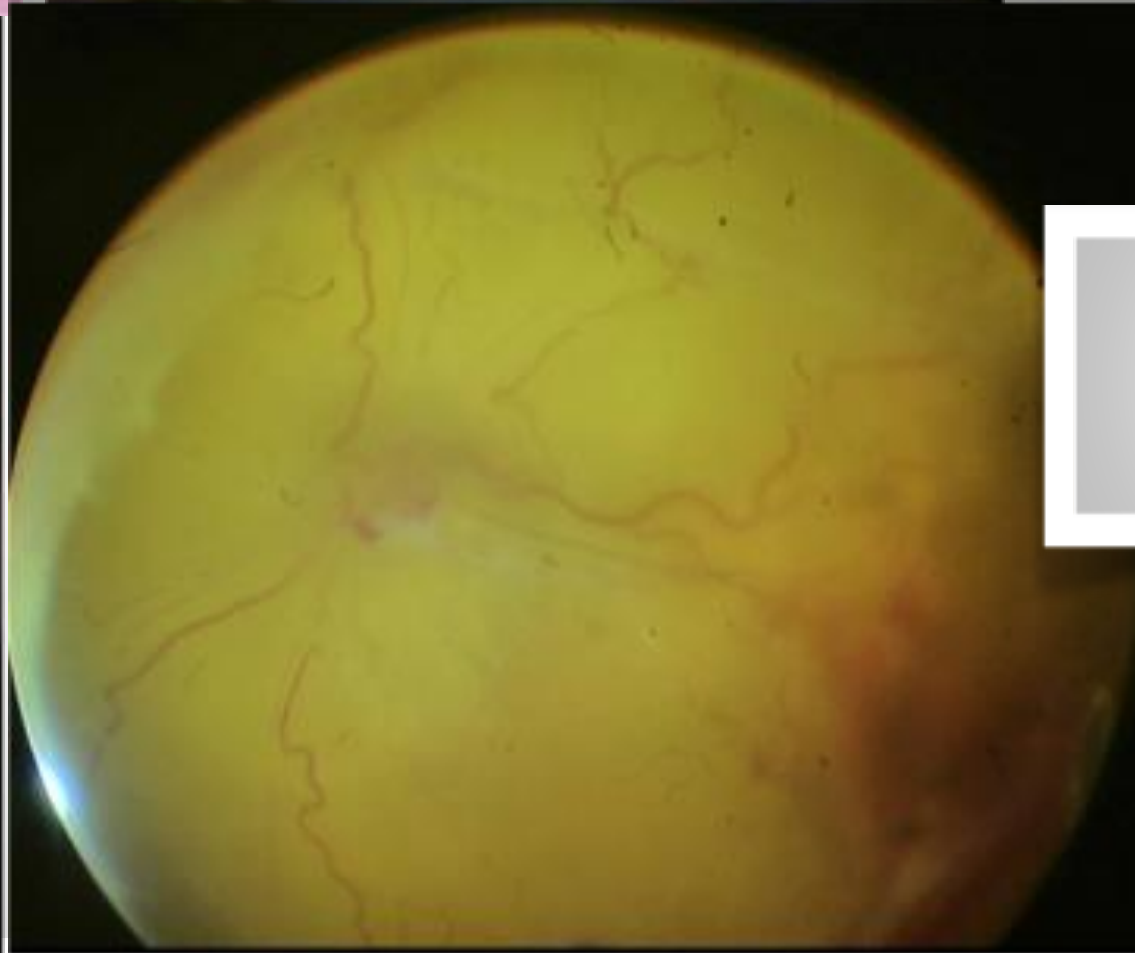
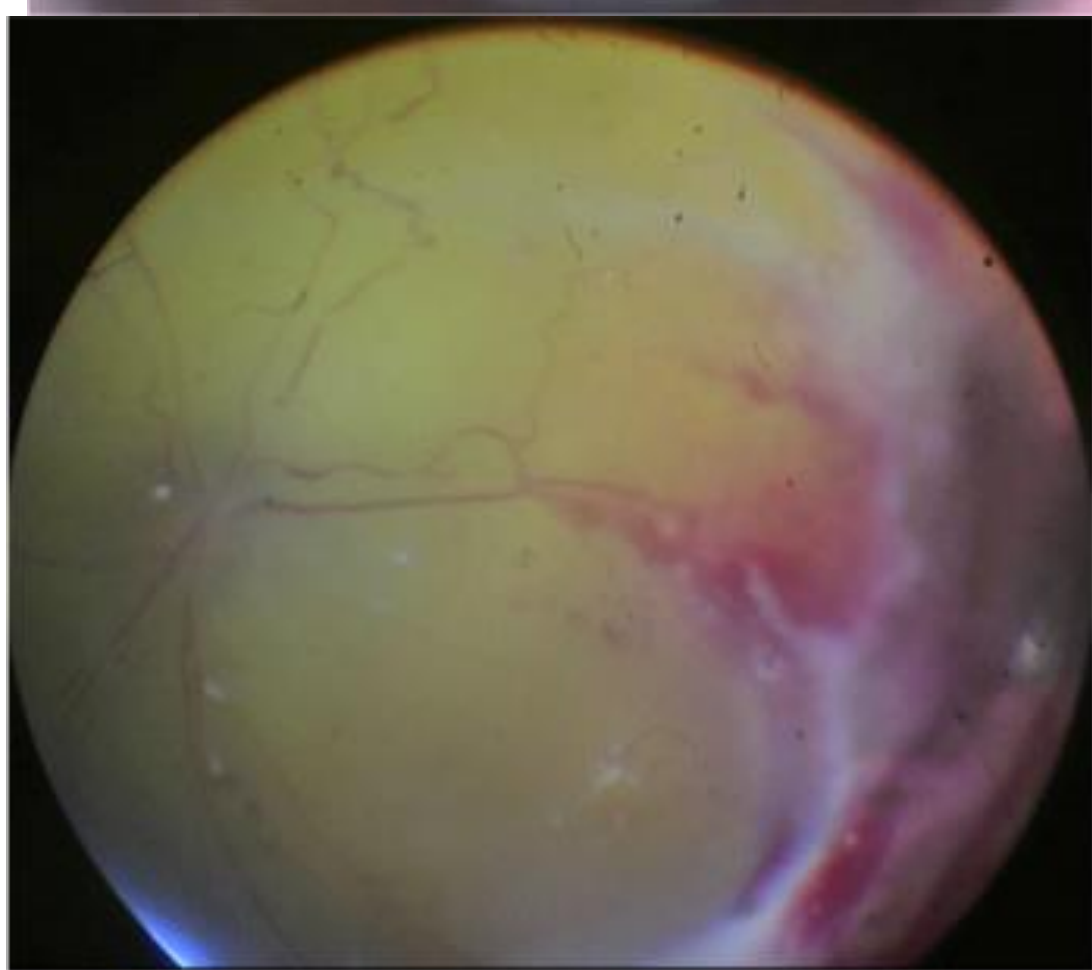




5y , VA: 0.25



GK: 1mps



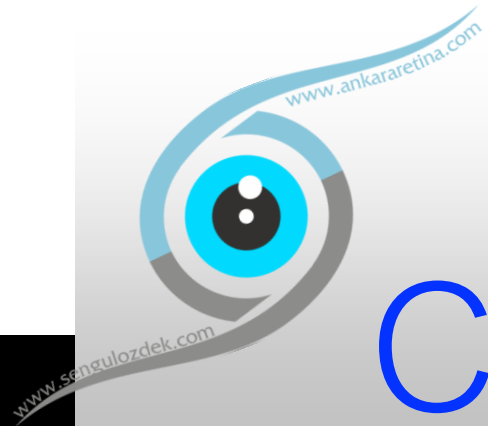
GK: 0.05



ROP CERRAHİSİ

POSTOP HEMORAJİ SORUNU

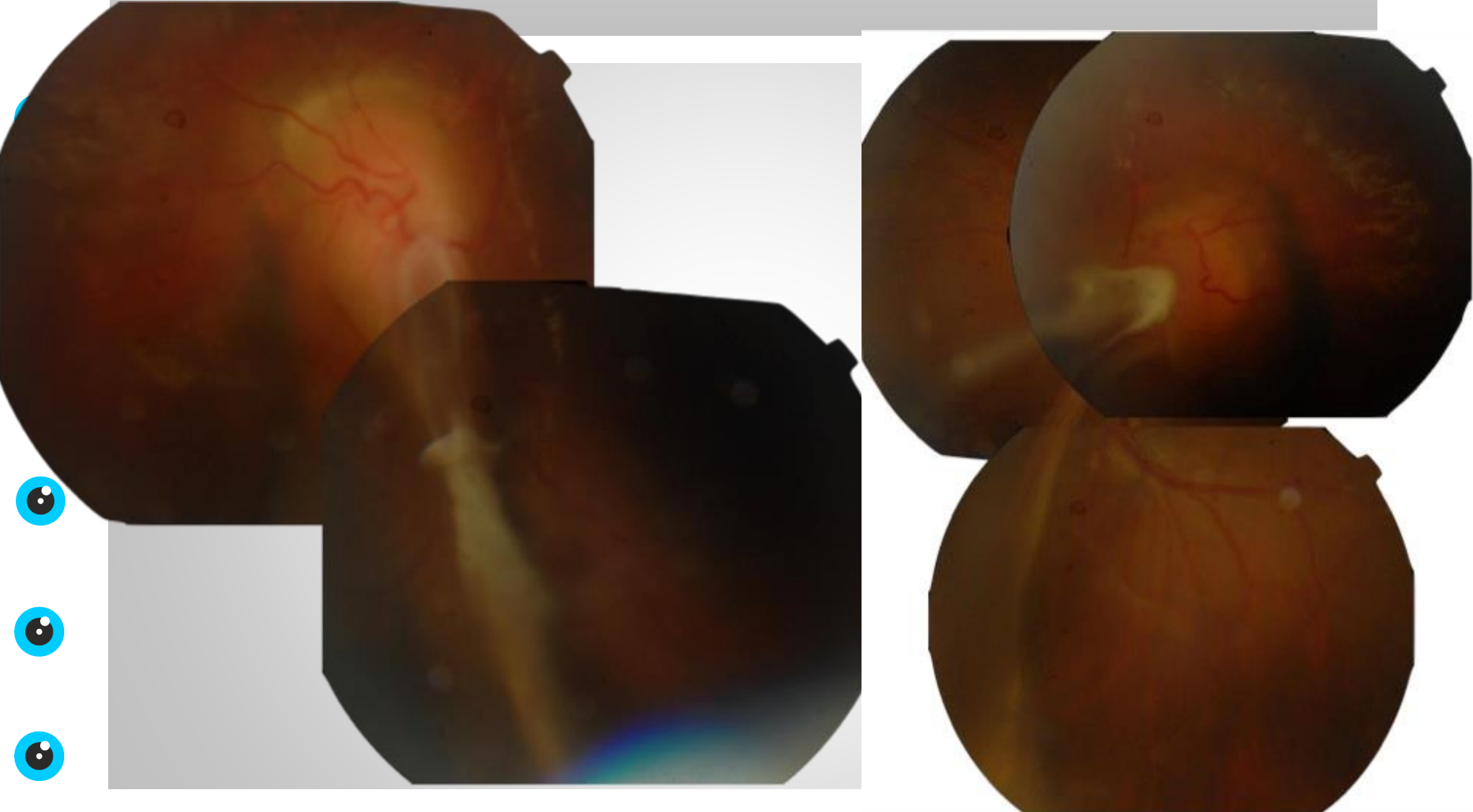
- PLUS (+) olan gözlerde preop avastin?
- Cerrahi sonunda hipotoniye izin verilmemeli
- Hava tamponadı
- OVD?

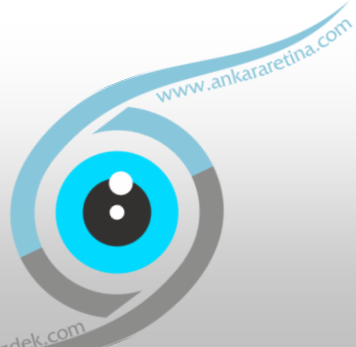


Skatrisyel ROP'da Cerrahi sonuç verir mi?

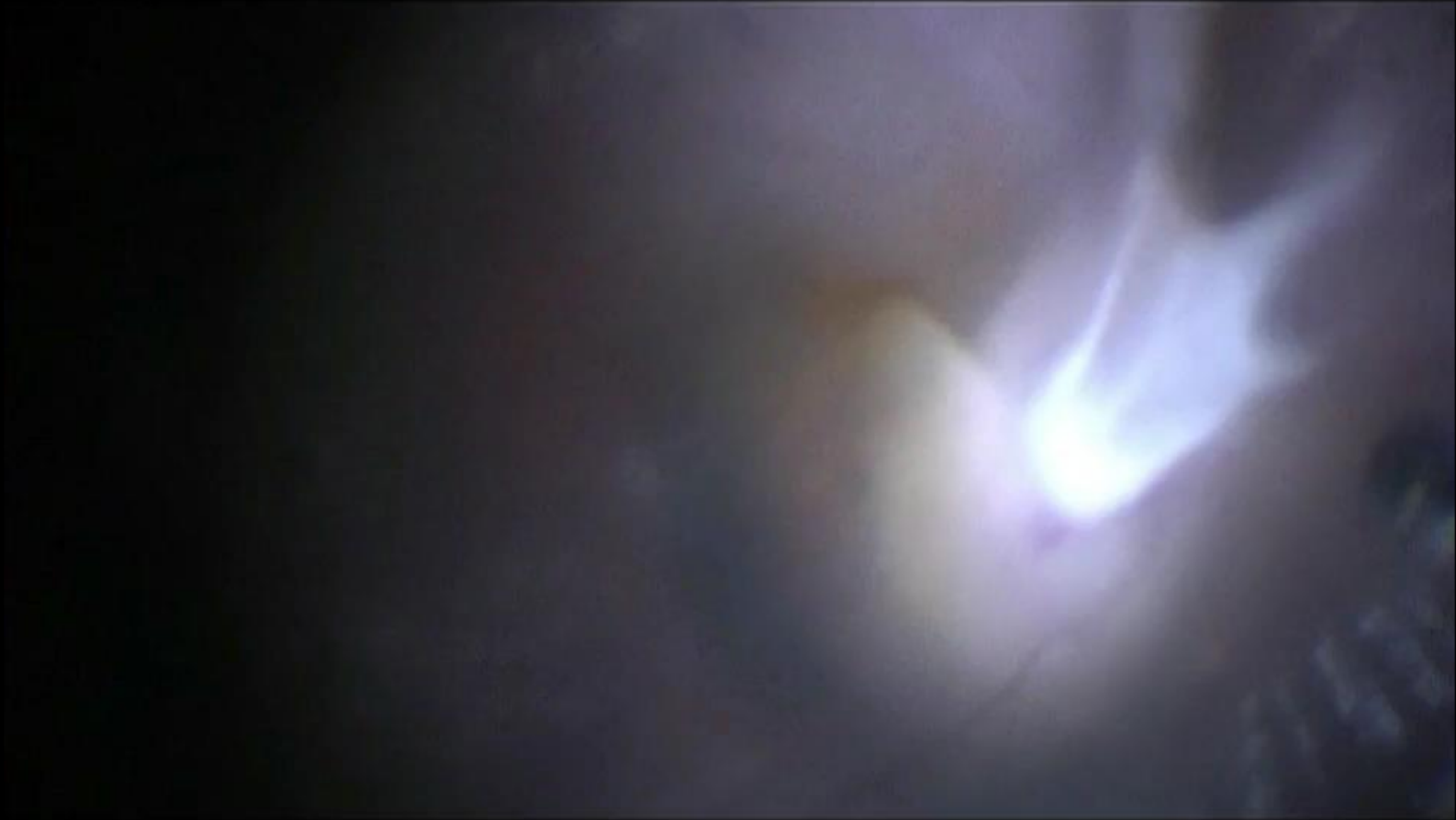
Olgu/Cinsi yet/Göz	Doğum Haftası/Kilosu (hft/gr)	Cerrahi Yaşı (ay)	Preop GK	Preop Tedavi	Cerrahi	Komplikasyon	Takip Süresi(ay)	Anatomik Başarı	Maküler katlantı Preop/Postop	Postop GK
1/E/Sol	28/1060	6	-	-	PPV+PPL	-	24	Kısmi Başarı	+/+	-
2/K/Sol	25/650	38	IOT(-)	LFK	PPV	-	5	+	-/-	1mps
3/E/Sol	29/1100	59	PPEH	LFK	PPV+PPL	latrojenik delik	1	-	-/-	PPEH
4/K/Sol	30/1370	10	IOT(-)	-	PPV	-	3	Kısmi Başarı	+/+	IOT(+)
5/K/Sol	28/1500	11	IOT(-)	-	PPV+PPL	-	20	+	+/-	0.1
6/E/Sağ	28/850	79	0.2	-	PPV	-	40	+	+/-	0.7
6/E/Sol	28/850	81	0.05	-	PPV	-	40	+	+/-	0.3
7/K/Sağ	28/1800	4	IOT(-)	-	PPV	-	24	+	+/-	0.05
8/K/Sağ	30/1290	104	1mps	-	PPV	-	6	Kısmi Başarı	+/+	0.05
9/K/Sağ	28/990	2	IOT(-)	LFK+İVB	PPV+PPL	-	19	Kısmi Başarı	-/-	IOT(-)
9/K/Sol	28/990	2	IOT(-)	LFK+İVB	PPV+PPL	Geç Vit Hem/RRD	19	-	-/-	IOT(-)
10/K/Sağ	28/900	213	1mps	-	PPV+PPL	-	12	Kısmi Başarı	+/+	1mps

6,5 yaşı, E, GK:0.1/0.15
28 hf 1300 gr doğum, Hiç tedavi görmemiş

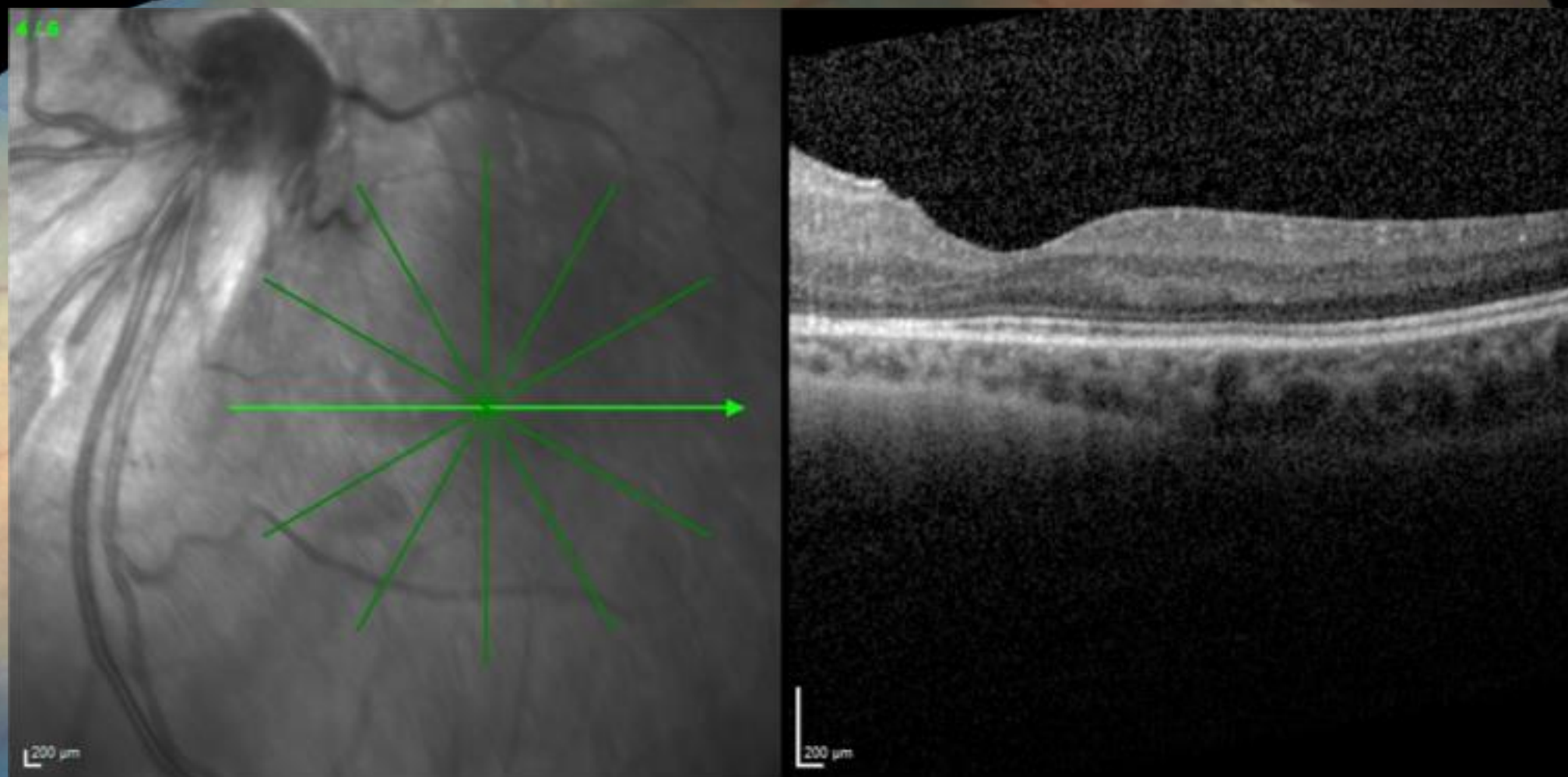




Skatrisyel ROP



Postop 3. yıl



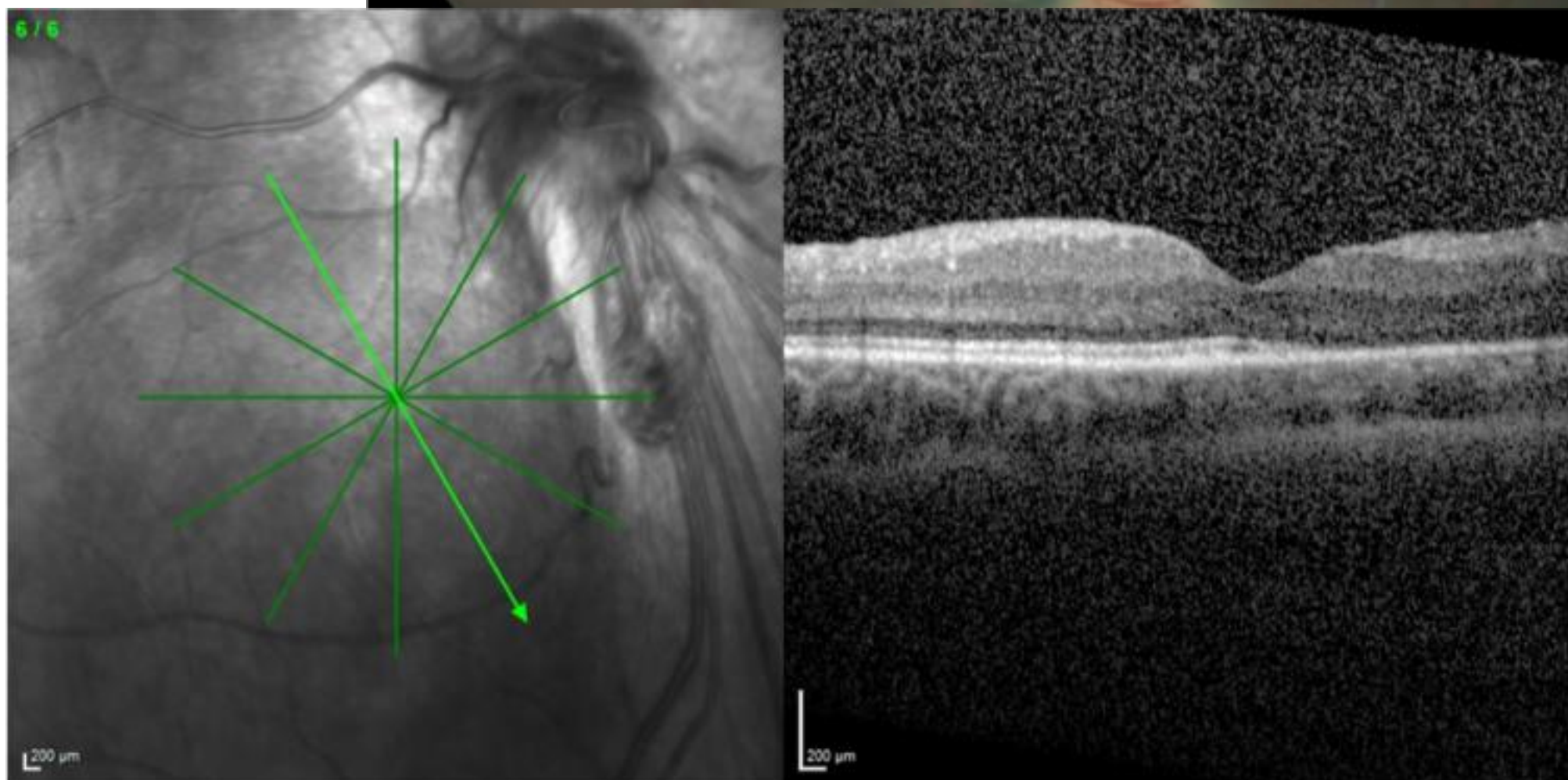
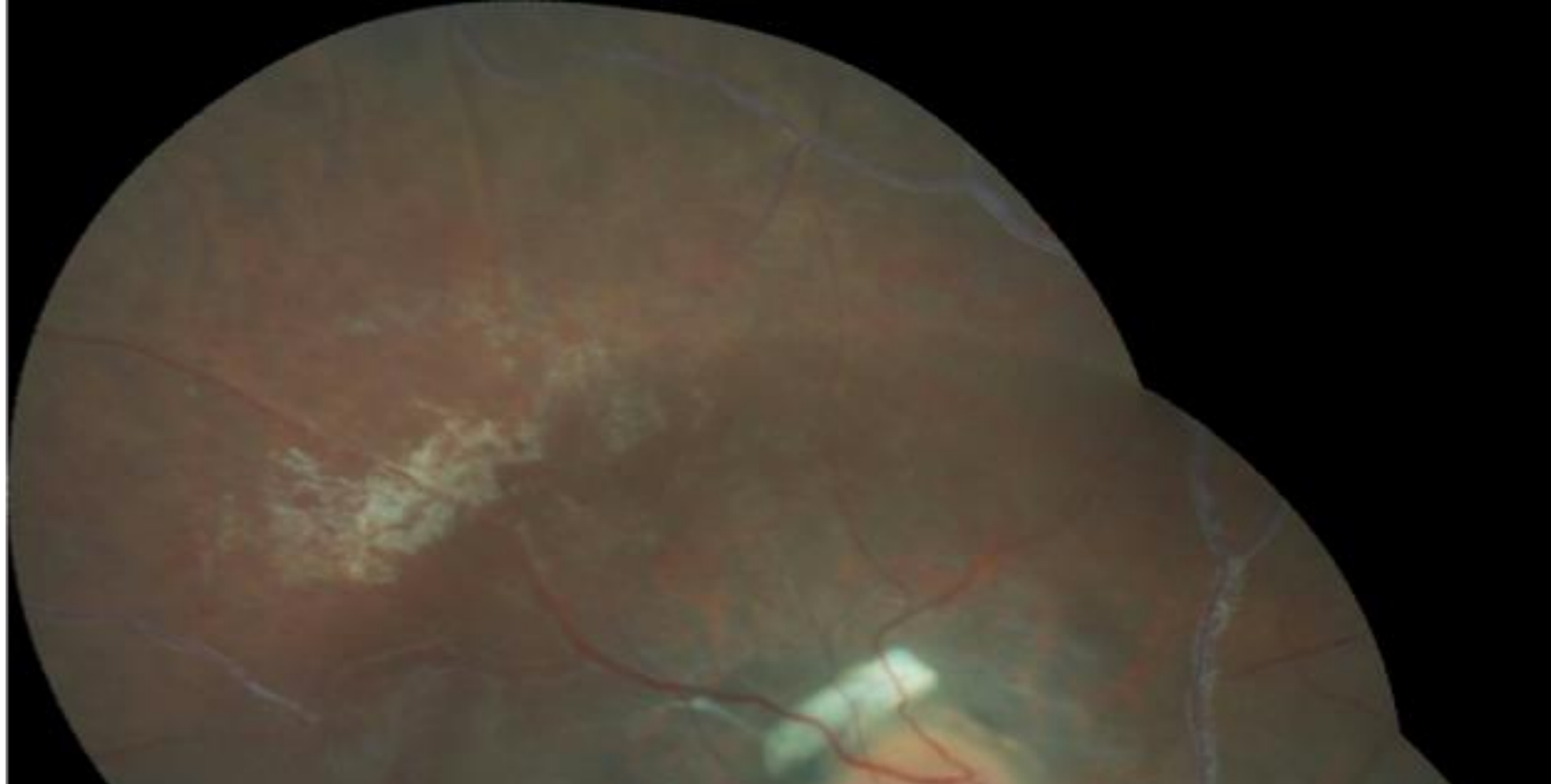
04.05.2015, OS

IR&OCT 30° ART [HS] ART(10) Q: 25

HEIDELBERG
ENGINEERING

GK: 0.7

Postop 3. yıl

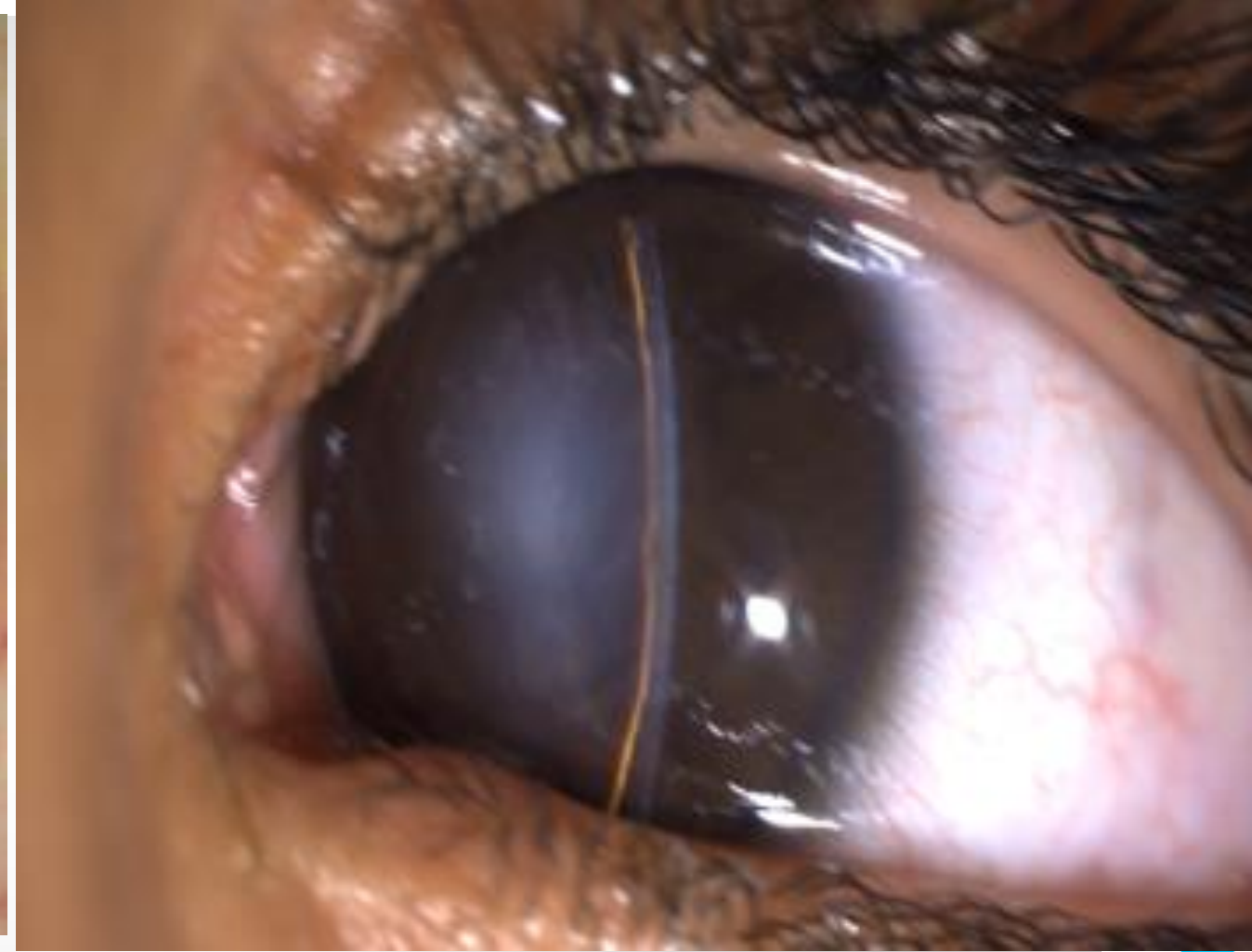
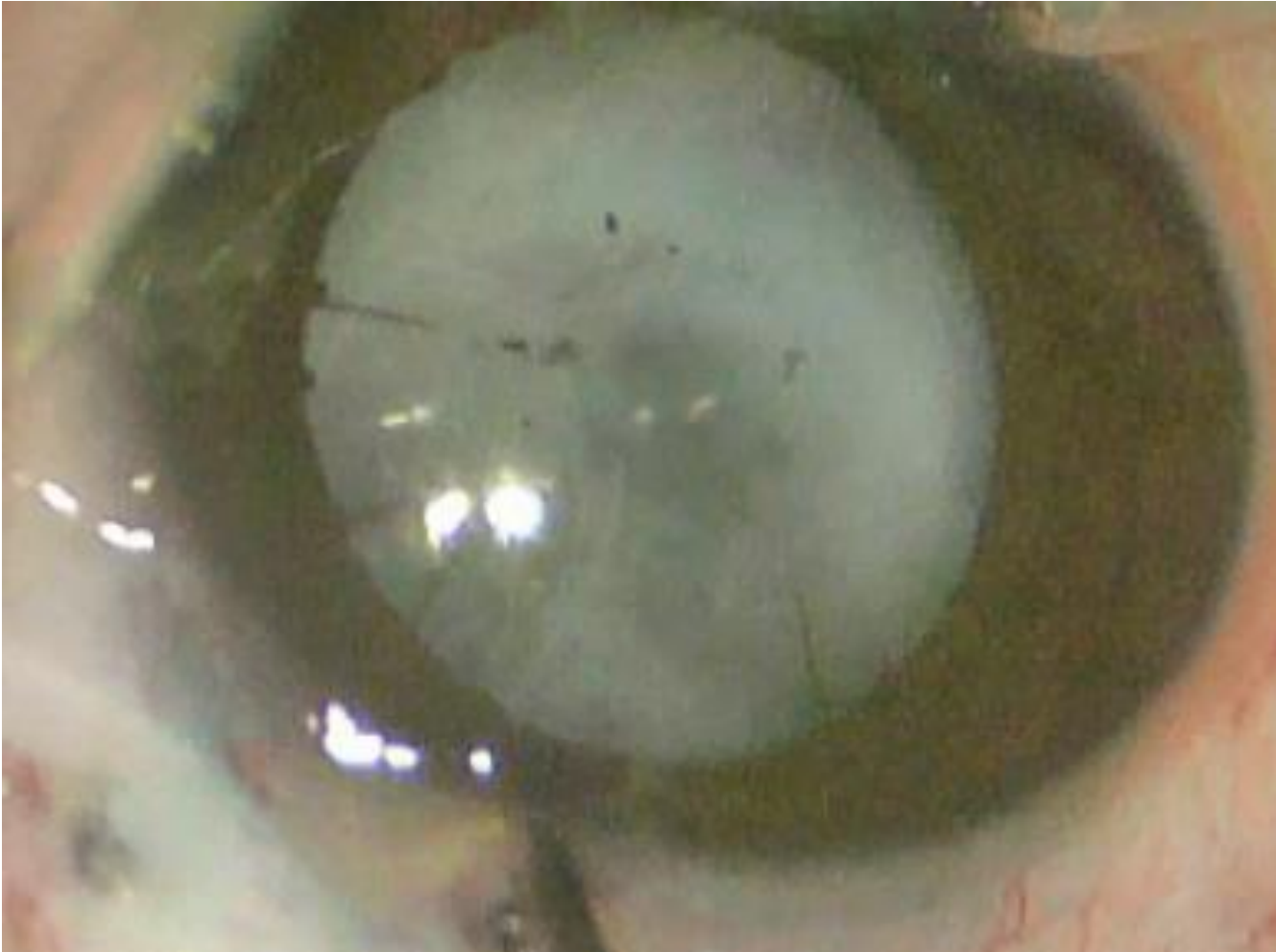


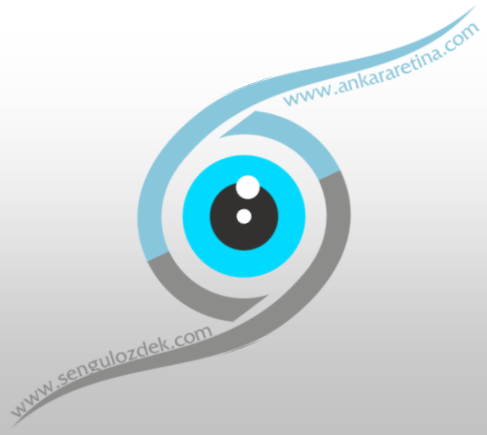
04.05.2015, OD

IR&OCT 30° ART [HS] ART(9) Q: 22

HEIDELBERG
ENGINEERING

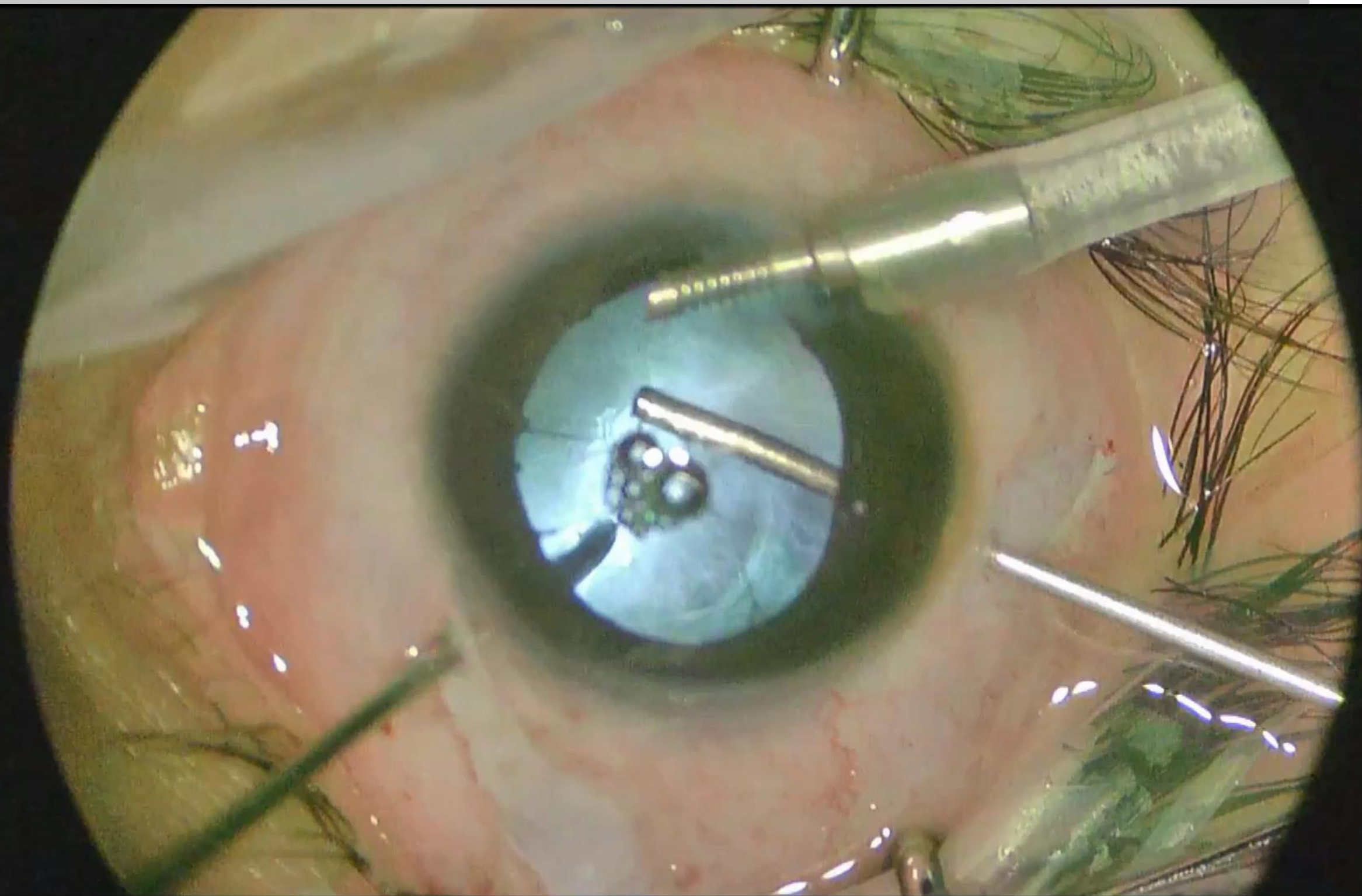
28hf, 950 gr doğum, tedavi görmemiş, 4 ay
sonra başvuru, (Ekim 2011), Bilat Evre 5-INOP
Lökokori, 4 yaş, İkiz eşi

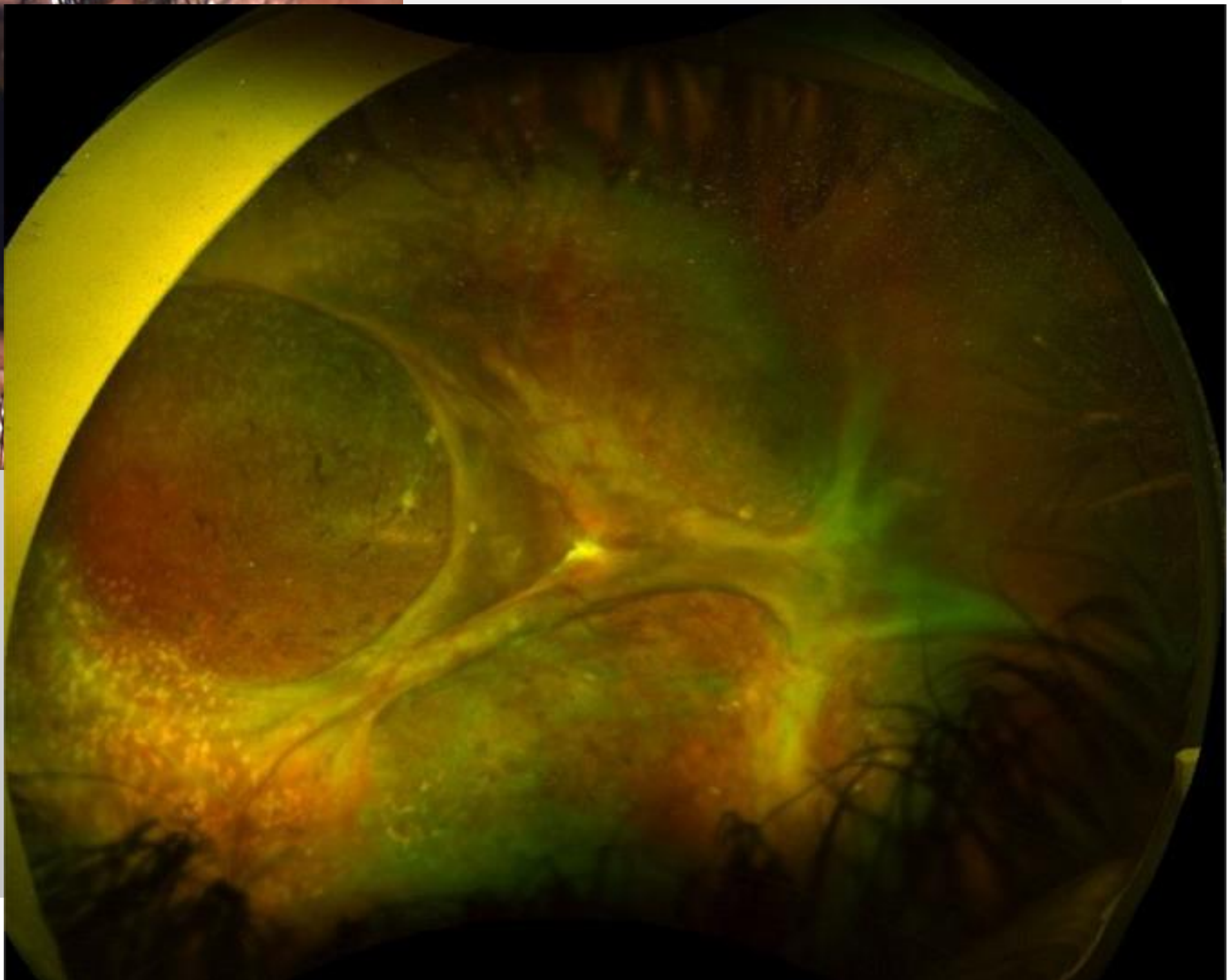
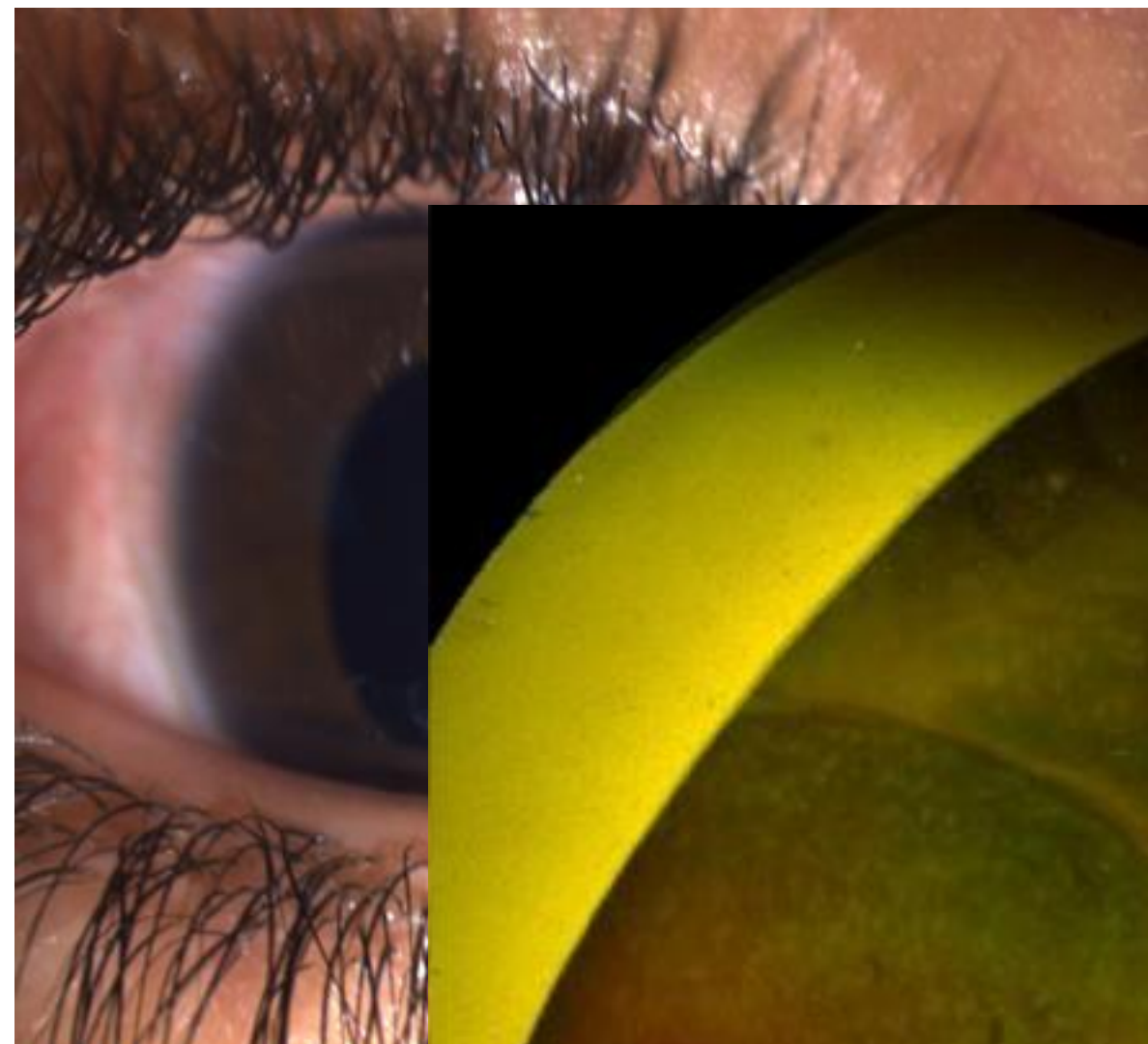


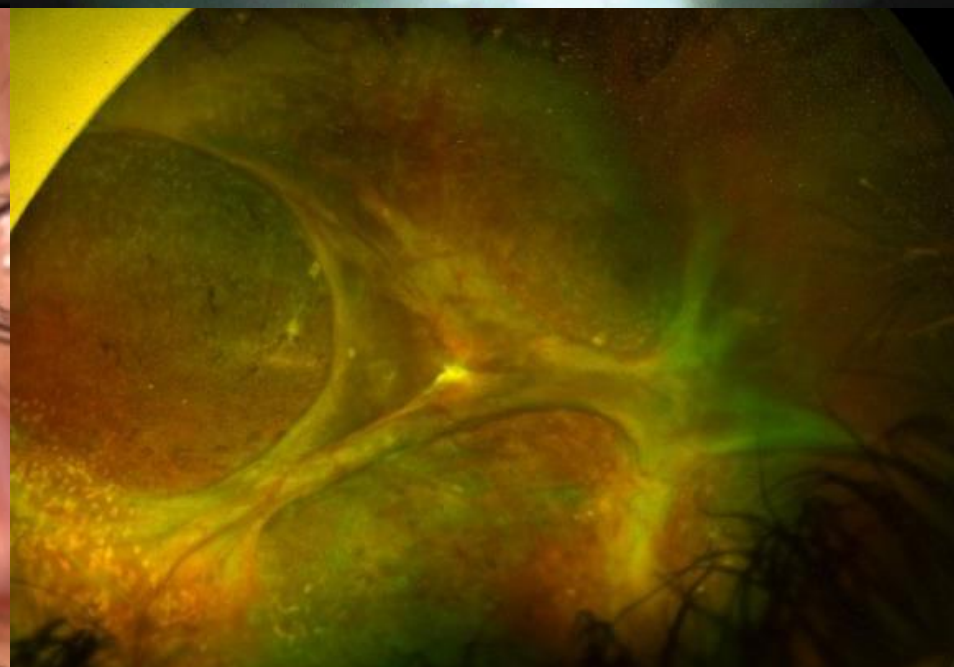
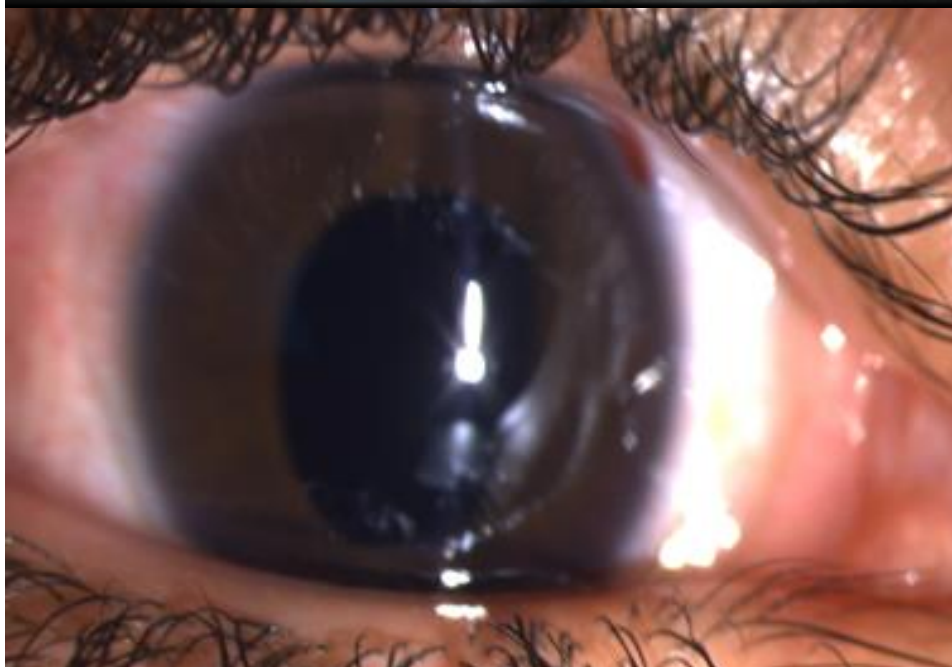
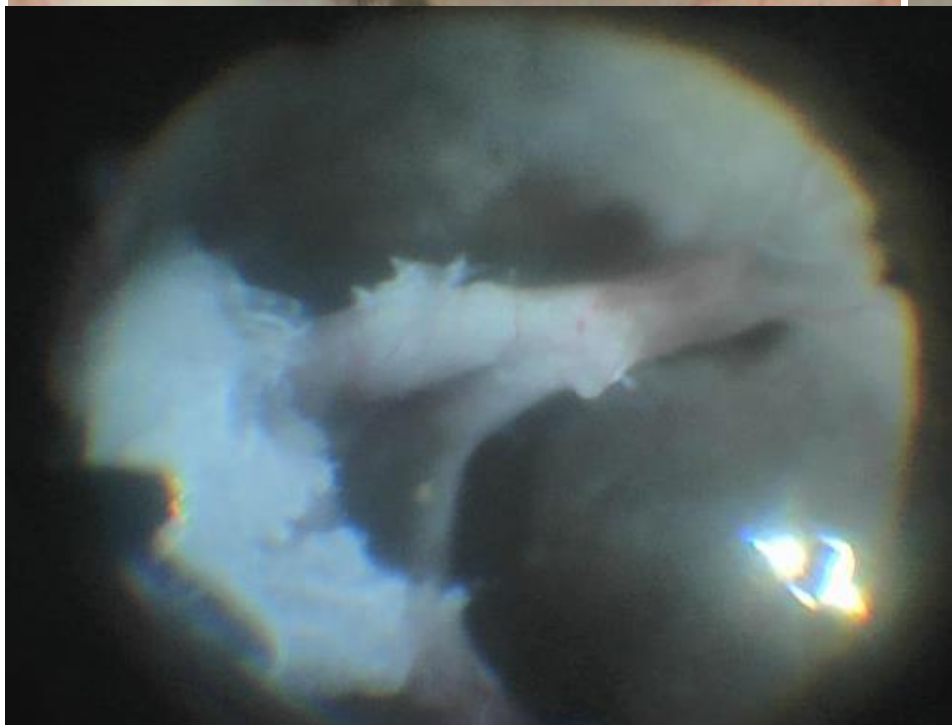
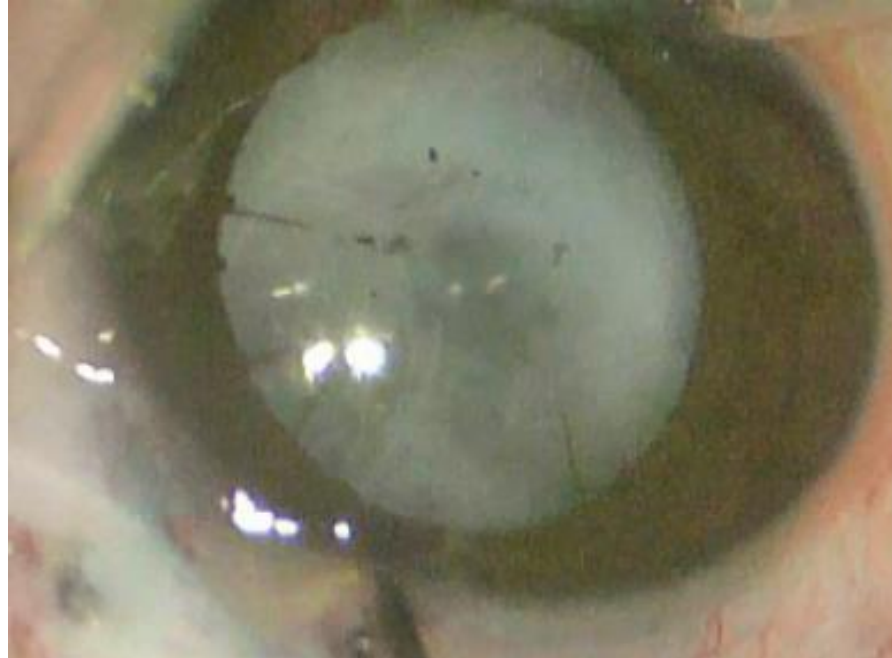


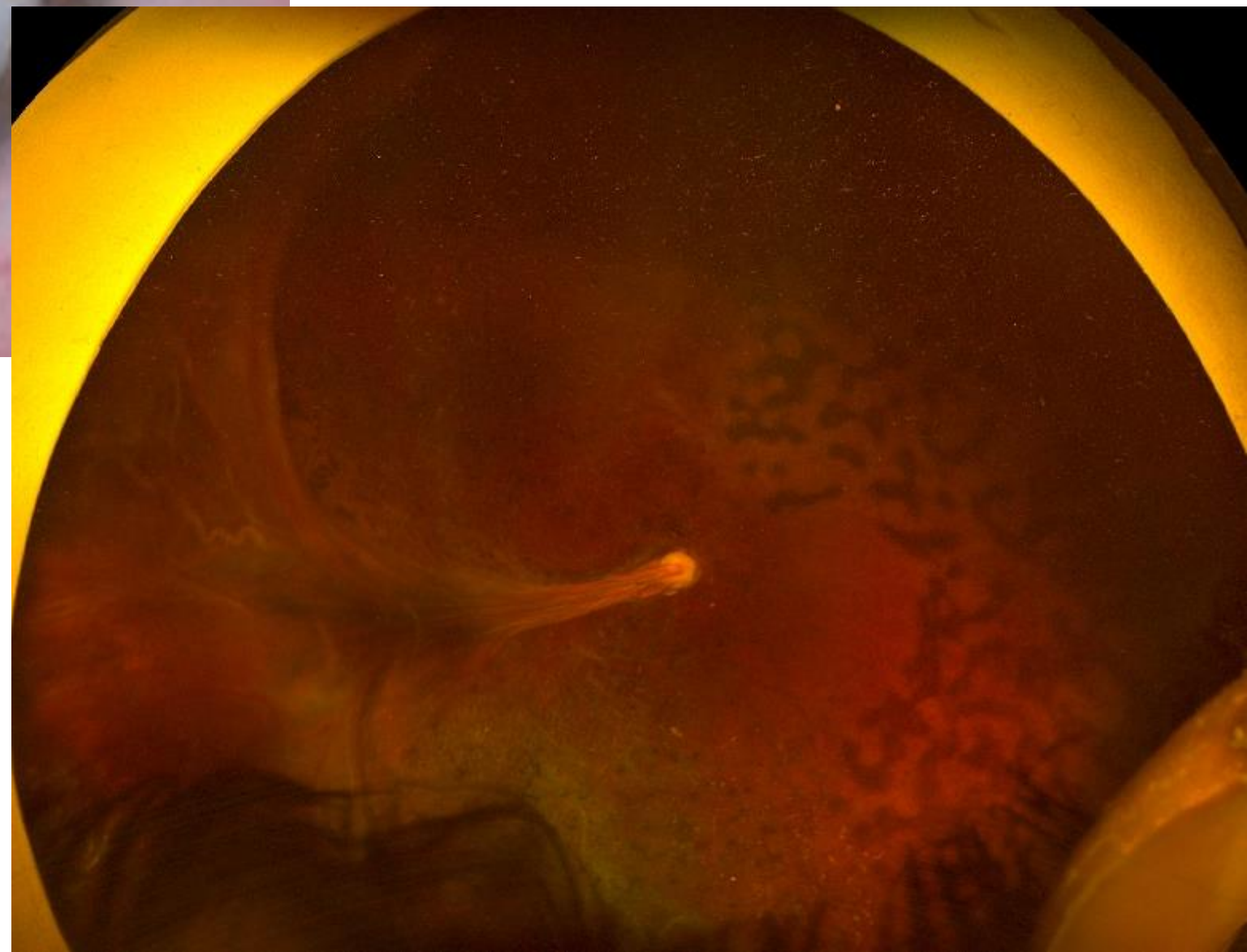
- Mart 2016 (5 yaş)
- Sağ: EH
- Sol P(-)
- Aile ve çocuk ameliyata çok istekli
- Kardeşi gibi olabilir mi?













