

**MODUL MAHASISWA**

**MODUL  
PROBLEM BASED LEARNING  
SISTEM INDRA KHUSUS**



**- Modul Gangguan Penglihatan**

**- Modul Mata Merah**

**Diberikan Pada Mahasiswa Semester V  
Fakultas Kedokteran Unhas**

**Fakultas Kedokteran  