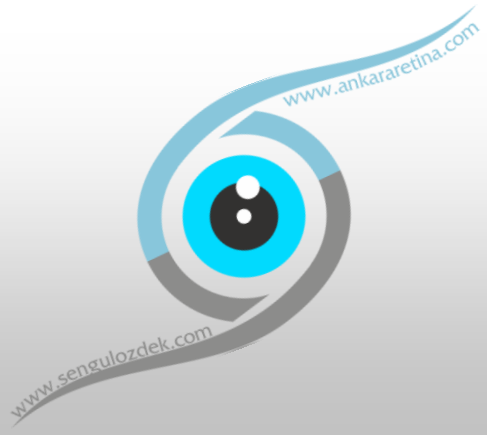


- Bazı evre 5 ve skatrisyel geç ROP vakalarında VRC ile iyi anatomik ve fonksiyonel sonuç almak mümkün olabilir.



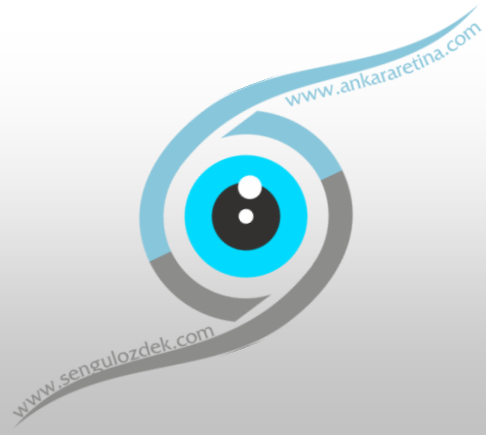
FEVR



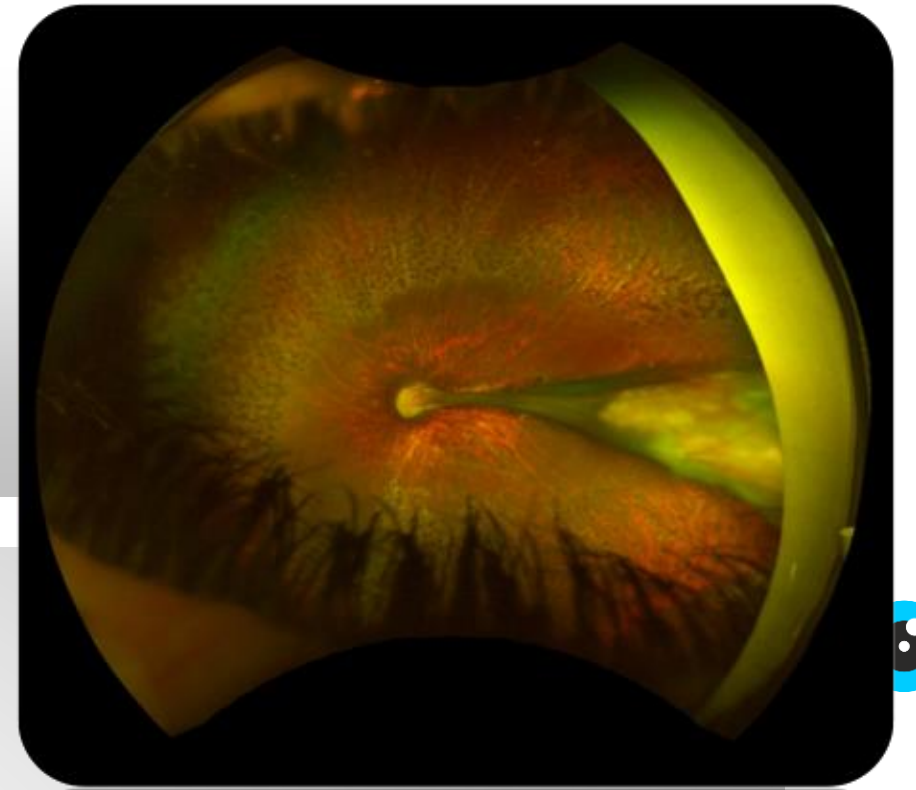


FEVR

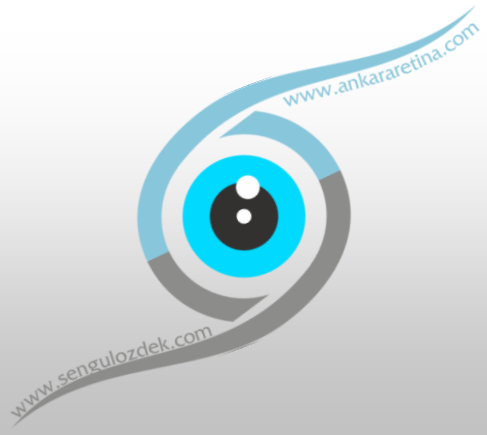
- Çoğunlukla **AD** geçiş
- NDP, FZD4, LRP5, TSPAN12, ZNF408: (Wnt-**NORRIN** sinyal yolundan sorumlu) **genler defektif**
- Patolojik retinal anjiogenez: Vasküler farklılaşma yetersiz
- Periferik retinal vaskülerizasyon tamamlanmamış
- %21- 64 RD: Traksiyonel-eksudatif



FEVR



- PENDERGAST-SINIFLAMA
 - EVRE 1: Periferik avaskuler retina
 - EVRE 2: Retinal neovaskularizasyon
 - EVRE 3: Makula on RD (maküler ektopi)
 - EVRE 4: Makula off RD (maküler fold)
 - EVRE 5: Total RD

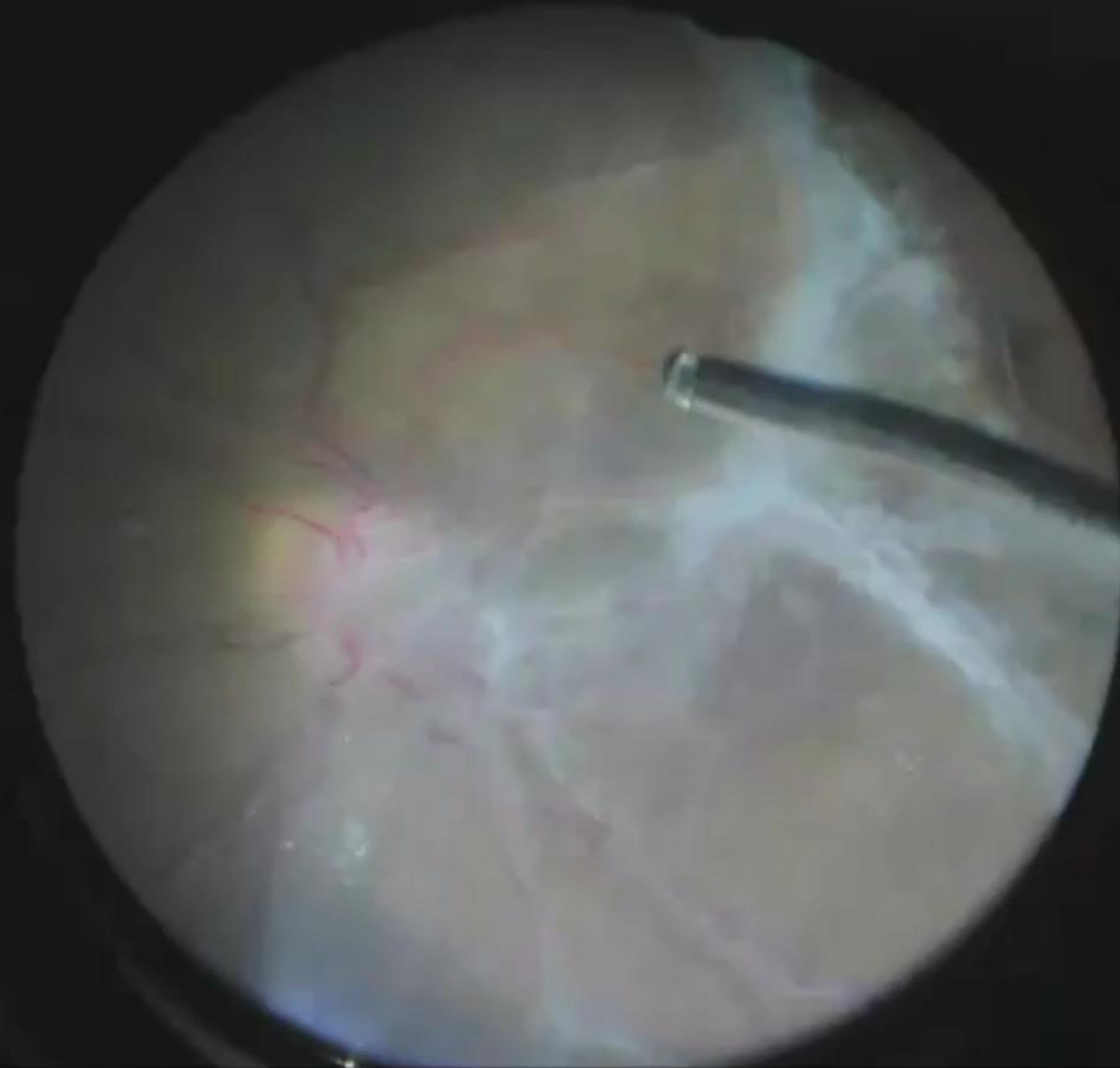


FEVR-Tedavi

- LAZER TEDAVİSİ
 - EVRE 1: Periferik avasküler retina
 - EVRE 2: Retinal neovaskularizasyon
- CERRAHİ TEDAVİ
 - EVRE 2: Retinal neovaskularizasyon-Vit hem
 - EVRE 3: Makula on RD (maküler ektopi)
 - EVRE 4: Makula off RD (maküler fold)

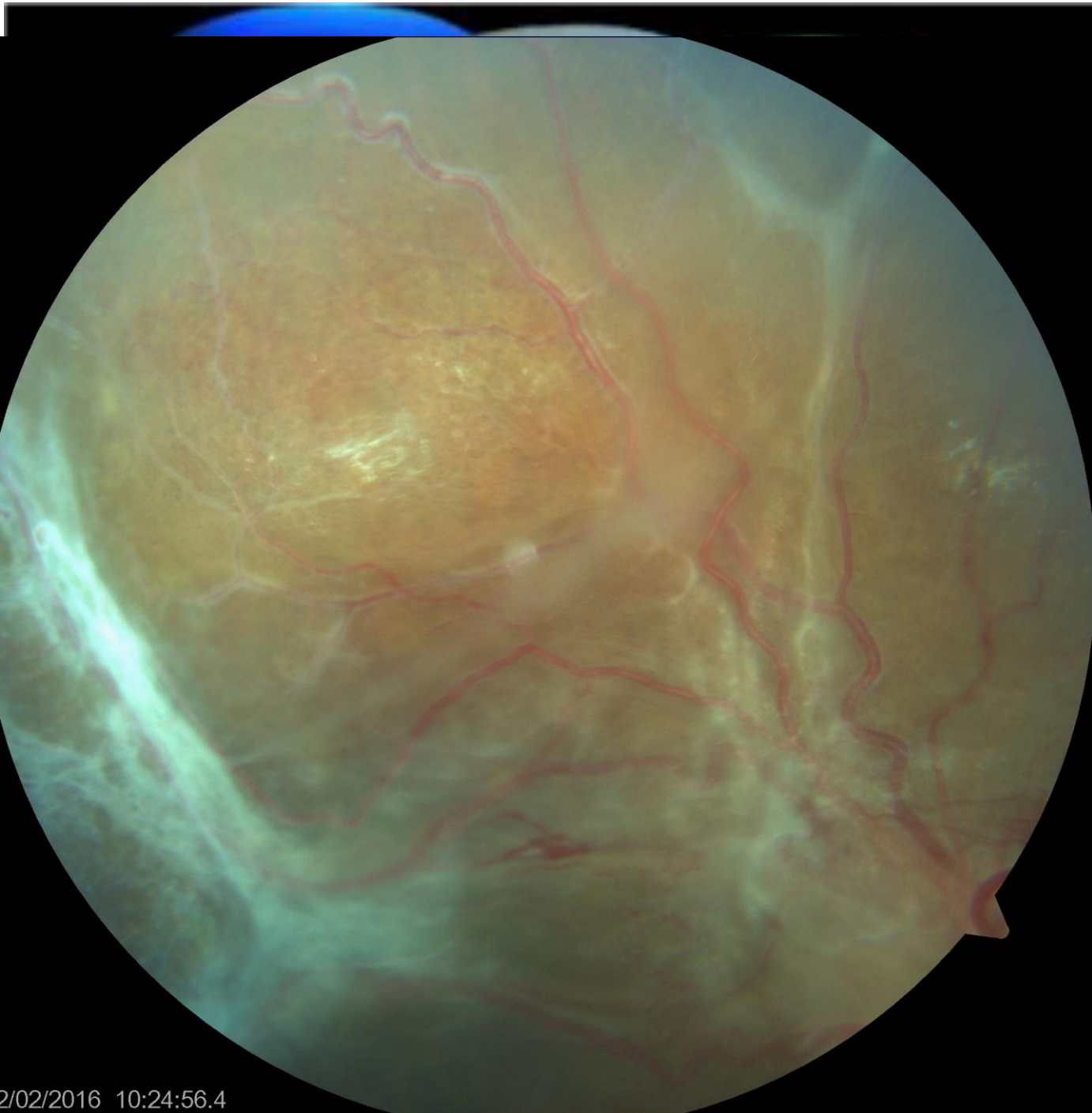
FEVR-Tedavi

6y, kız, bilat TRD, GK: 0.05

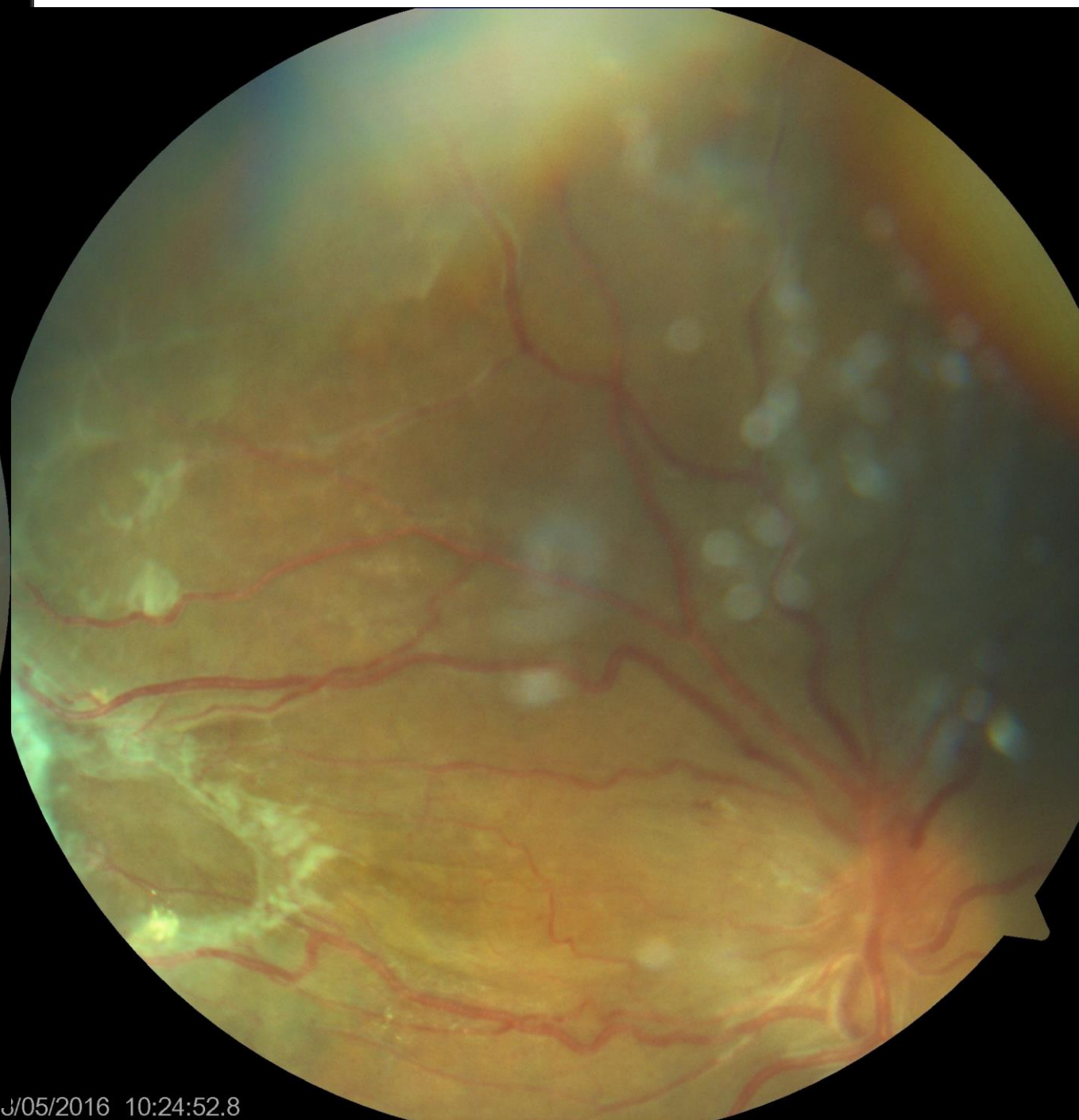


FEVR-VRC

VA: Preop: 0.05 Postop: 0.4



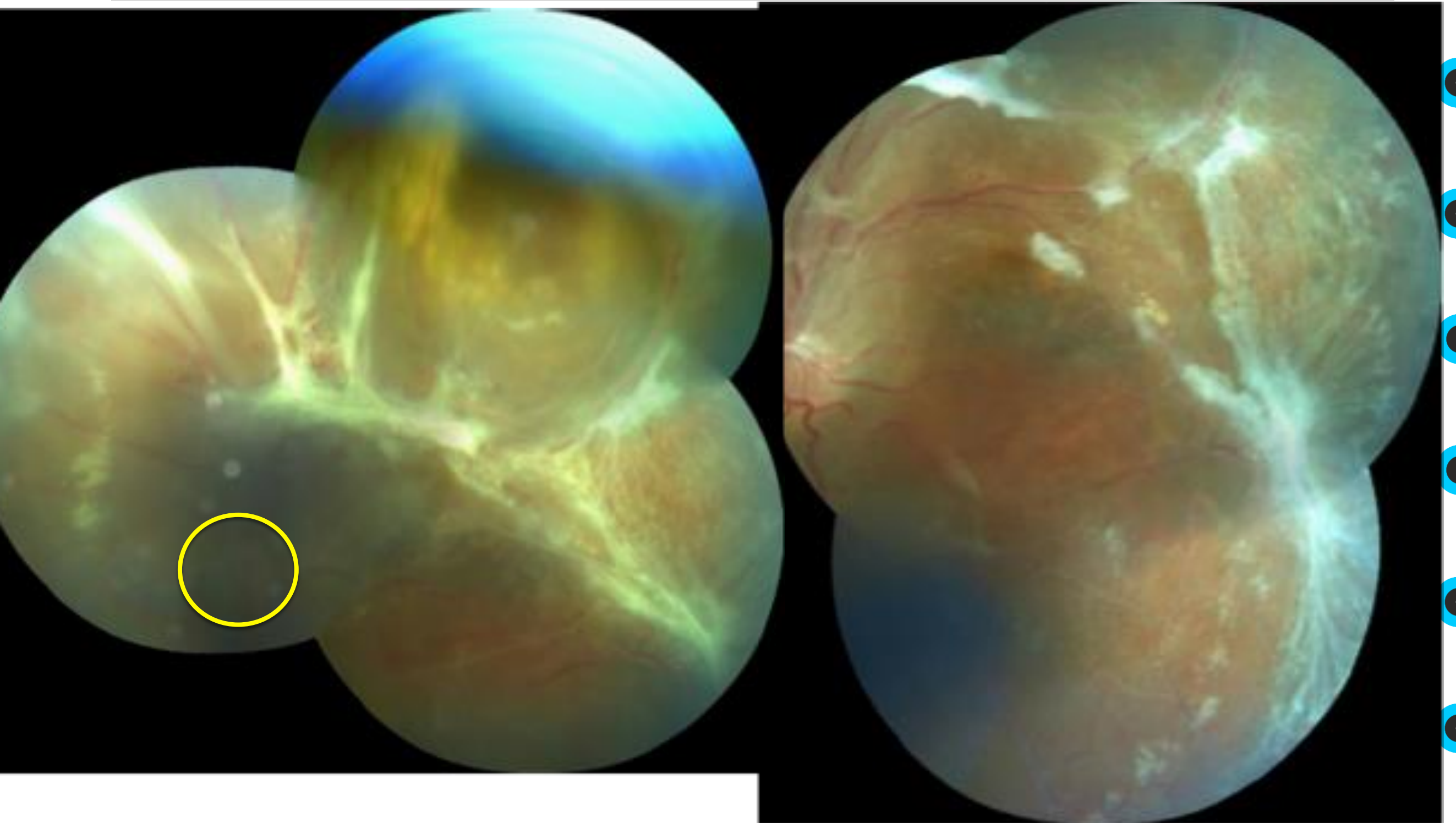
2/02/2016 10:24:56.4

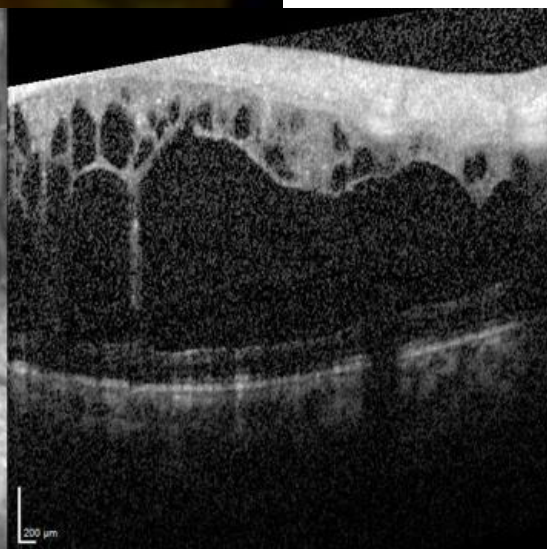
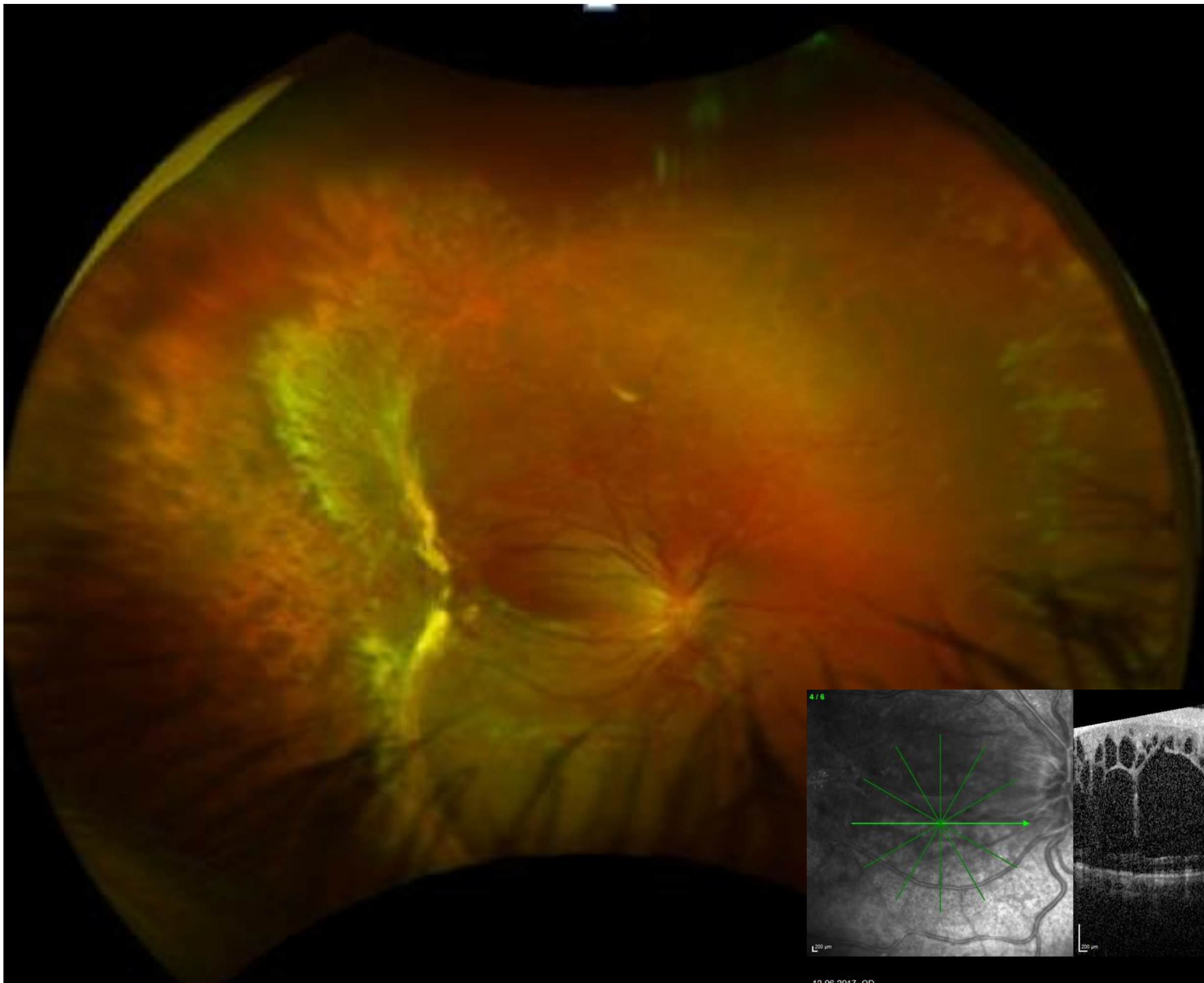


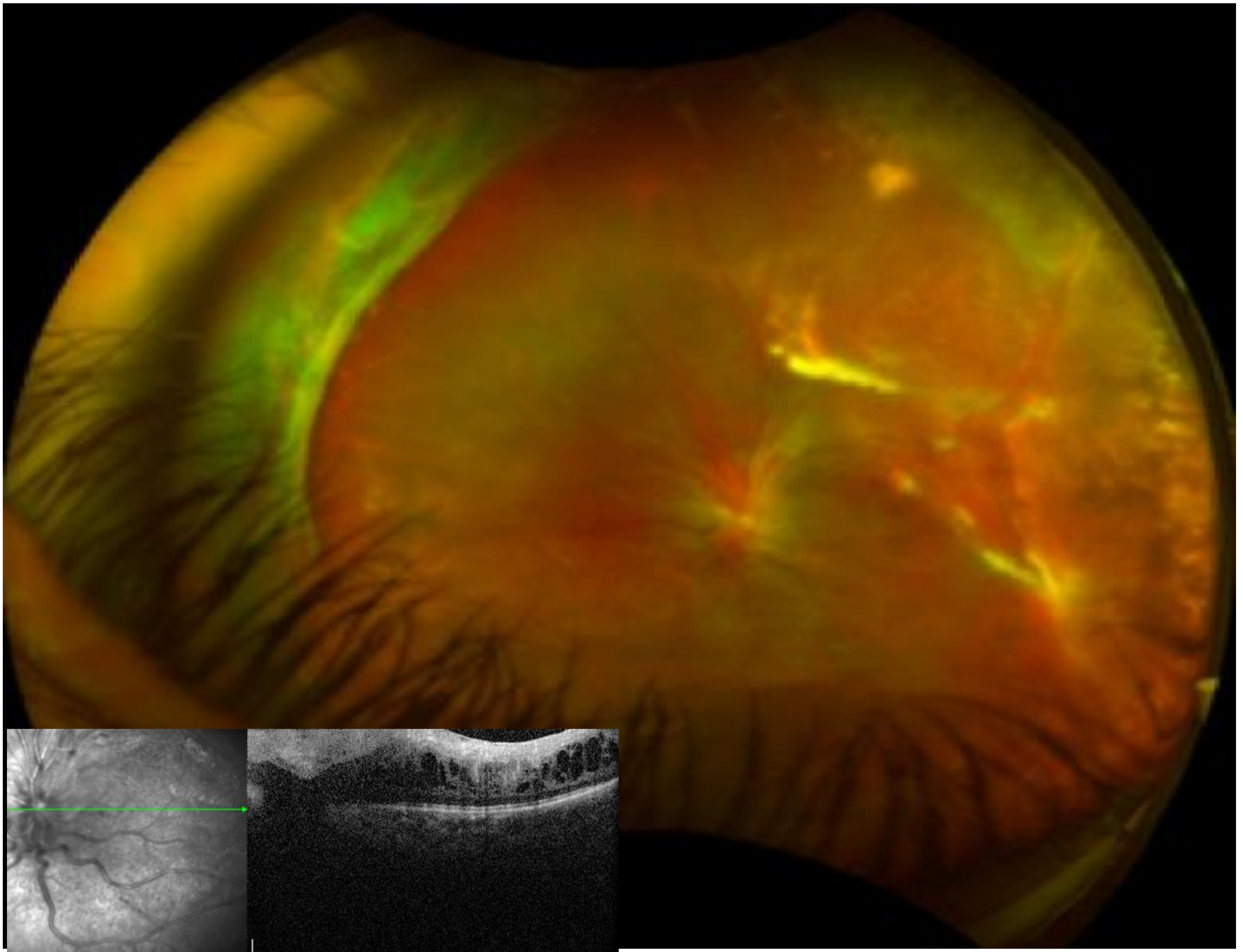
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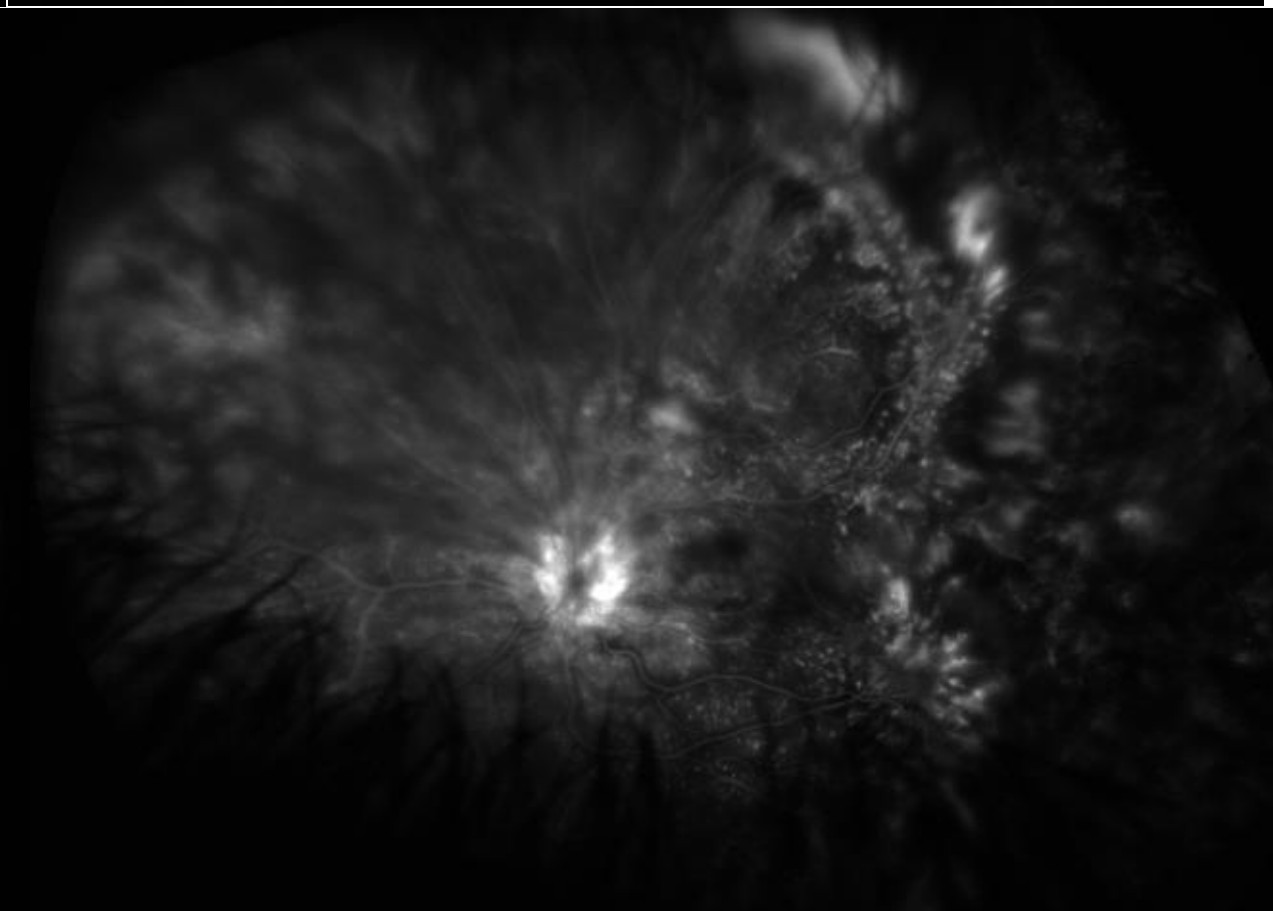
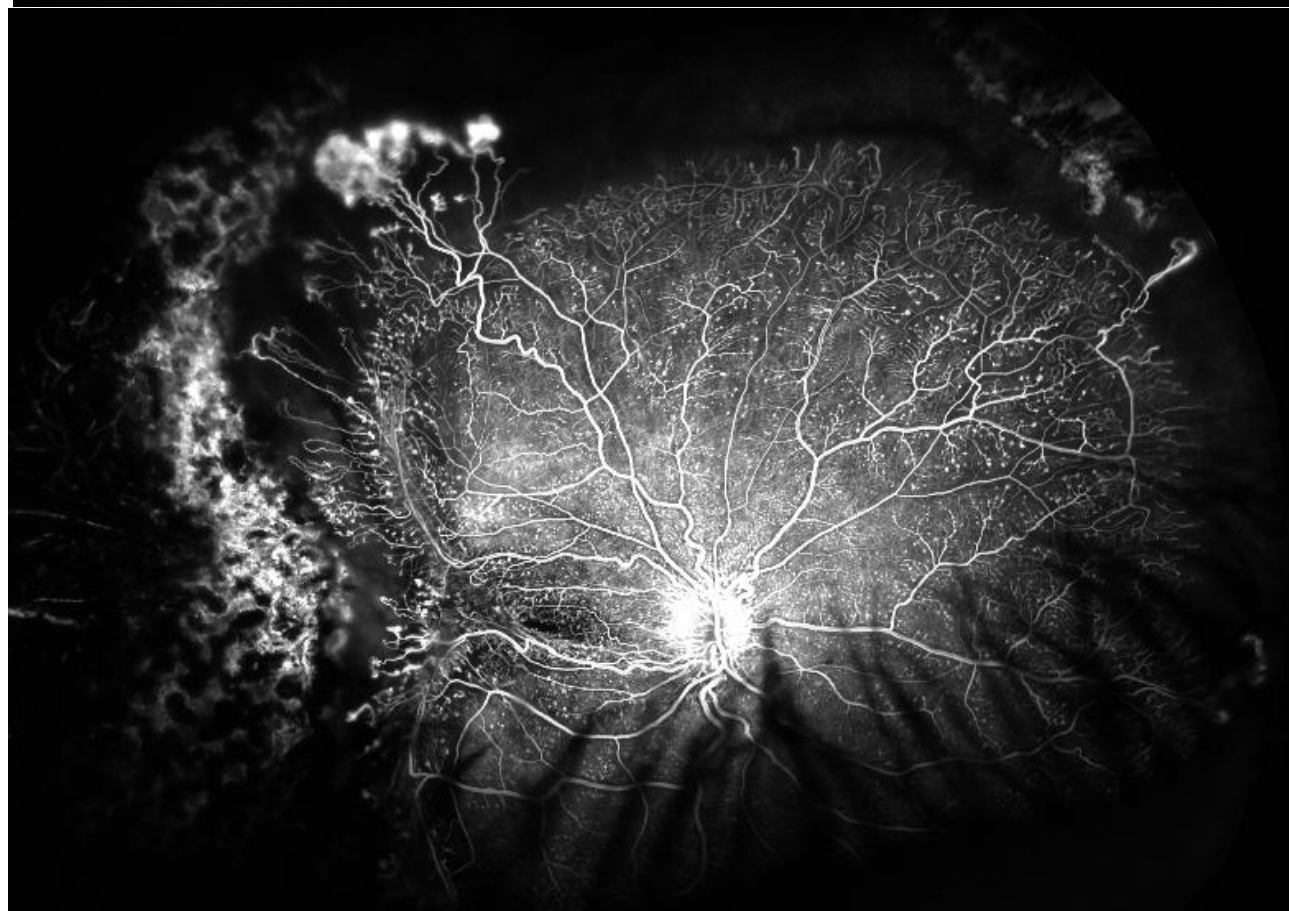
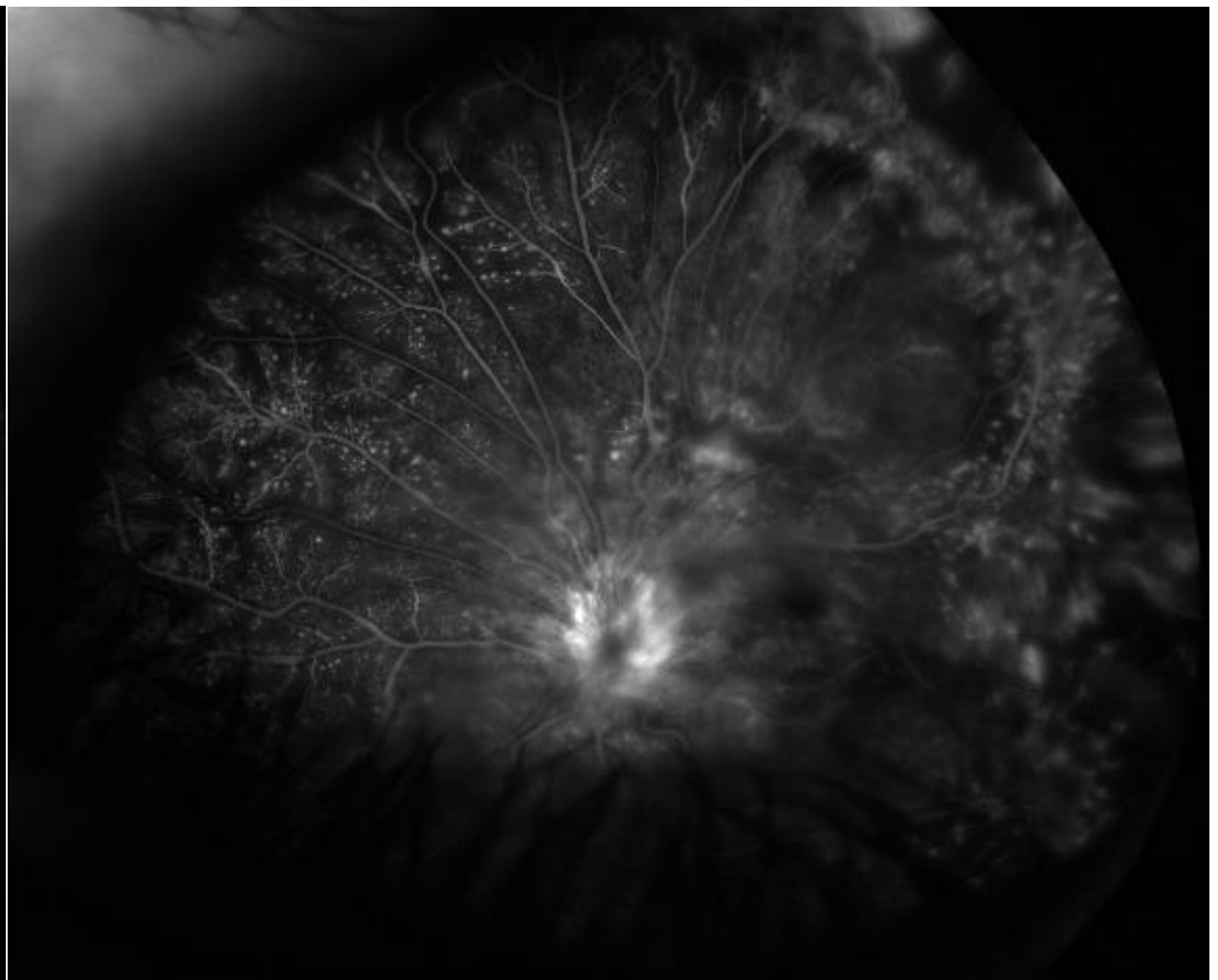
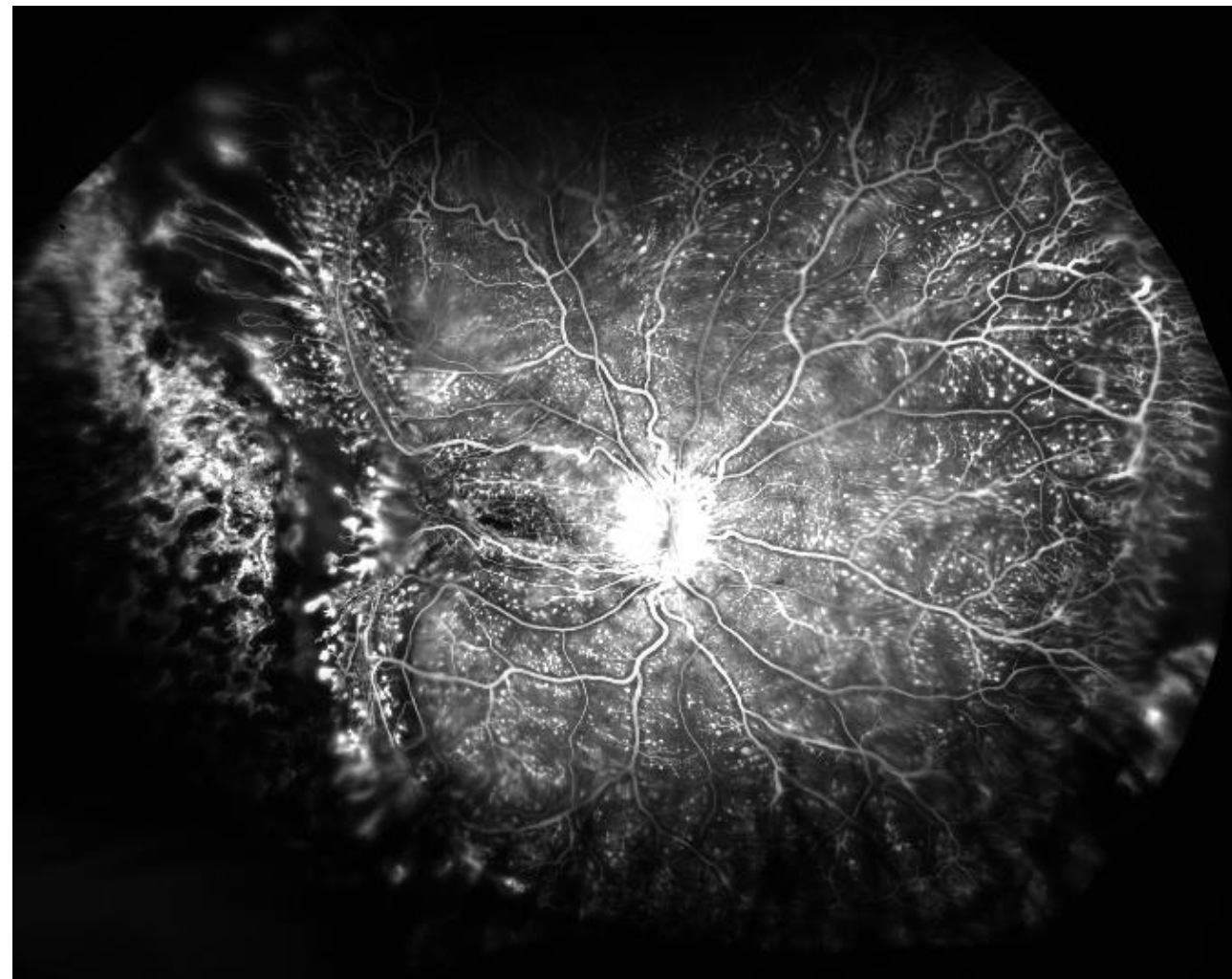
FEVR-Cerrahi

VA: Preop:0.05 Postop: 0.3

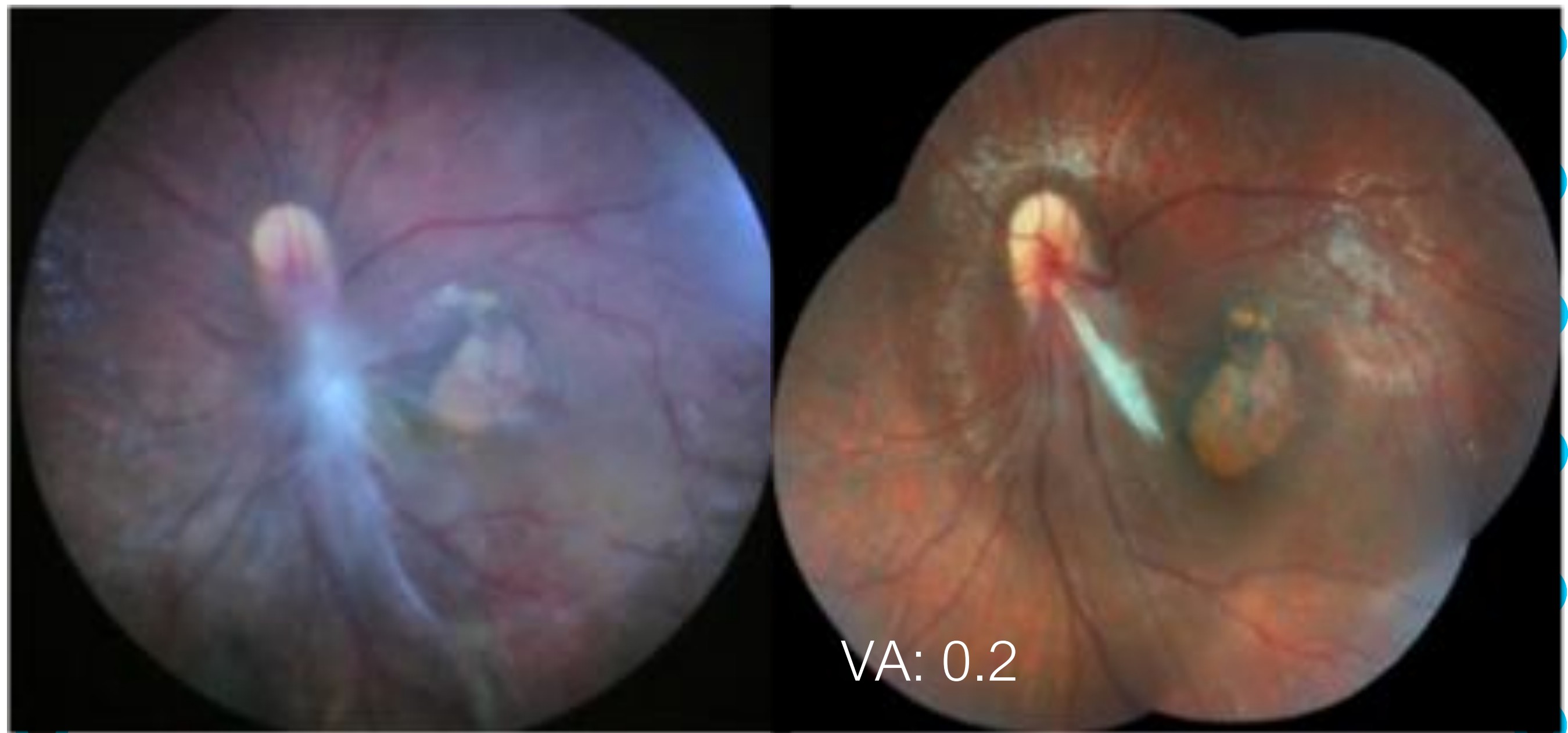




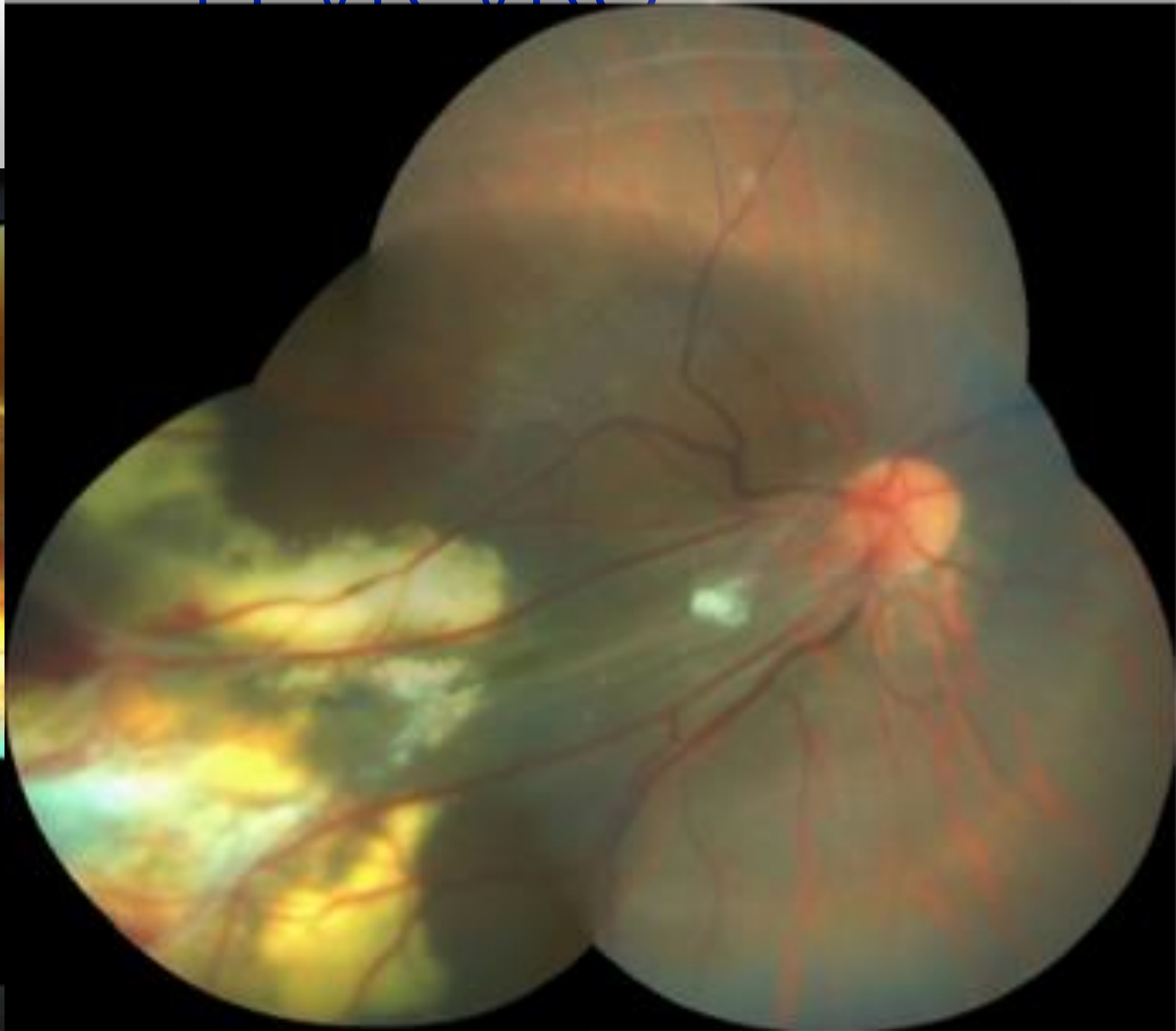
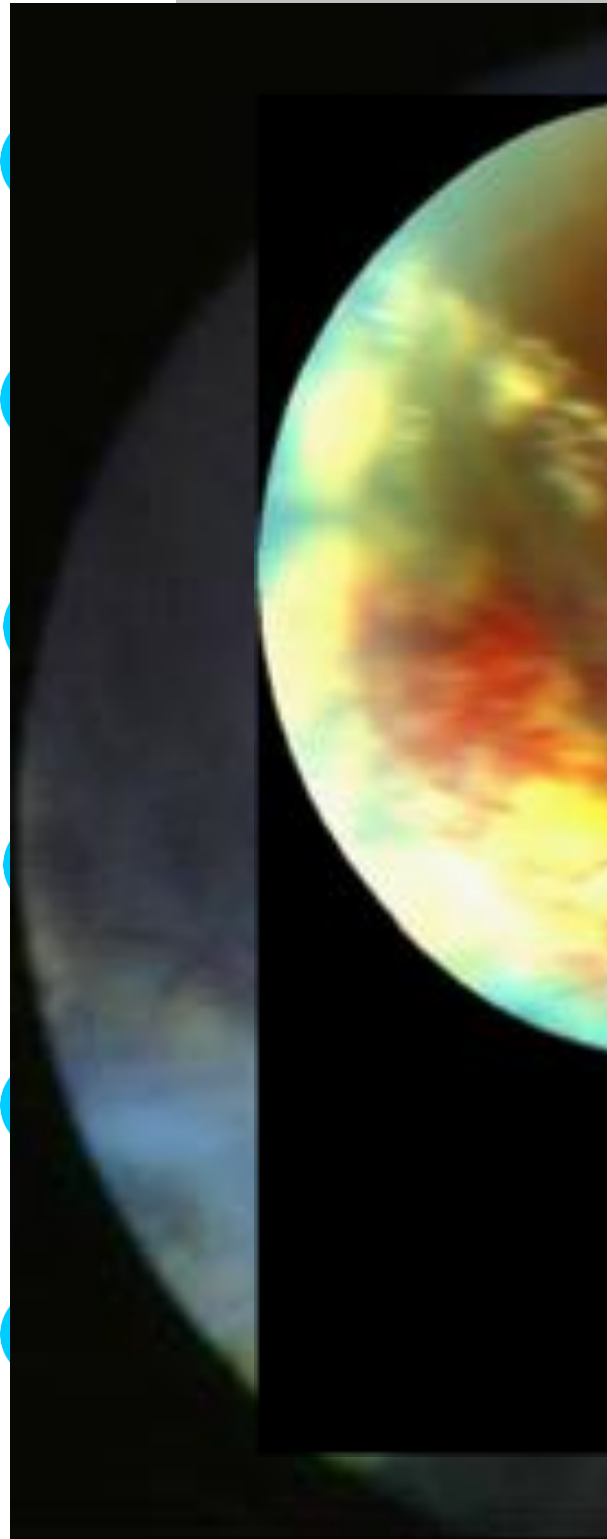


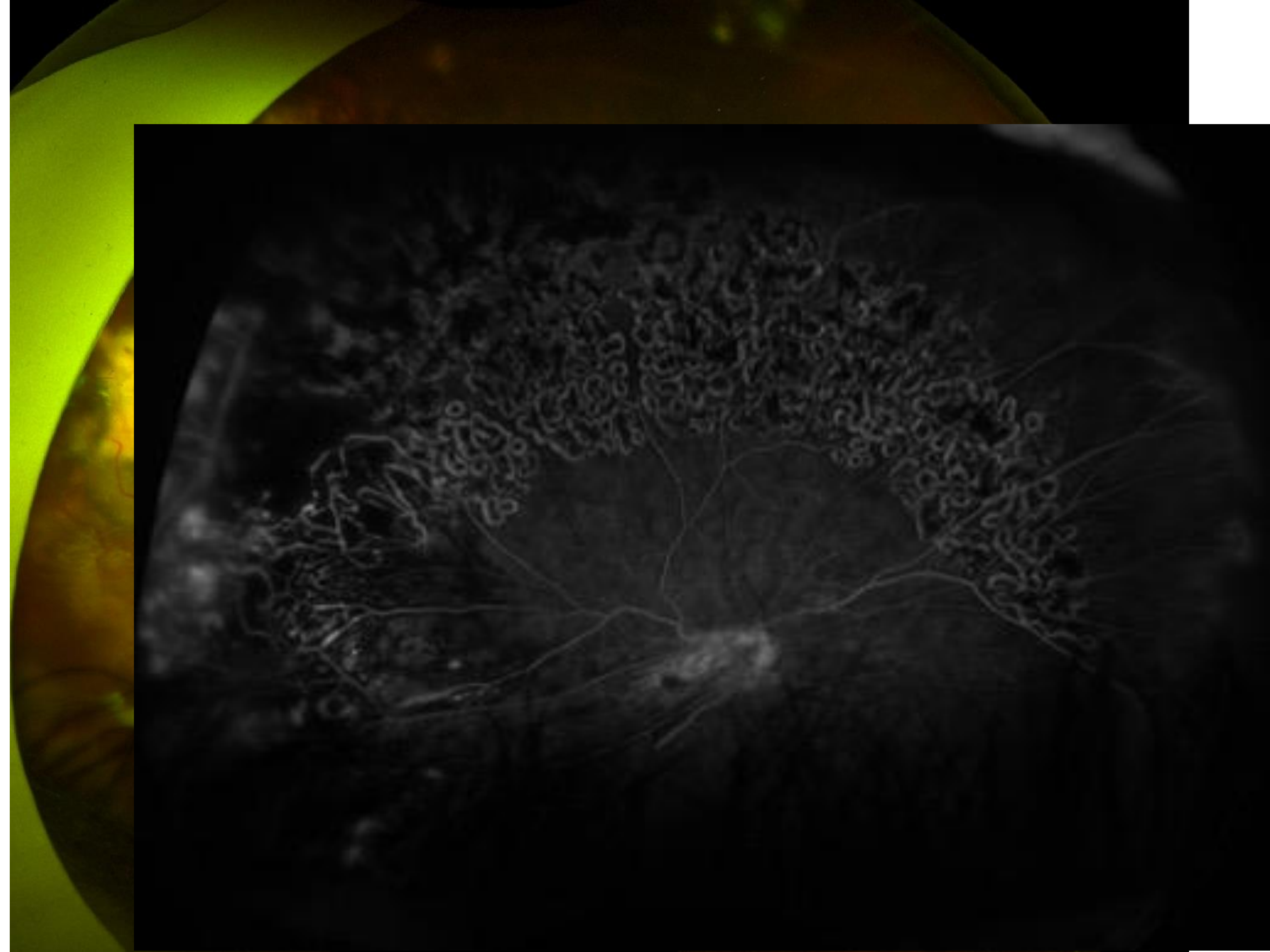


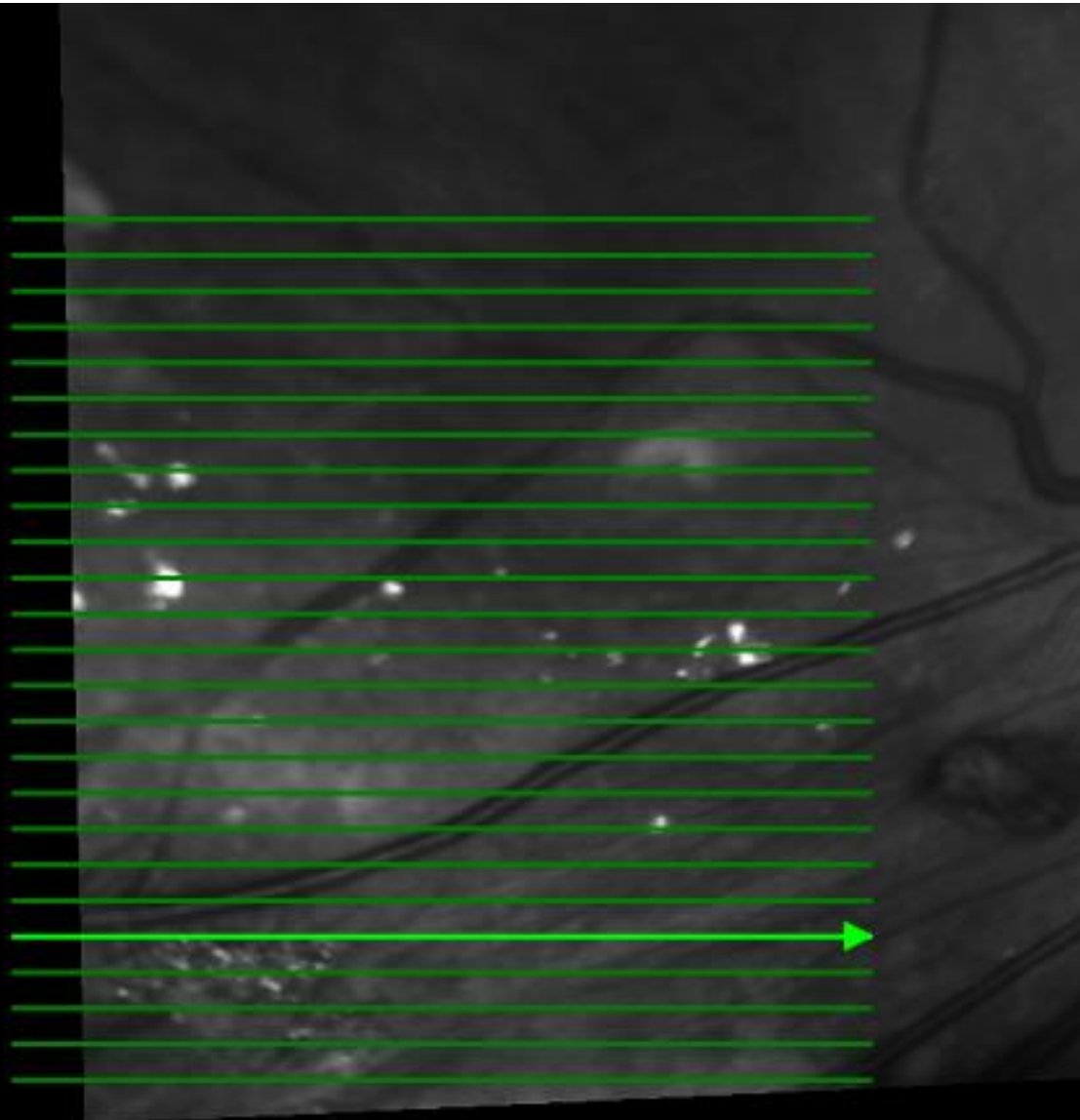
FEVR VRC



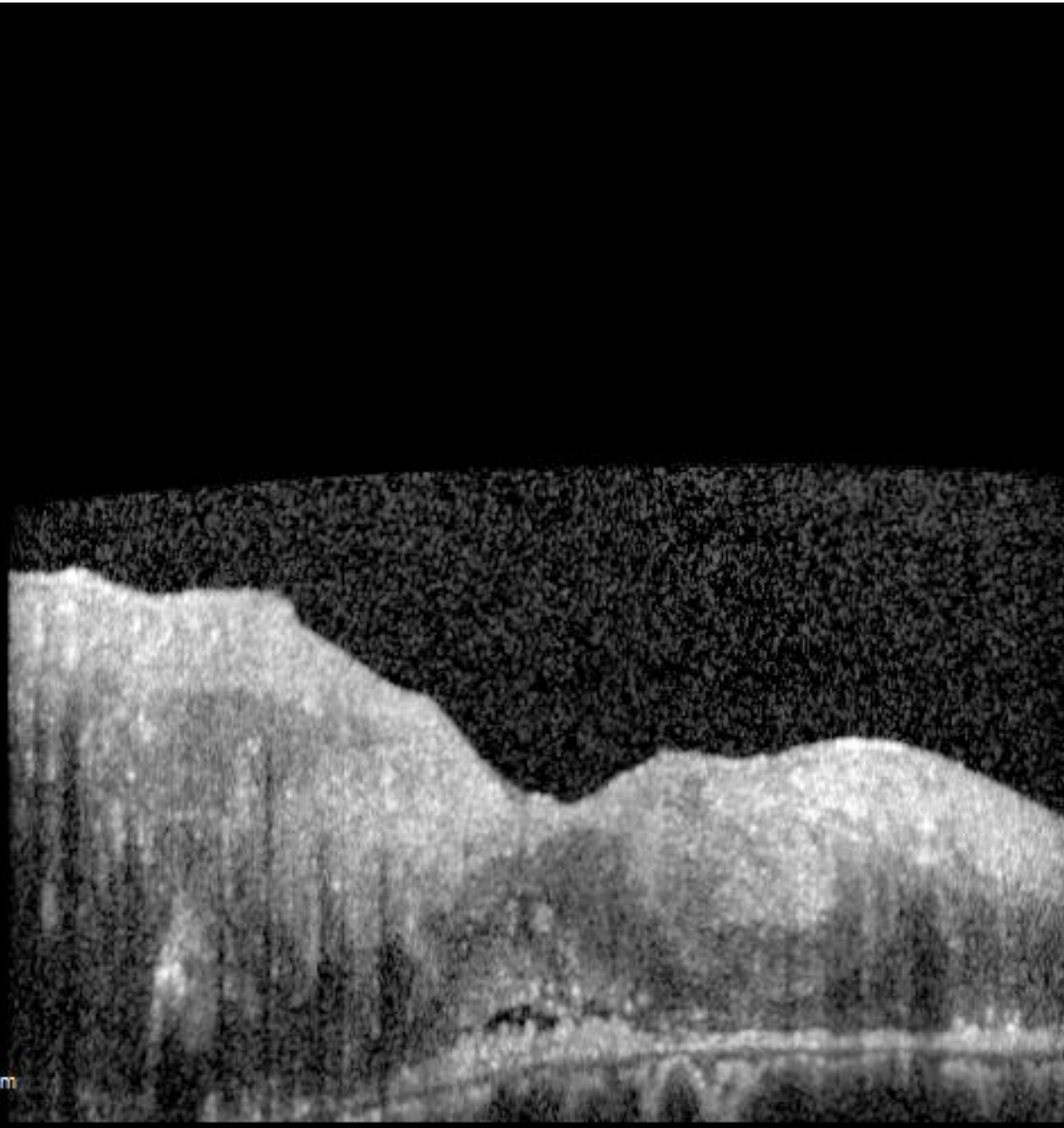
FFVR-VRC



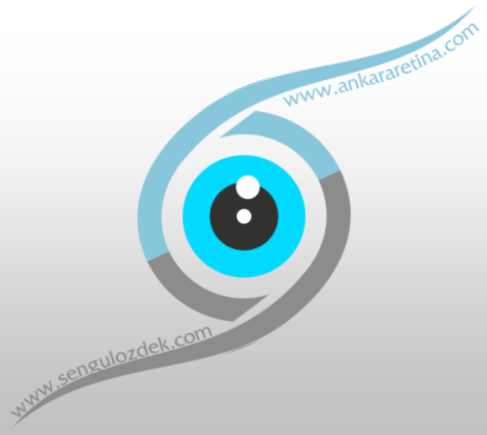




200 μ m



200 μ m



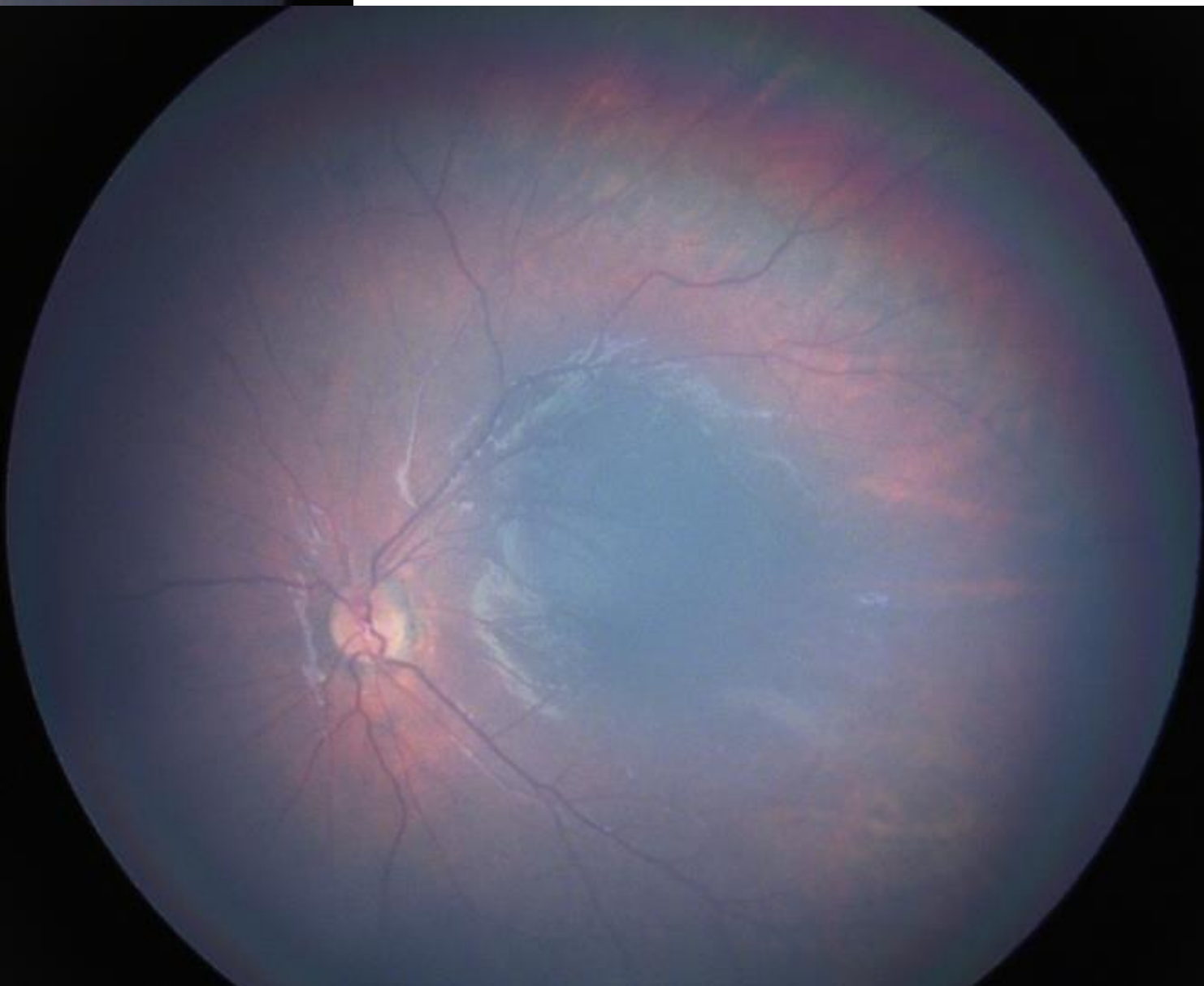
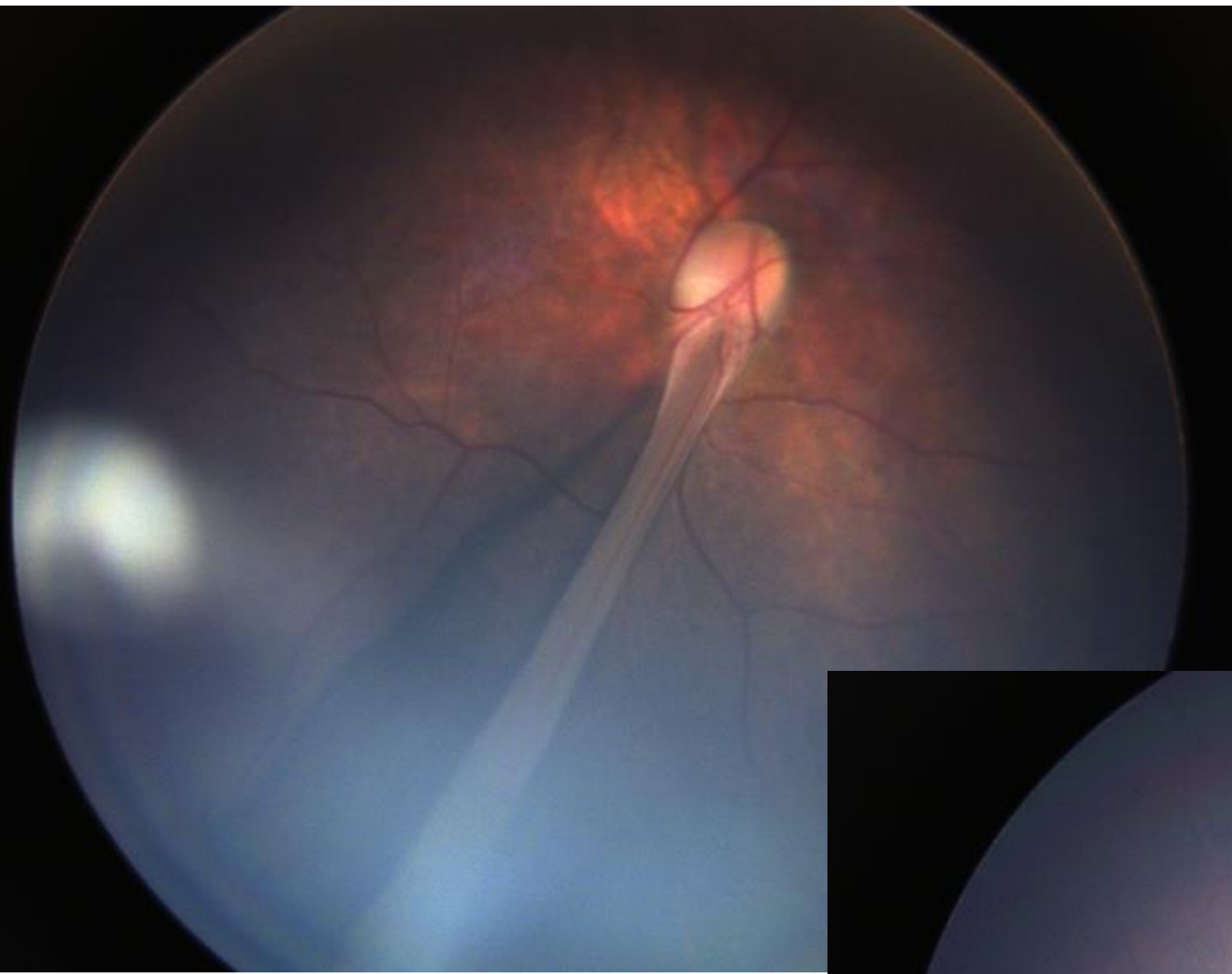
FEVR

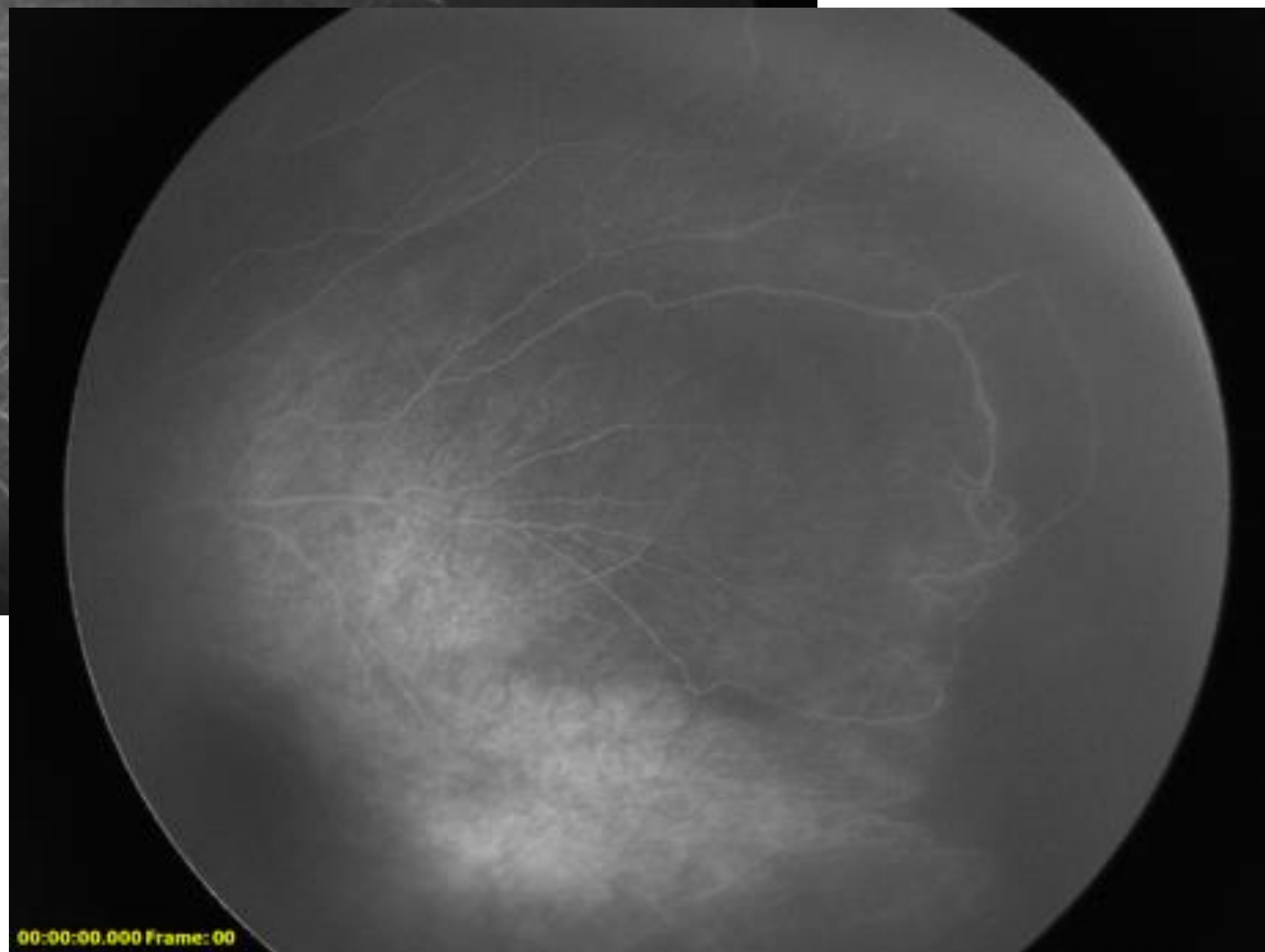
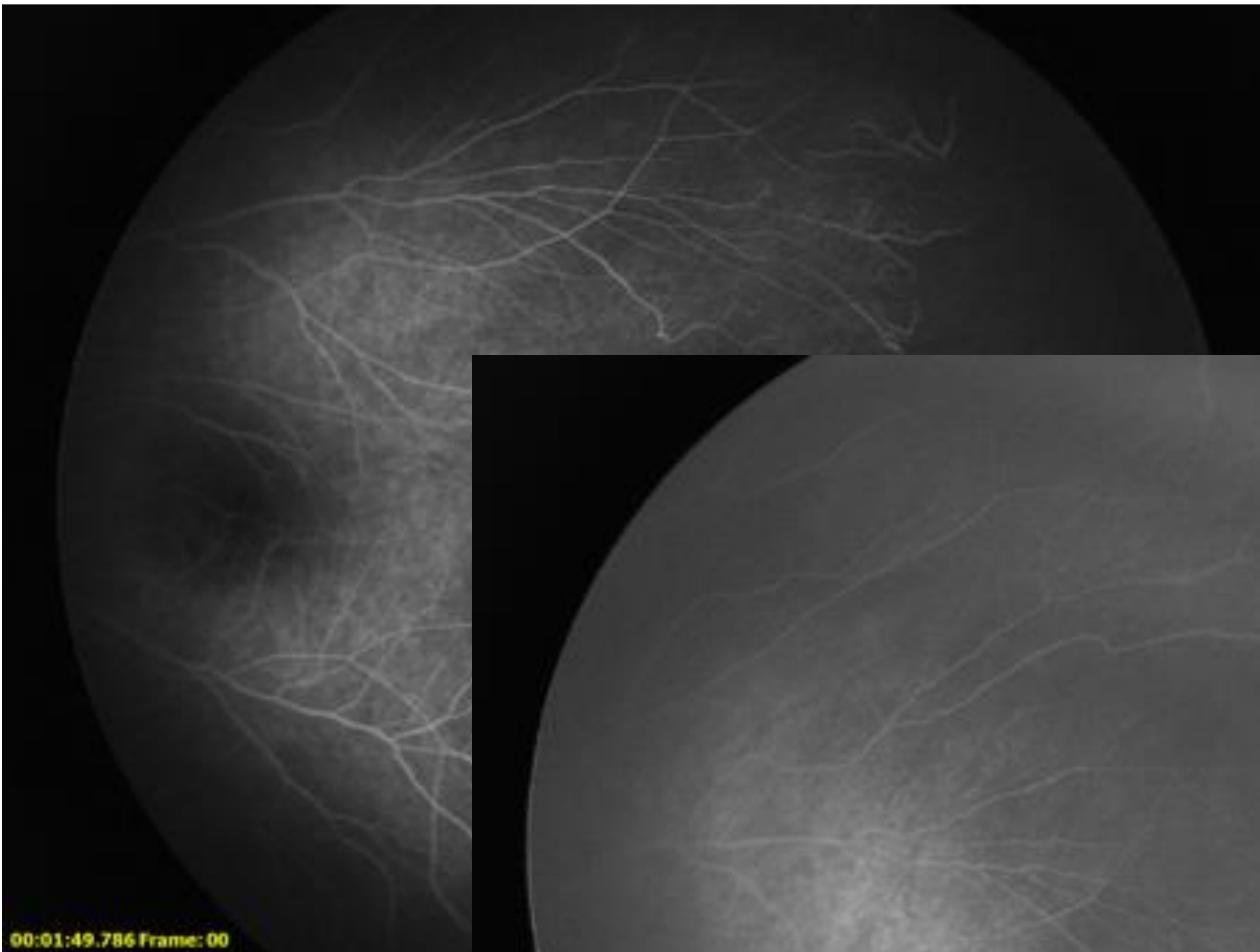
Asimetrik olabilir!

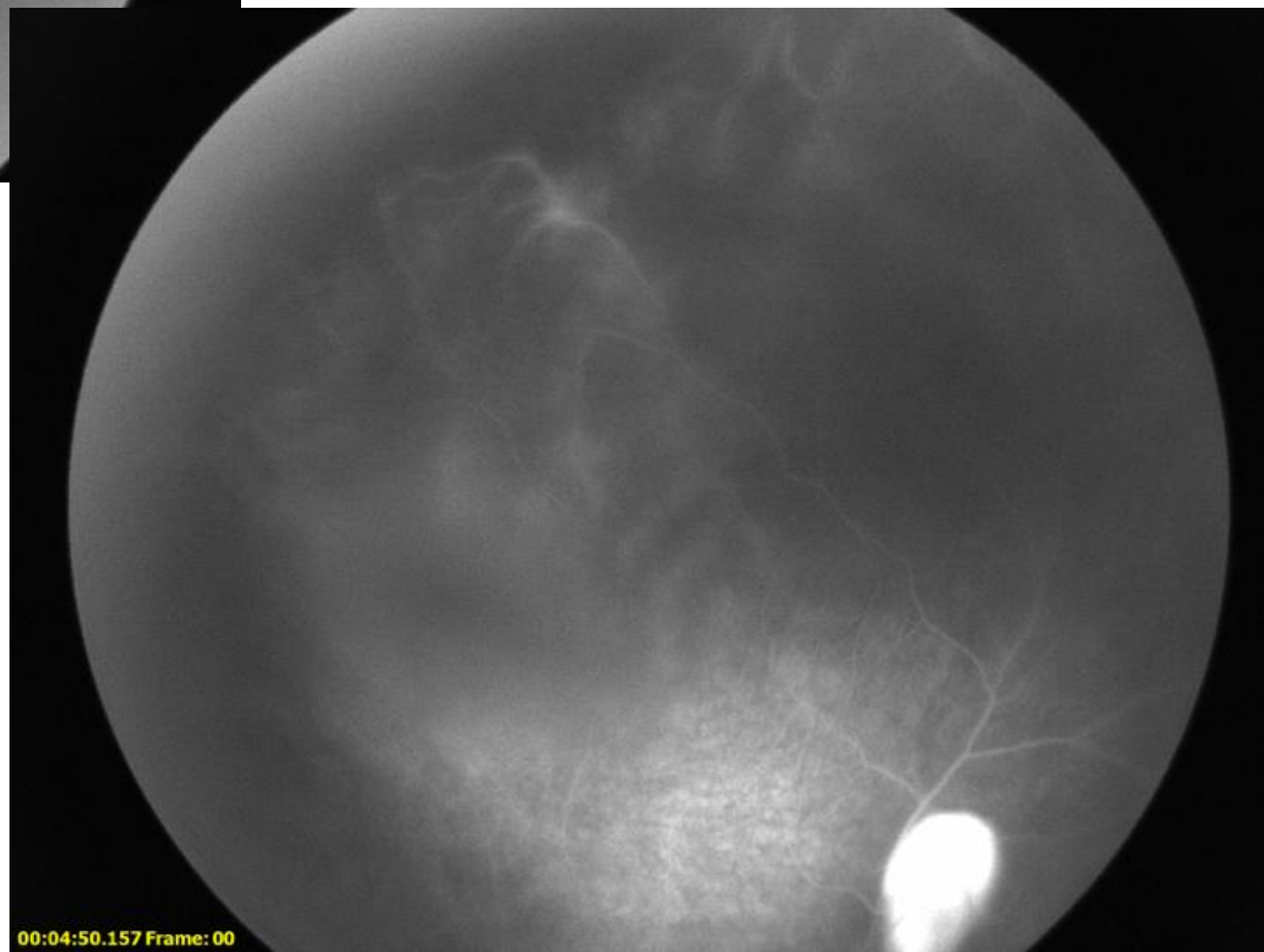
- 34 hf, 1700gr doğum, Mikrosefali
- Şimdi 14 aylık
- Sağ gözde içe kayma
- Hafif mental motor gelişme geriliği
- Sağda retinal temporal fold, sol normal

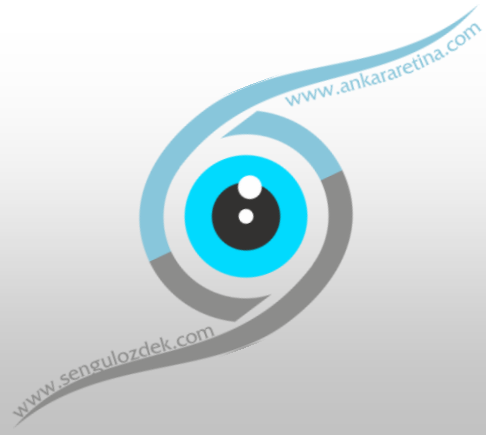
PROF. DR. ŐENGÜL ÖZDEK











Tanı? ROPER

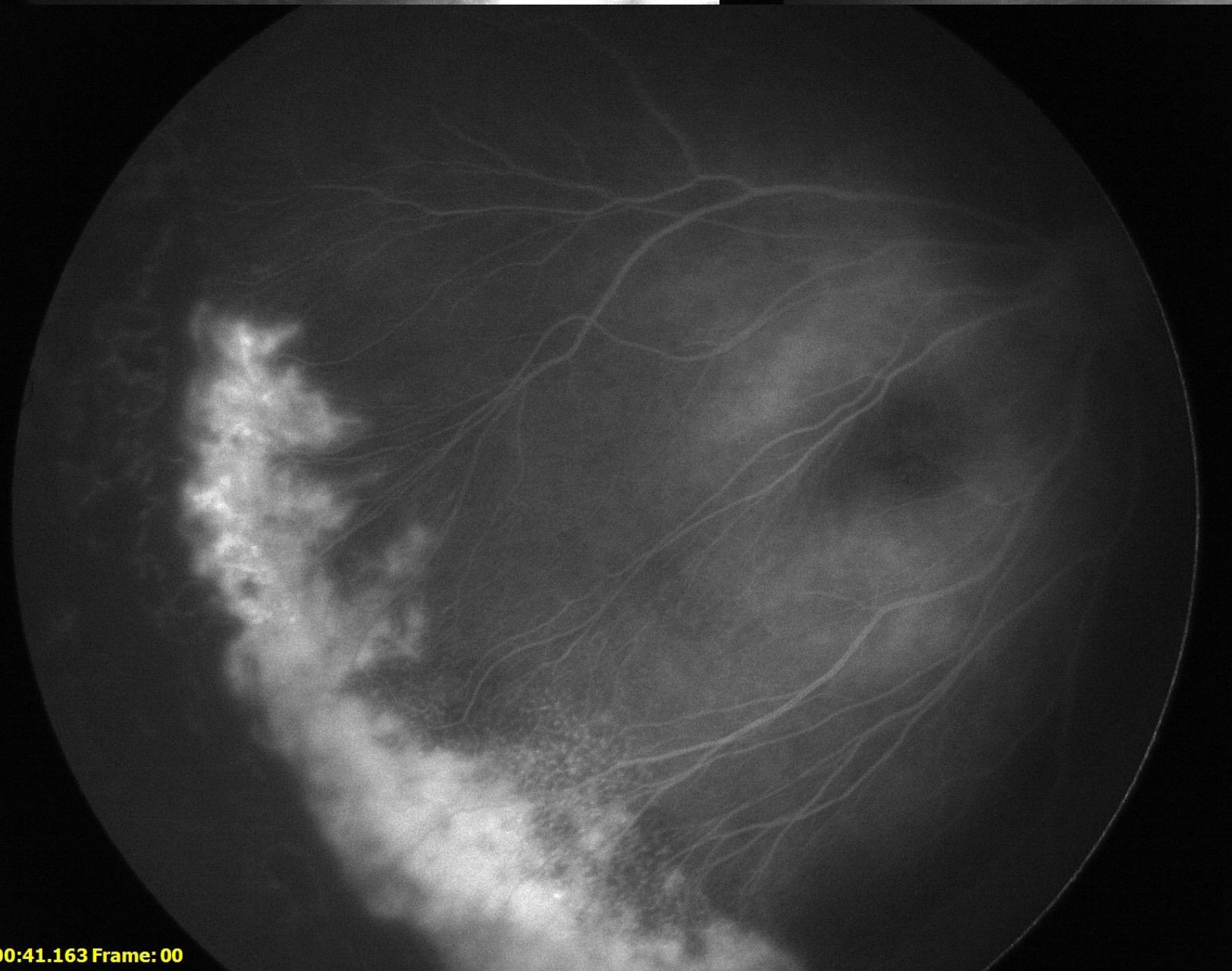
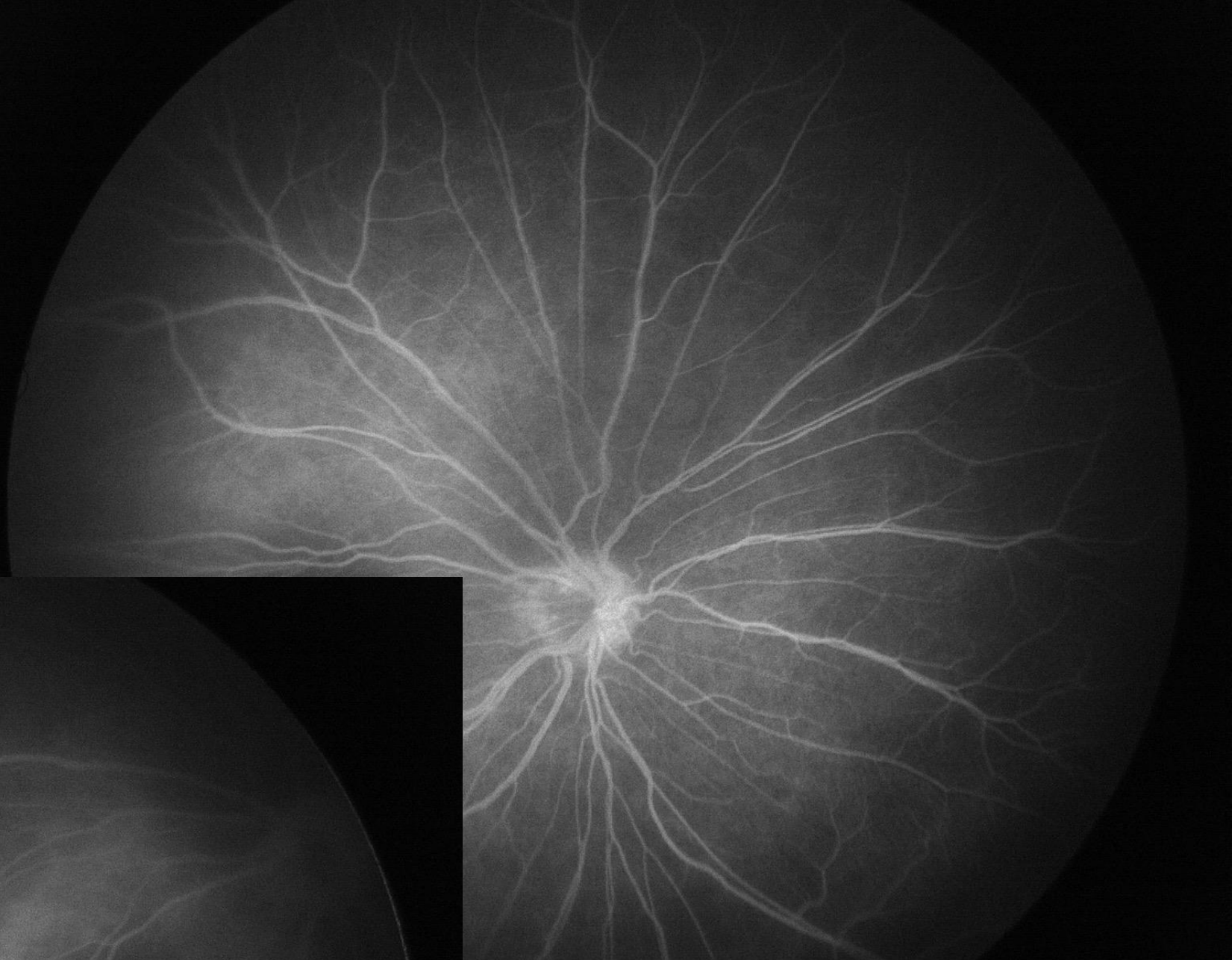
- ROP?
- FEVR?
- John VJ, McClintic JI, Hess DJ, Berrocal AM. Ophthalmic Surg Lasers Imaging Retina. 2016. Retinopathy of Prematurity Versus Familial Exudative Vitreoretinopathy: Report on Clinical and Angiographic Findings.

FEVR-LAPPEL Belirtisi

- **L**Ate-**P**hase angiographic posterior and **P**Eripheral vascular **L**eakage
- Retinada endotel hücre enflamasyonunun markeri
- Capillary dropout precursor



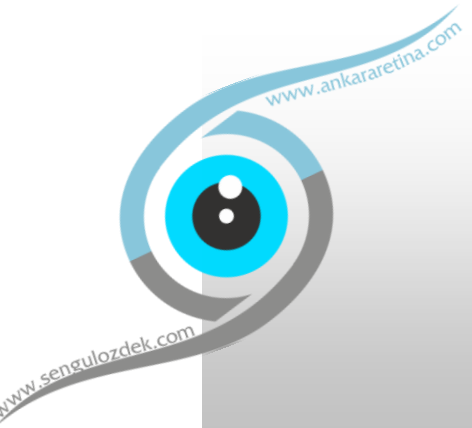
Thanos A, Todorich B, Trese MT. A Novel Approach to Understanding Pathogenesis and Treatment of Capillary Dropout in Retinal Vascular Diseases. Ophthalmic Surg Lasers Imaging Retina. 2016



FEVR-LAPPEL Belirtisi

- LASER fotokoagülayon iyi gözü kurtarır!
- FEVR de ömür boyu takip ve tedavi





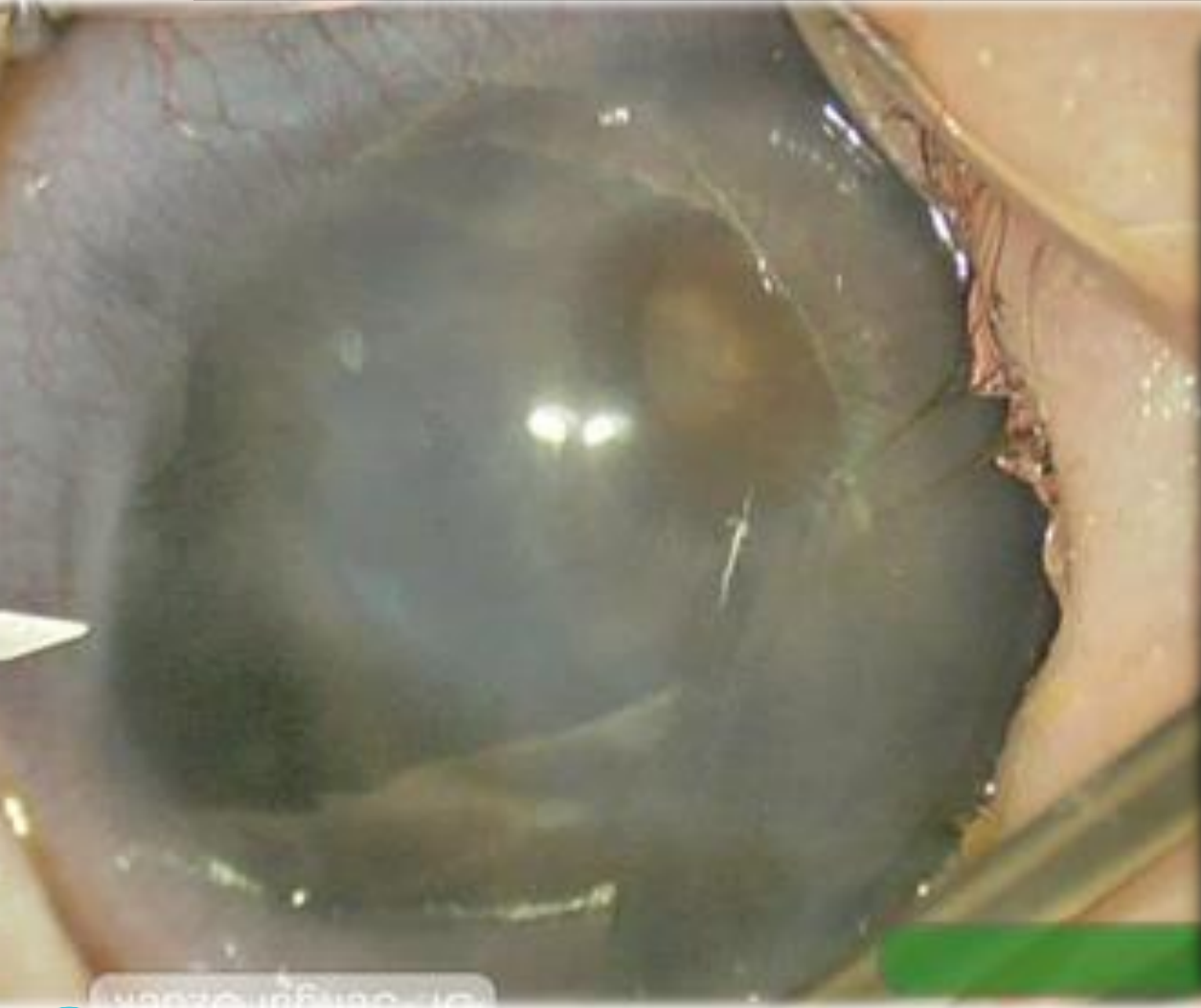
Buftalmus-RD

- 10 aylık, erkek
- Term doğum, ek hastalık yok
- 2 aylıkken farkedilen her iki gözde büyüme
- Azopt 2x1, Xalatan 1x1 kullanıyor.
- Dış merkezlerde inoperable kabul edilmiş.
- Aile öyküsü ve cerrahi öyküsü yok

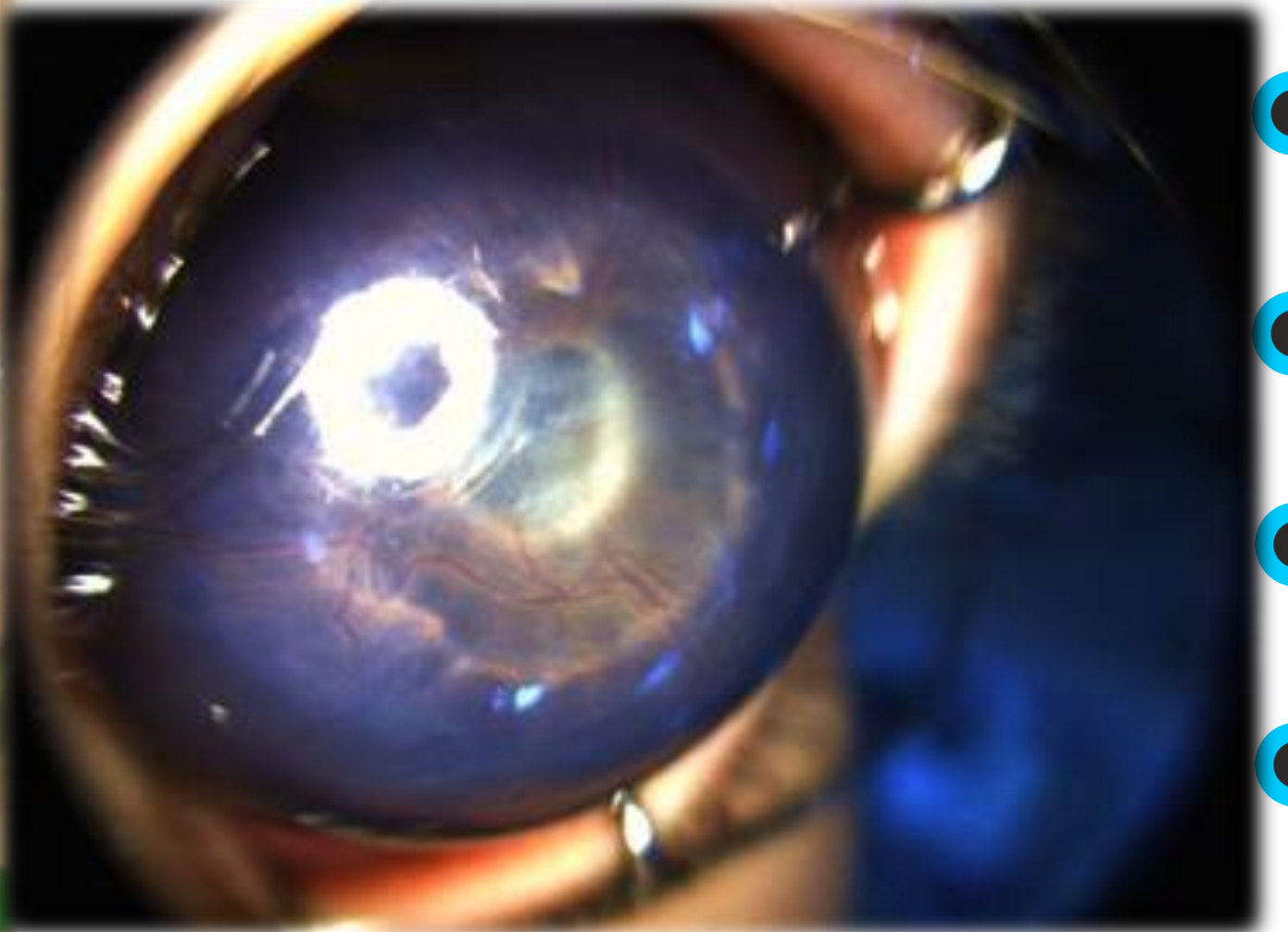
Buftalmus-RD



GK:IOT yok, Yoğun RI, total iridokorneal adezyon, pupillalar ektopik ve oblitere



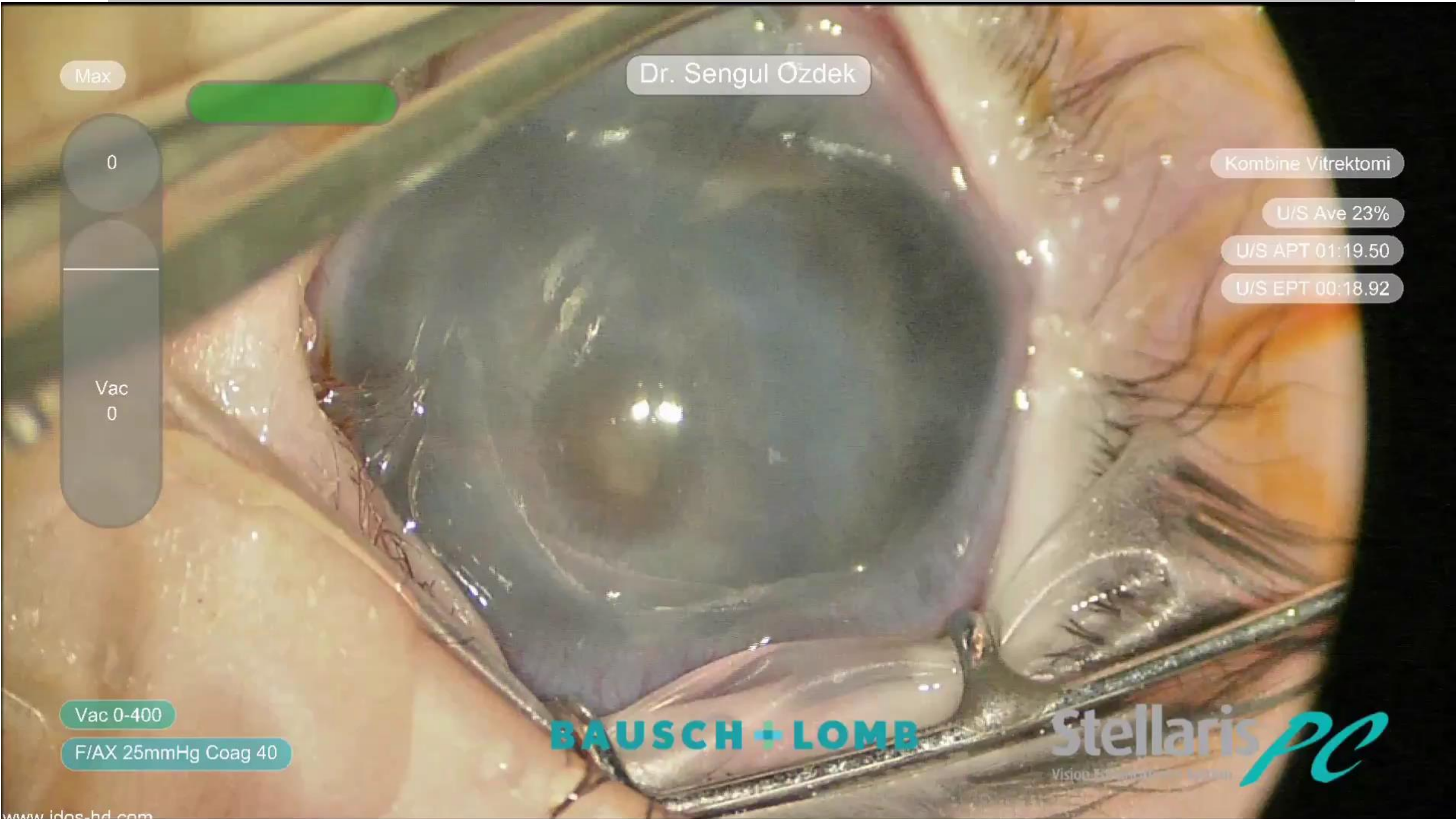
- To: 35 mmHg,
- KÇ: 15x16 mm



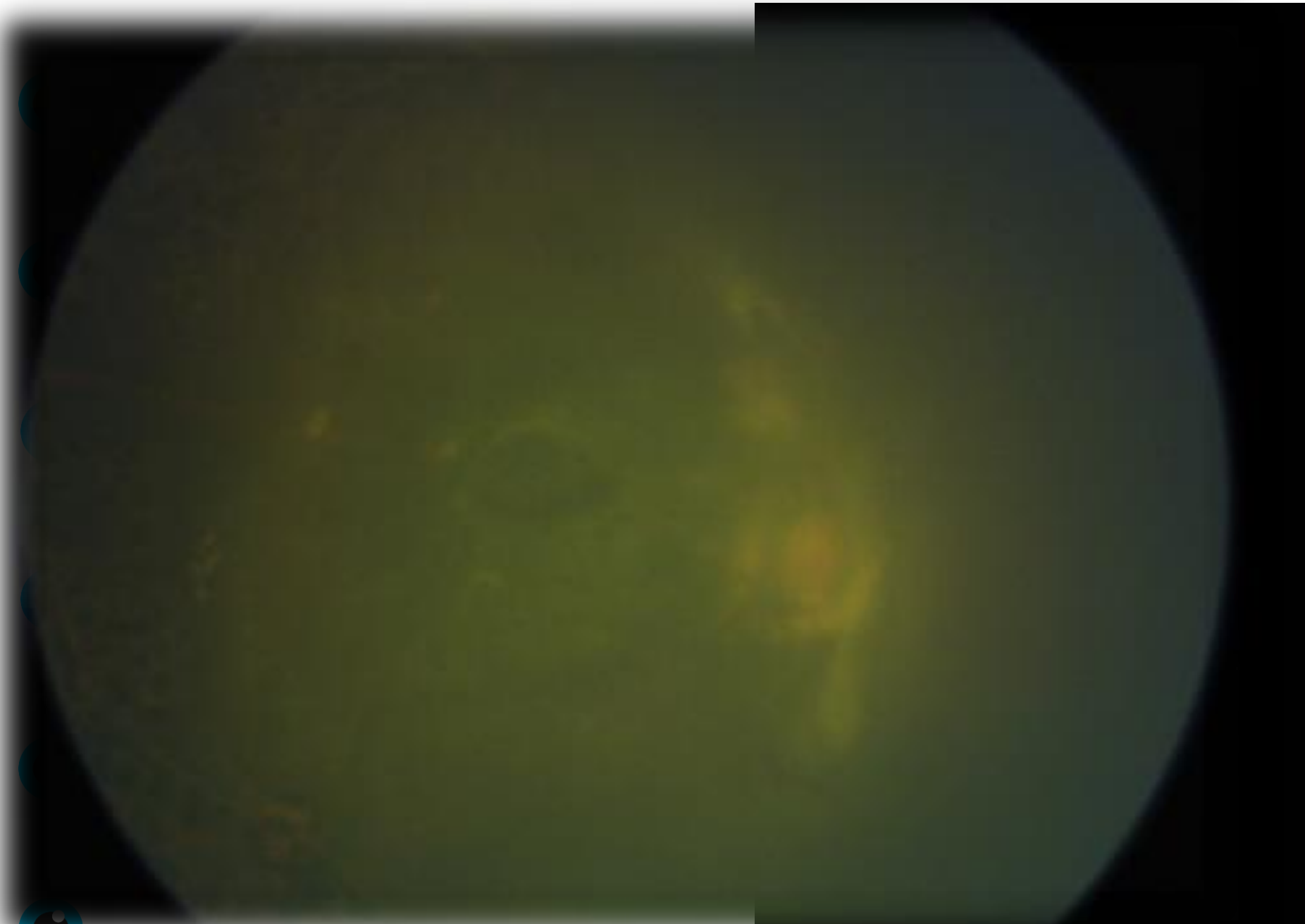
- To: 40 mmHg,
- KÇ: 16x17 mm

USG: Bilateral vitreous opasiteleri ve RD uyumlu bulgular

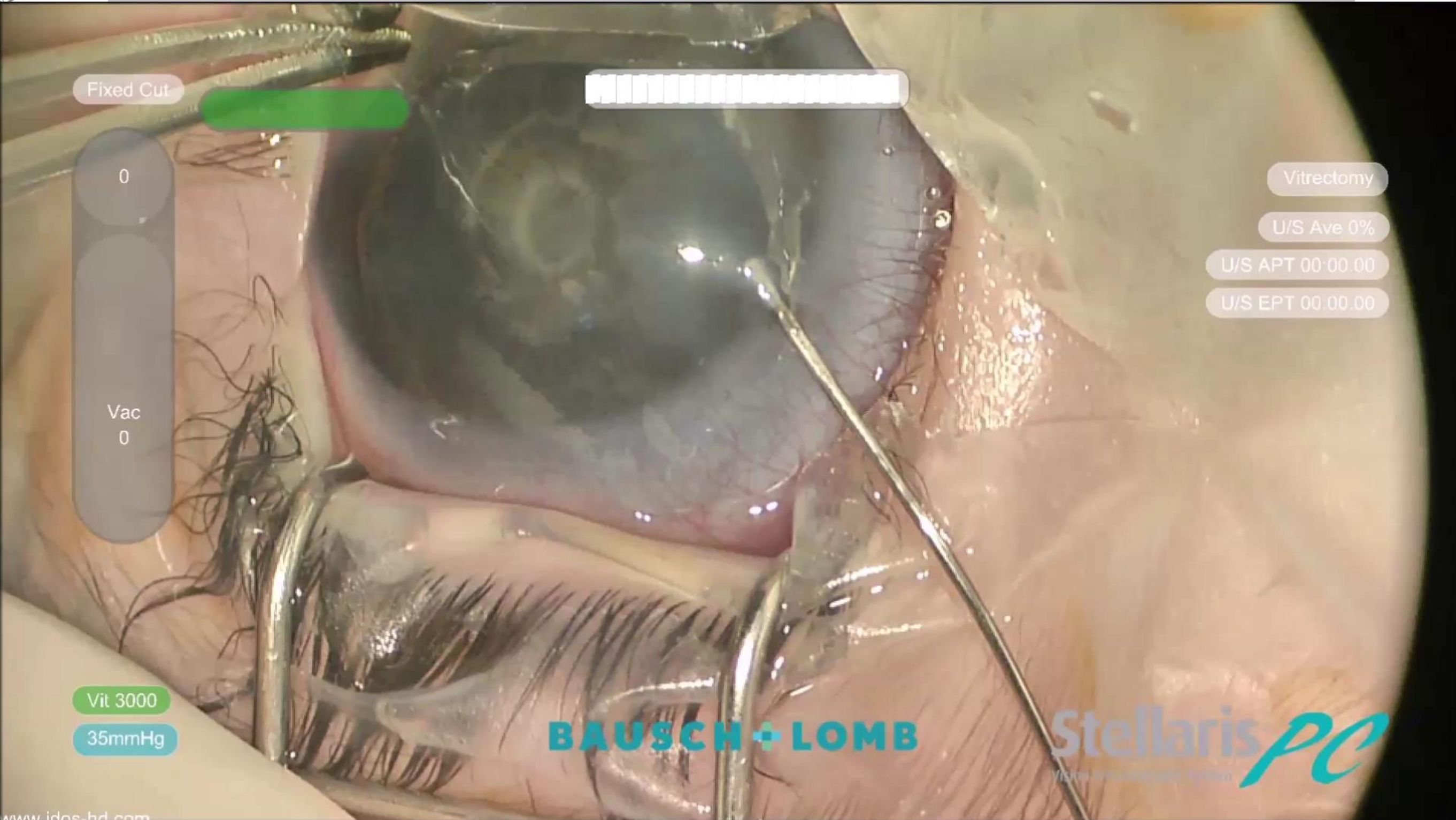
Cerrahi?



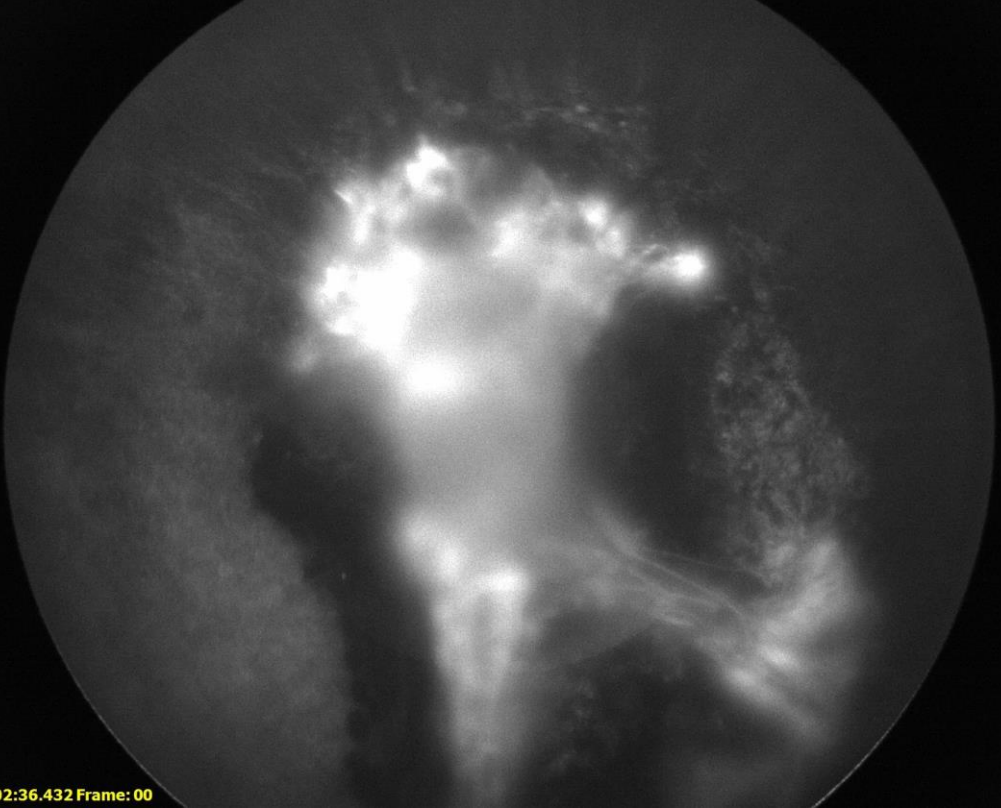
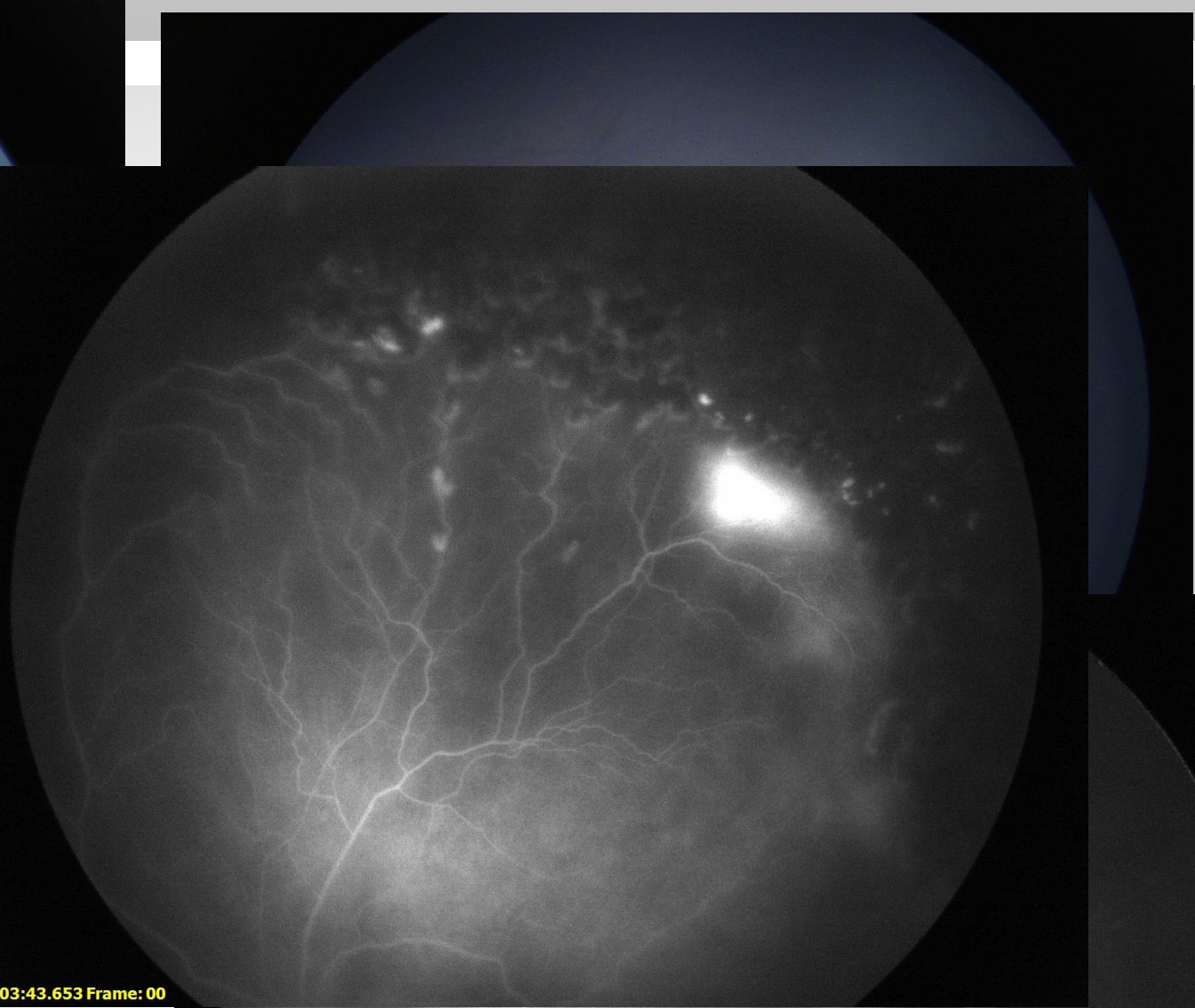
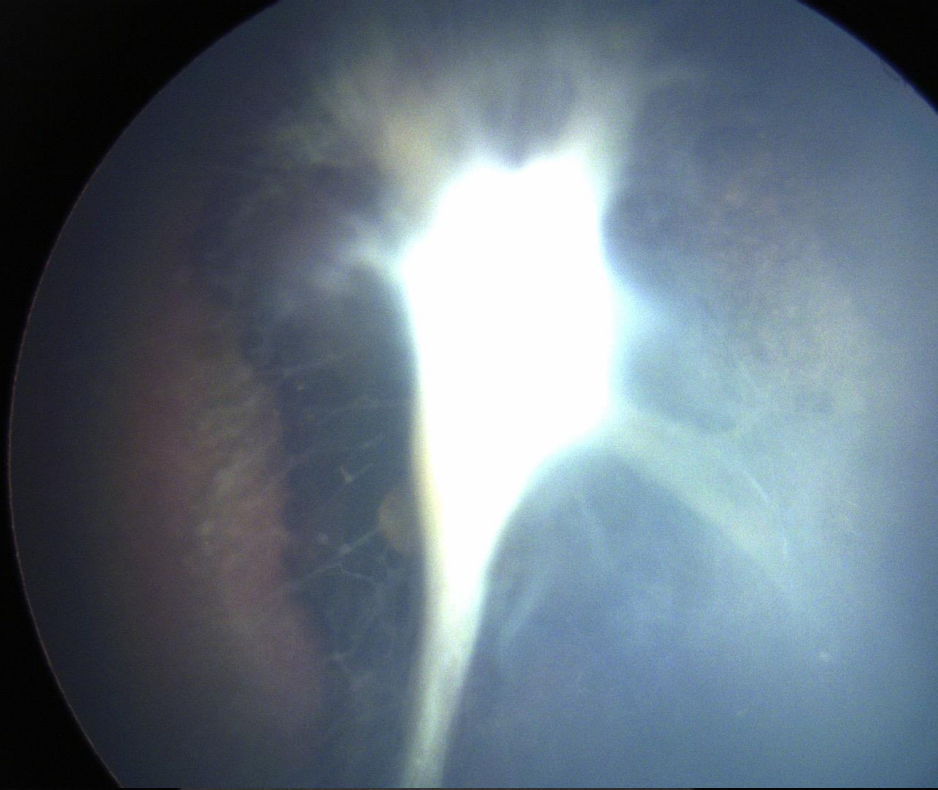
Postop 3. hafta TO: 15/16mmHg



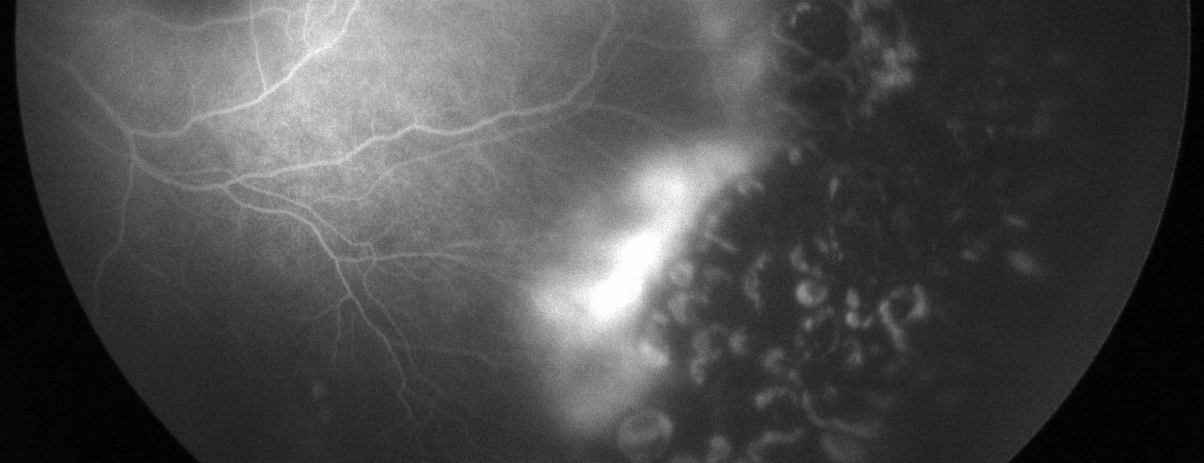
Sol: Cerrahi



2 aylık, Kız bebek, Miadında doğum, Tek taraflı lökokori



00:03:43.653 Frame: 00



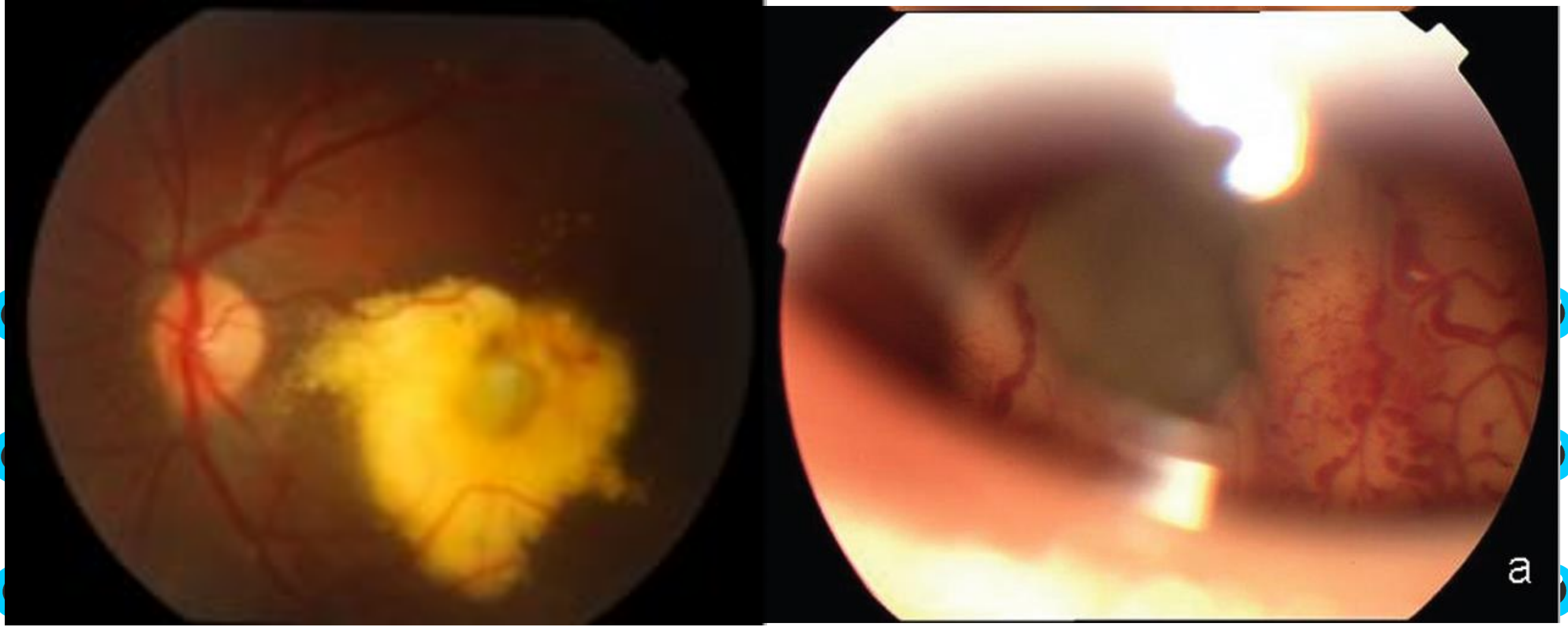
00:02:36.432 Frame: 00





Inkontinentia pigmenti



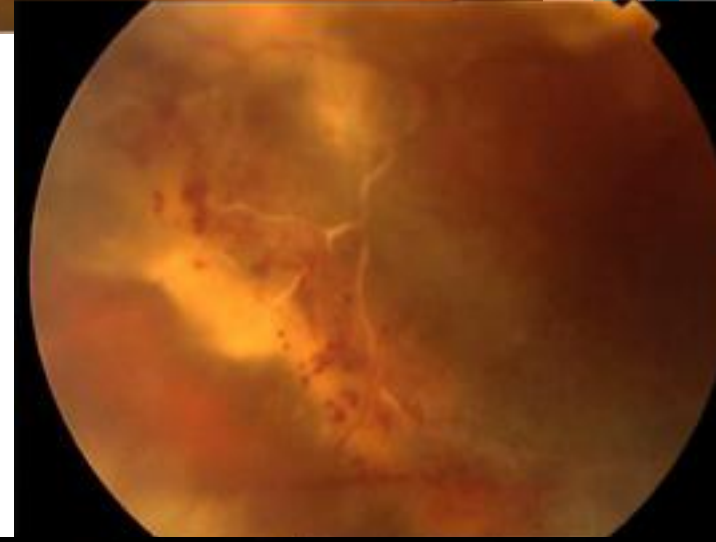
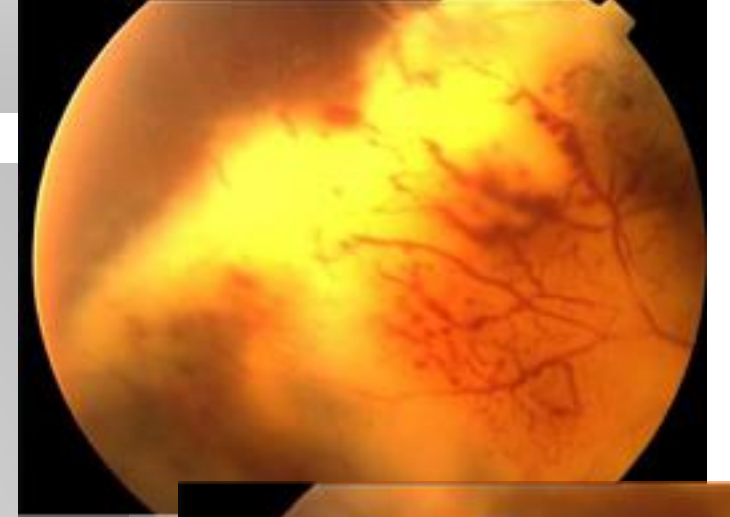


COATS' HASTALIĞI



COATS HASTALIĞI

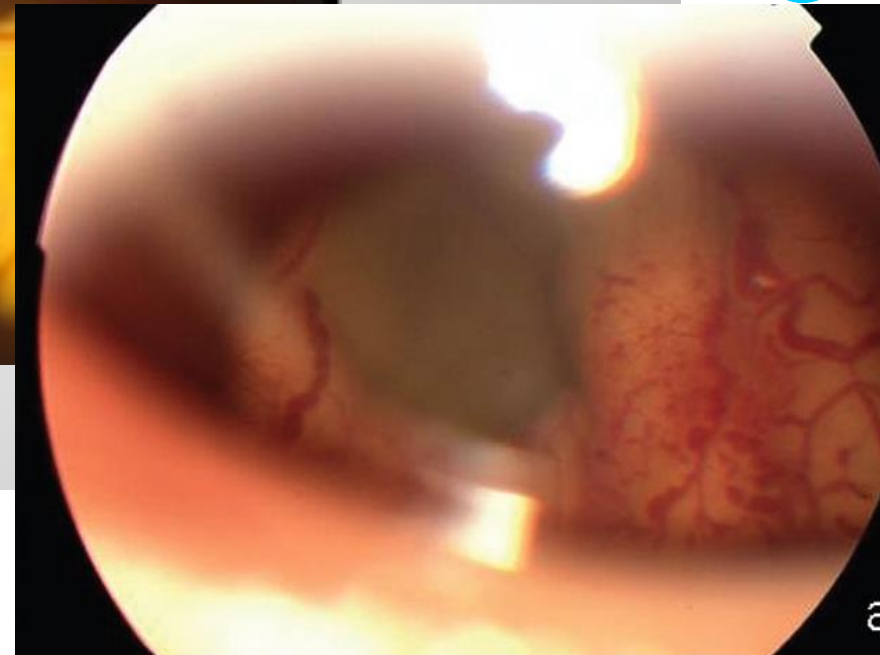
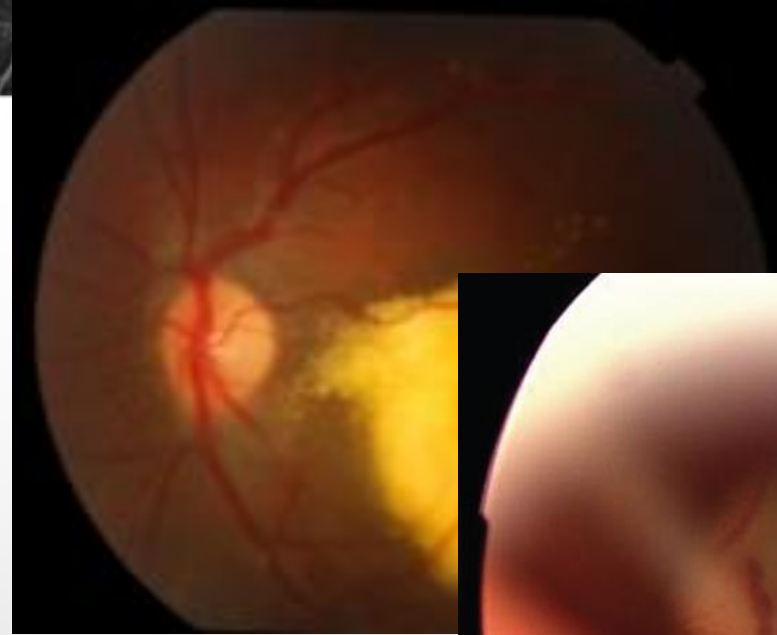
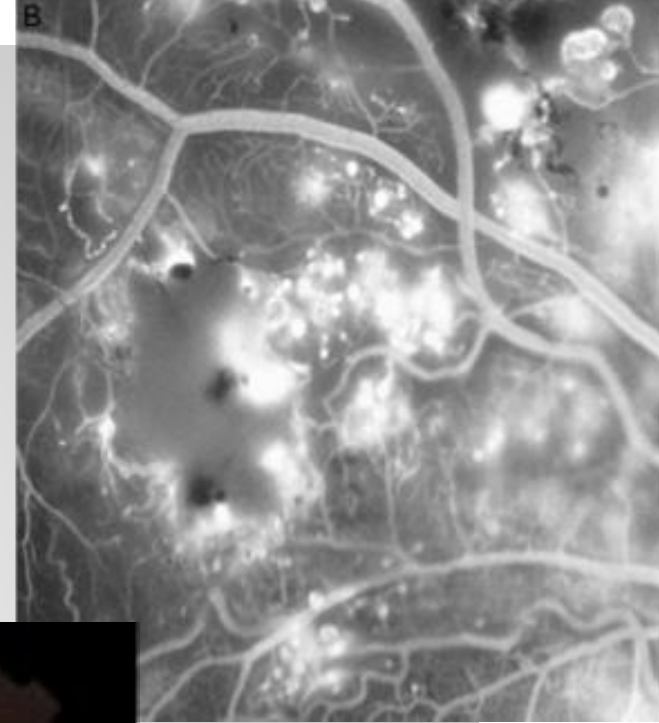
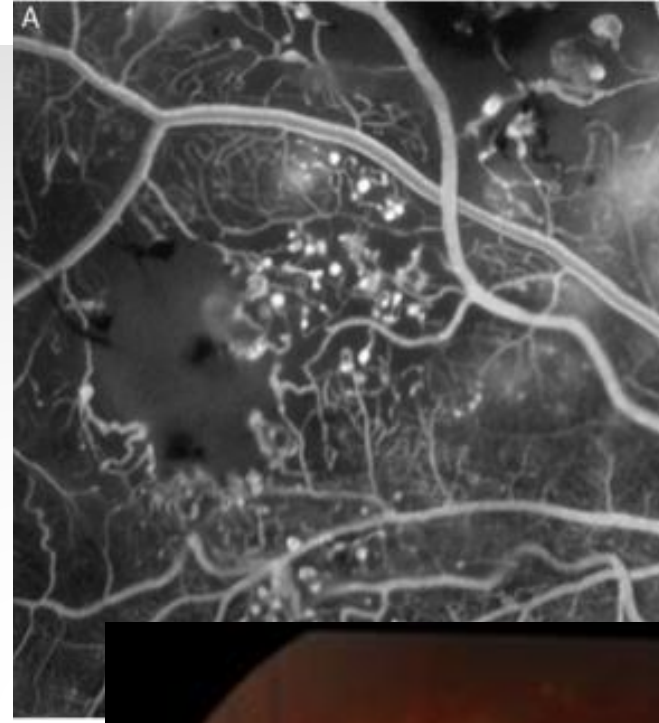
- Endotel ve perisit hastalığı: İç K-R Bariyeri bozuk
- Unilateral, ilk dekad, erkek çocuk



COATS

Sınıflama-Shields

1. YALNIZ TELENJİEKTAZİ
2. TELENJİEKTAZİ VE EKSUDASYON
 - A. extrafoveal eksudasyon
 - B. foveal eksudasyon
3. EKSUDATİF RD
 - A. subtotal
 - B. total
4. TOTAL RD + NV GLOKOM
5. SON EVRE HASTALIK (Ağrılı kırmızı göz)



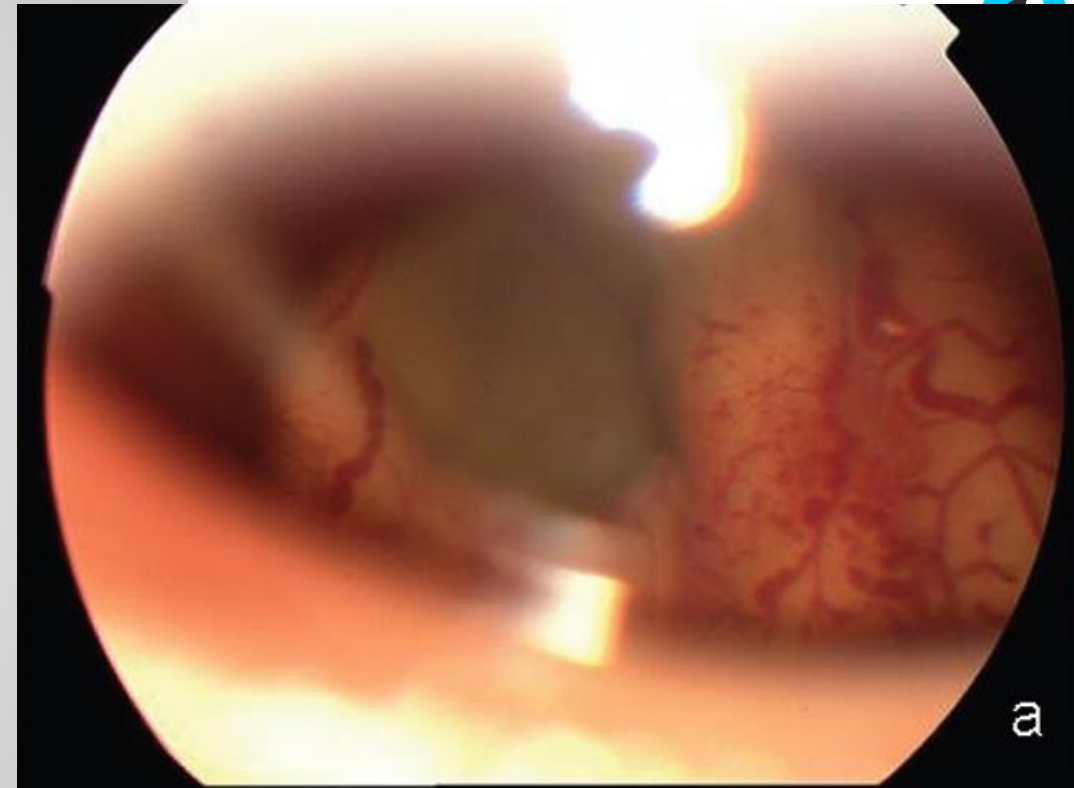
COATS-Tedavi

- Primer tedavi: Lazer FK (Evre 1,2,3)
- Krioterapi: Evre 3
- Cerrahi: Evre 3-4
 - BP-Krio veya Laser-Anti-VEGF (steroid)
 - BP-PPV

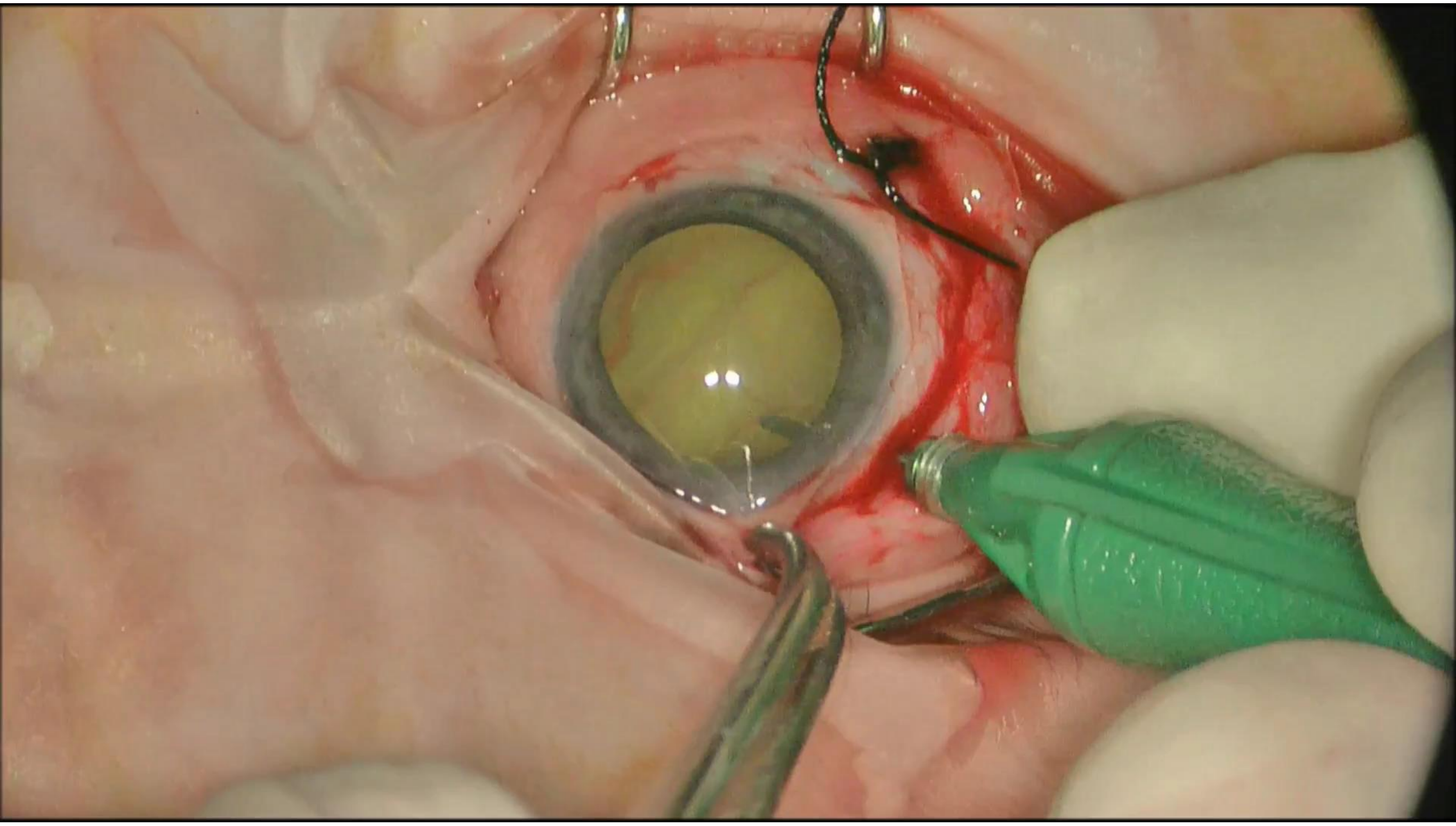


COATS Tedavi

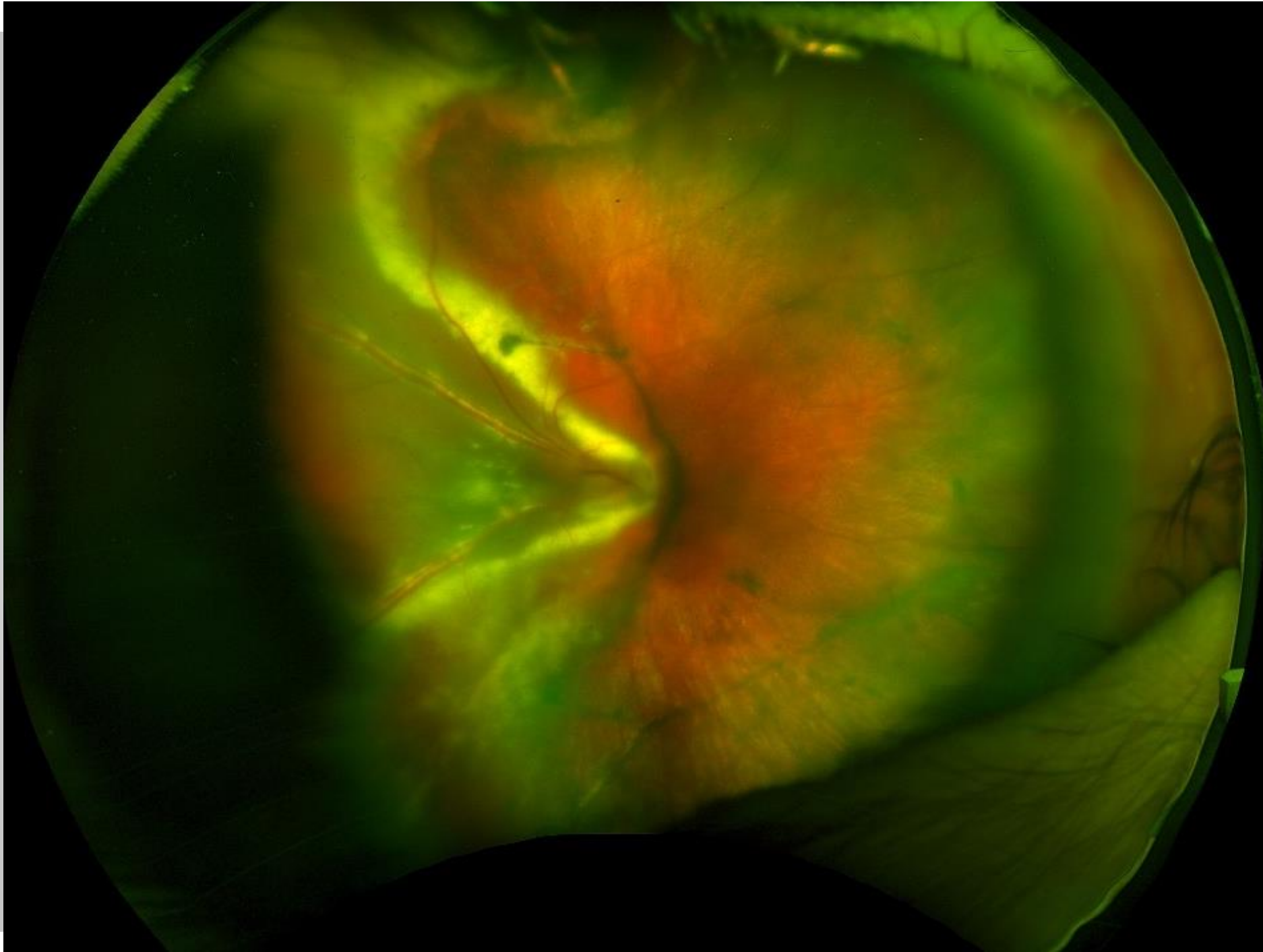
- Cerrahi tedavi ileri evre coats vakalarında konfor ve kozmetik amaçlı
- Amaç vizyon değil gözü korumak
- Drenaj retinotomisinden kesinlikle kaçınılır
- Ağrısı olmayan vakalara takip?
- Coats hastalarının %16 sına NVG, ağrı nedeniyle enükleasyon uygulanmakta

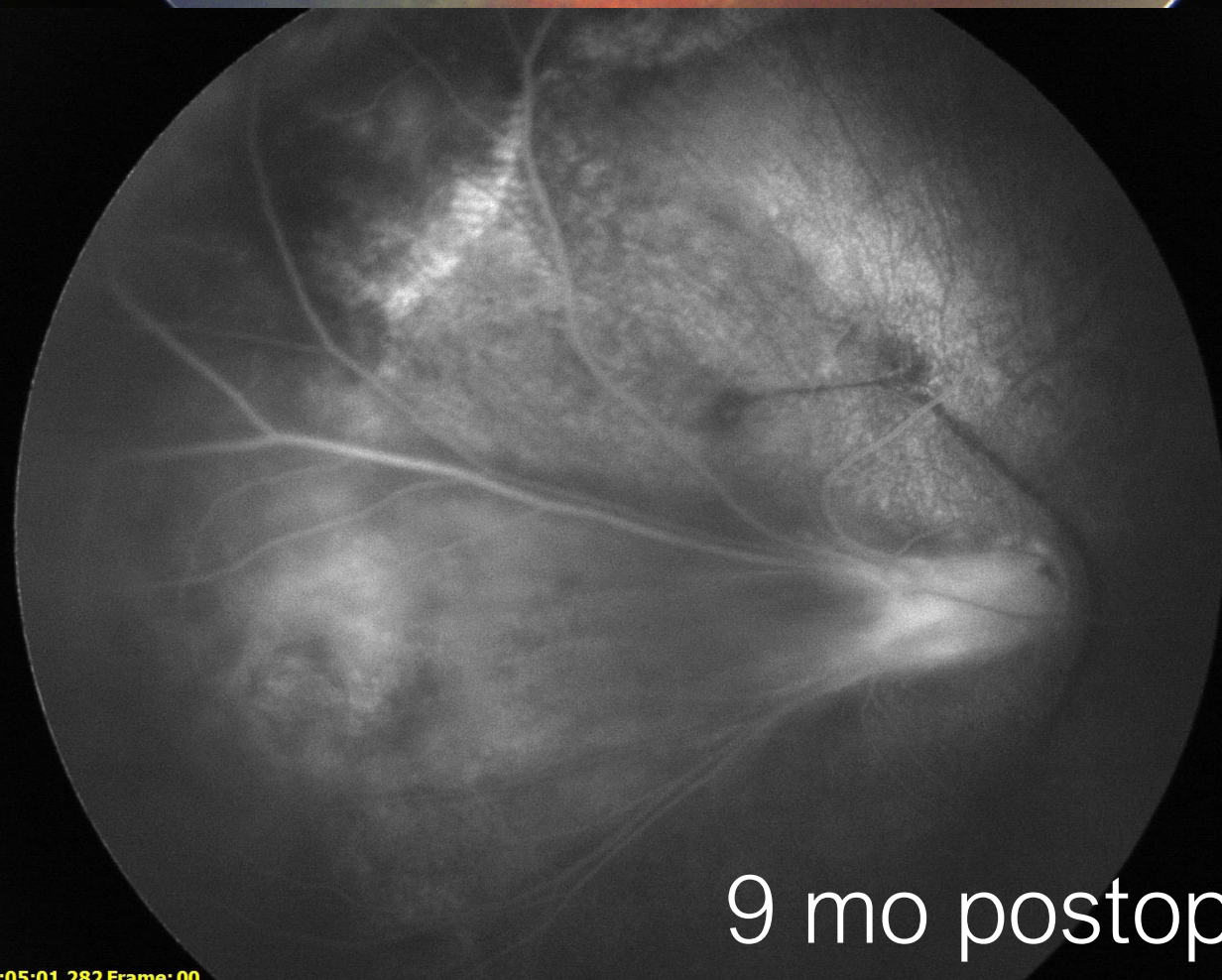
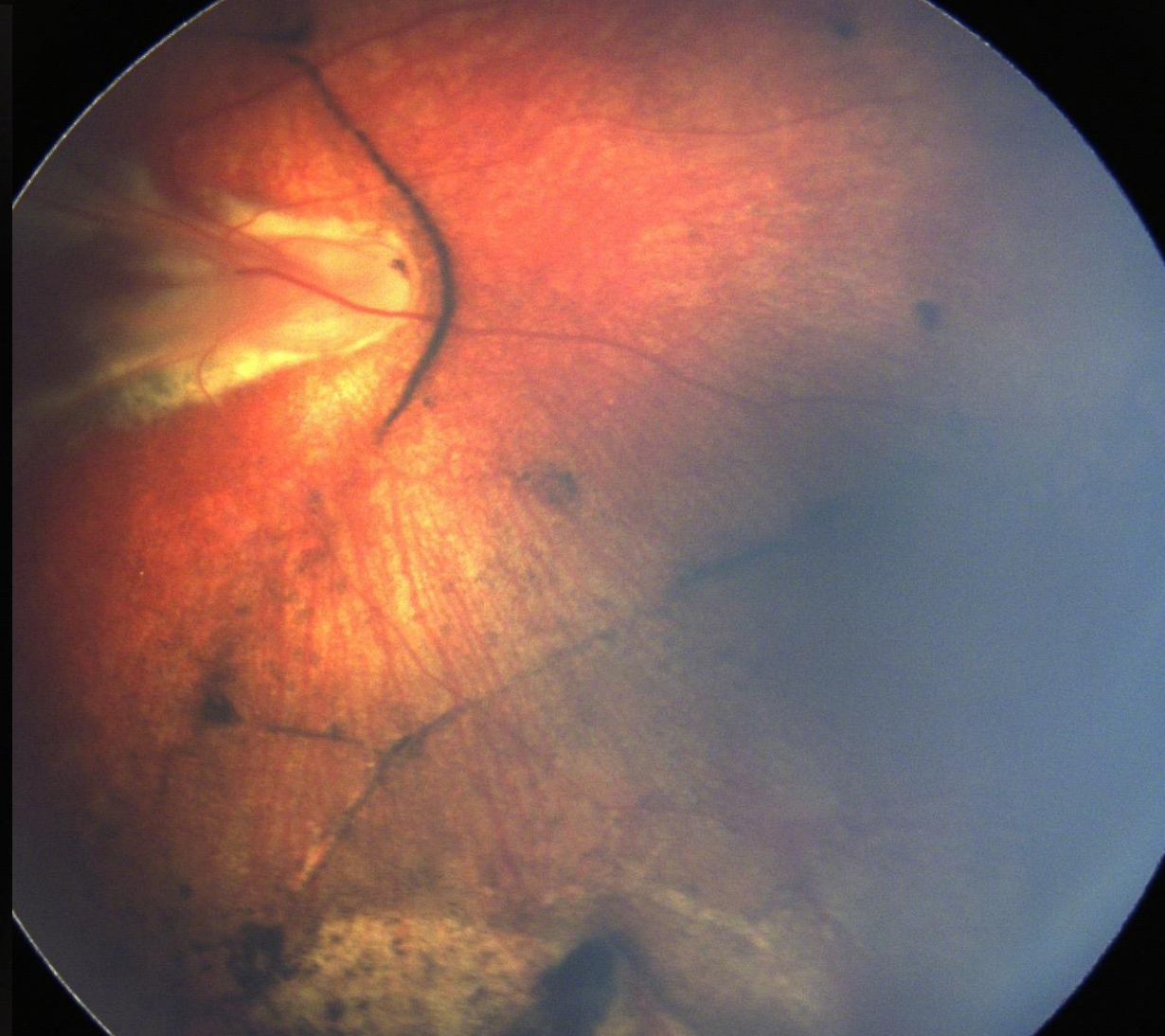
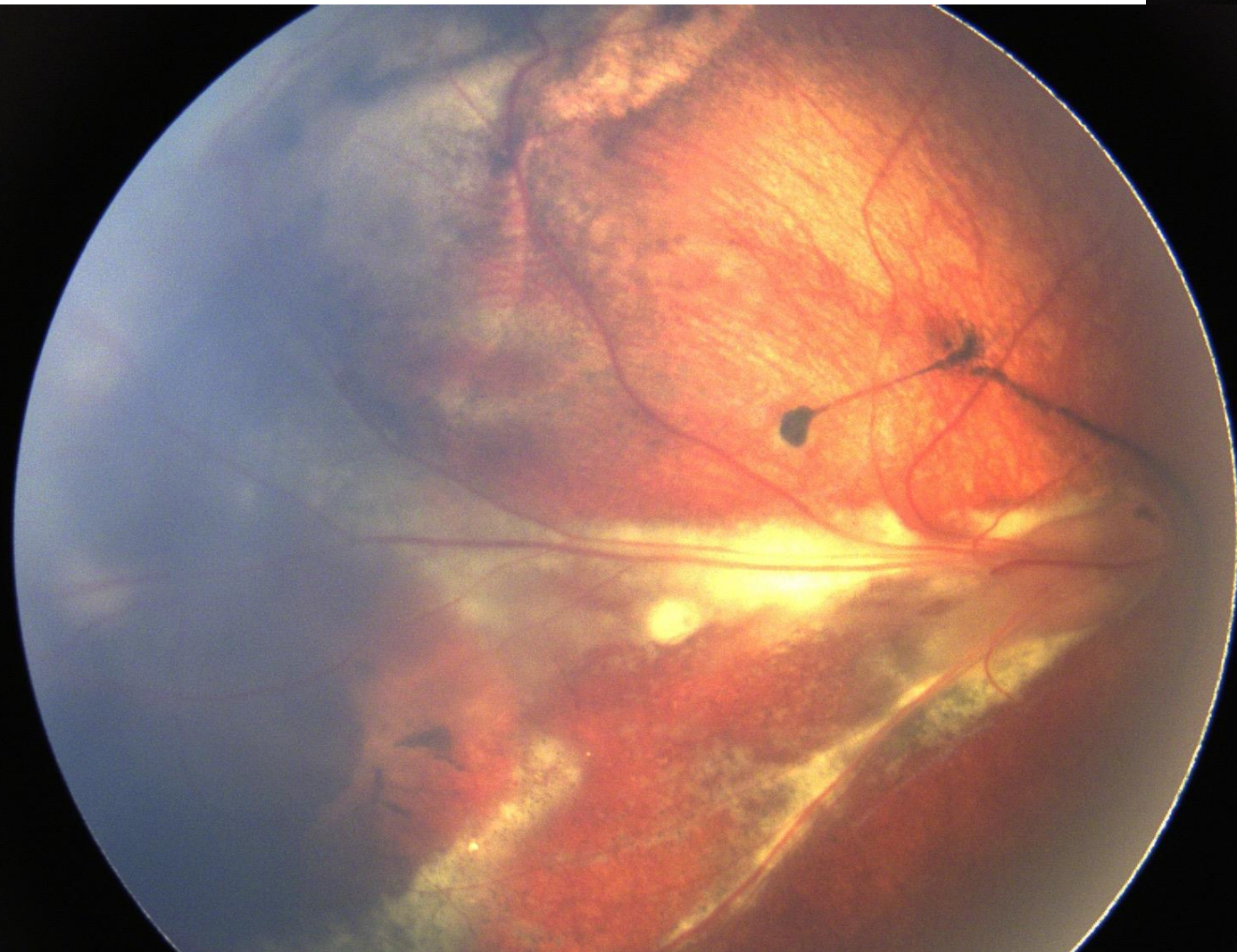


9 aylık E, Evre 4 Coats Drenaj Krio



9 aylık E, Evre 4 Coats Drenaj Krio

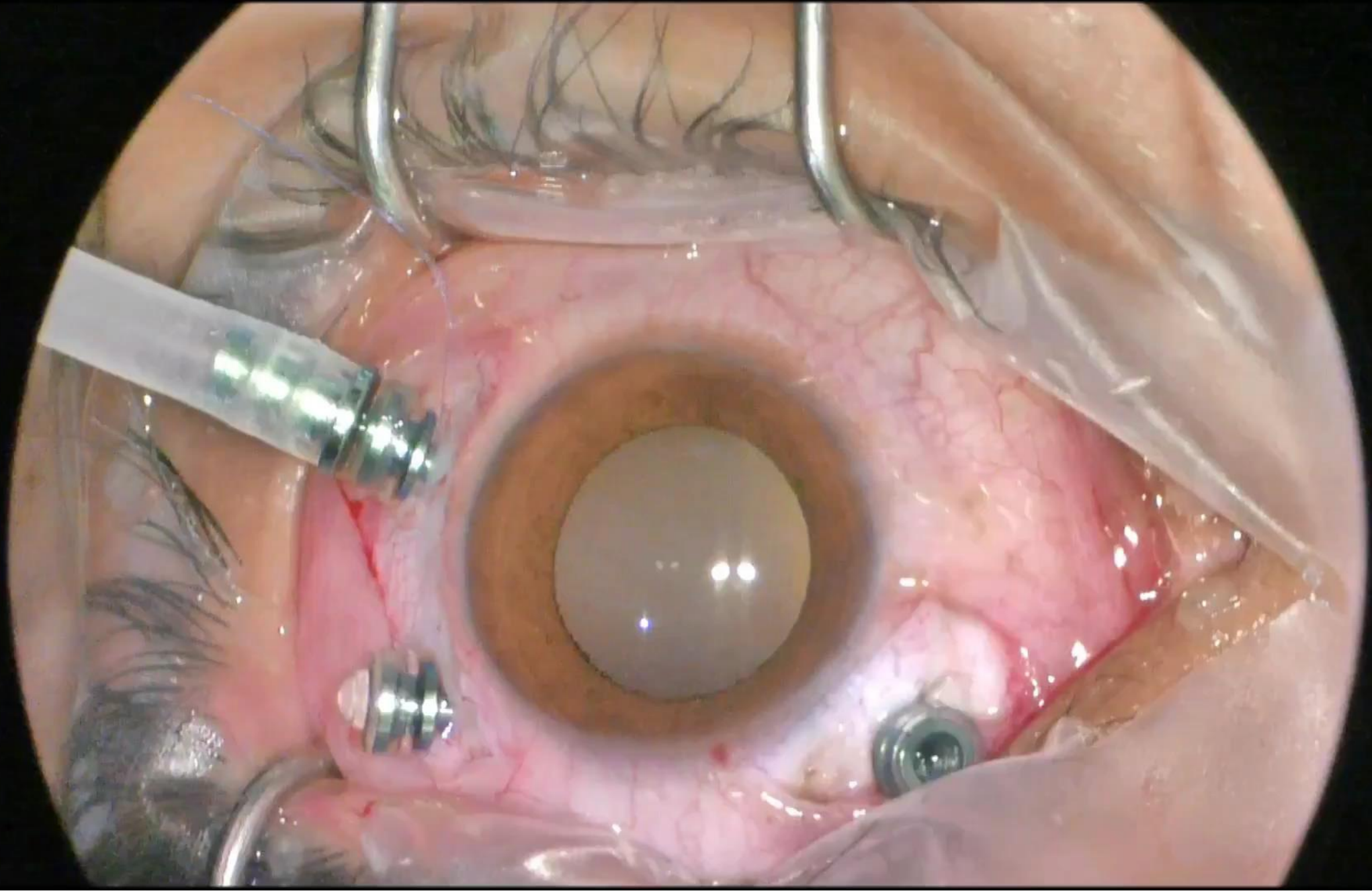


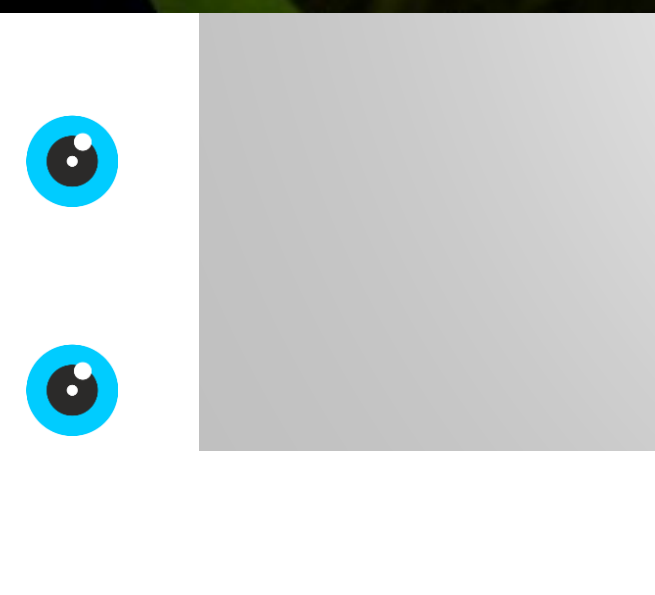
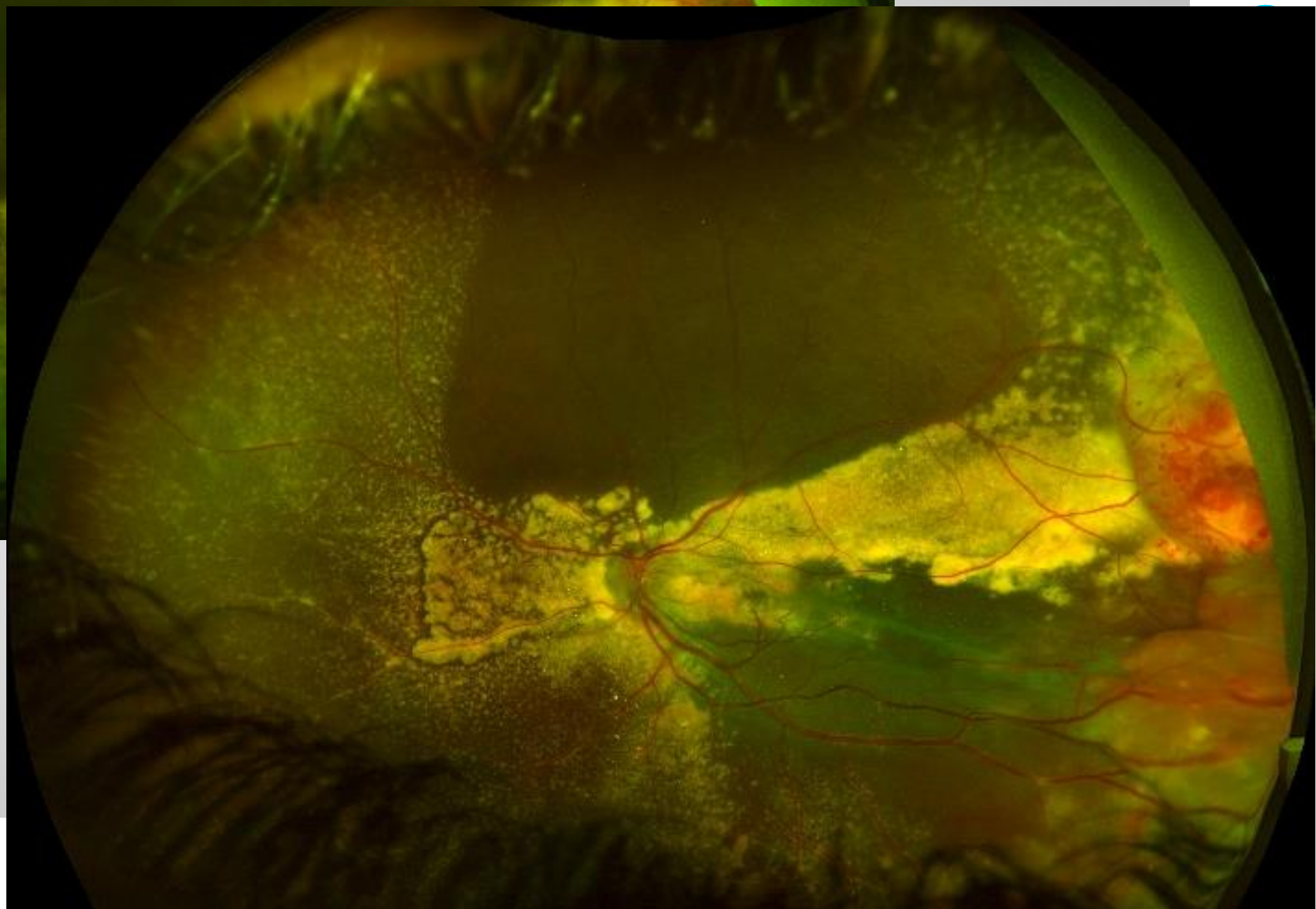
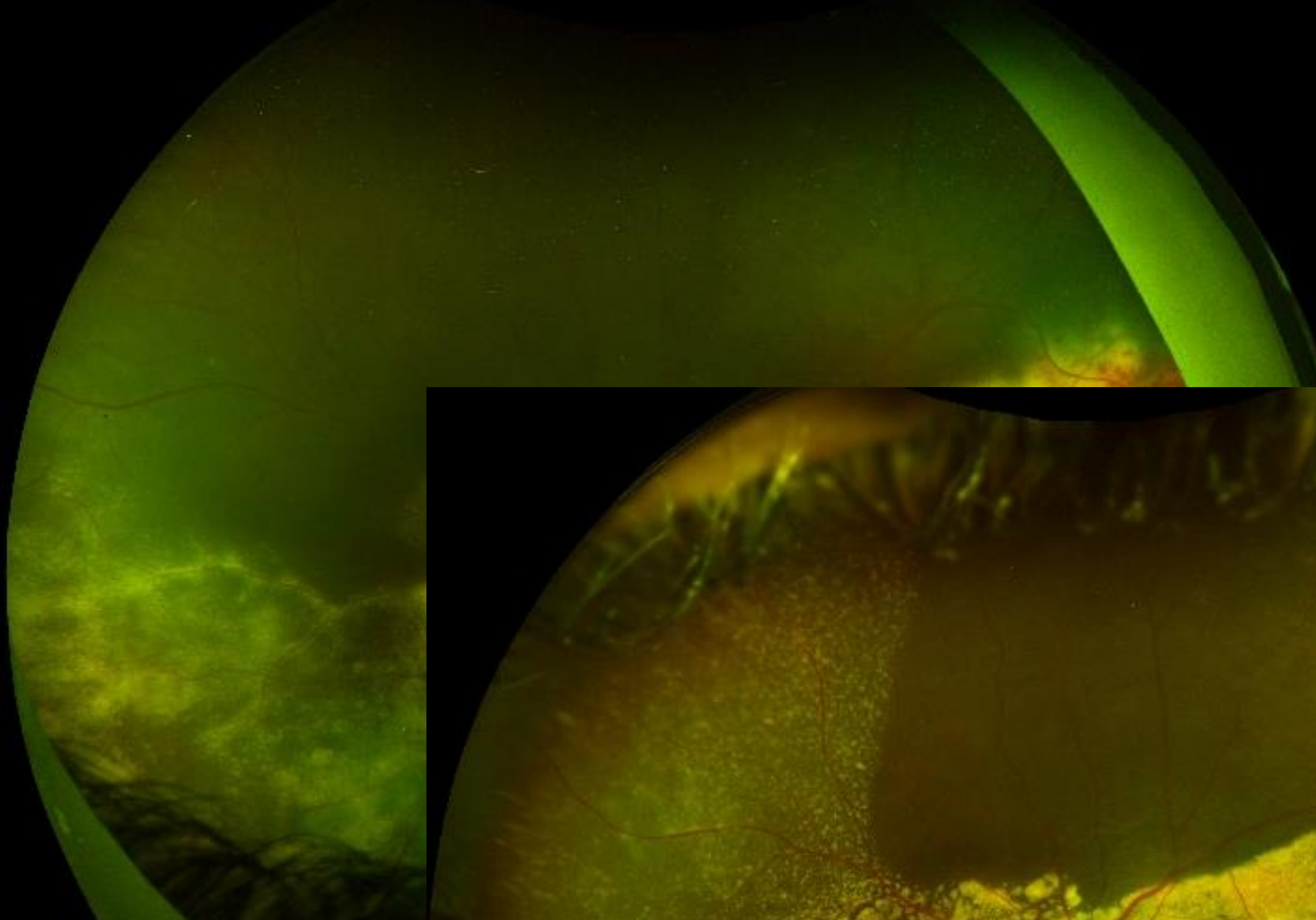


9 mo postop

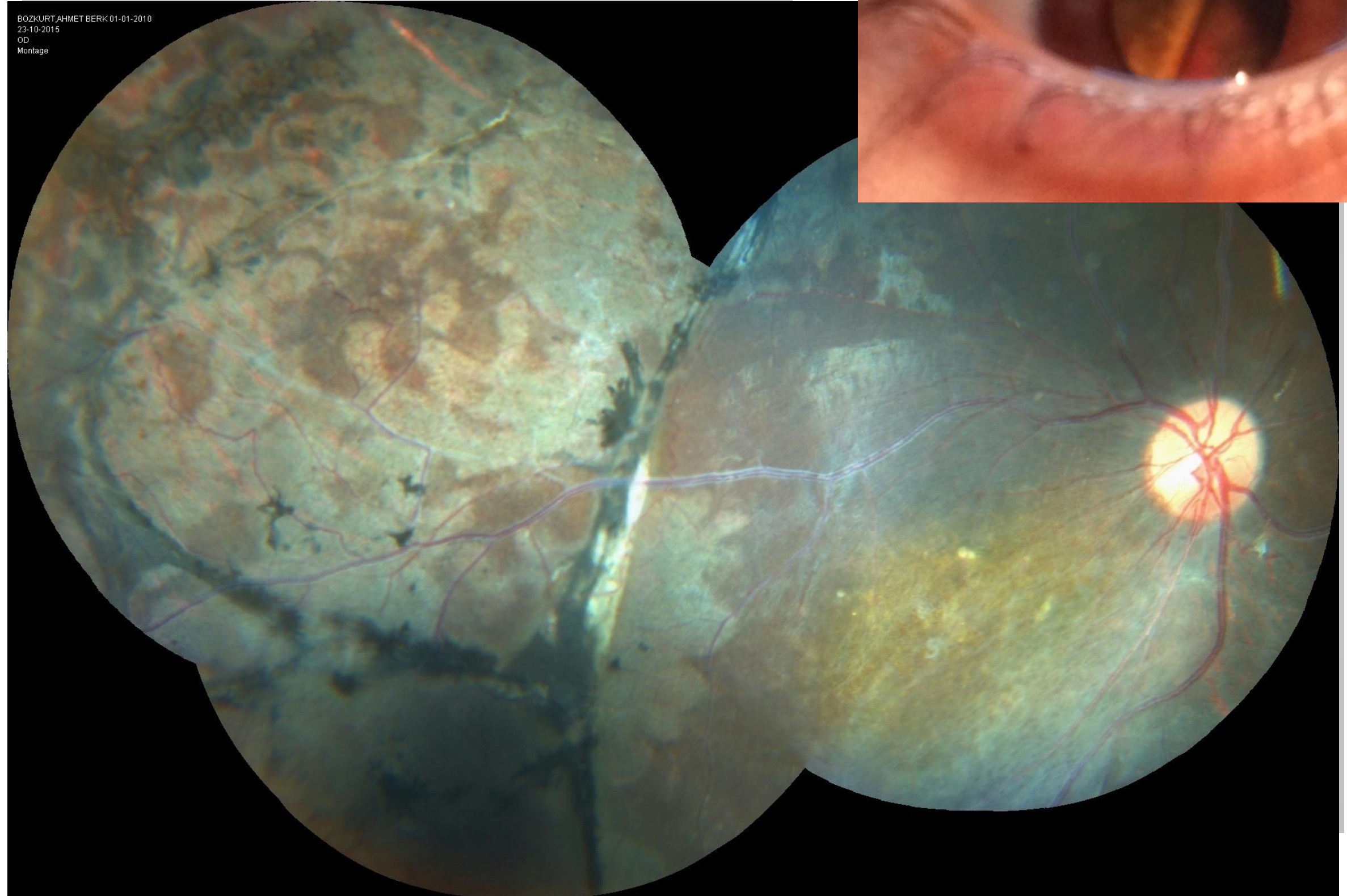


2y, E, Evre 4 Coats
TRD, PPV

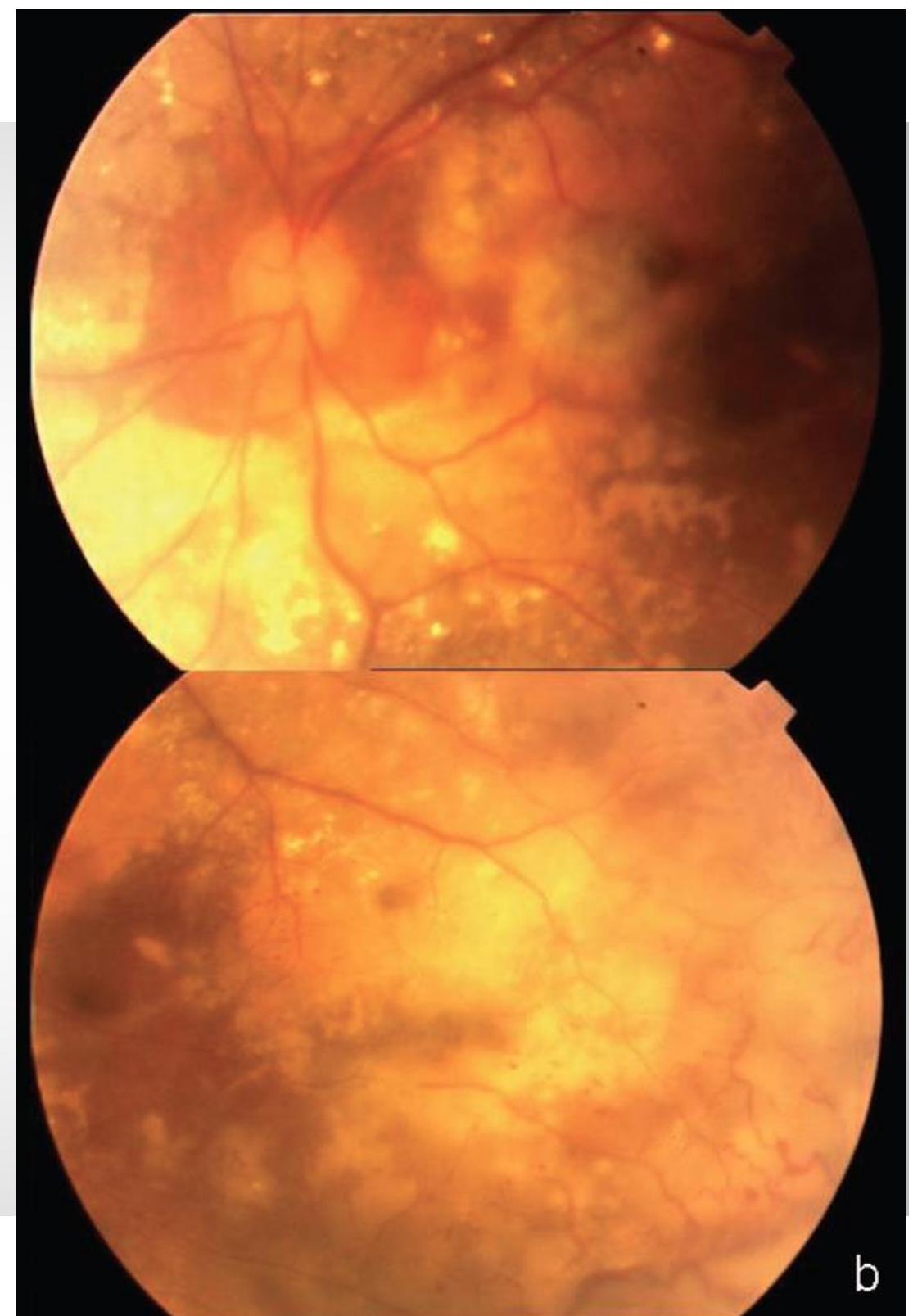
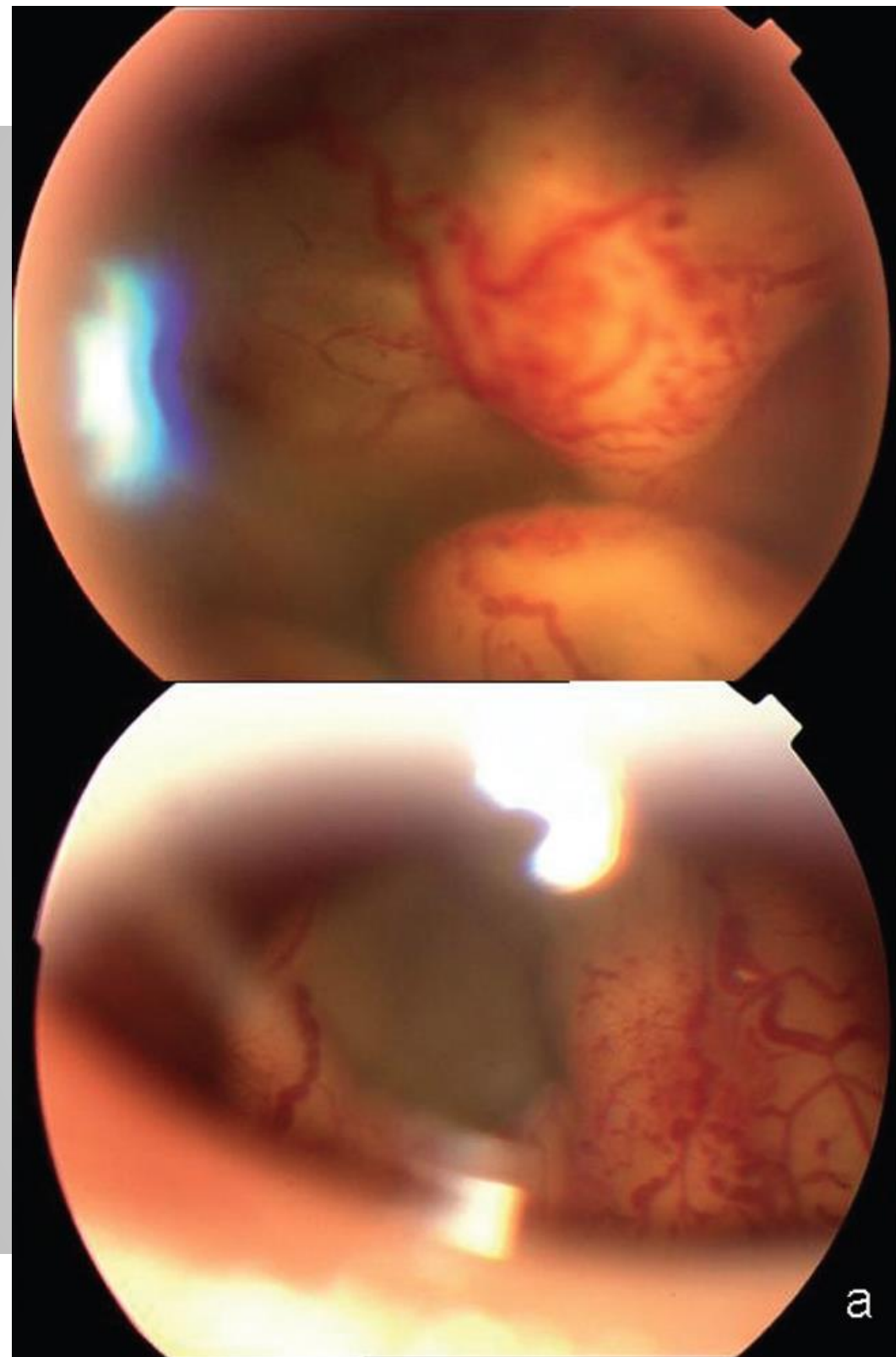




Stage 4 Coats

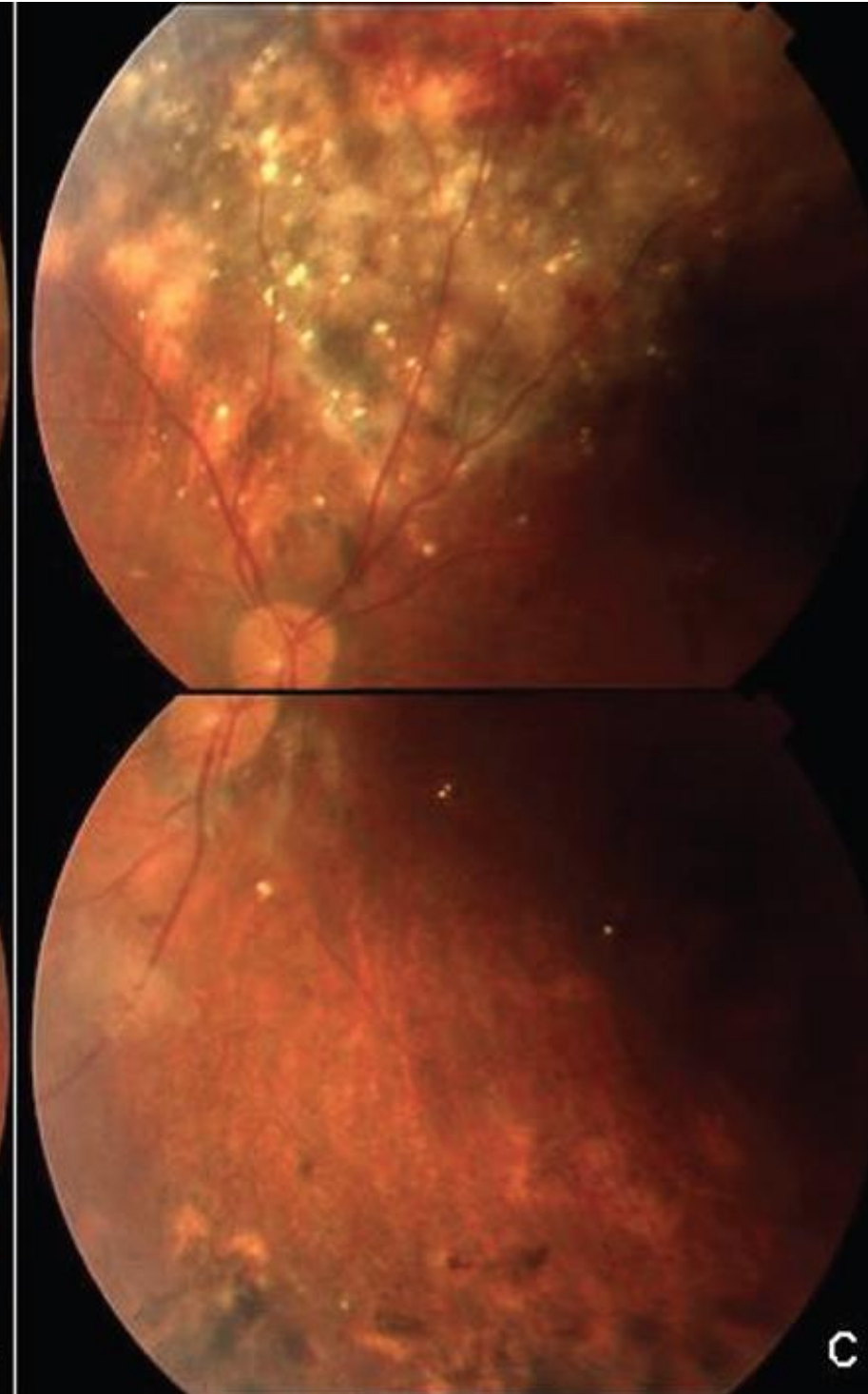
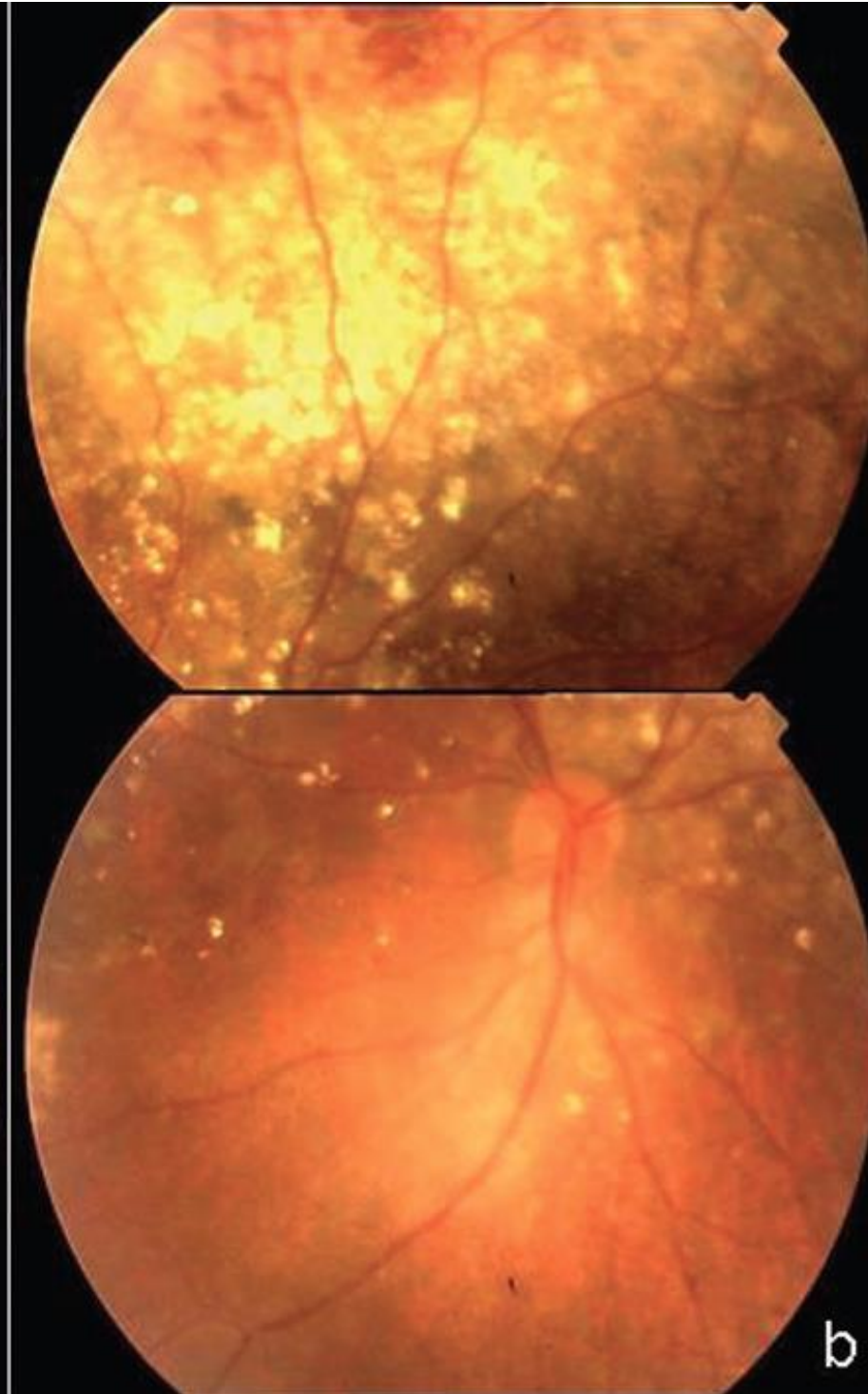
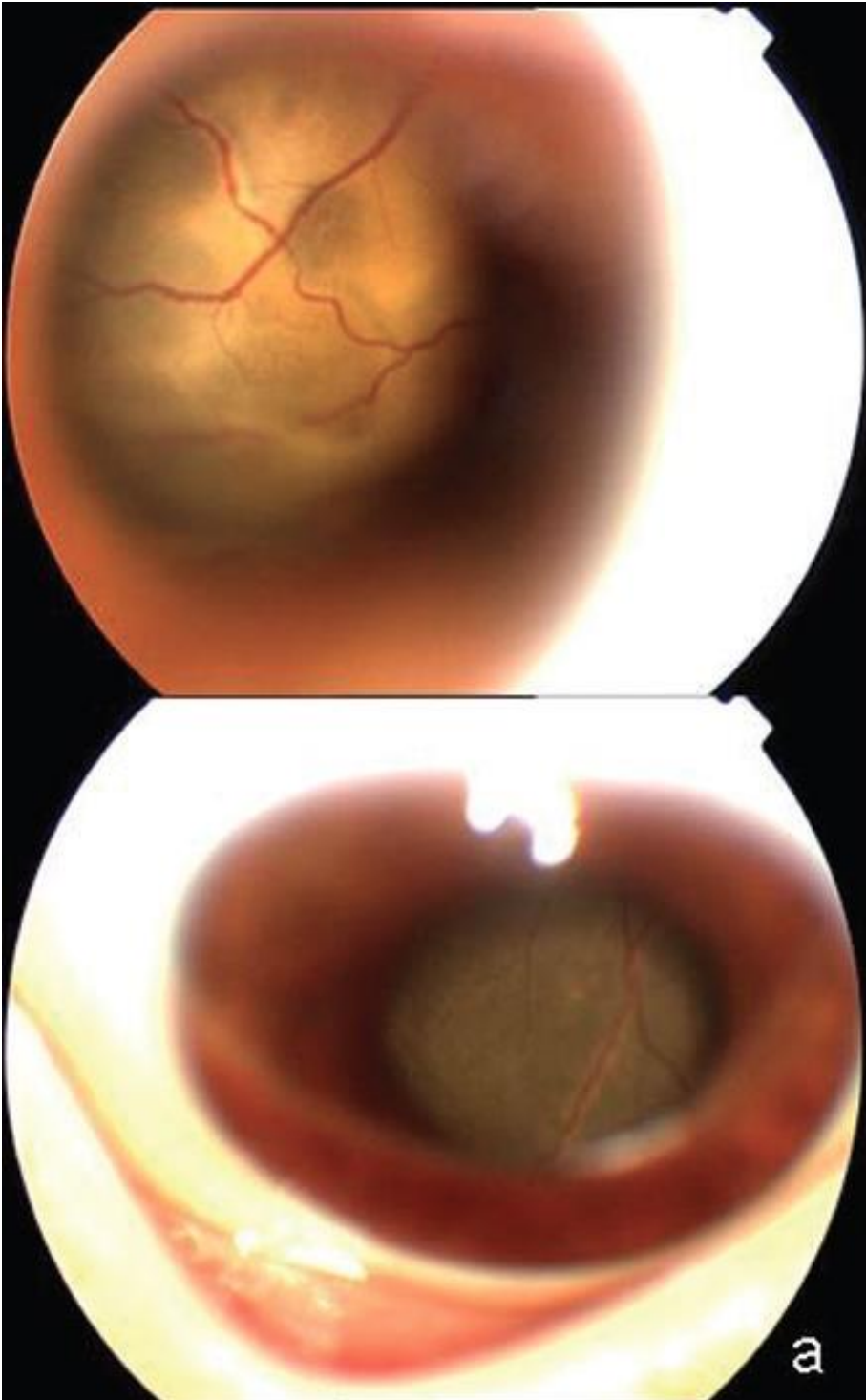


Ozdek S et al. Spontaneous Regression in Two Unusual Cases of Advanced Coats' Disease. J Pediatr Ophthalmol Strabismus. 2010 Mar 26:1-4.



COATS

4y, kız, lökokori

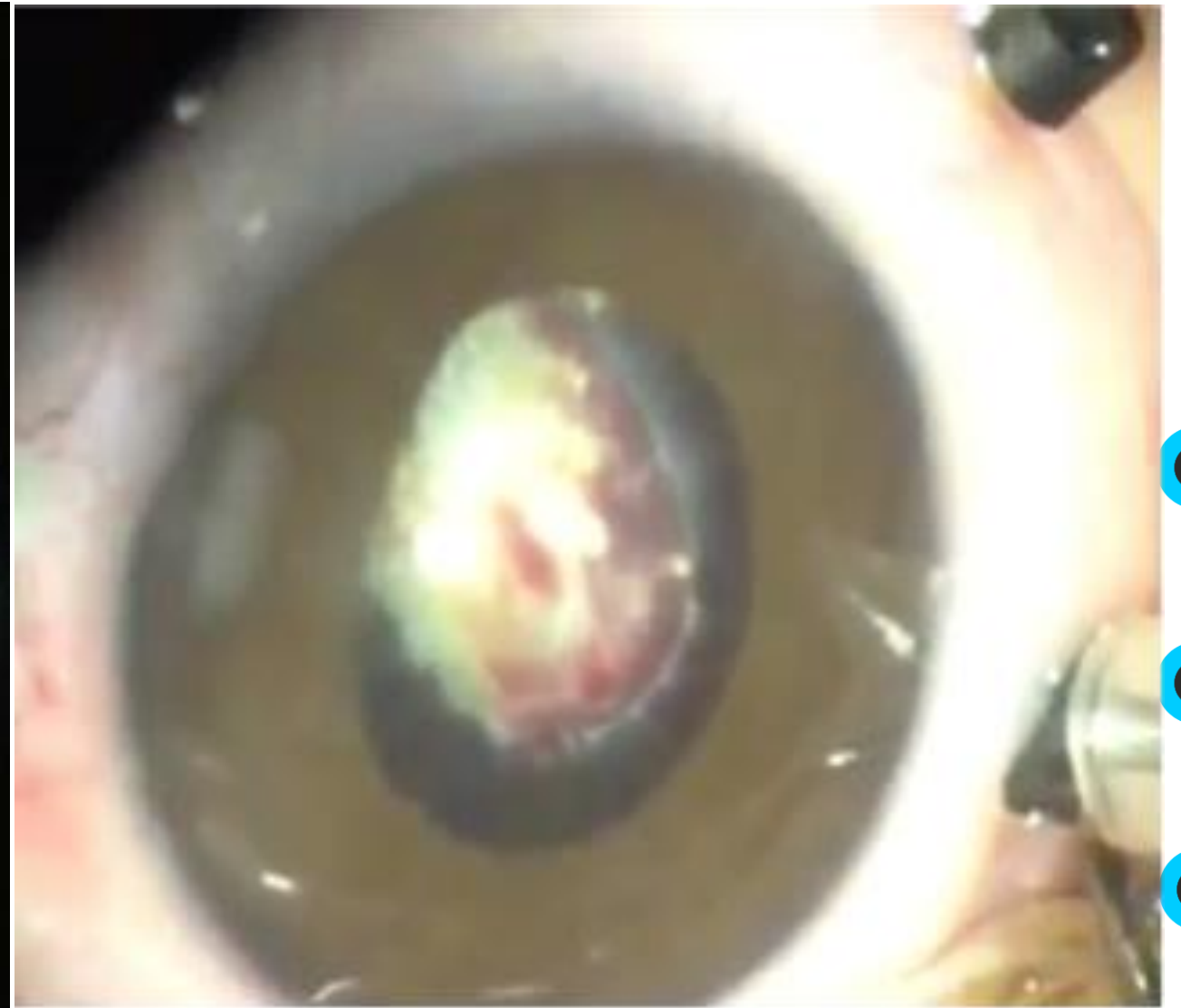
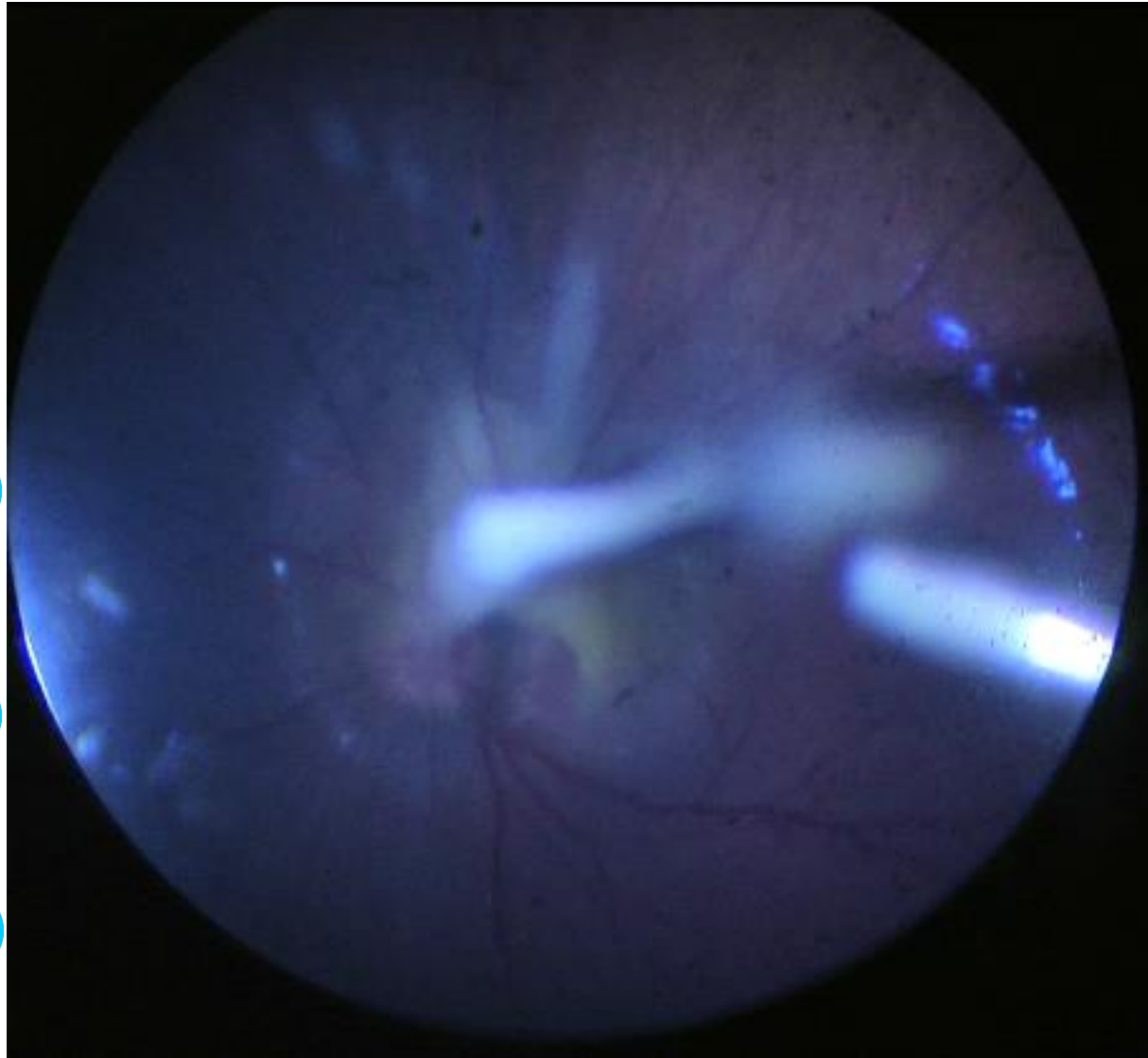


Mutlulukla gören ve gülen gözlere...



TEŞEKKÜRLER

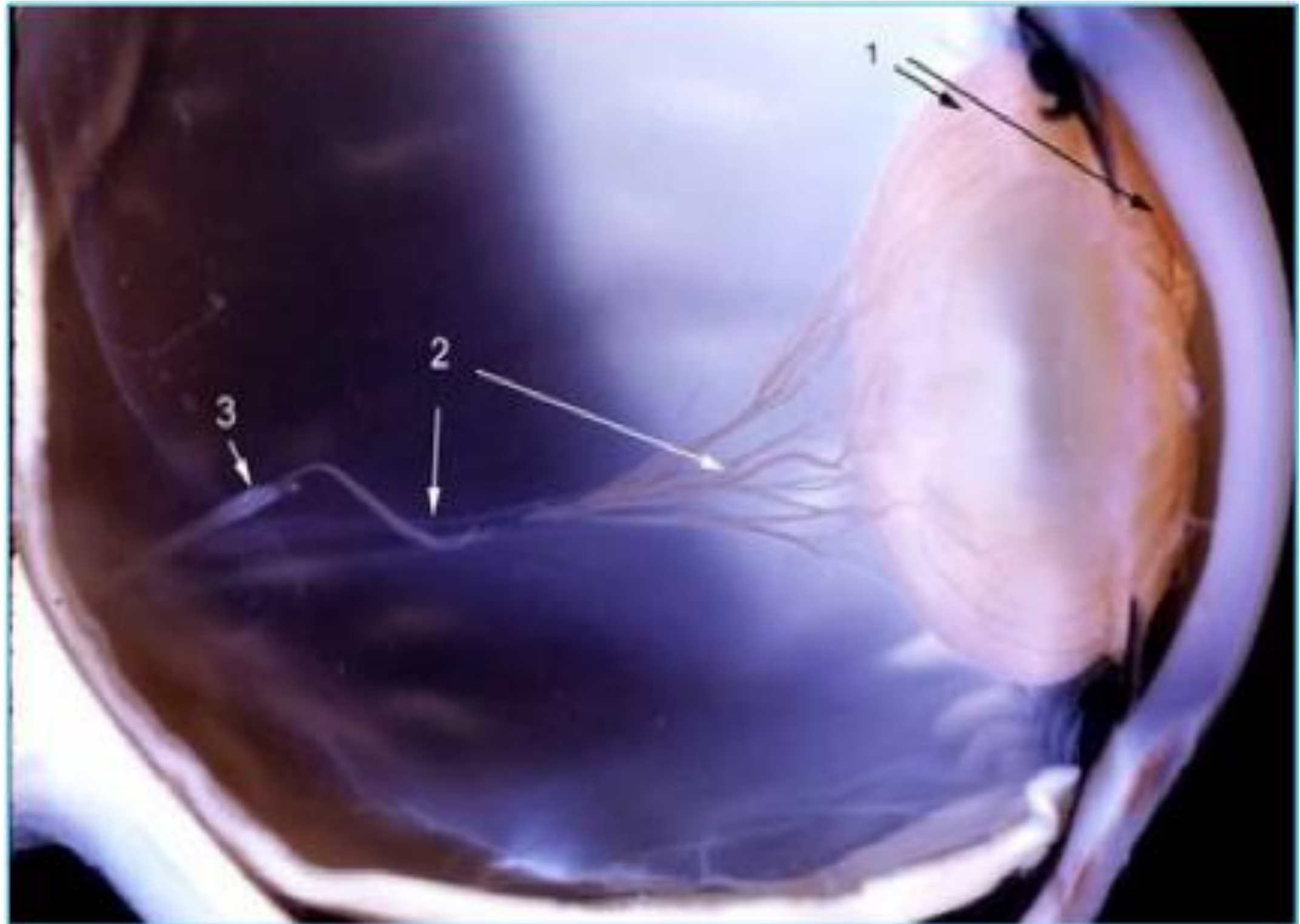




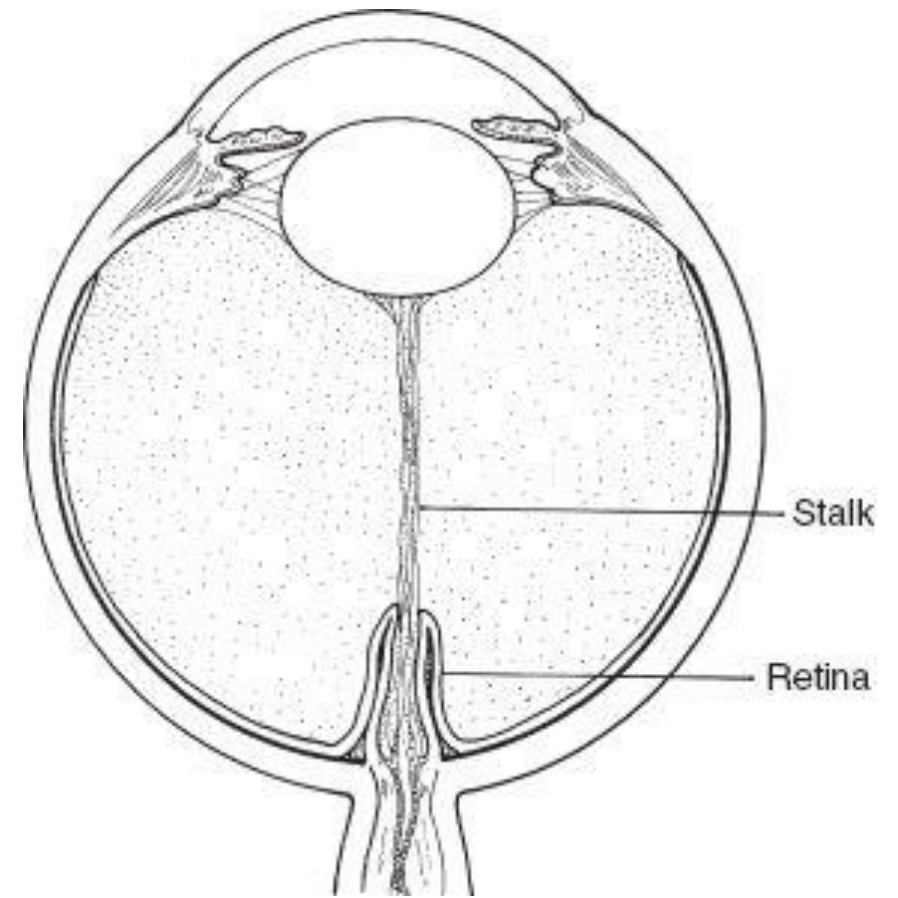
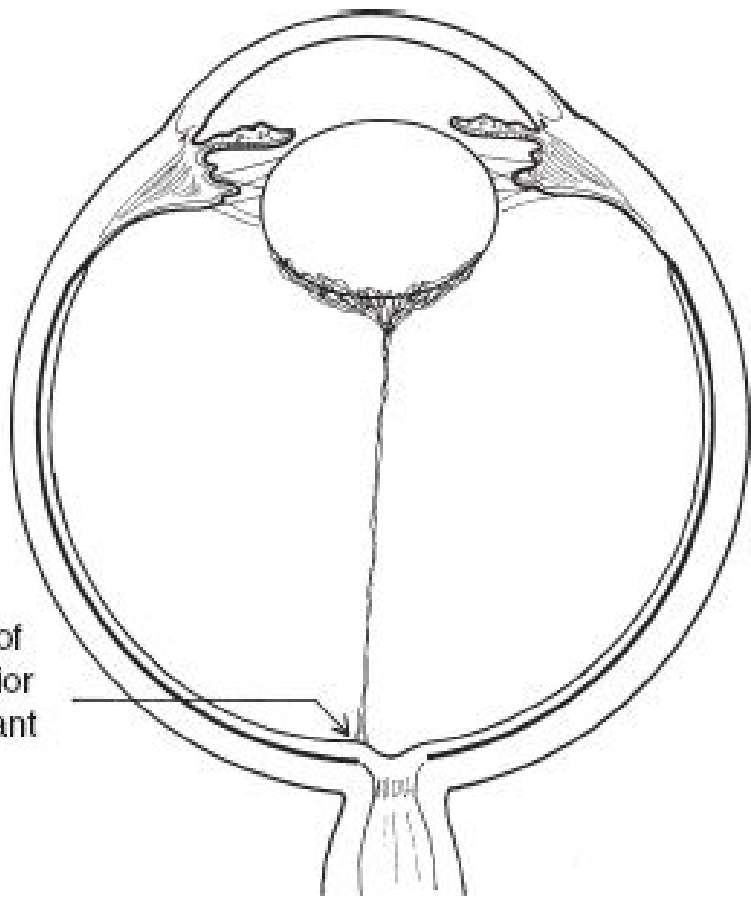
PFV

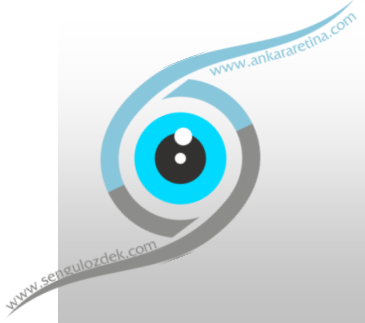


PFV



PFV





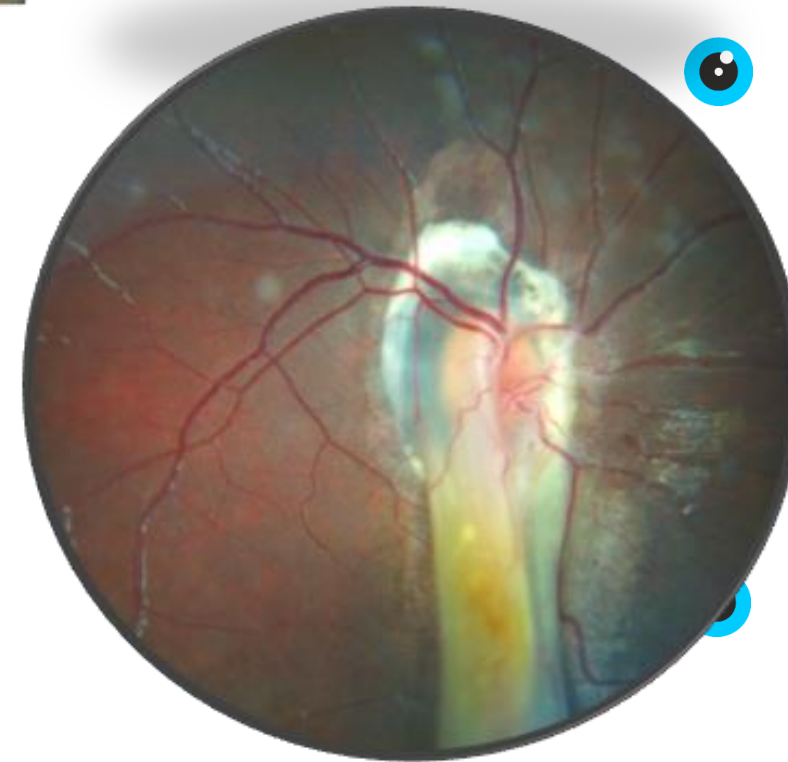
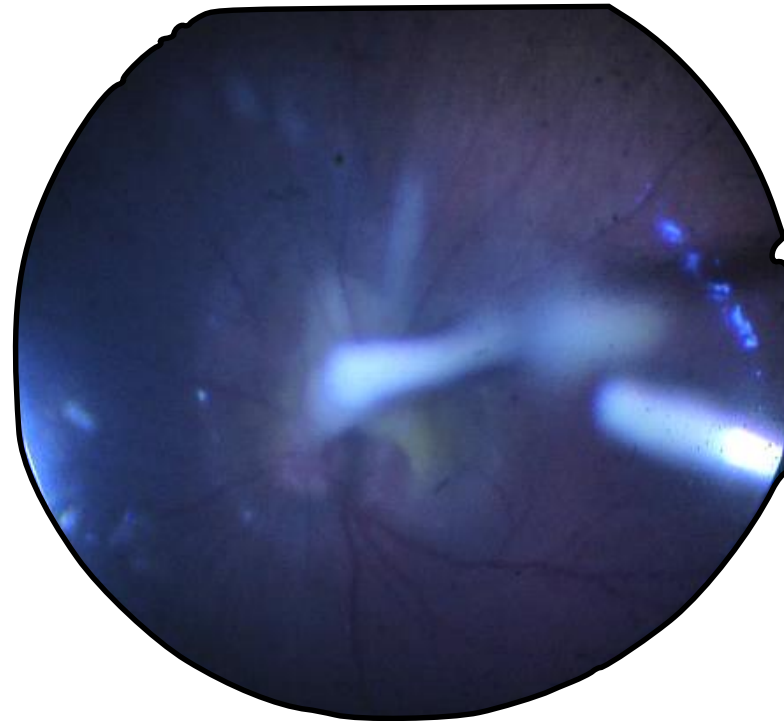
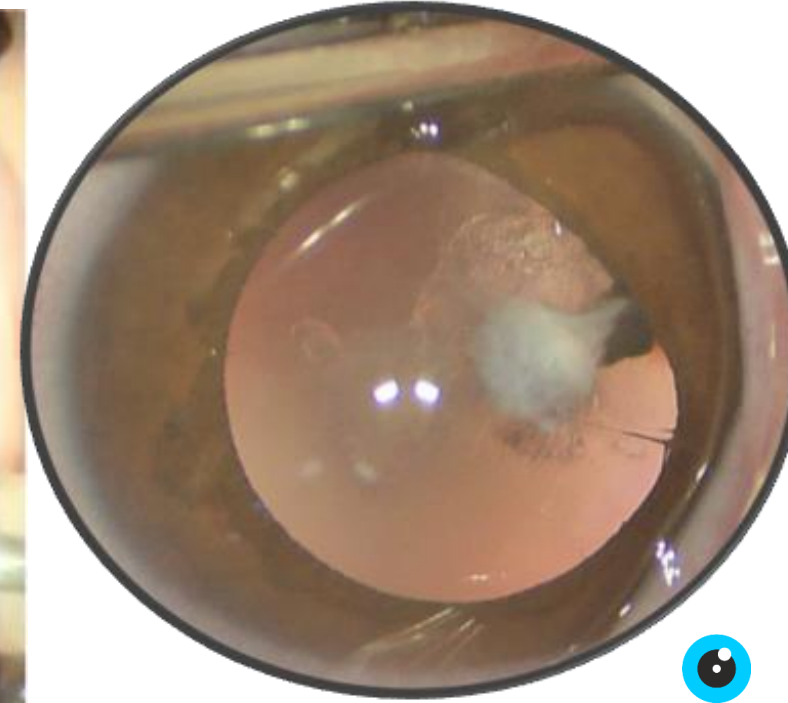
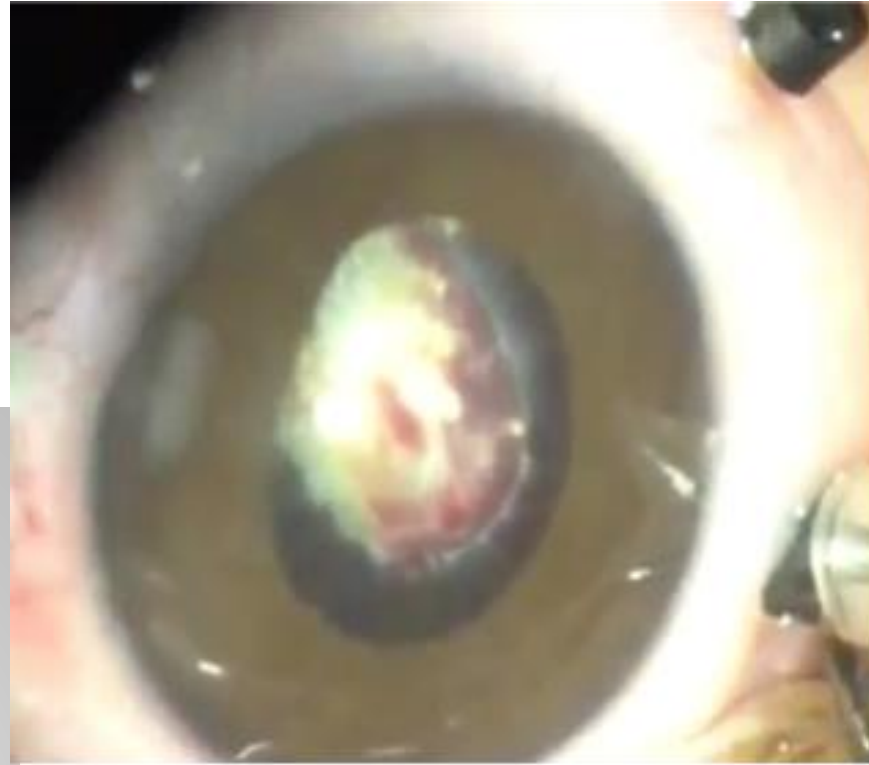
PFV

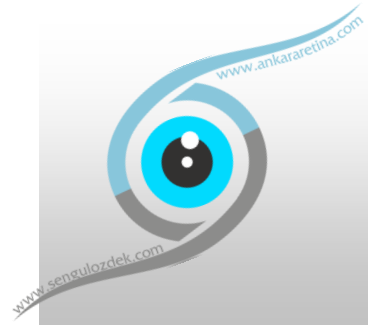
Anterior

Posterior

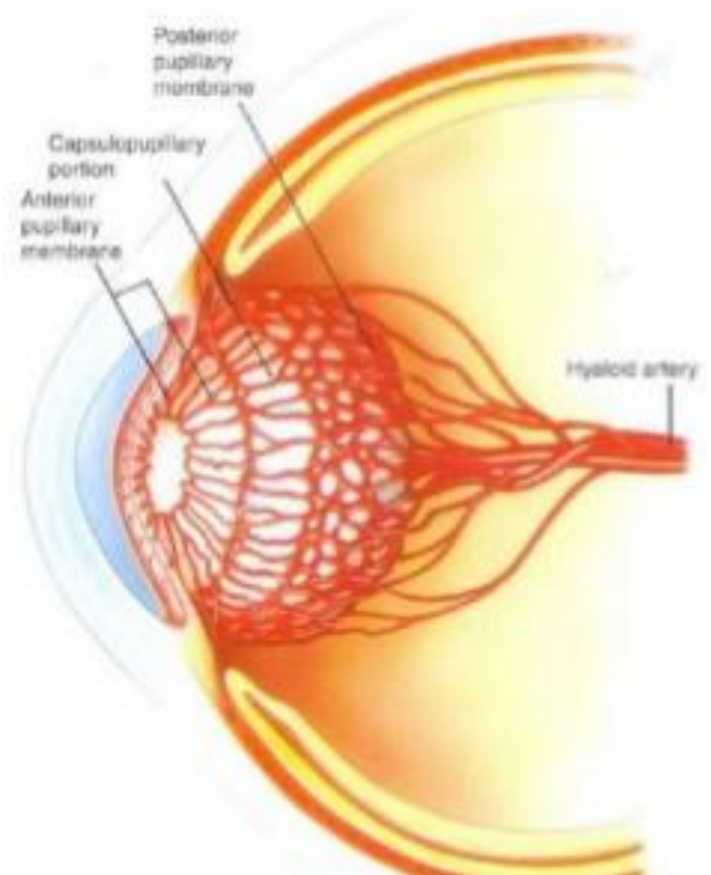
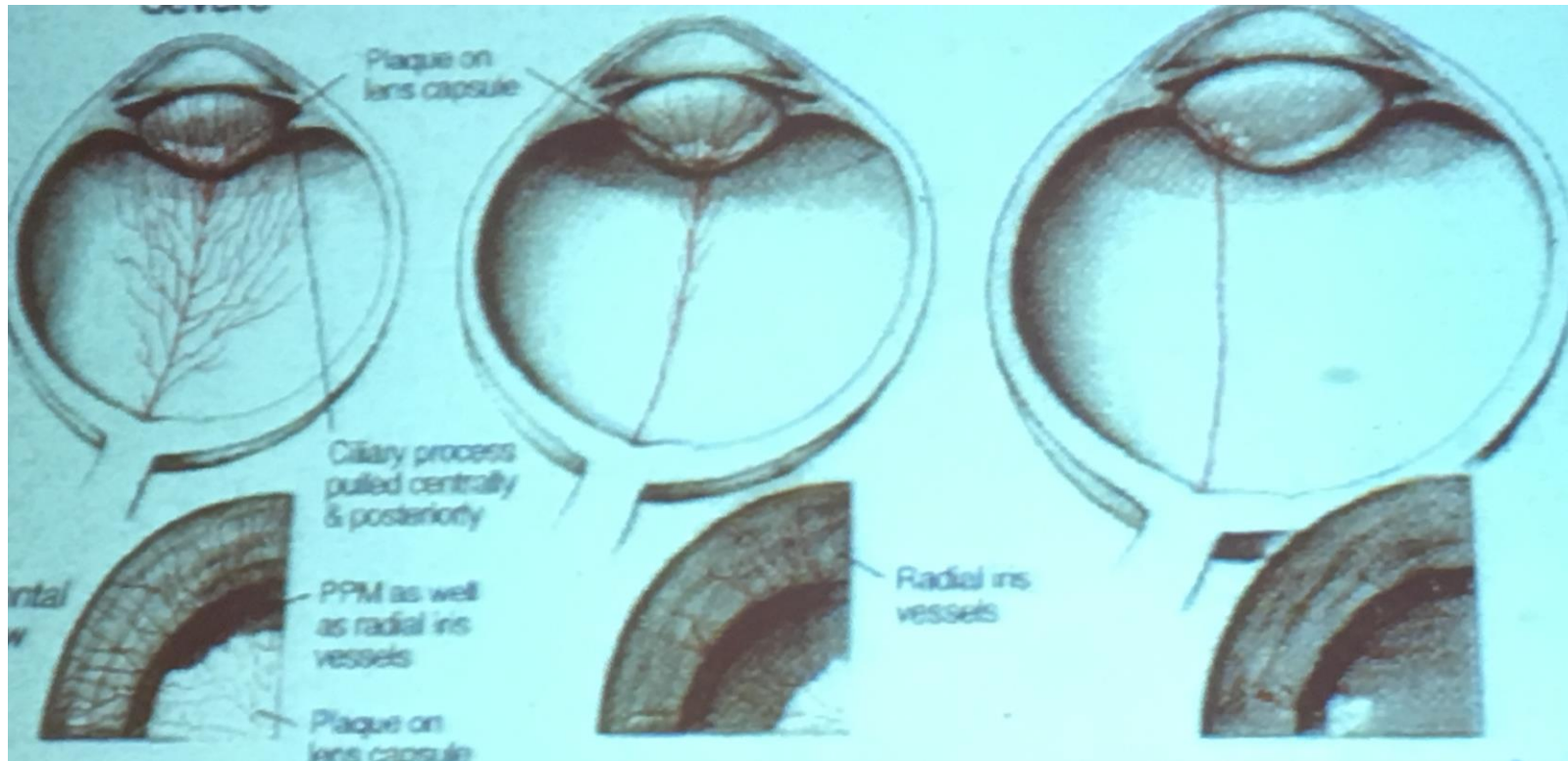
Mixed

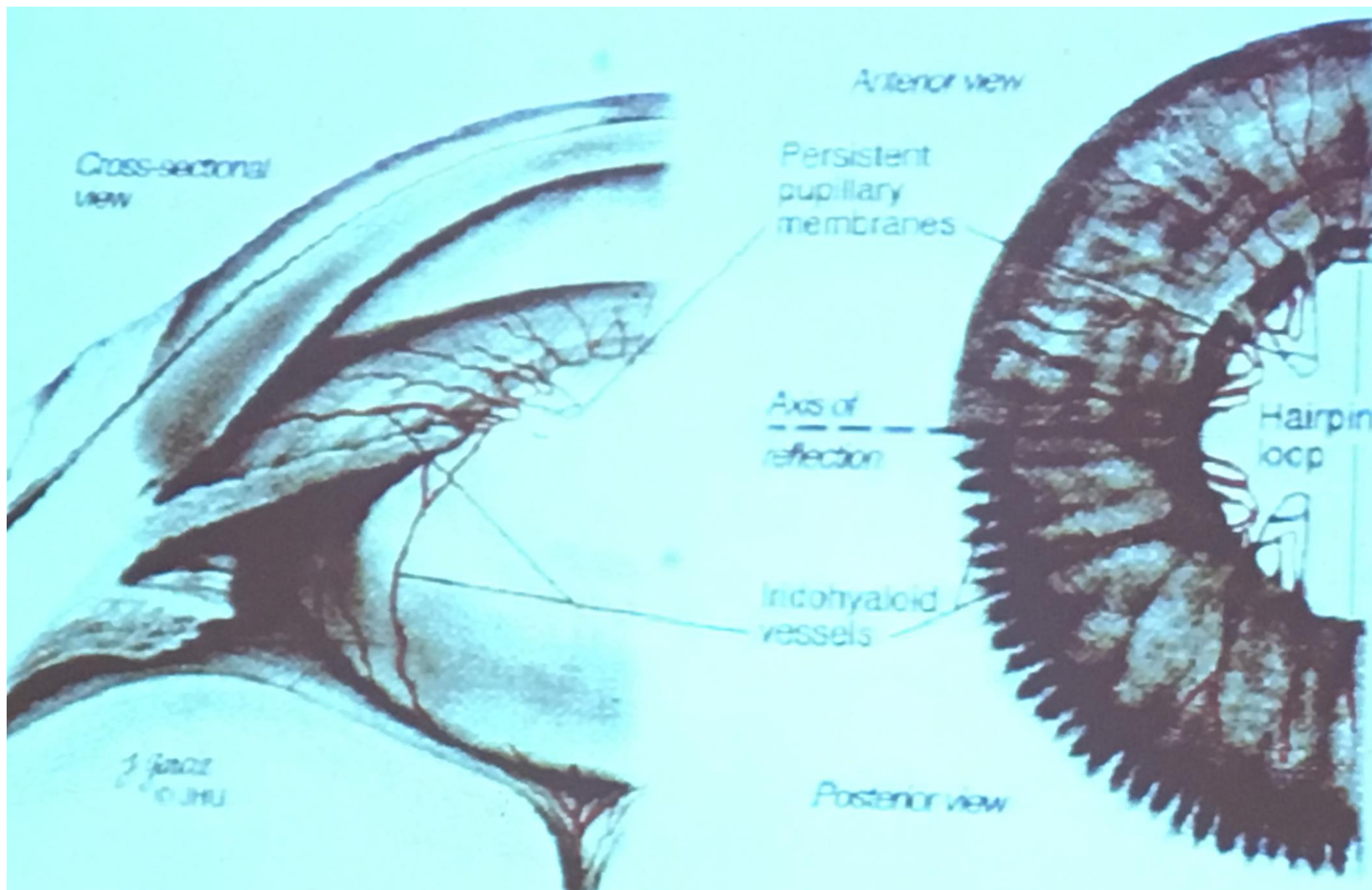
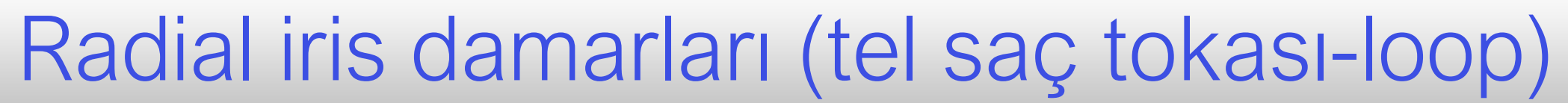
Diğer retinal patolojilerle
kombine (Peters,
Kolobom etc)





PFV-anterior





PFV Cerrahisinin amaçları

Anatomik ve fonksiyonel olarak kabul edilebilir sonuçlara ulaşmak

- Ortam opasitesini kaldırmak: ambliyopiyi önlemek
- Traksiyonel güçleri gevşetmek
 - TRD, glokom ve FB gelişimini engellemek,
 - Göze büyüme şansı vermek

PFV Cerrahisinin amaçları

GÖZ BÜYÜR! FİBROTİK DOKU BÜYÜMEZ!

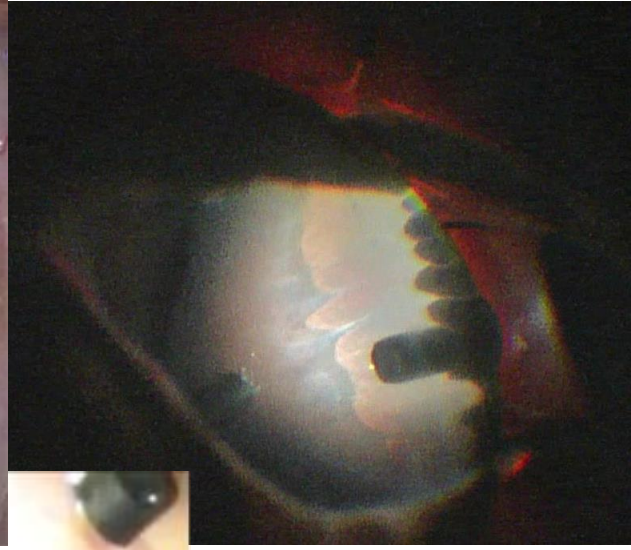
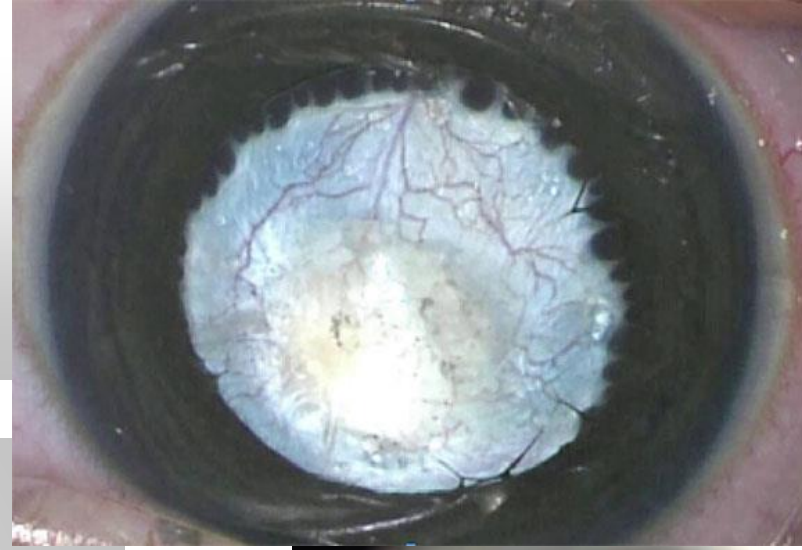
TRAKSİYONEL GÜÇLERİN ARTMASINA NEDEN OLUR

KOMPLİKASYONLAR (GLOKOM, FB, TRD)

Anterior PFV

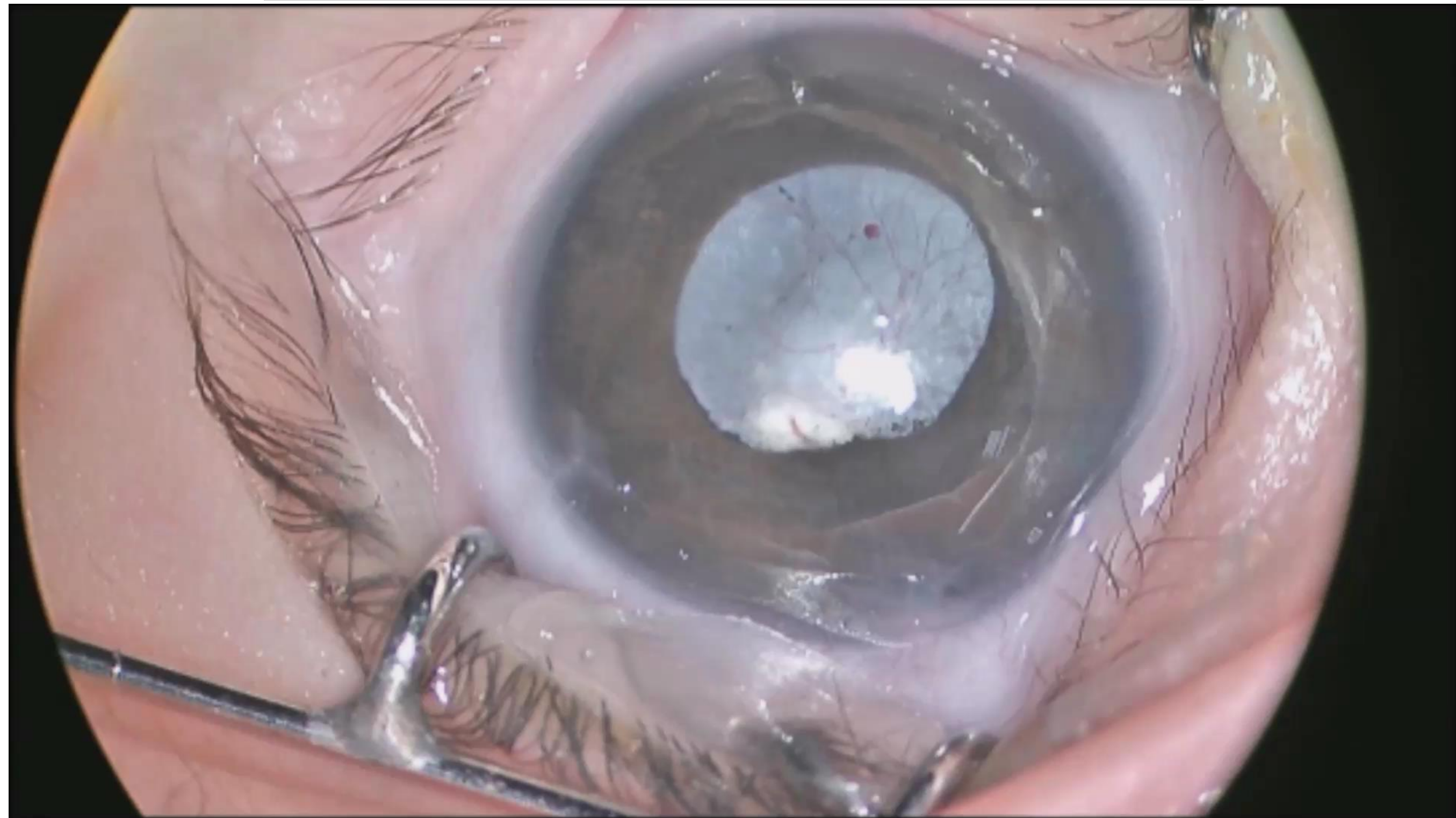
Anatomik farklılıklar

- PP gelişmemiştir,
- Zonuller yoktur,
- Silier prosesler uzamıştır.

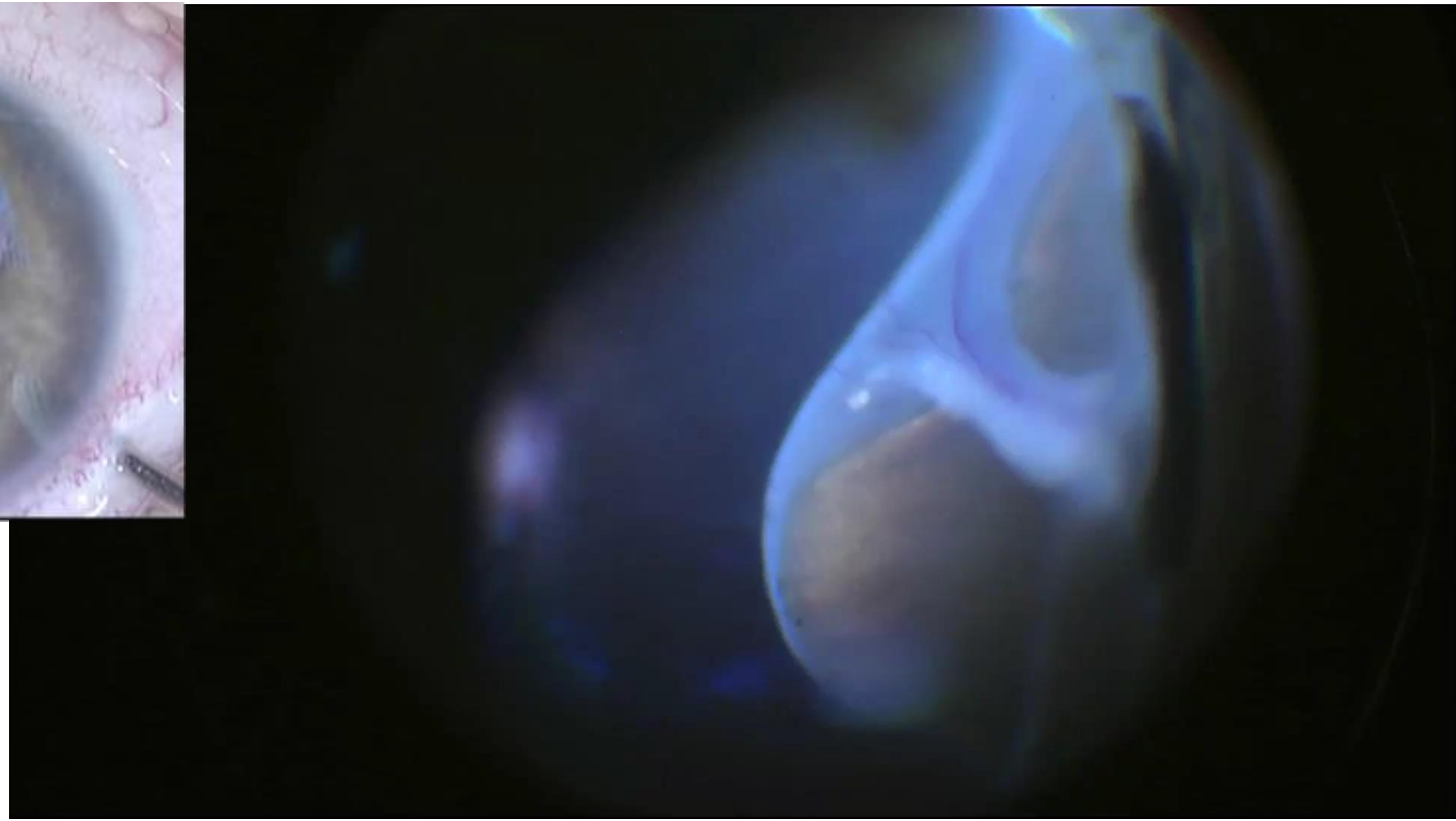
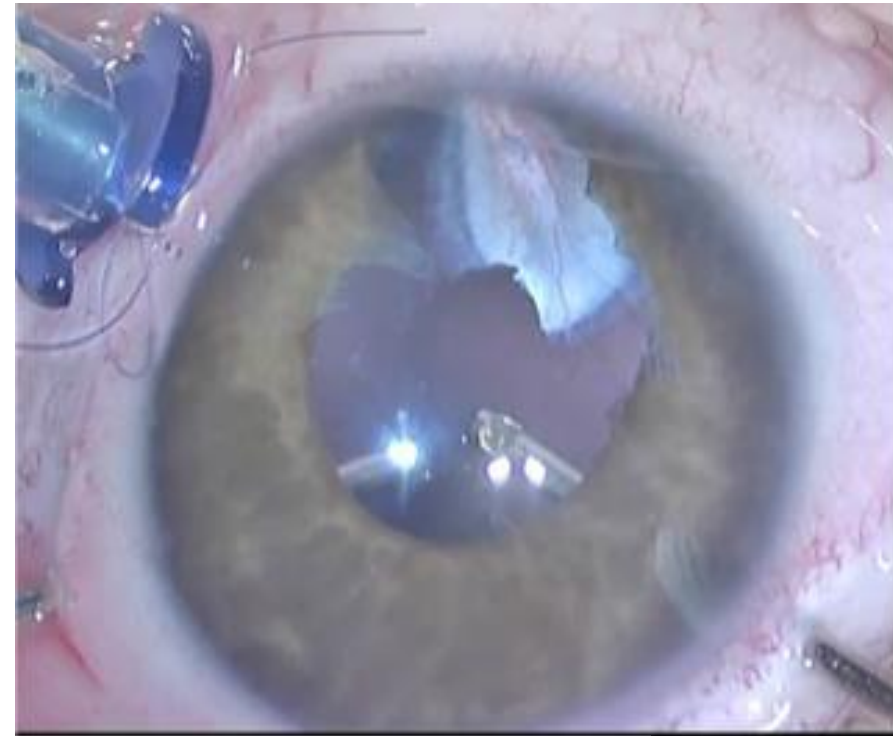


Anterior fibrovasküler plak retina ile devamlılık gösterebilir!.....

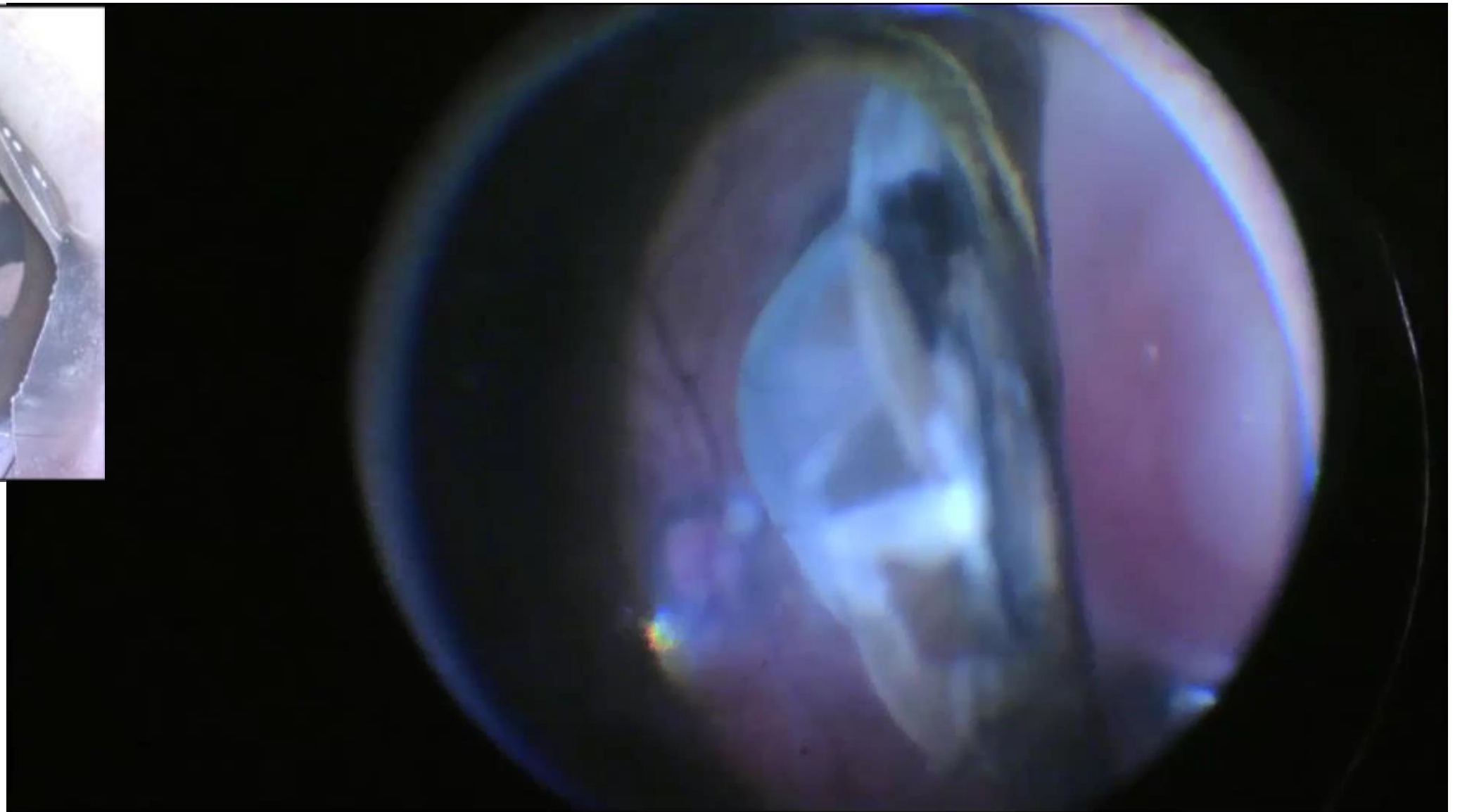
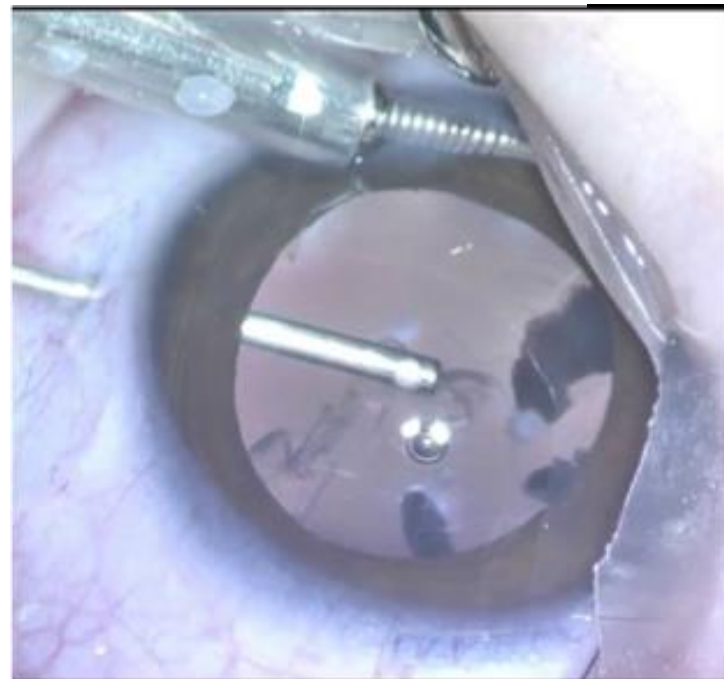
PFV-Kötü sürpriz!



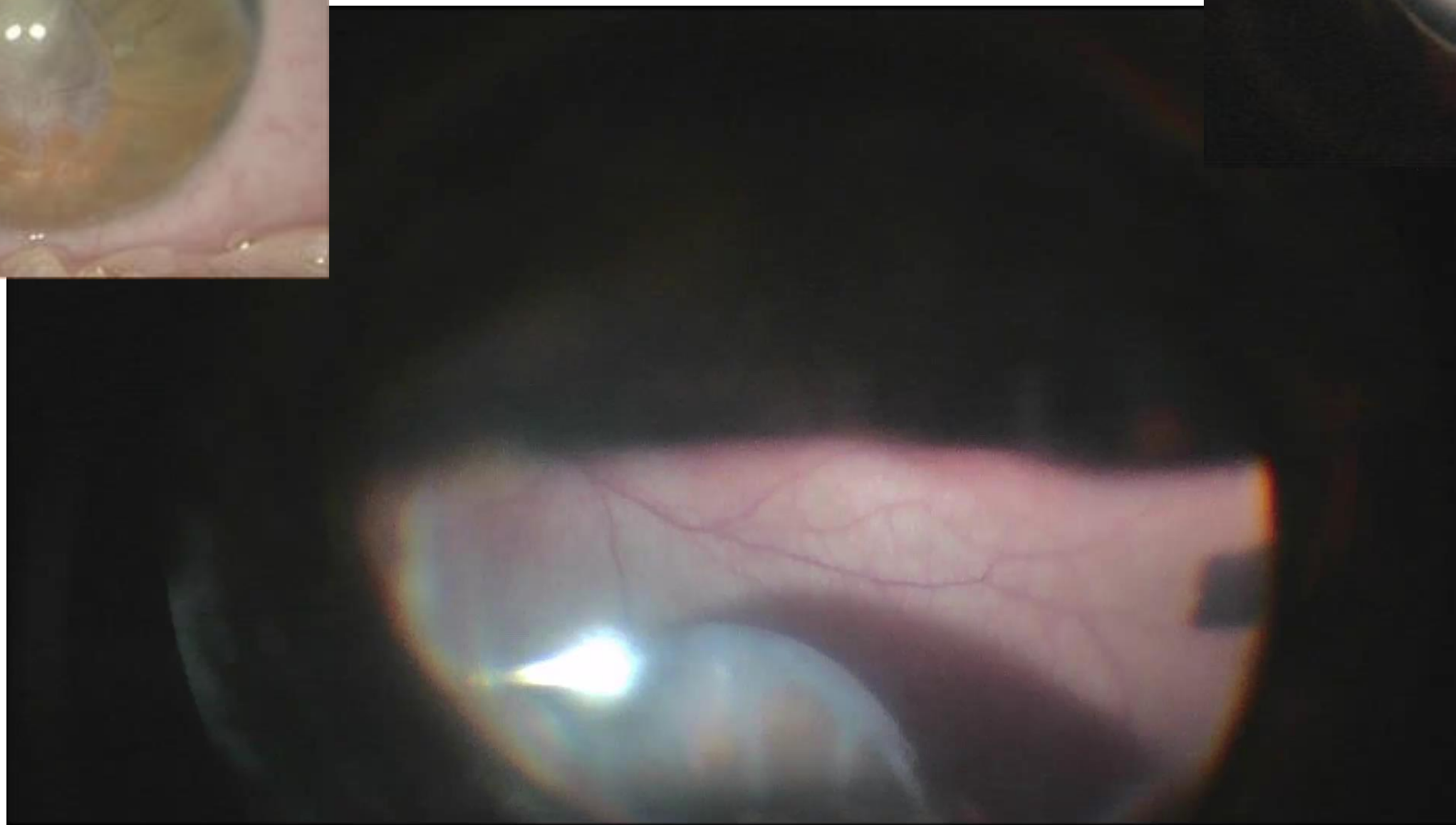
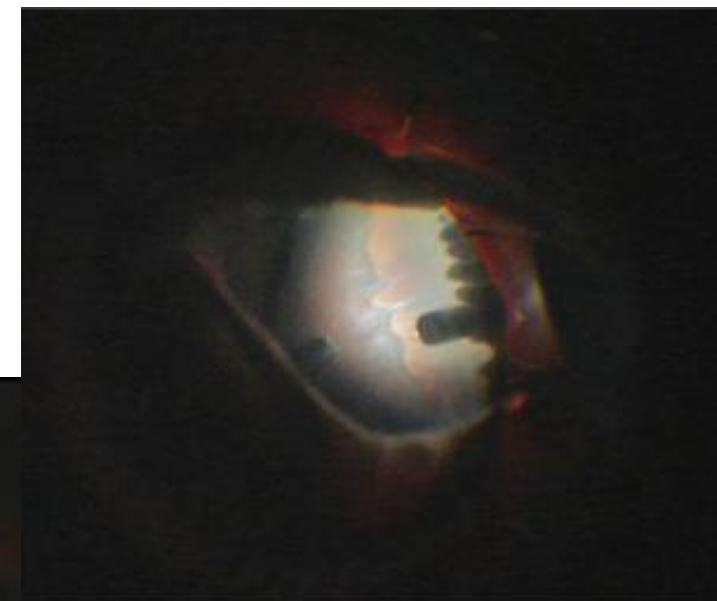
PFV-anterior retinal uzanim
fibrovasküler plak ile devamlı olabilir



İpuçları: Pigmente plaklara dikkat!
Nazal ve inferior bölgede daha sık

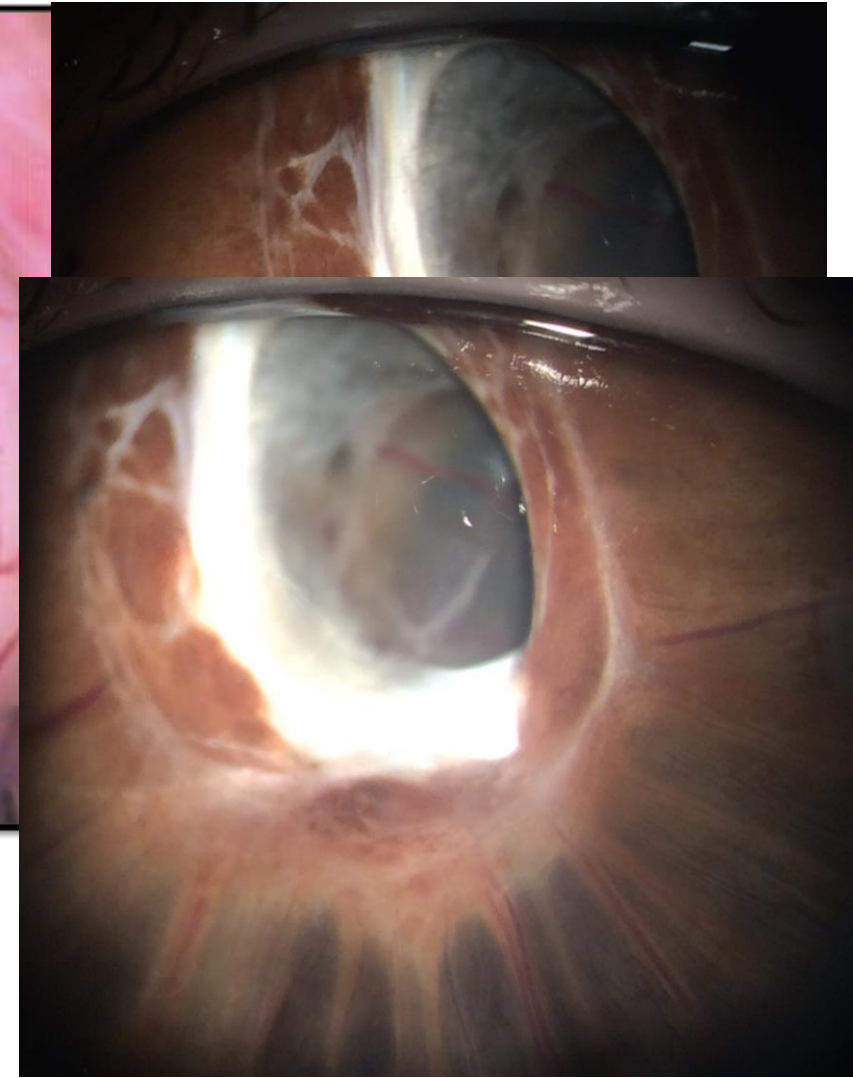
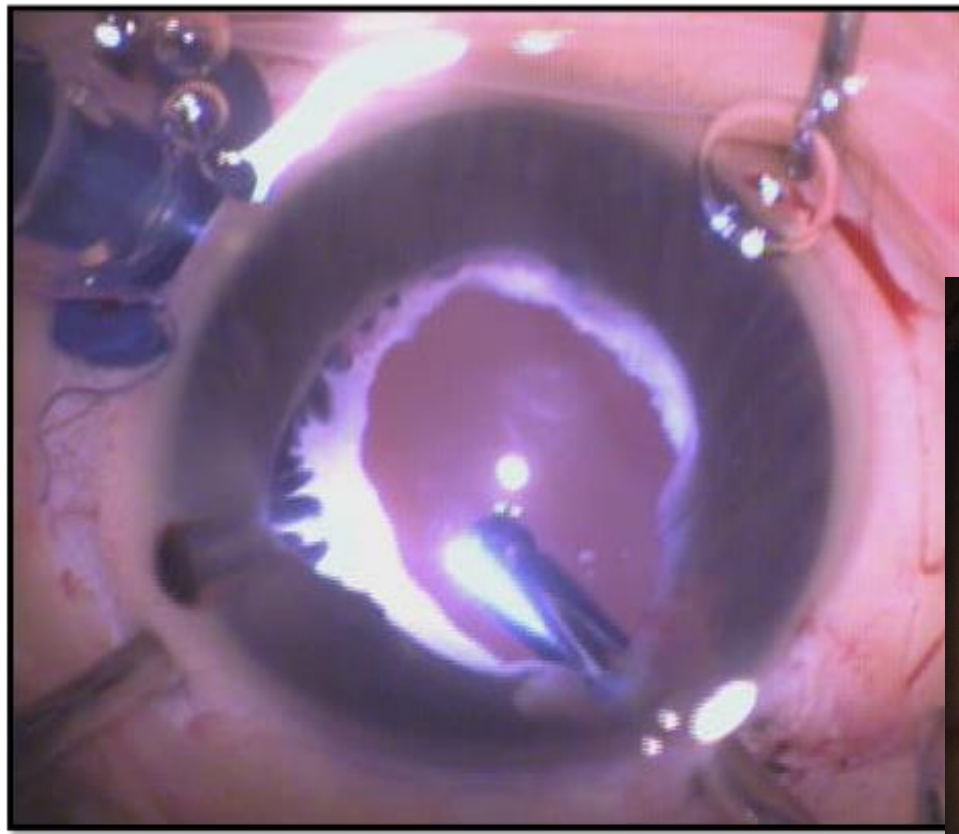


PFV-anterior retinal uzanim



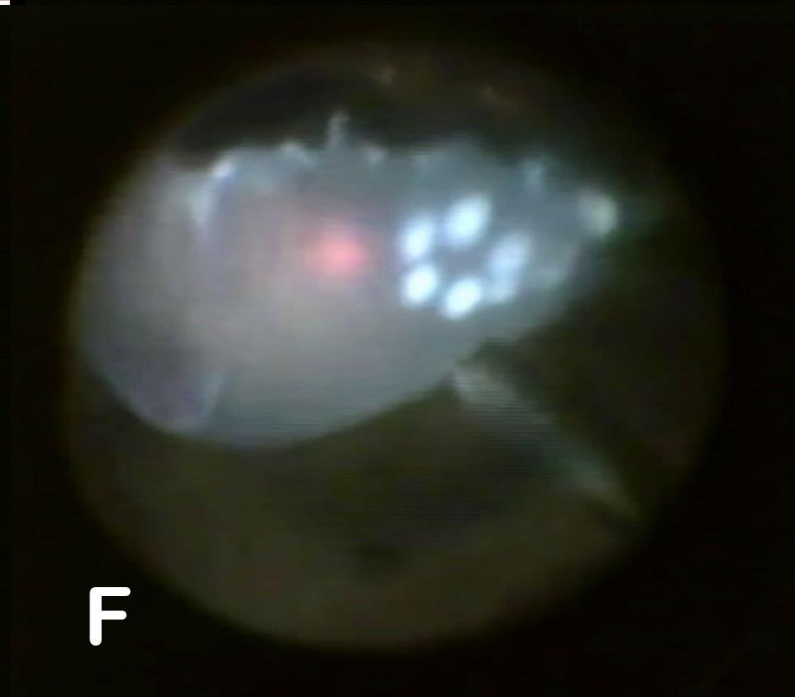
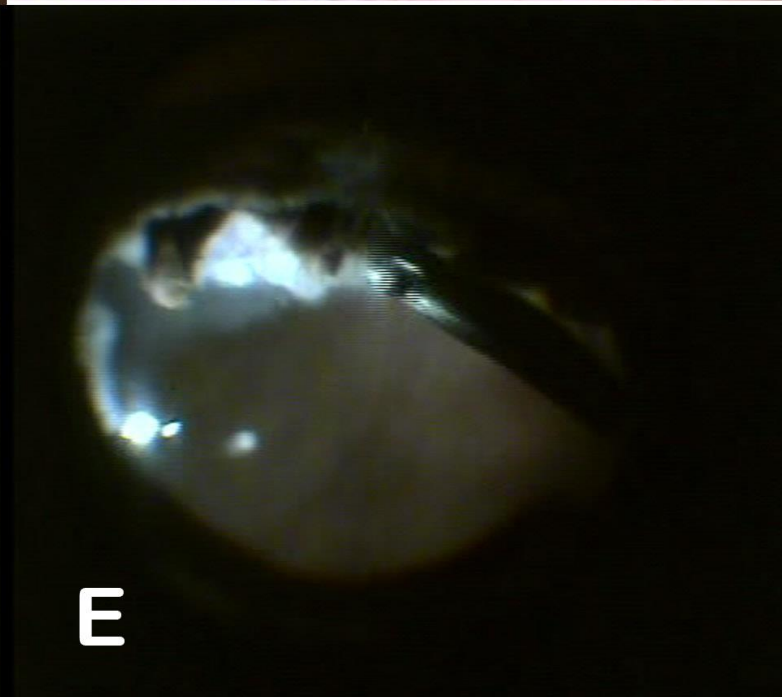
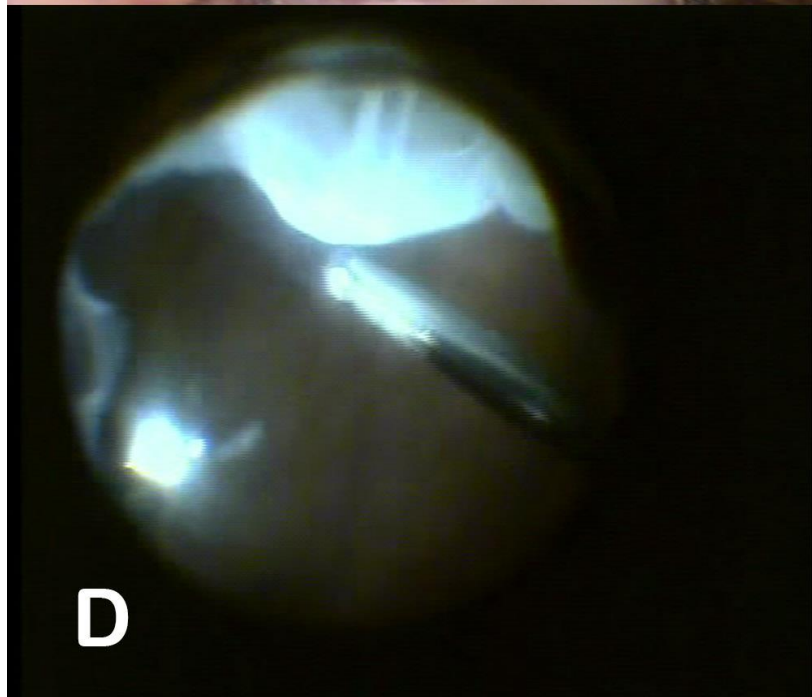
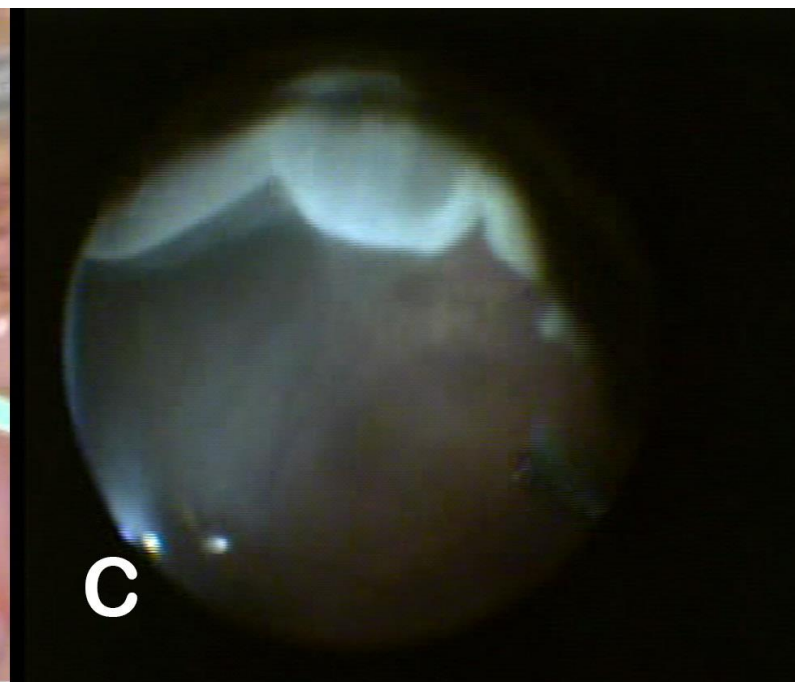
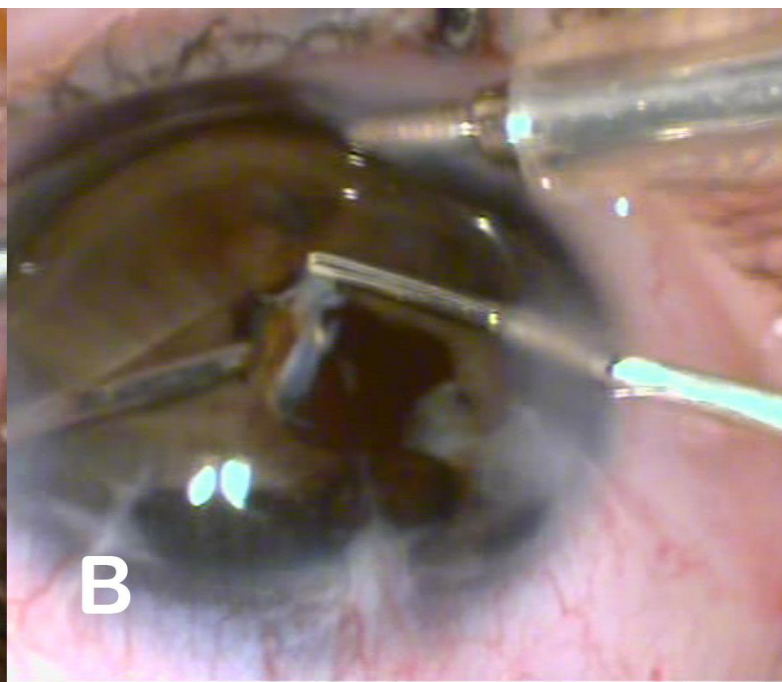
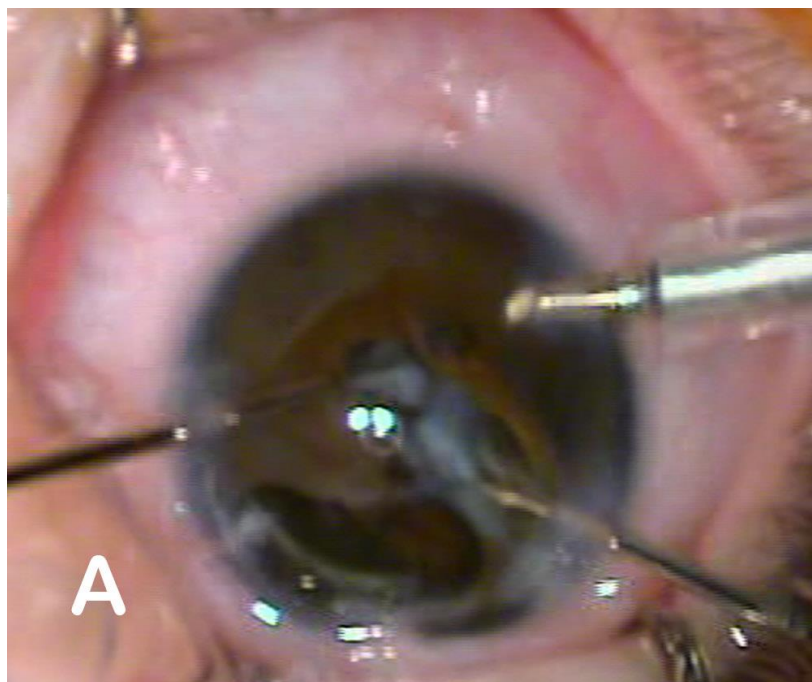
Fibrovasküler Plak

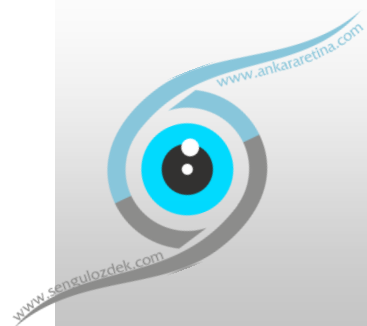
Total eksizyon mu? Periferik bölümün bırakılması mı?



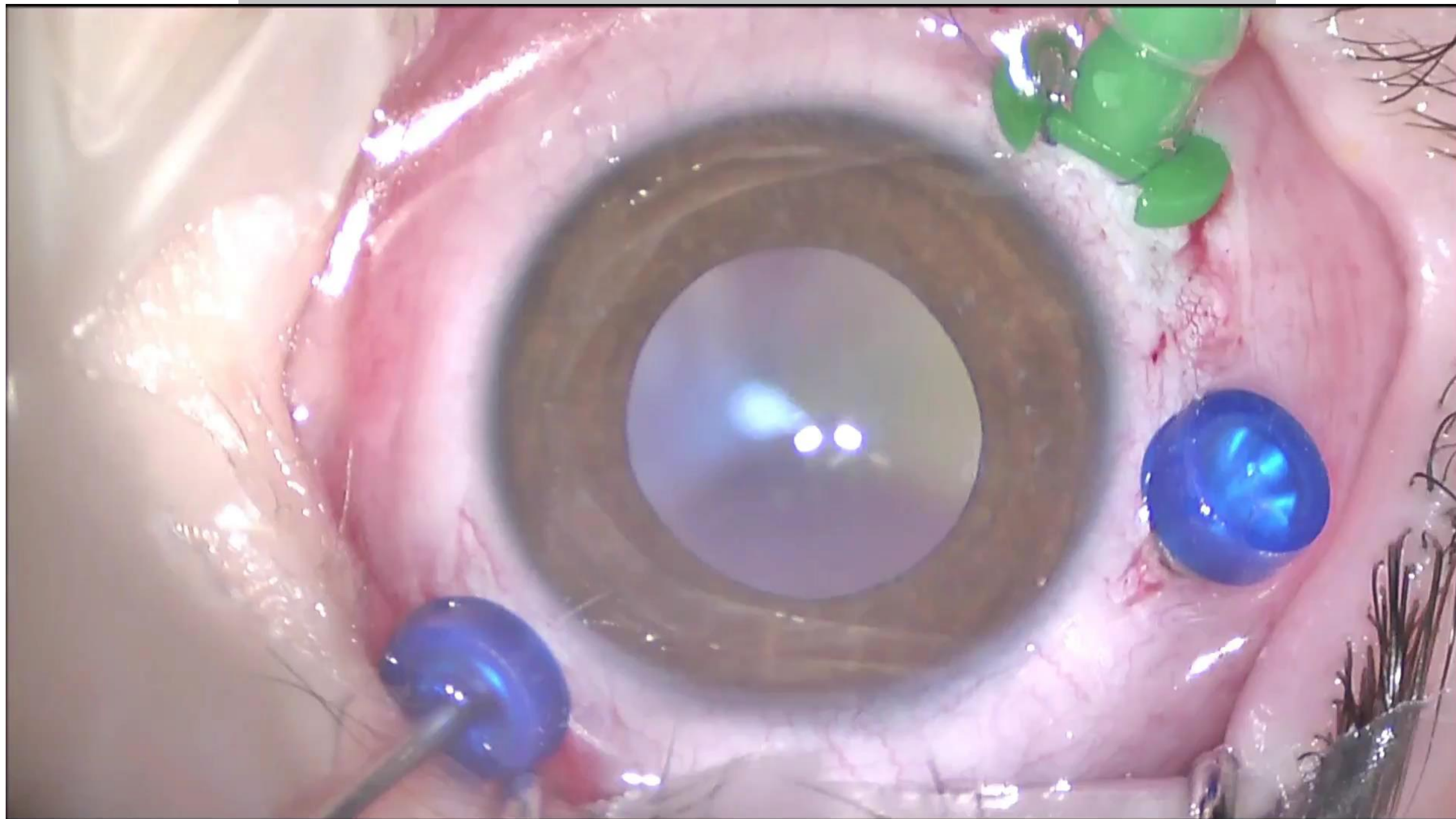
obliterasyona veya yıllar içinde kontraksiyonla periferik retina dekolman

Pupiller obliterasyon!

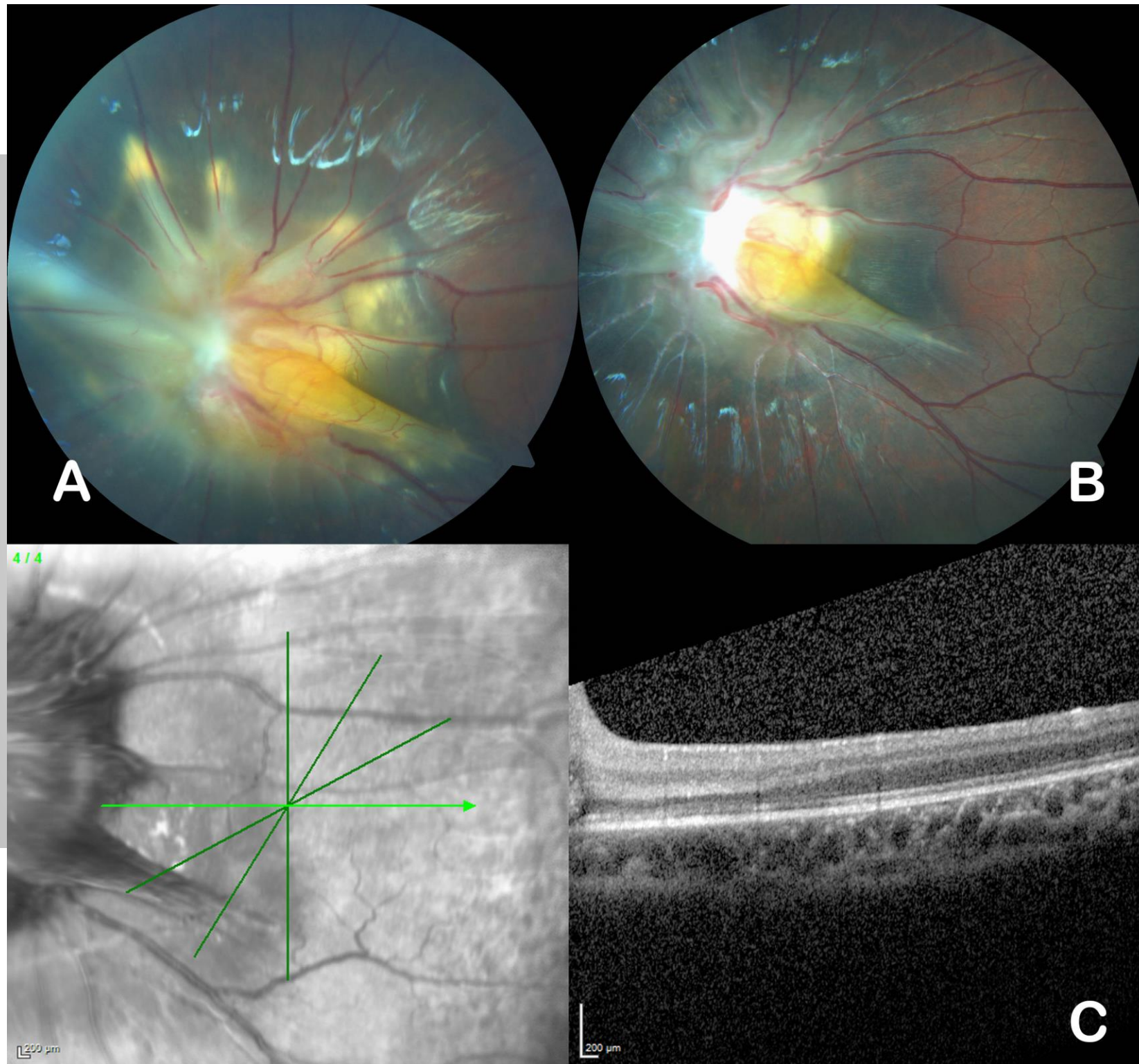




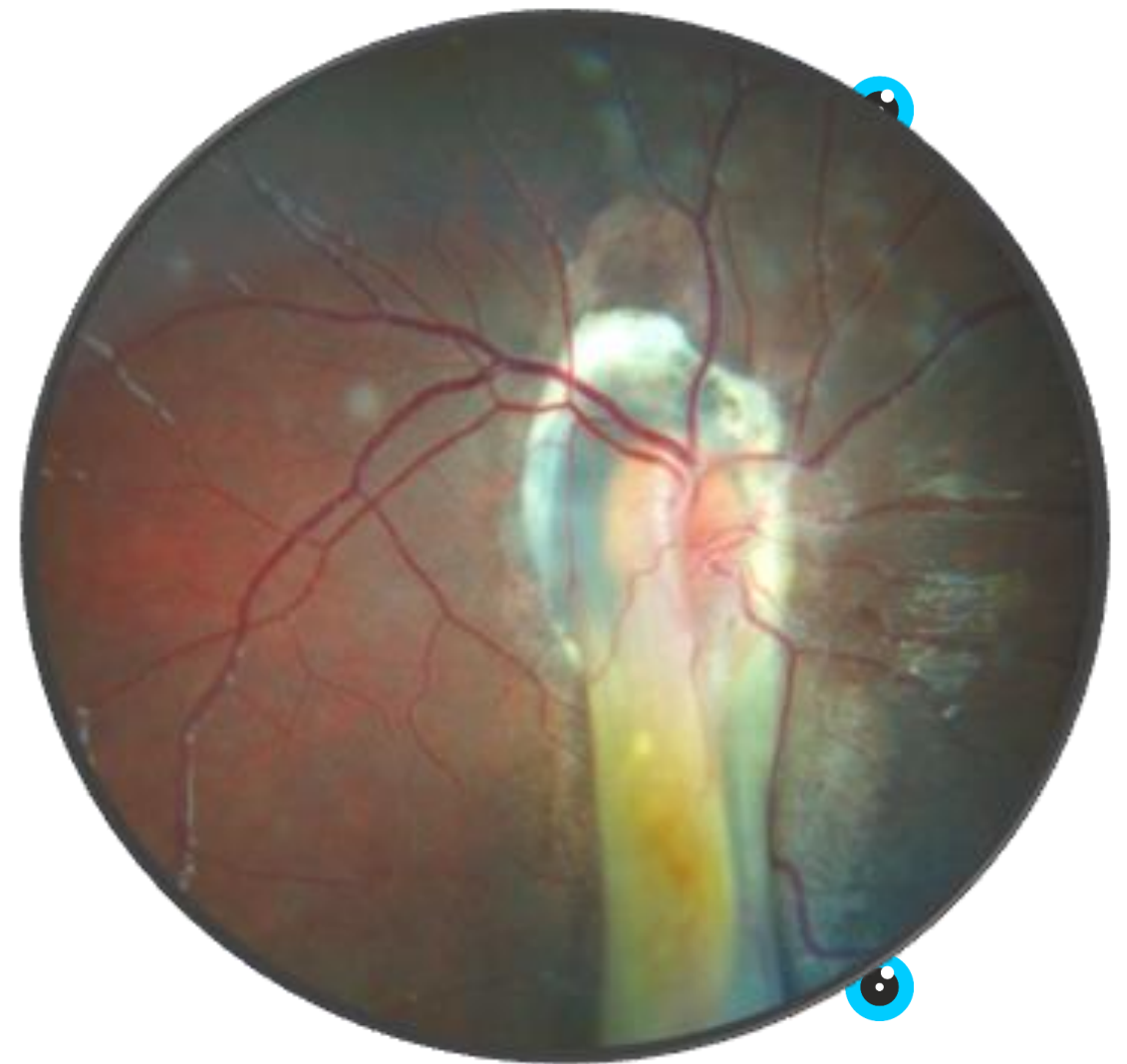
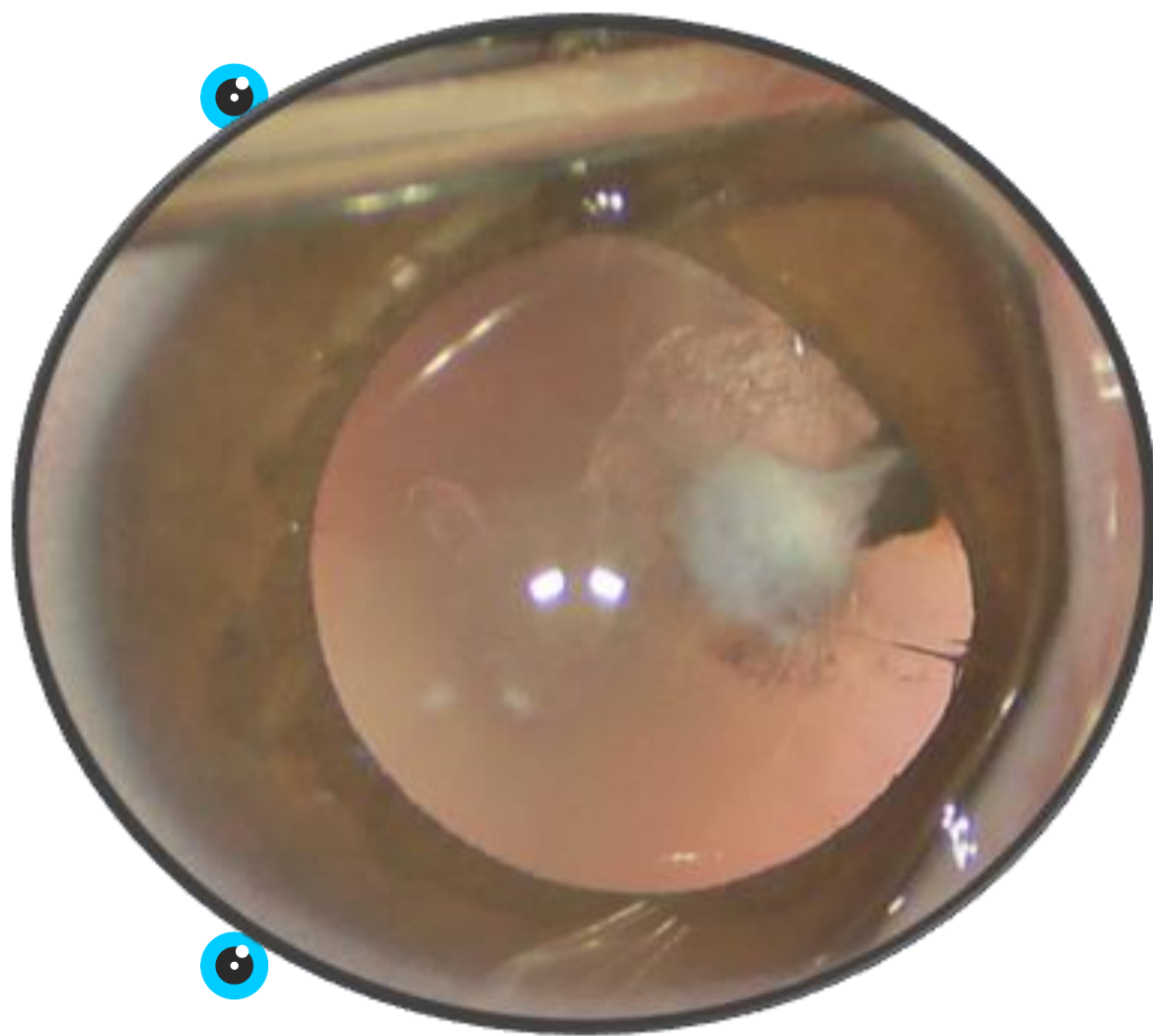
PFV-posterior



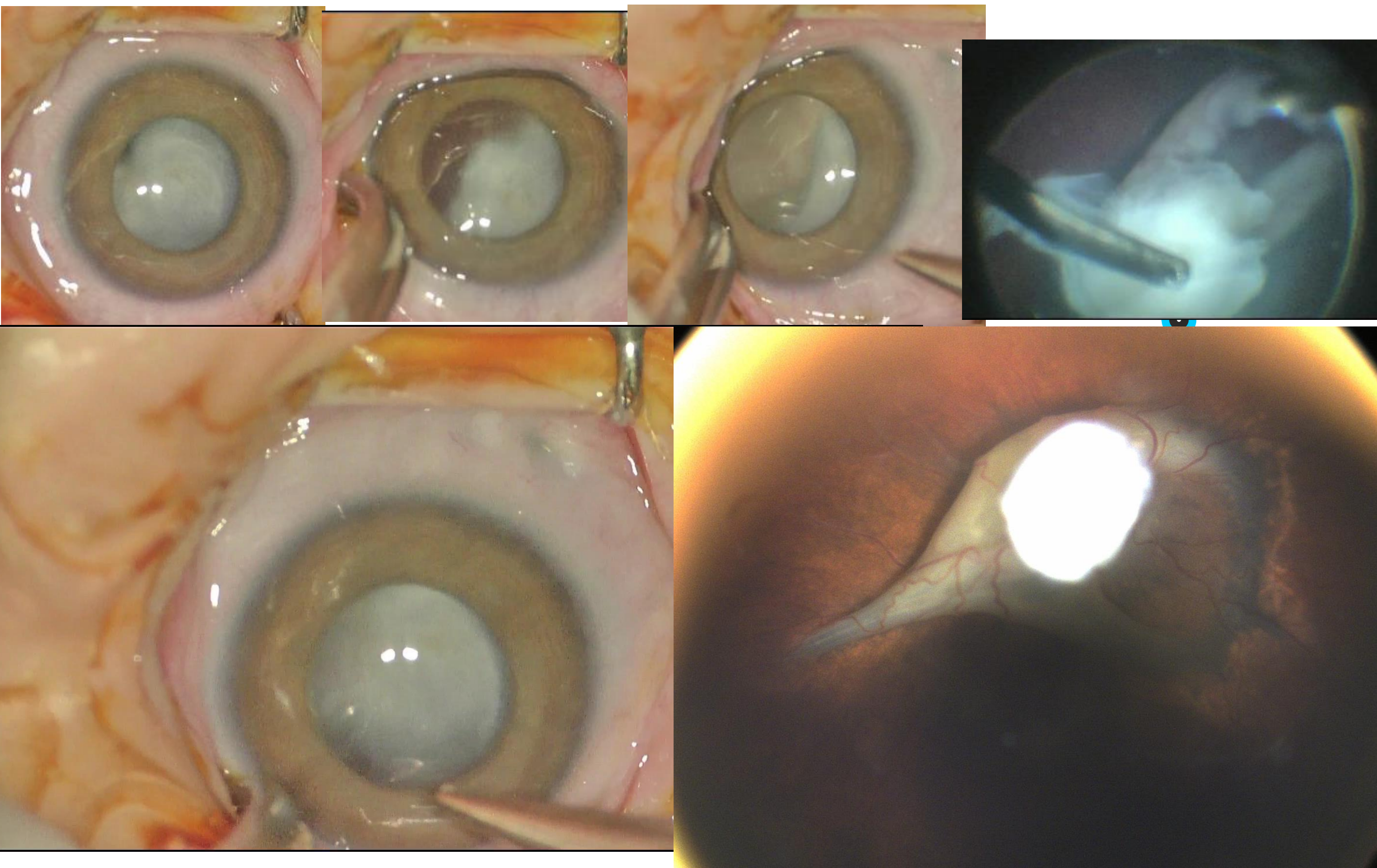
PFV-posterior-postop



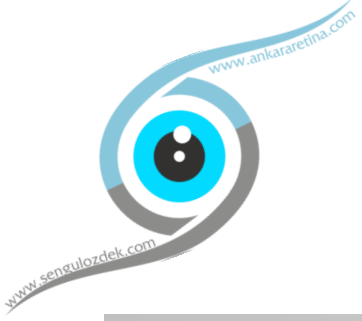
PFV-mixed



PFV-mixed



Hastalar ve Metod

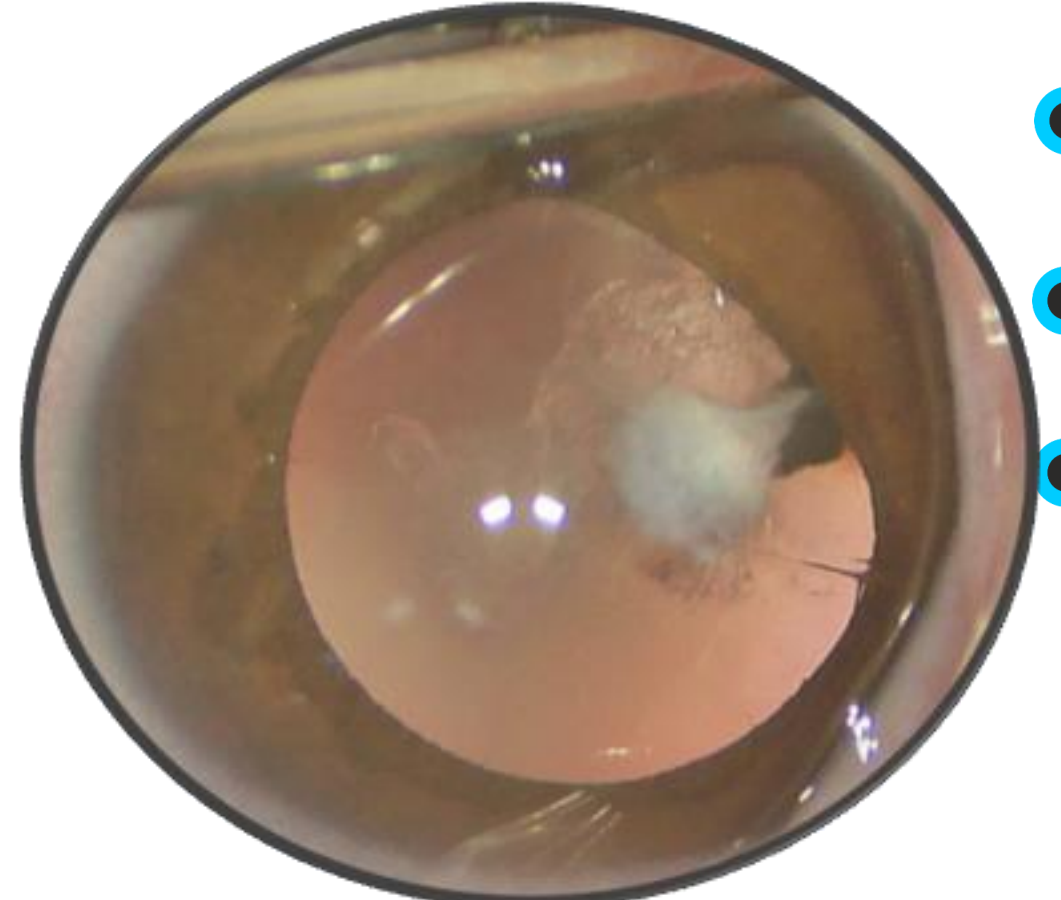
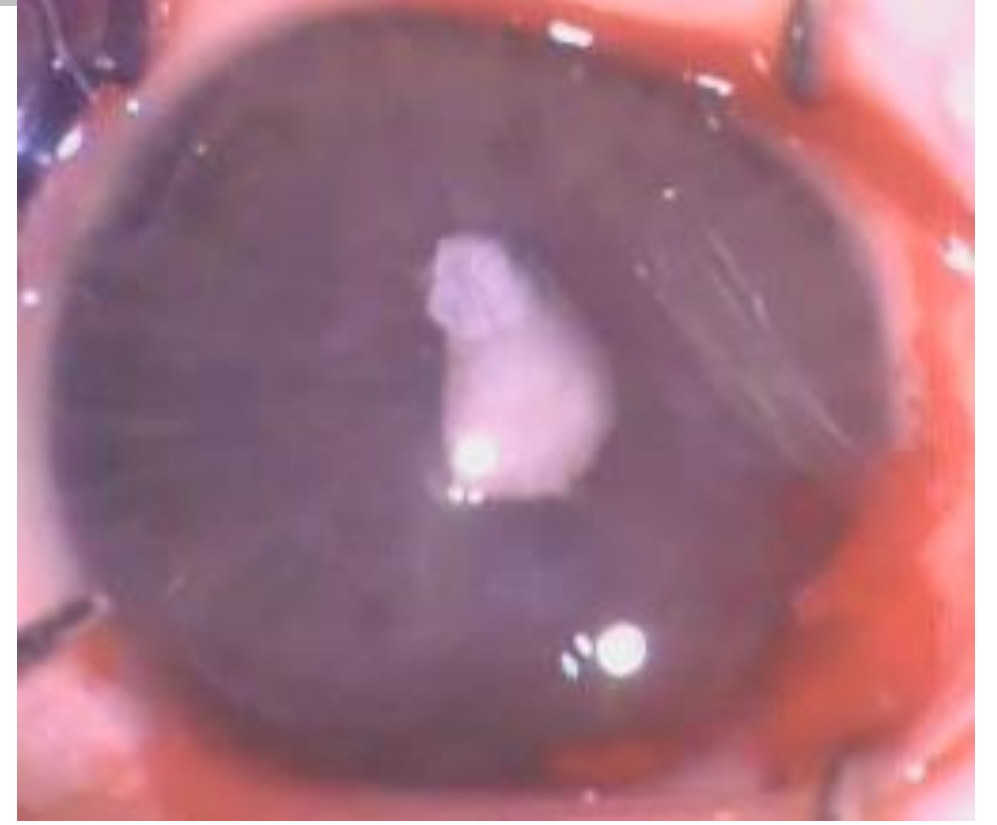


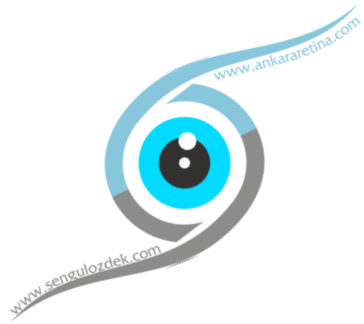
- 29 göz (son 6 yıl)
- 19 (%67.1) erkek
- 14 göz (%47.7): Anterior PFV
- 10 göz (%34.5): Posterior PFV
- 5 göz (%17.2): Mixed tip
- Ort takip: 14 ay (6 ay- 5.5 yıl)



Anterior PFV Sonuçlar

- Anterior retinal uzanım: %64.3 (ant PFV), (%10 - Post PFV),
- Anatomik başarı: %84.6
- Son GK: %38.5 inde $\geq 20/200$





Komplikasyonlar

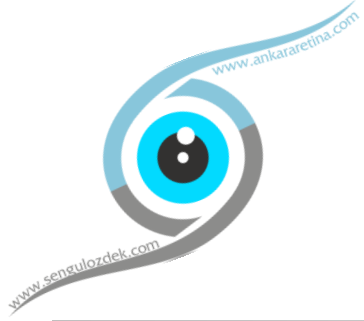
Table 2. Complications

	Retinal complications		p-value [†]		Anterior segment complications		p-value [†]	
	Yes	No	Univariate	Multivariate	Yes	No	Univariate	Multivariate
	n (%)	n (%)			n (%)	n (%)		
Extend of lens opacity (n=19)*								
Less than half (n=8)	0 (0)	8 (100)	0.018 [†]	0.009 [‡]	0 (0)	8 (100)	0.045 [†]	0.026 [‡]
More than half (n=11)	6 (54.5)	5 (45.5)			5 (45.5)	6 (54.5)		

*includes anterior and combined cases.

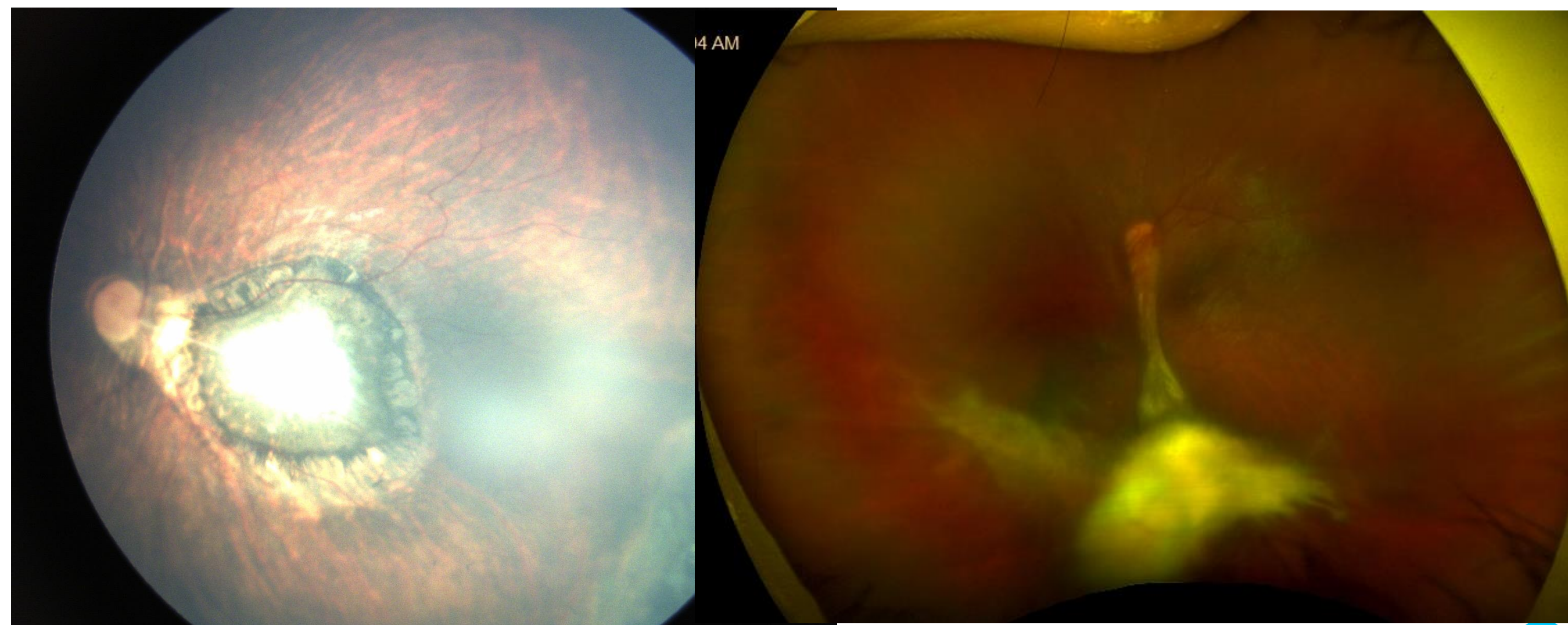
[†]Fischer exact test.

[‡]OLS



Alınması gereken mesajlar

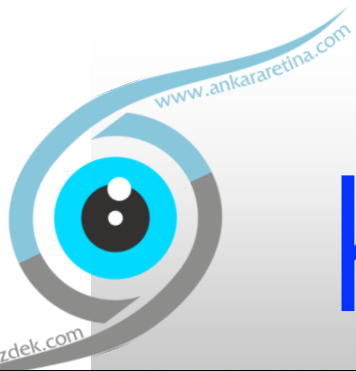
- Özellikle şiddetli ant PFV de periferik anterior retinal uzanımlardan haberdar olunmalı
- Periferde fibrovasküler doku bırakılmamalı: Pupiller obliterasyon, glokom, TRD ye neden olabilir.
- RD cerrahisine hazırlıklı olunmalı.
- Özellikle şiddetli vakalar VRC lar tarafından yapılmalıdır.



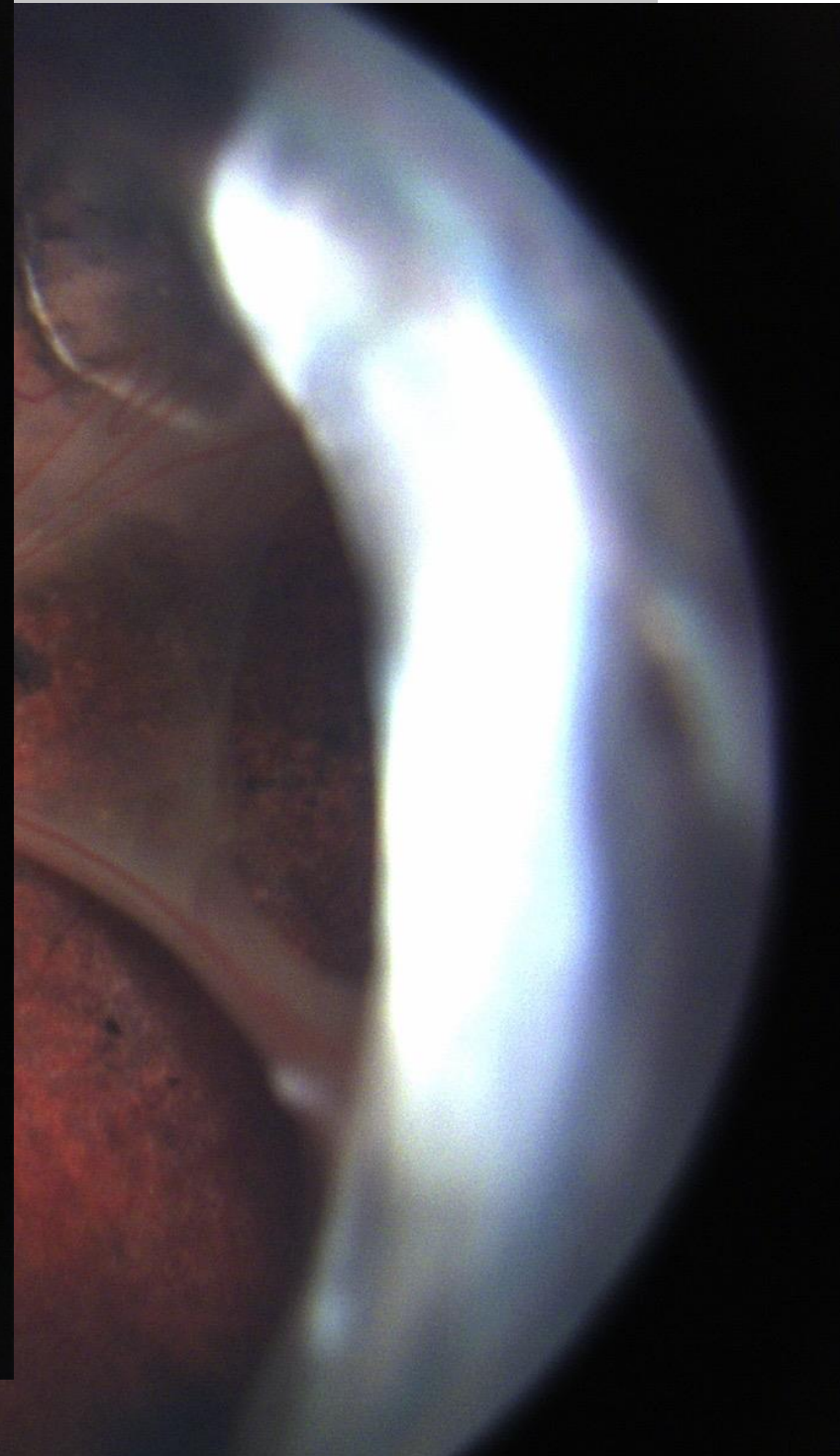
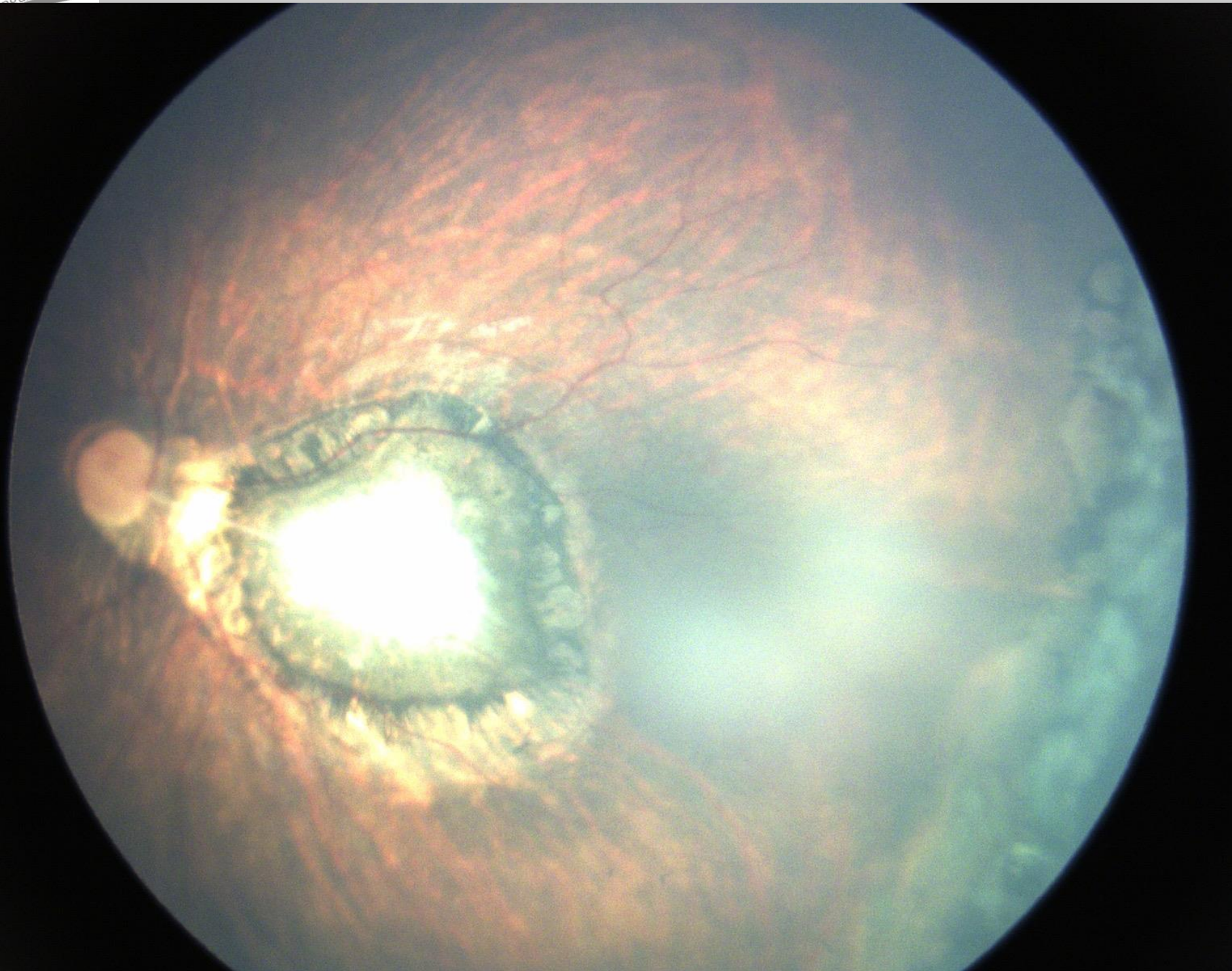
ENFLAMATUAR LÖKOKORİ

Toxoplazma, Toxocara

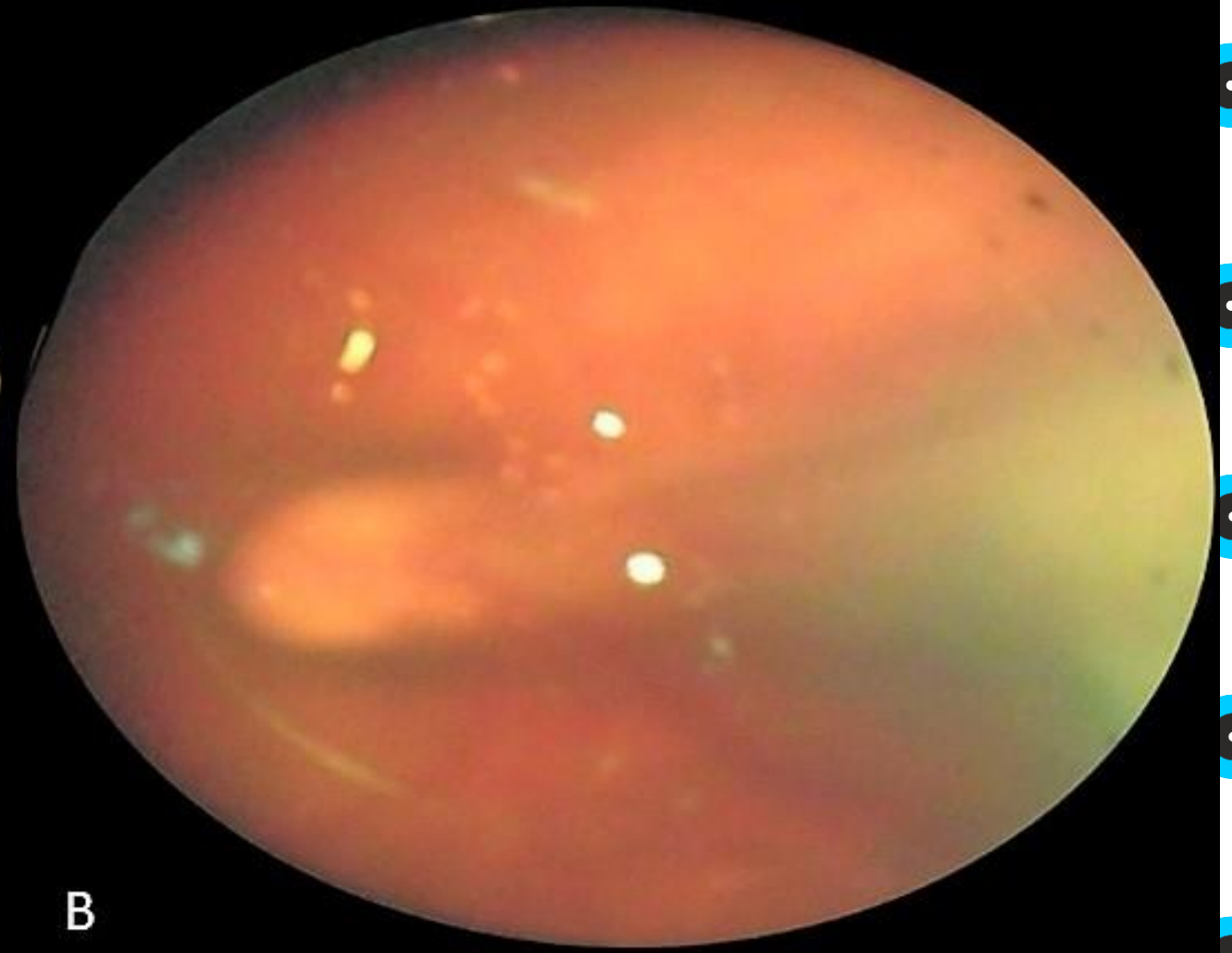
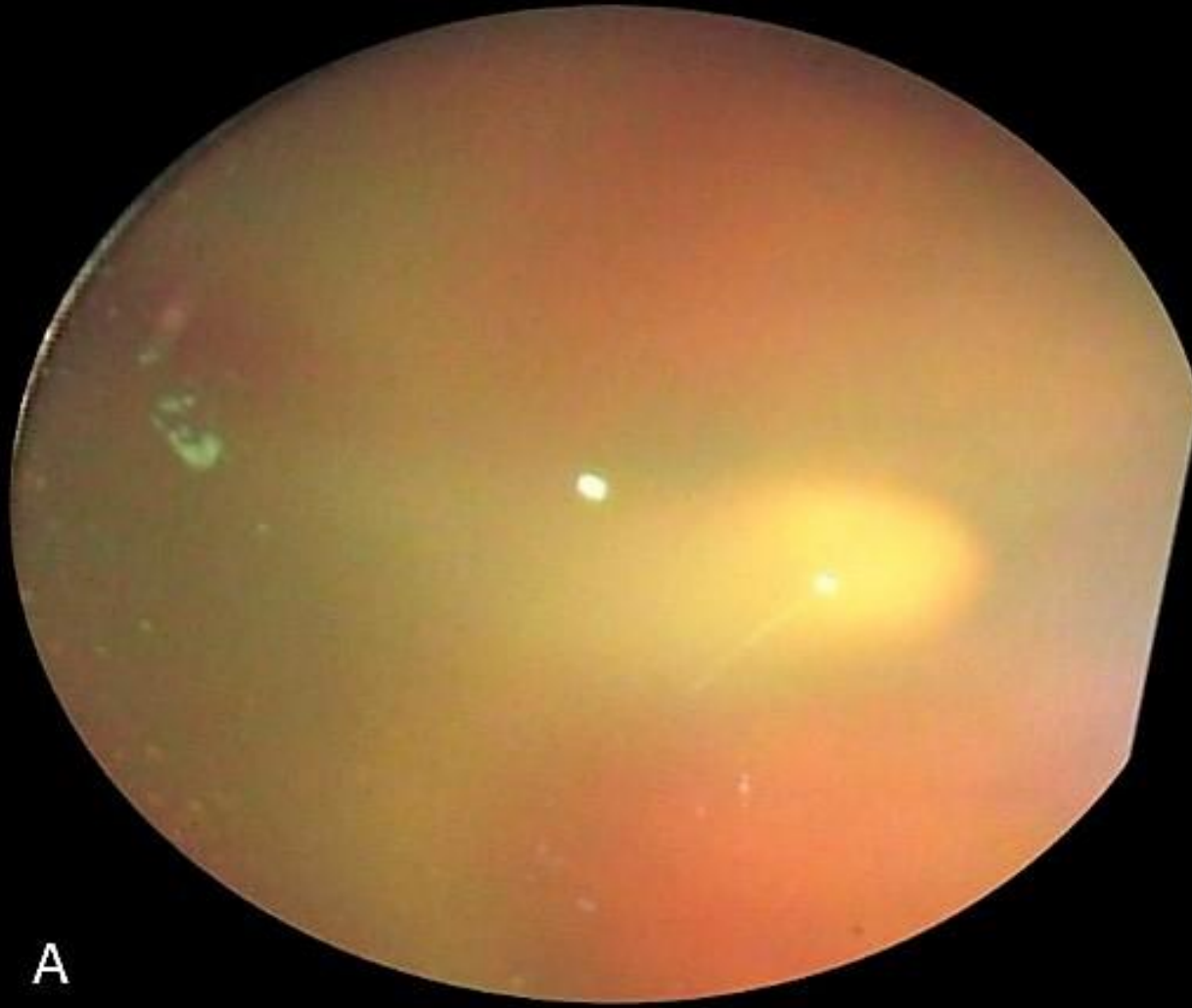




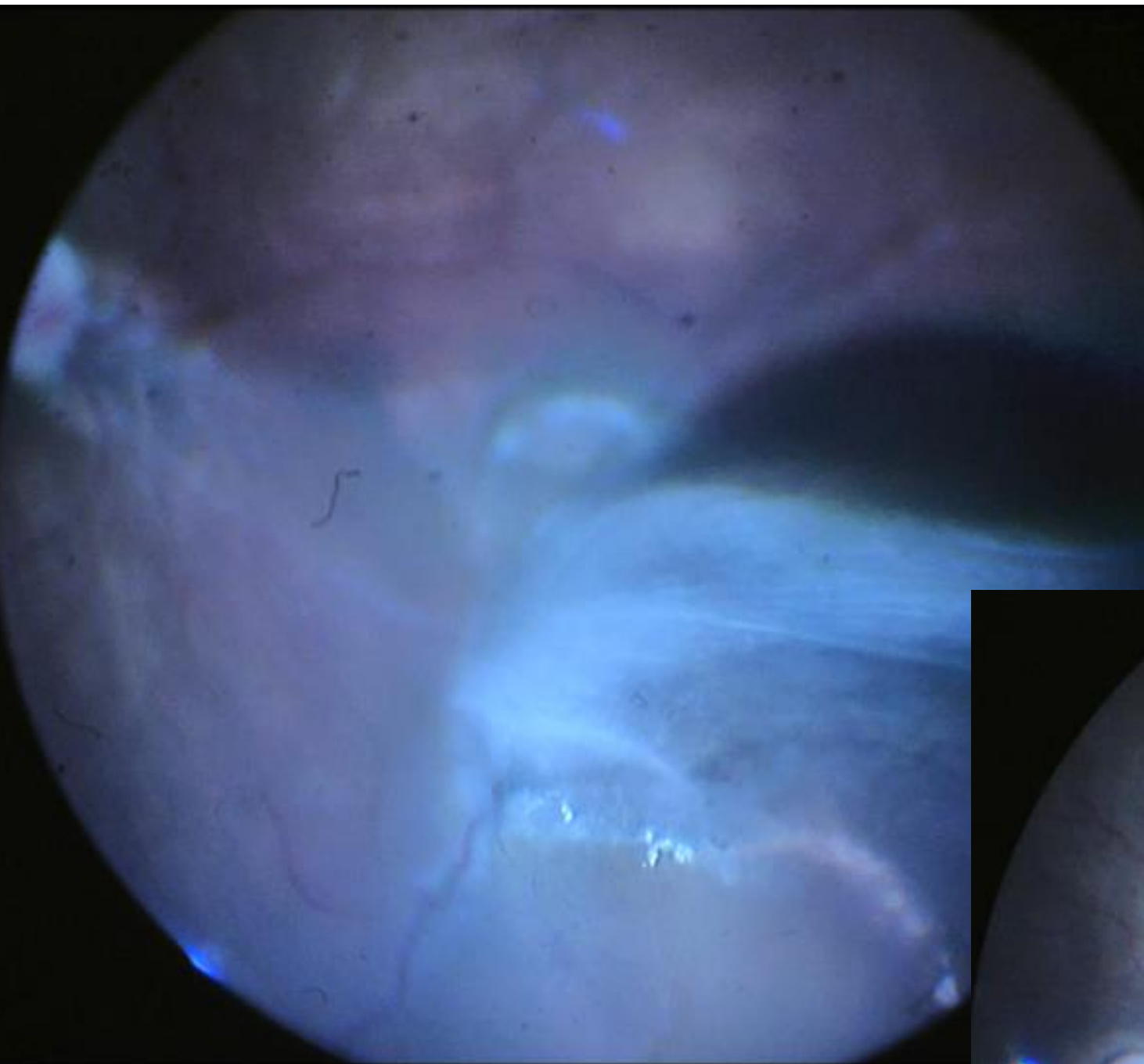
Konjenital Toksoplazma

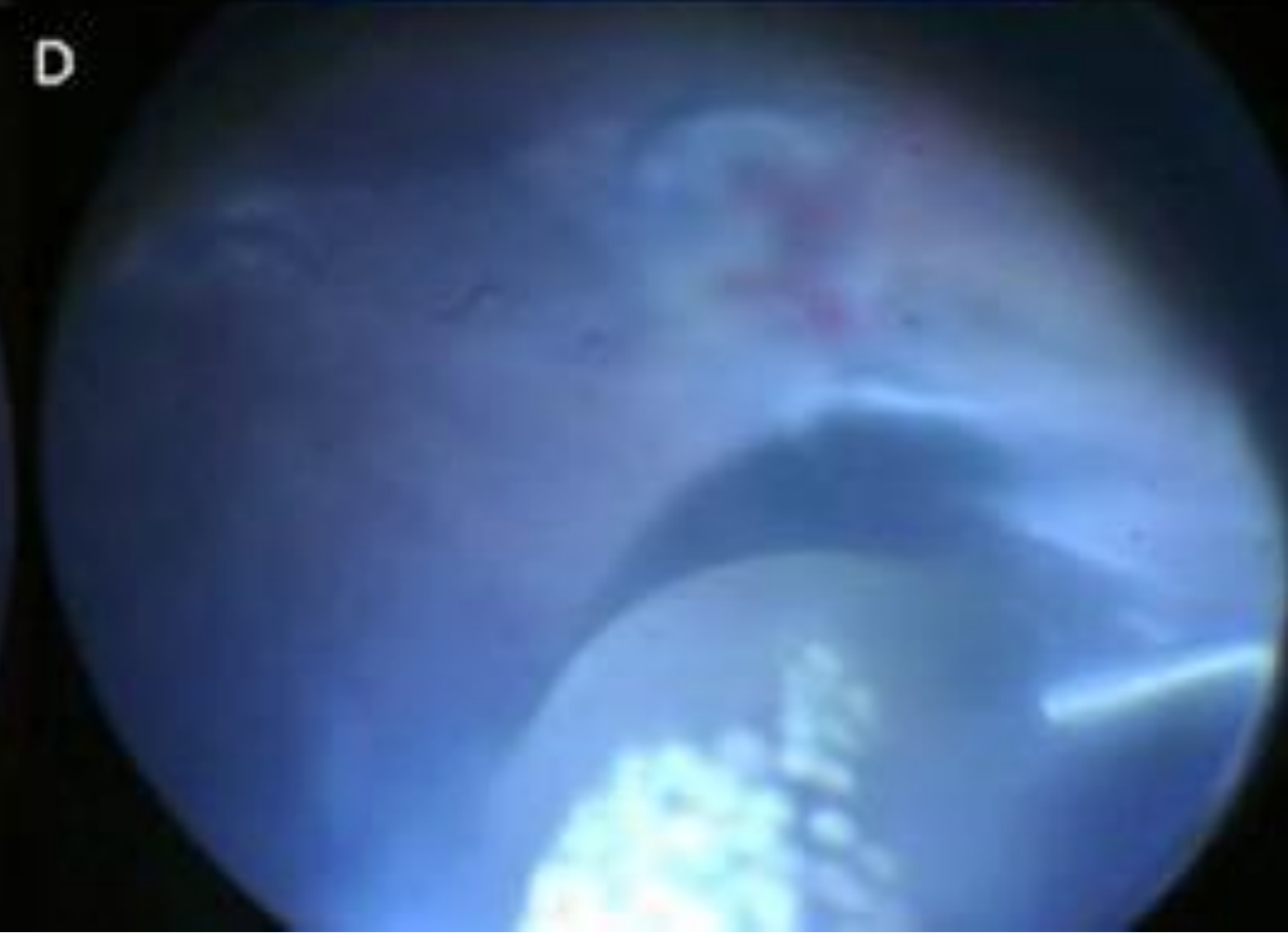
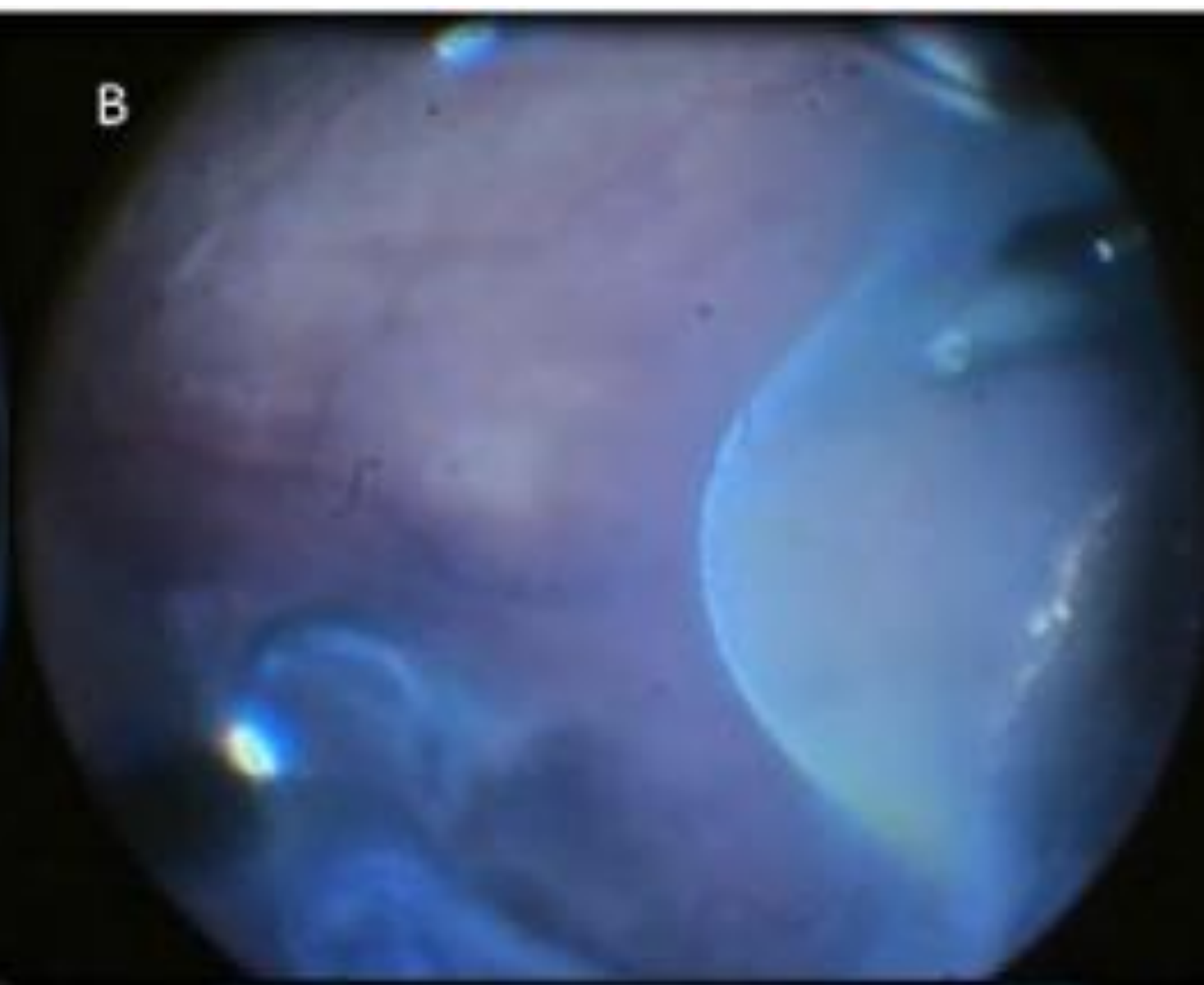
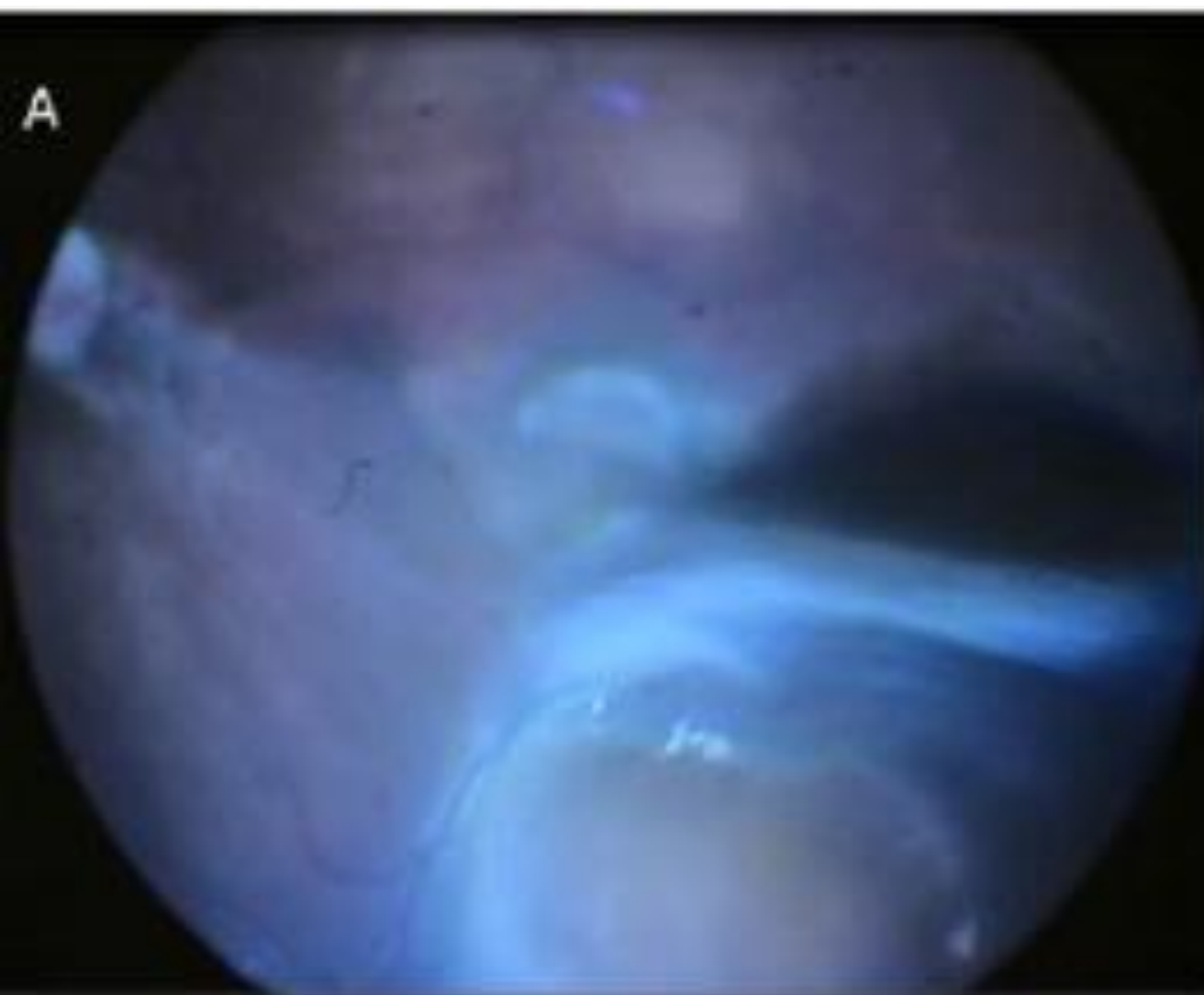


34 hafta 2230gr, kız bebek, hidrocefali
konjenital toxoplazma tanılı, YDYG toxo
tedavisi (+)

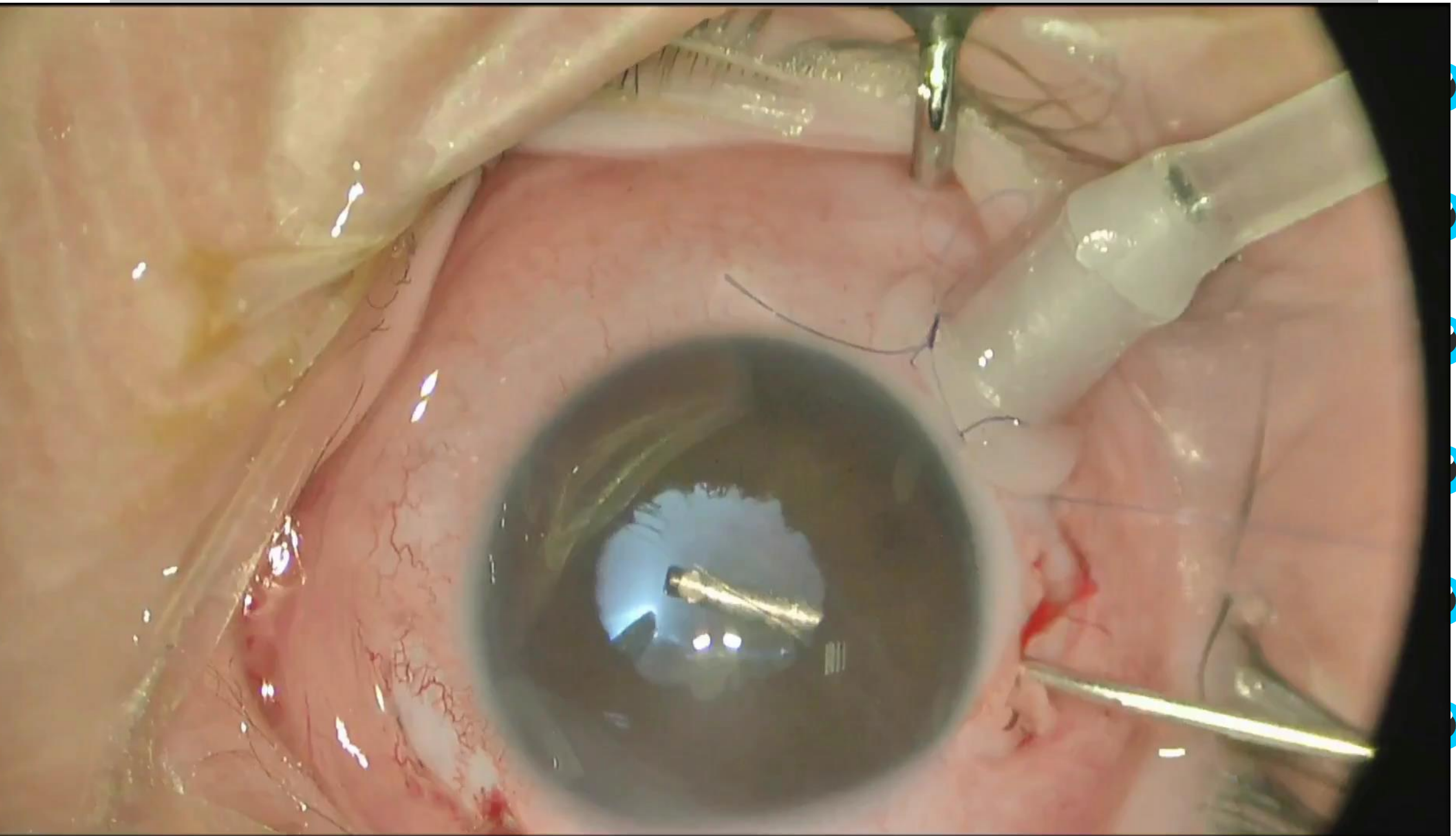


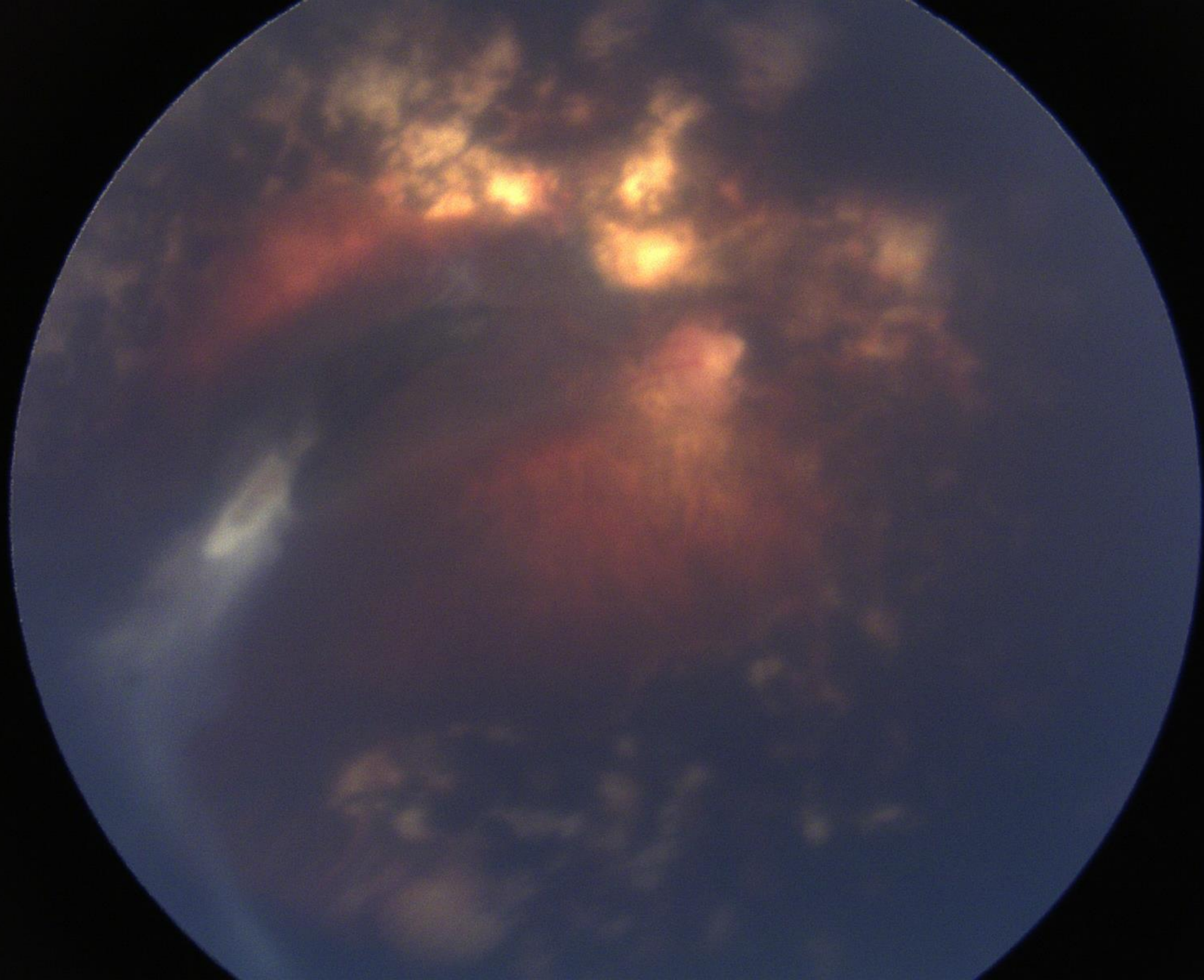
vasküler alanlar





32 hf 1590 gr, E, Hidrosefali, sağ: buftalmus,
posterior sineşi, katarakt, **RRD**
Sol: mikroftalmik, Anti-Toxo ted alıyor,







Konjenital Toksoplazma-ROP

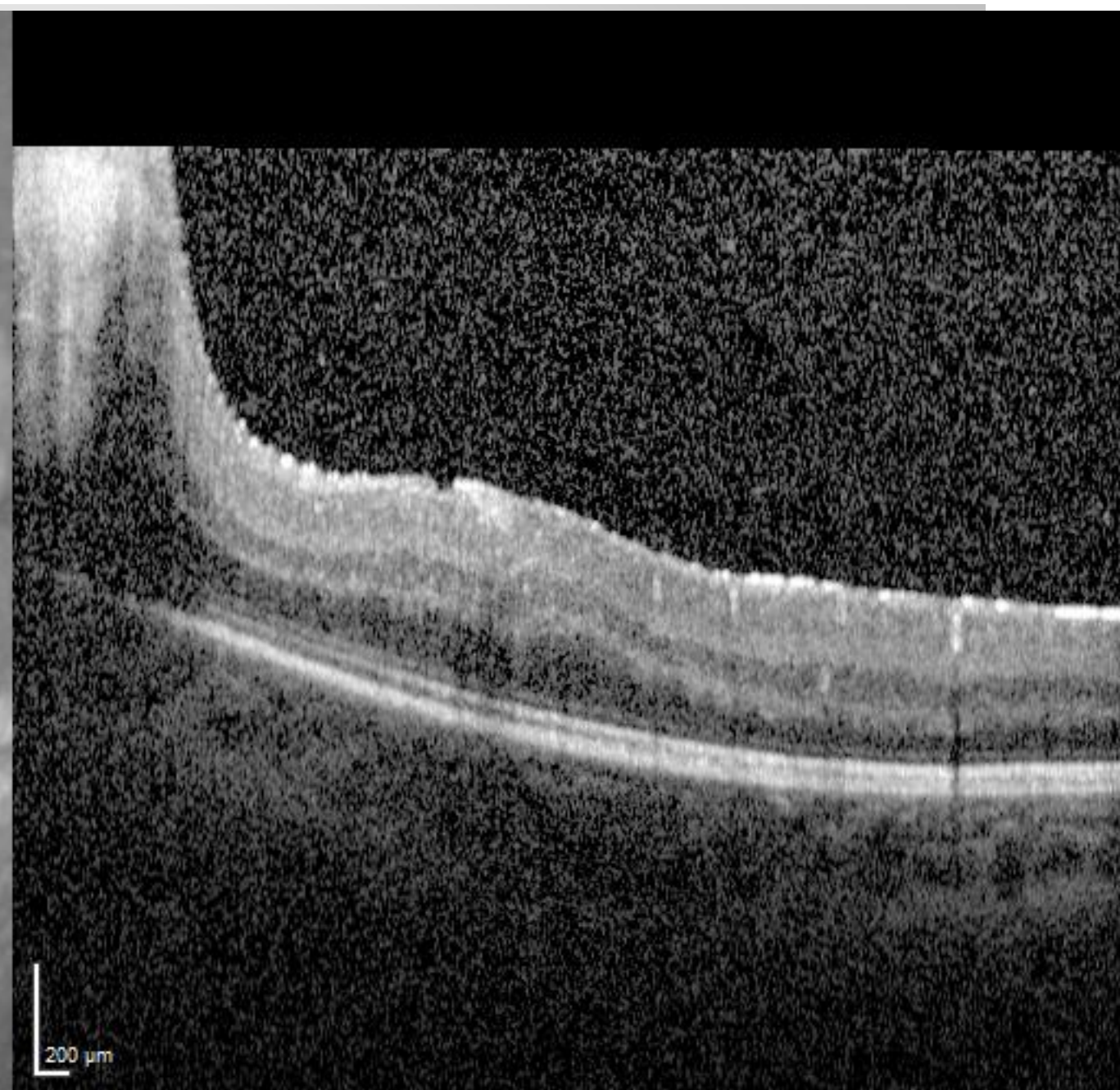
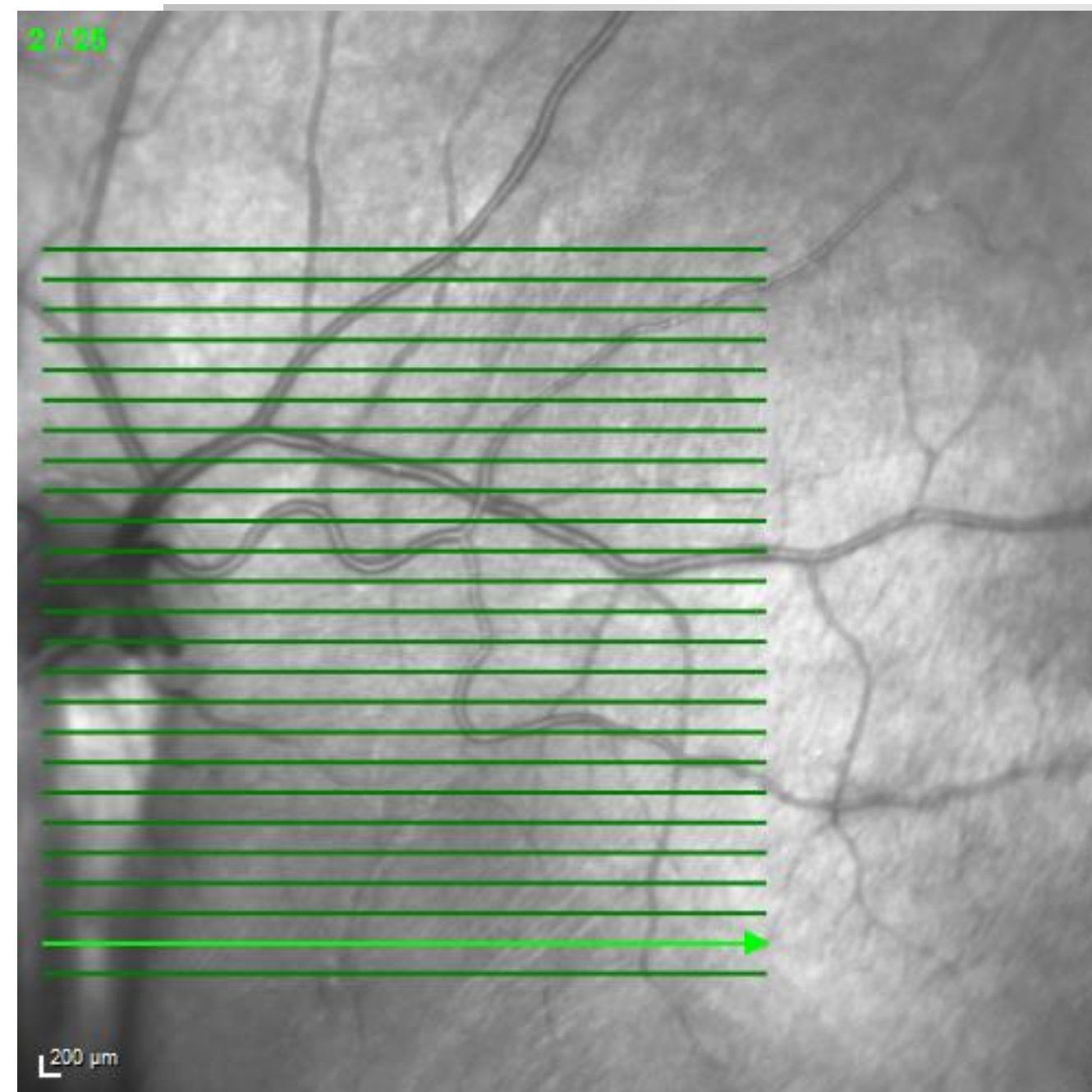
- Enflamasyon büyük bebeklerde ROP gelişimini stimüle edebilir.
- Toksoplazma prematür bebeklerde TRD ile sonuçlanabilir ve cerrahi tedavi gerekebilir.

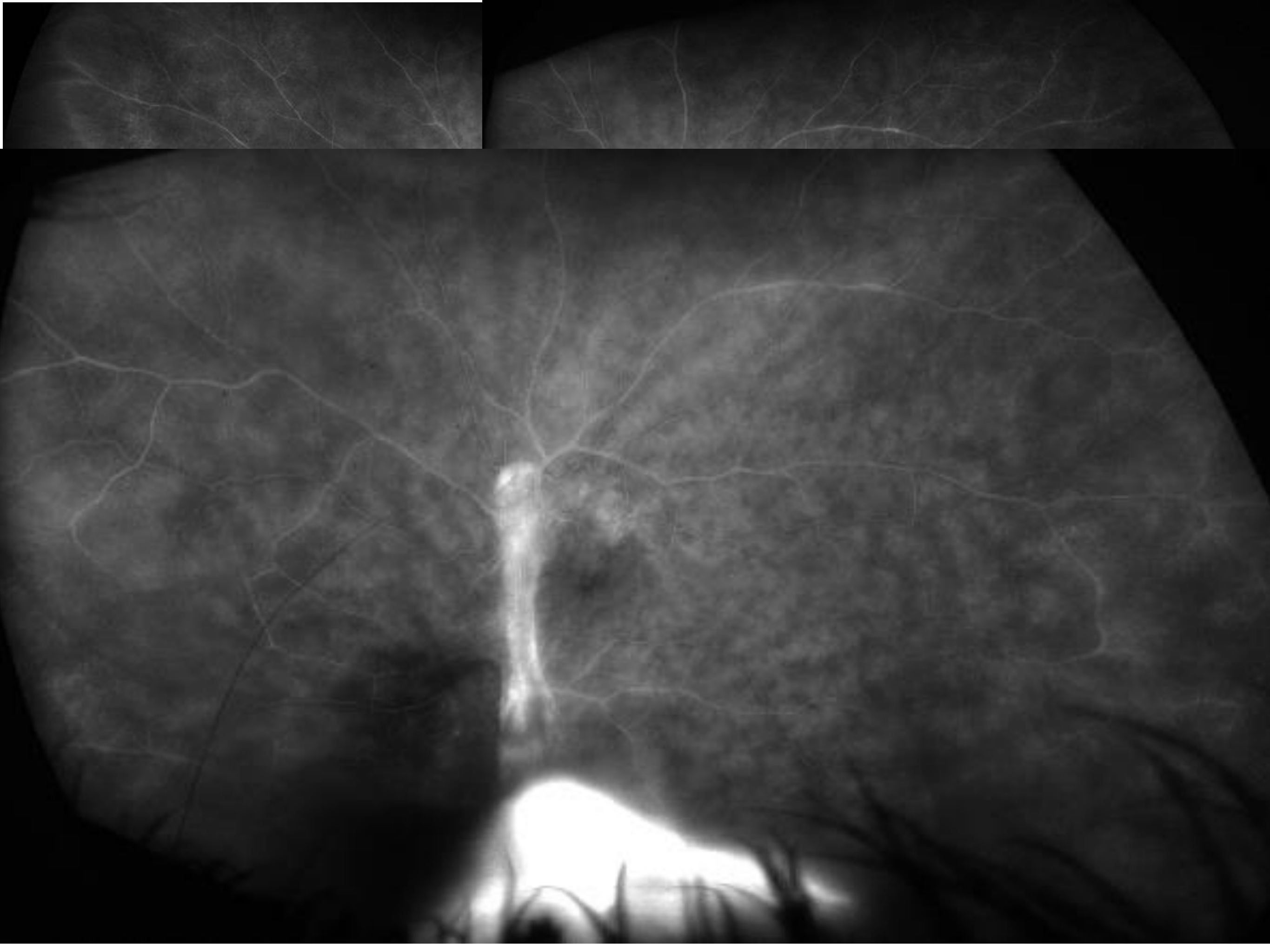
- 8y, Kız çocuk,
- Sol gözde 2 yıldır kayma, yeni başlayan kızarıklık, Panüveit/endoftalmi? Erzurum'dan sevkli
- GK: Tam/4mps
- XT, Hipertropya, ÖK da 1(+) hücre
- Sağ: Doğal, Sol: Vitreusda 2-3(+) hücre, vitreus haze, Retinal fold (OSB dan inf a uzanan)

14 AM



Konjenital Toxocariasis







Konjenital Toxocariasis

Toxocara IgM, IgG

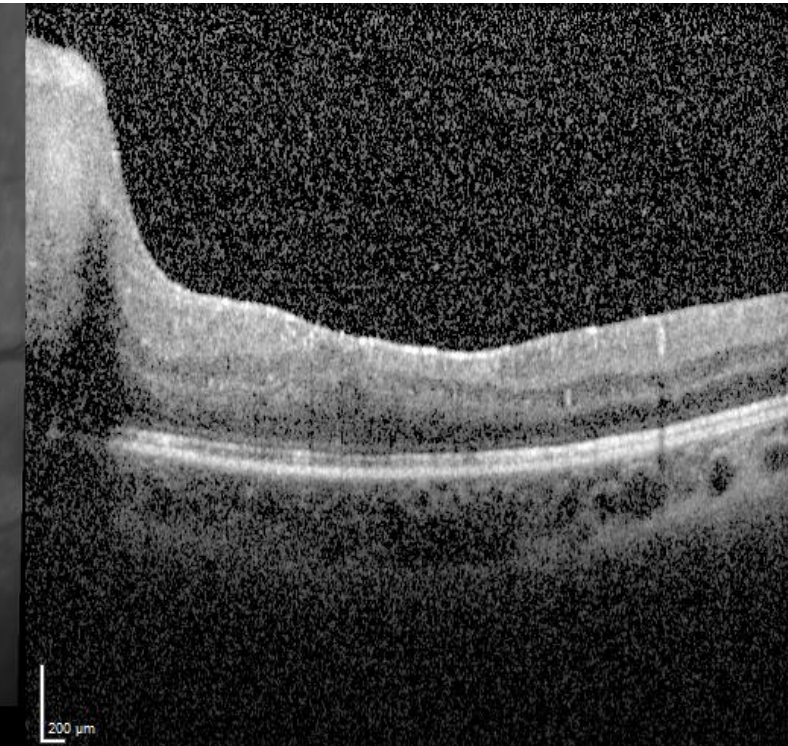
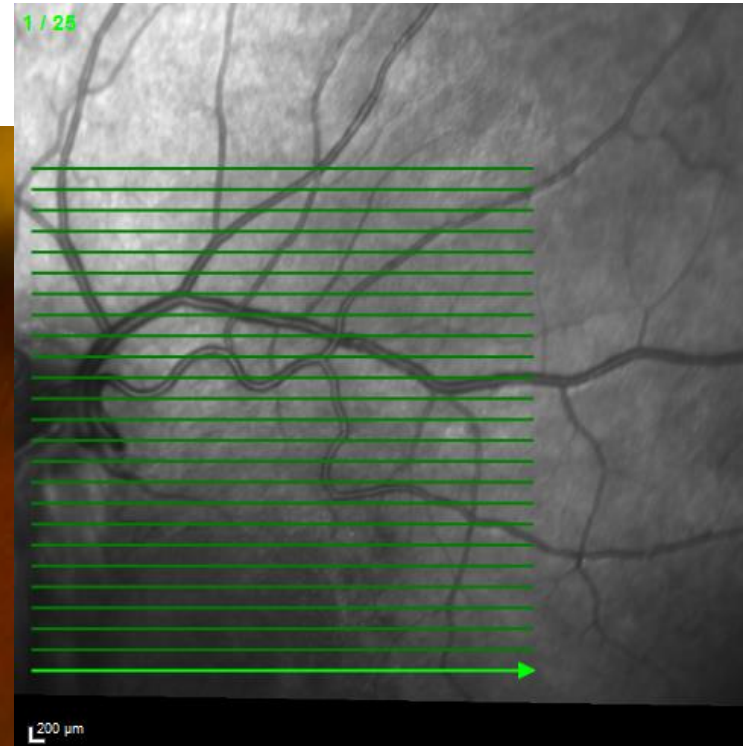
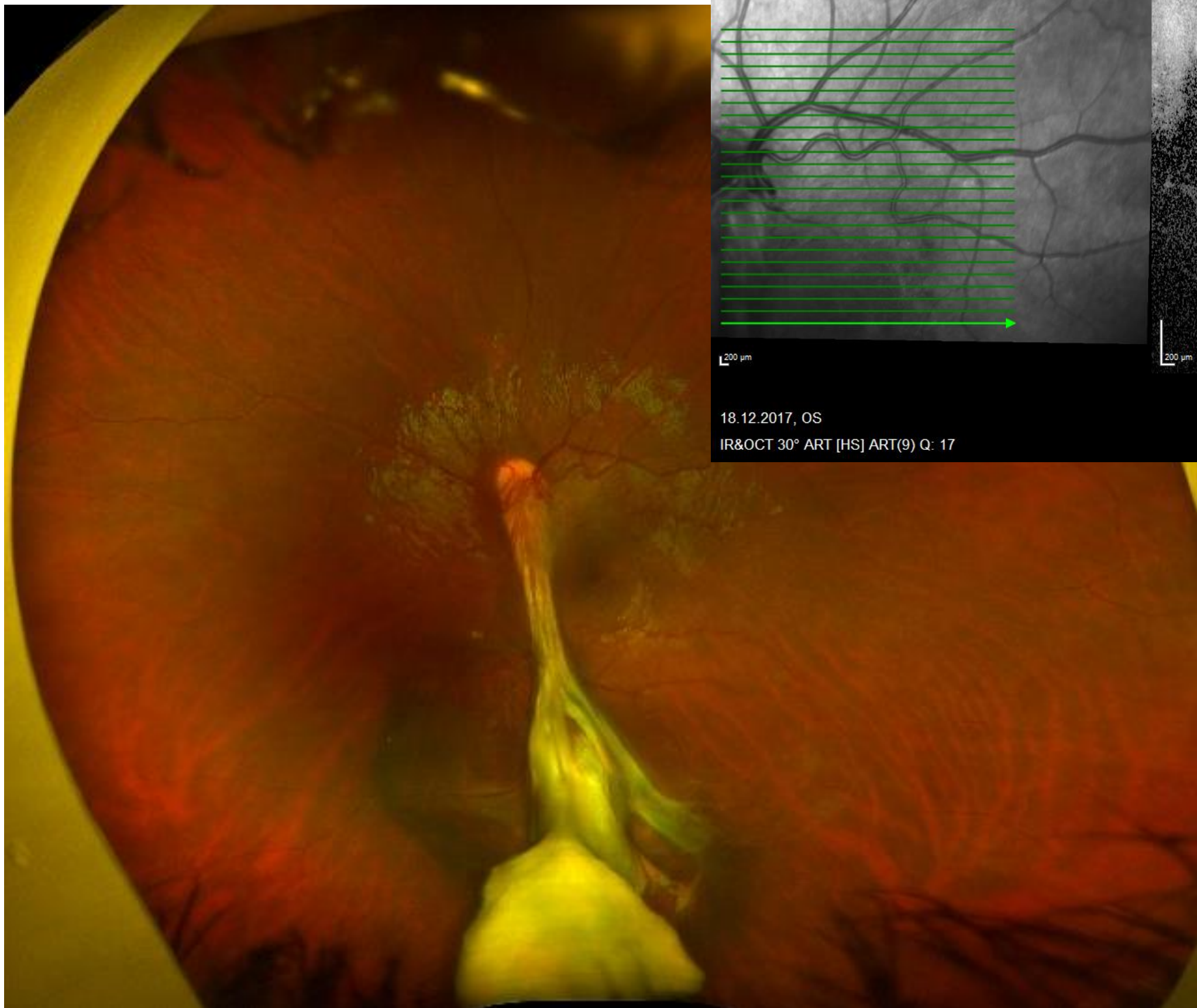
Sistemik Albendazol

Topikal steroid

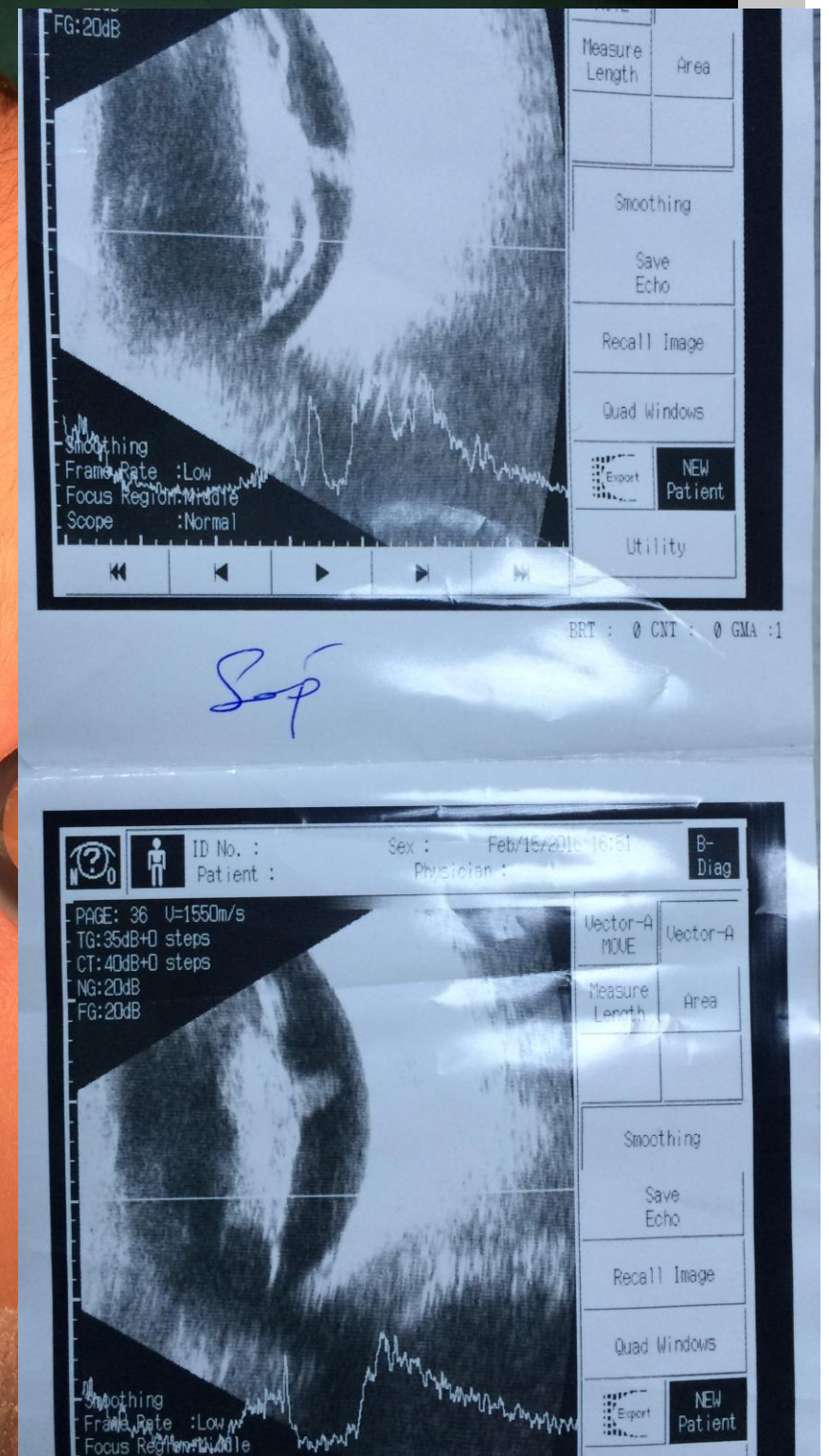
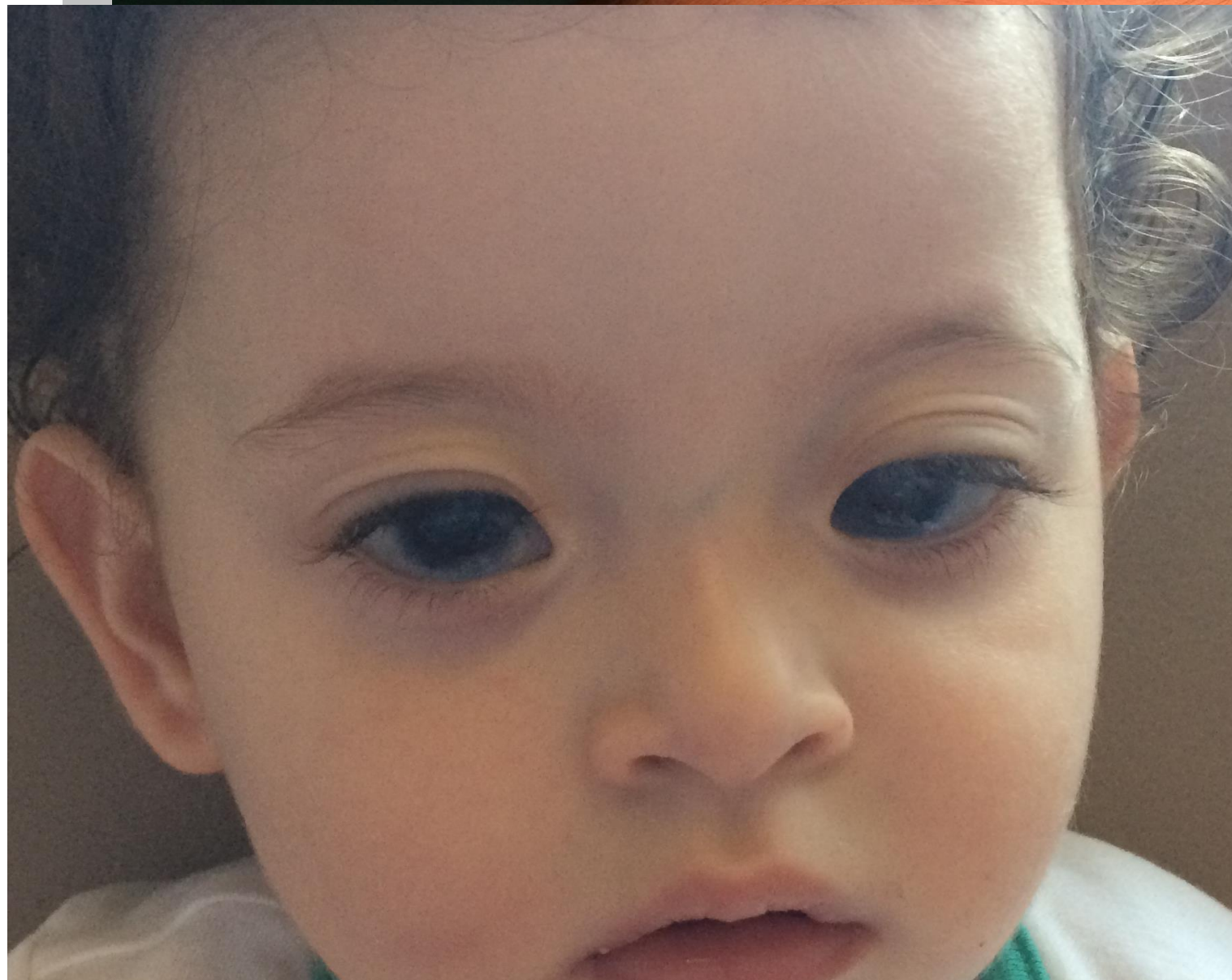
Sikloplejik



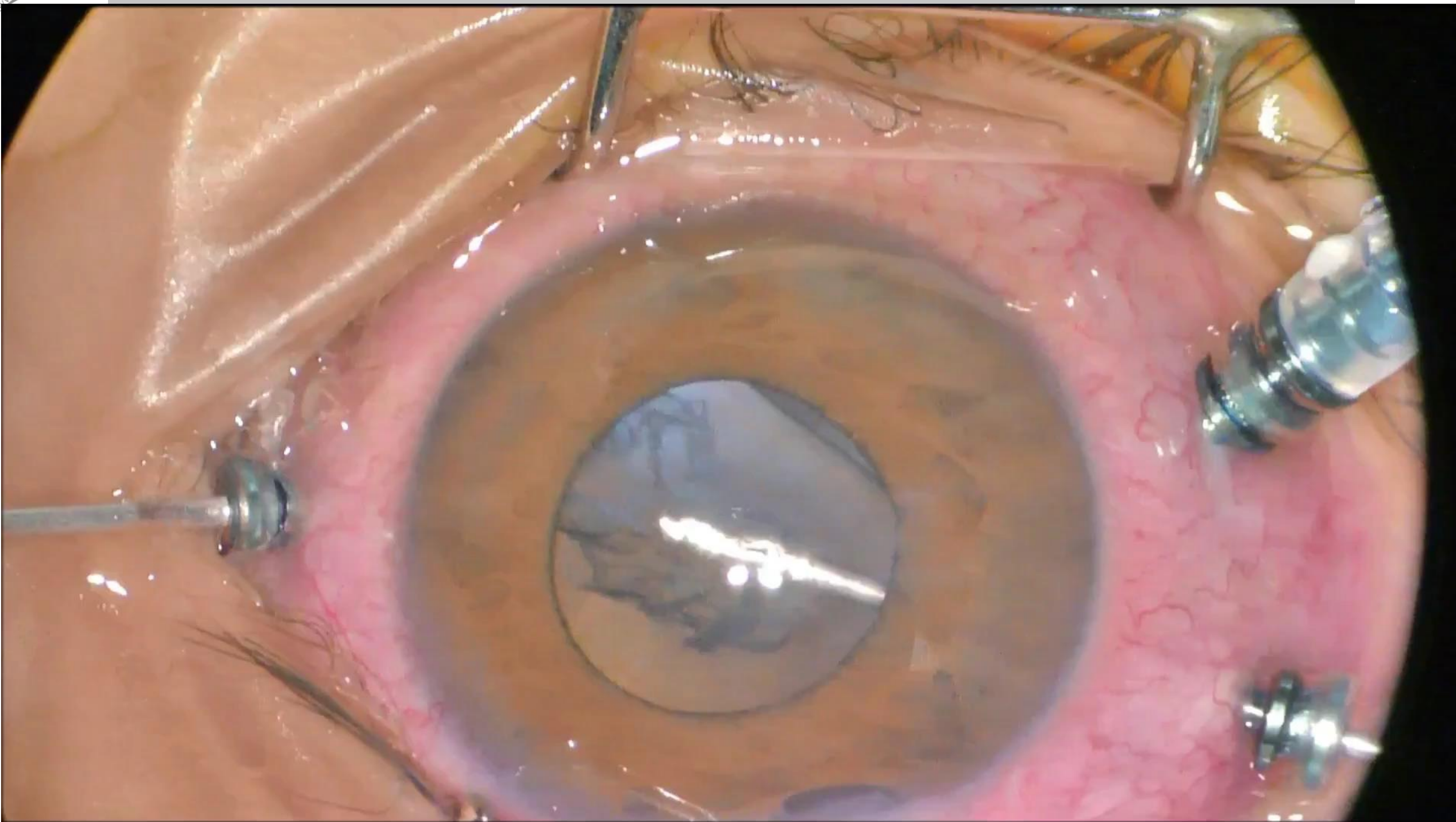
Postop 2. hafta, GK: 0.1



Buftalmus-RRD



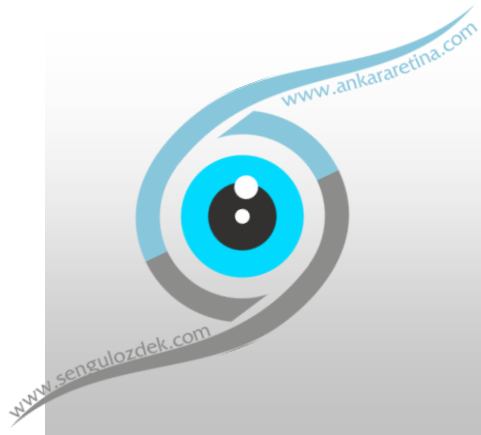
Buftalmus-RRD





KONJENİTAL X-BAĞLI RETİNOŞKİZİS CXLR





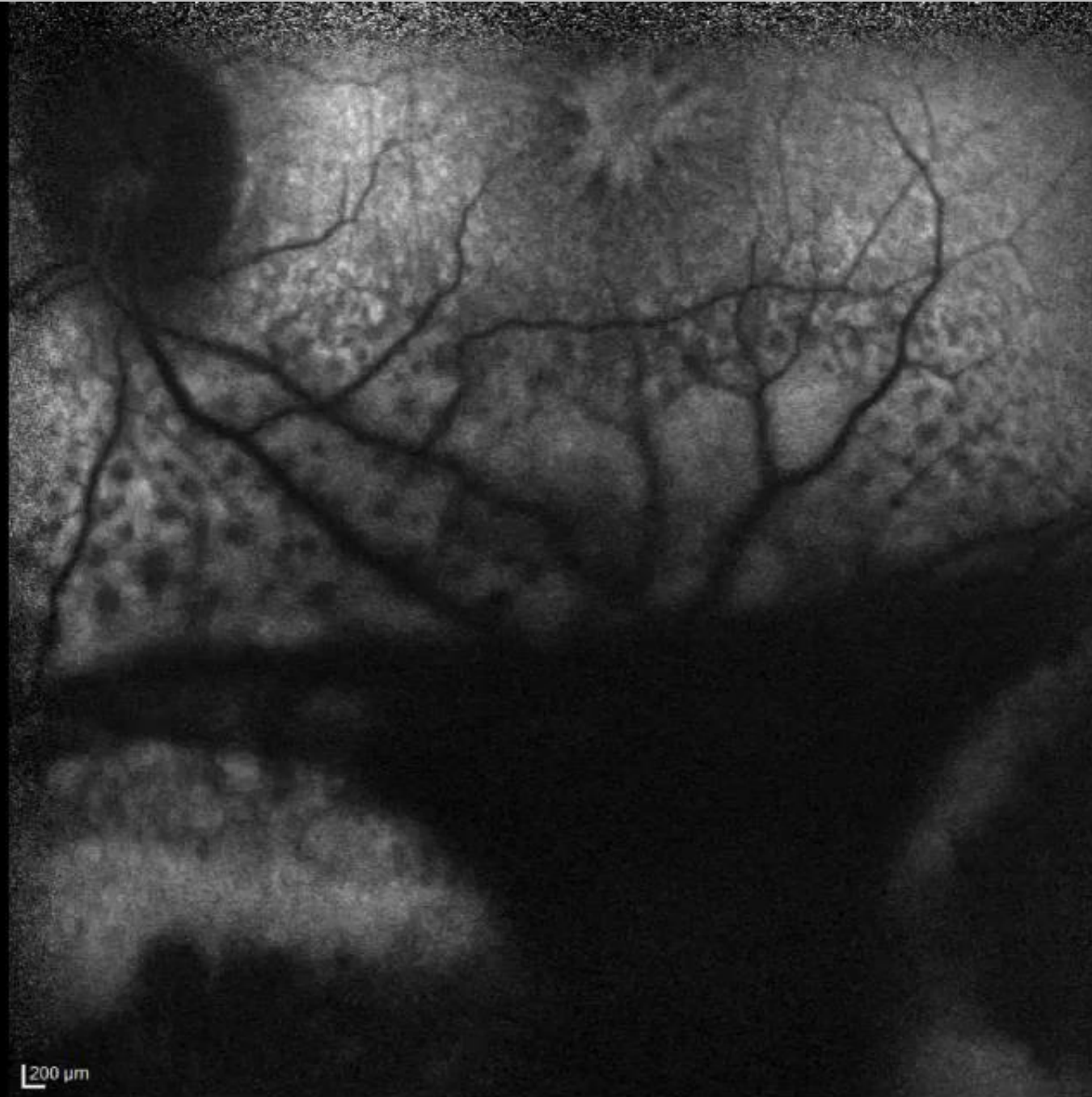
CXLR

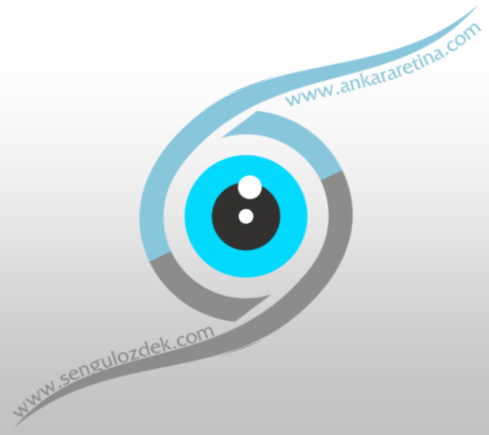
- Erkeklerde
- Bilateral, periferik+ foveal retinoskizis
- Tekrarlayan vitreus hemorajileri
- RRD

8 aylık E, Bilateral Vit Hem,
Hematolojik araştırma yapılmış!

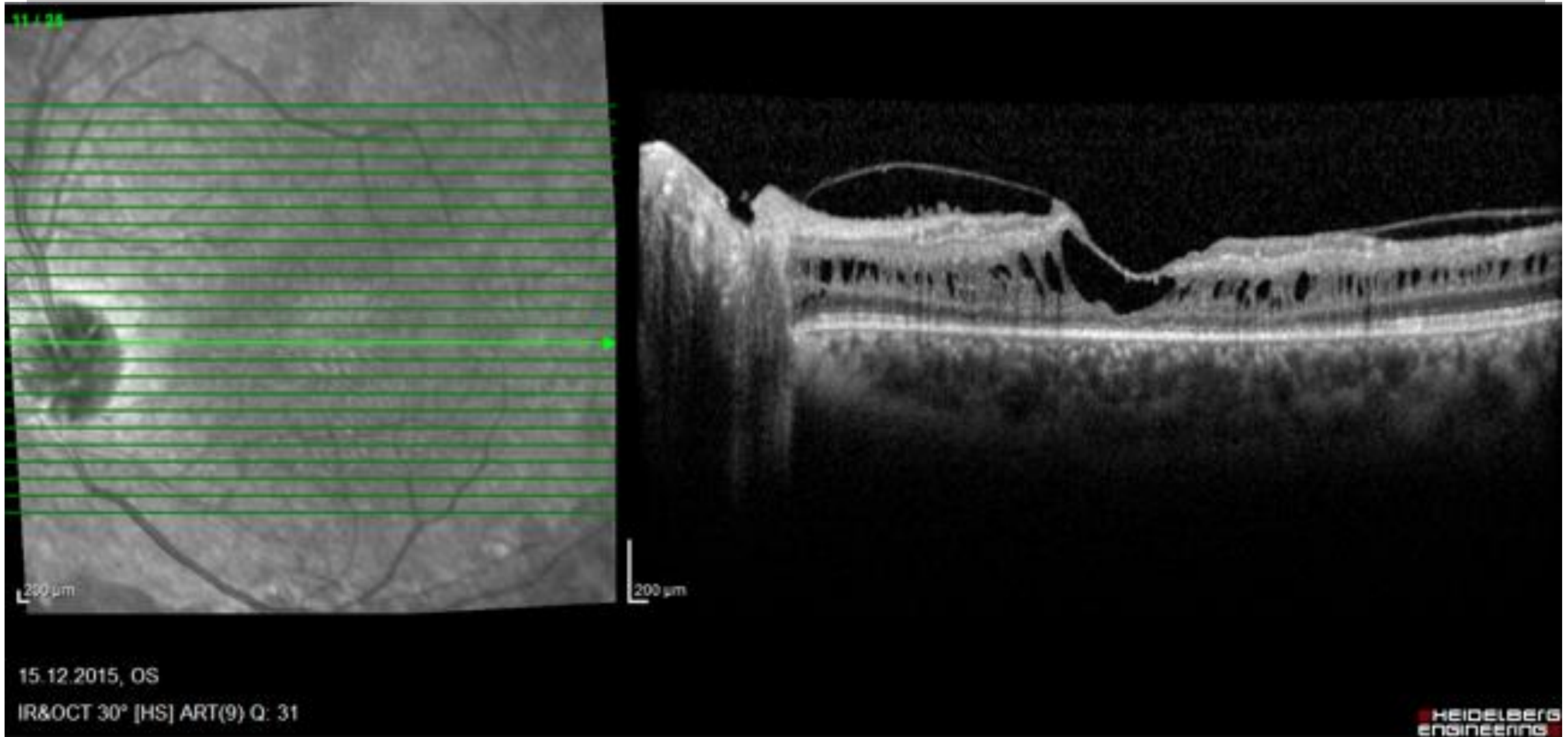


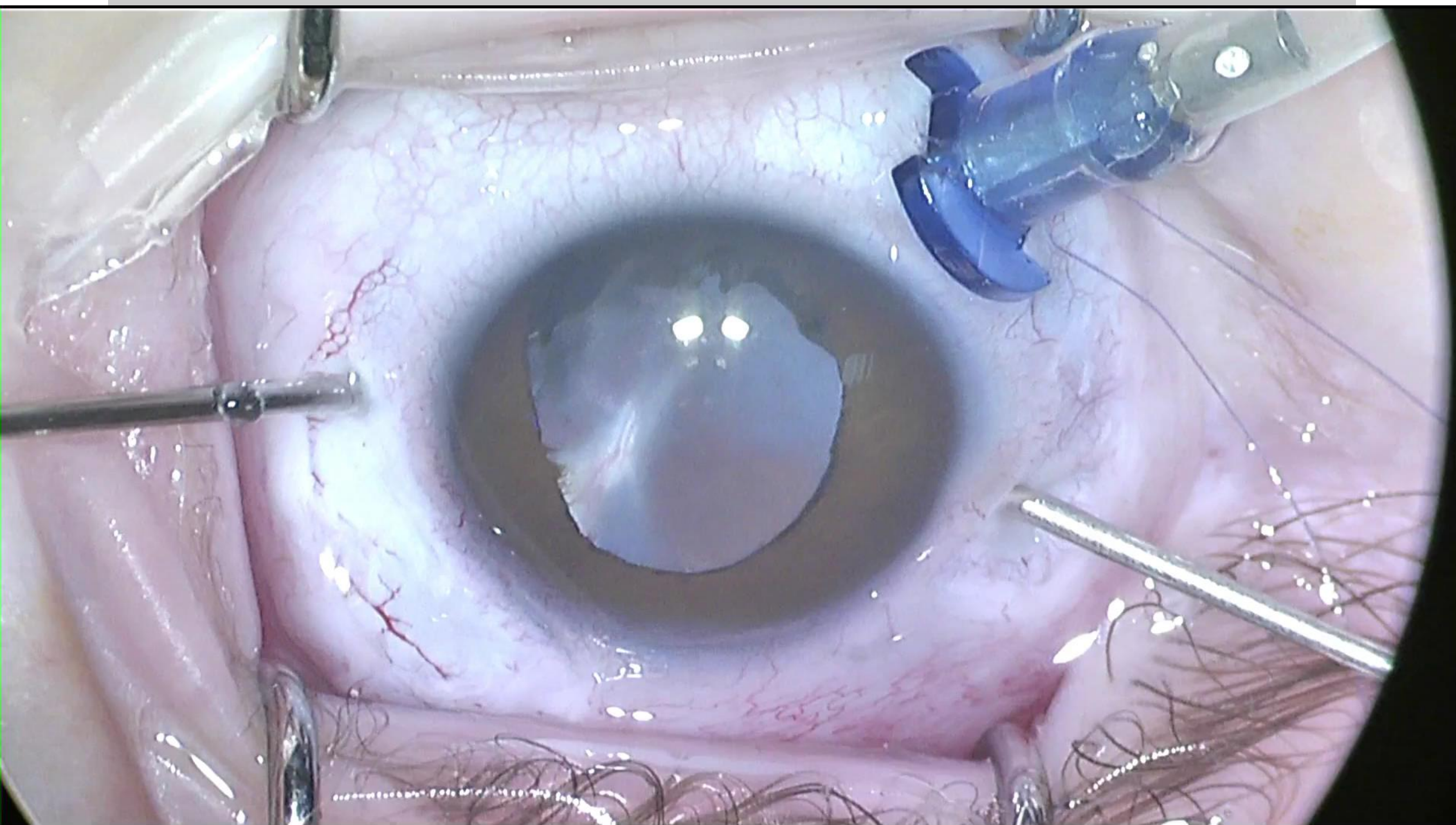
21y, E, GK: 0.3
15 yıl önce bilat PPV op, sağ göz FB

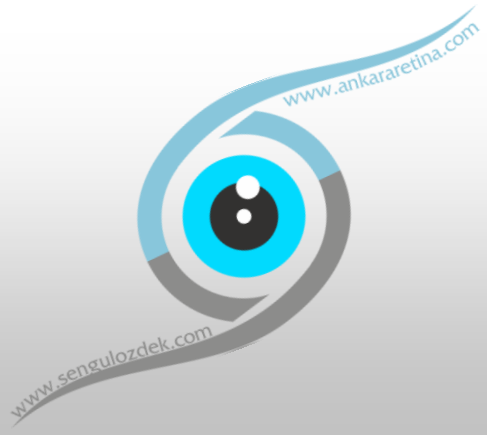




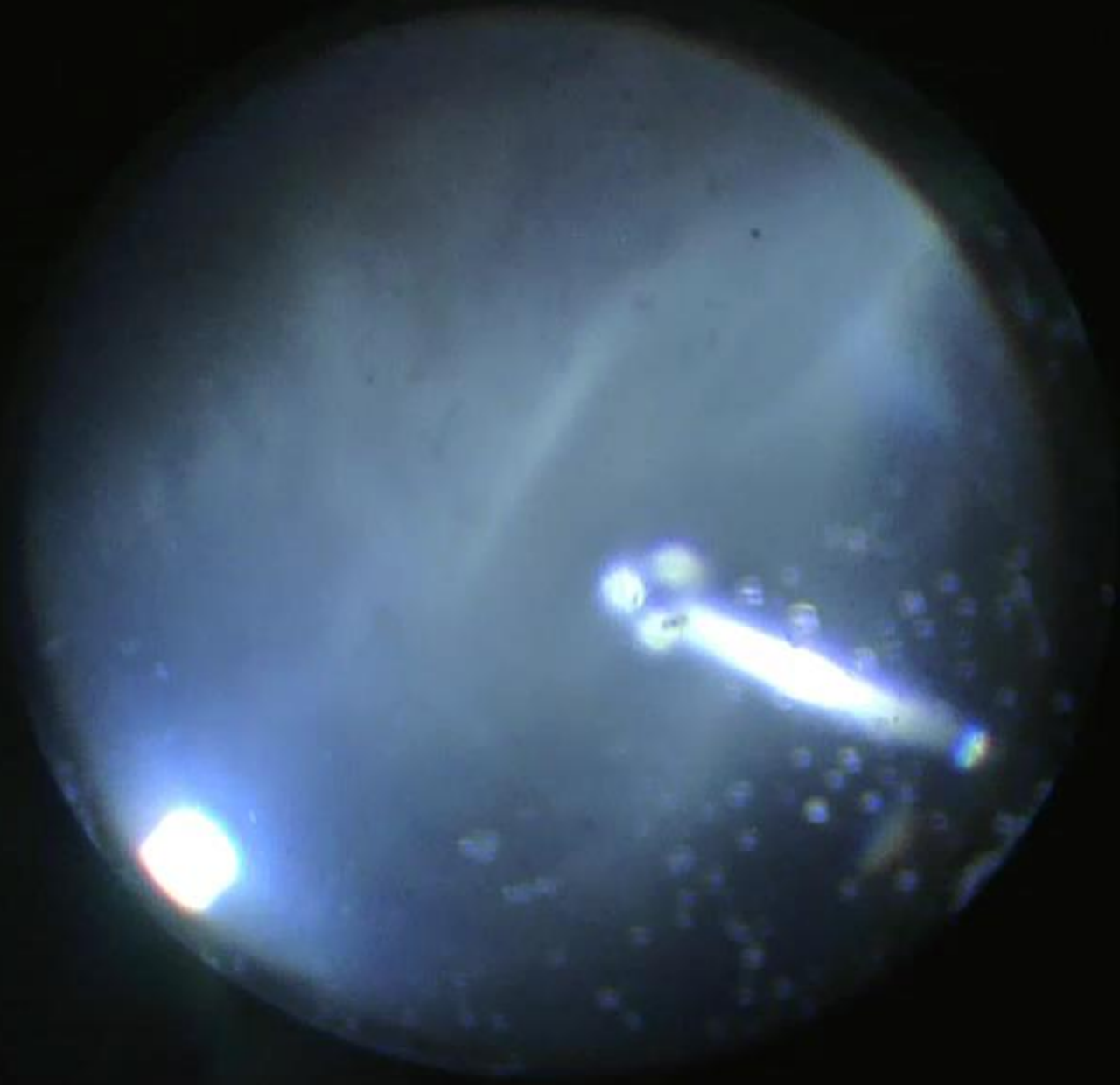
GK: 0.4





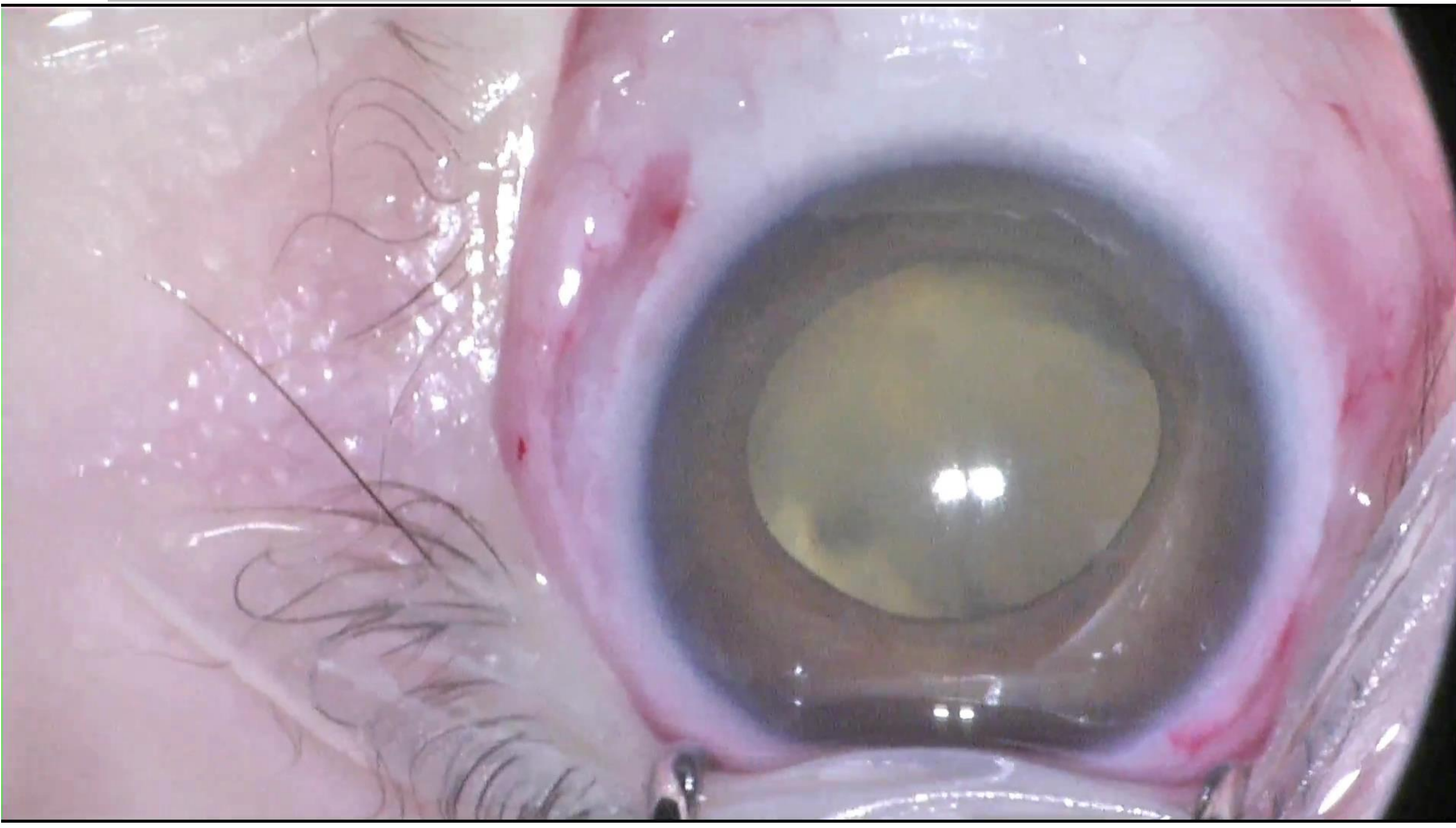


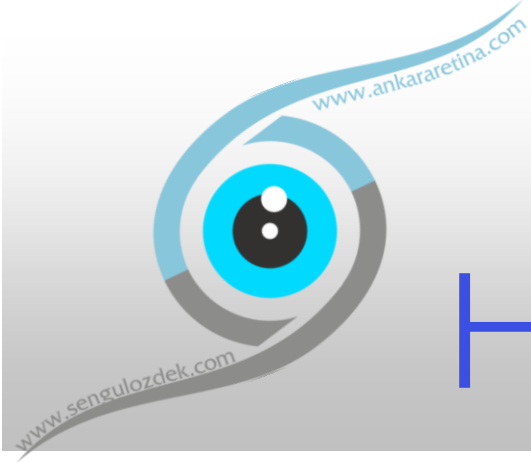
SHAKEN BABY





Shaken Baby? Terson?





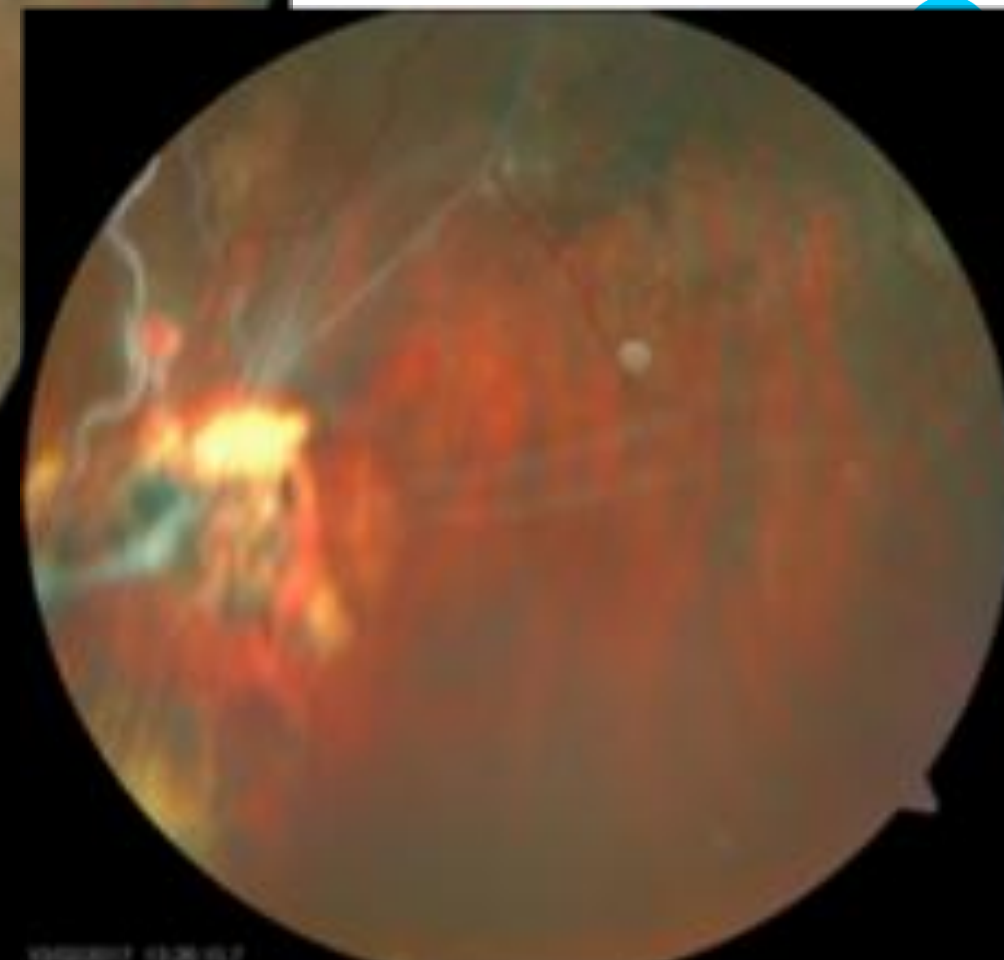
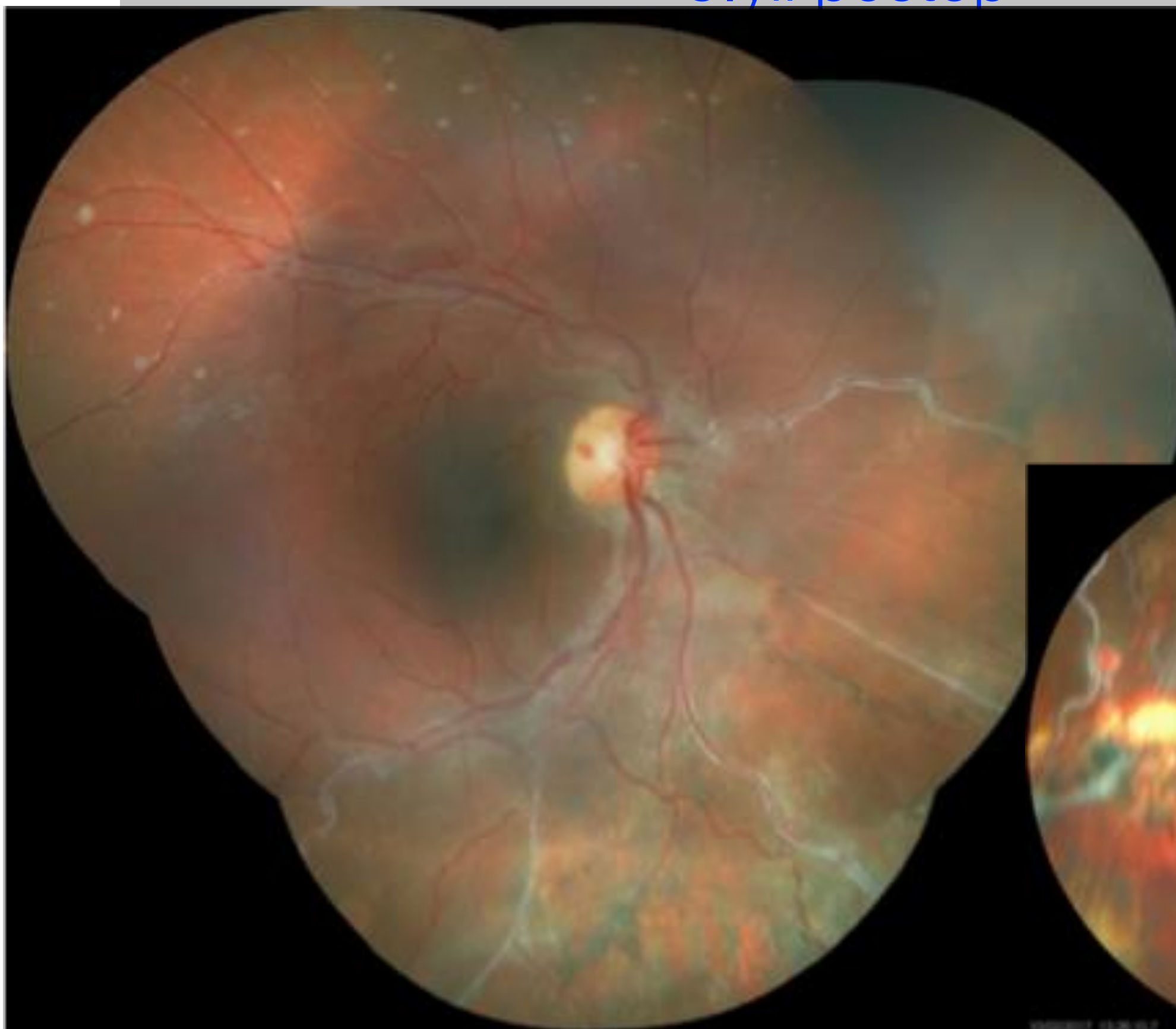
RETİNAL HEMANJIOBLASTOM

14y, VHL, Cerebellar hemanjioblastoma op.



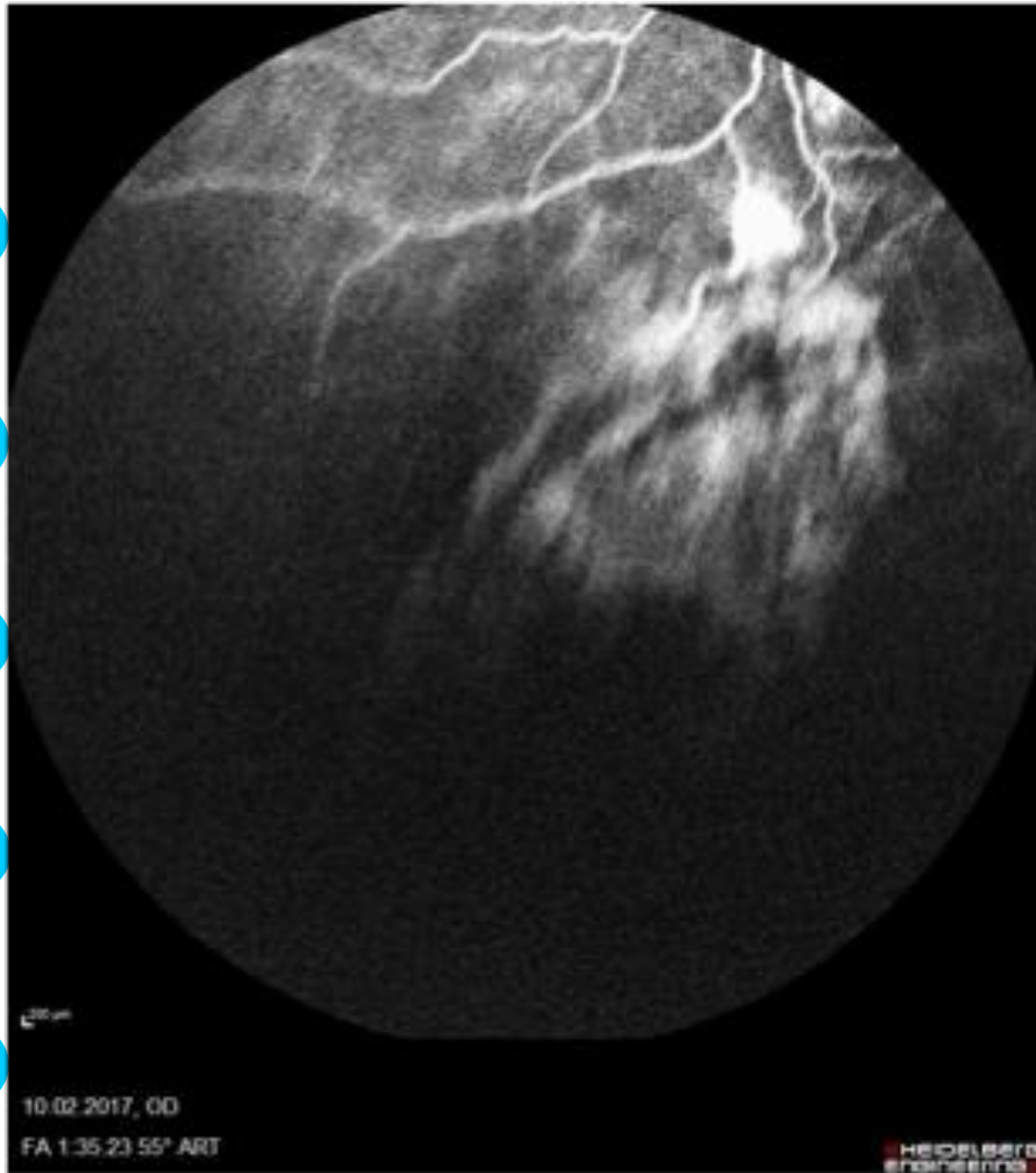
RETINAL HEMANGIOBLASTOM

3.yıl postop



RETINAL HEMANGIOBLASTOMA

Her 4-6 ayda bir FFA ile takip edilmeli



TEŞEKKÜRLER



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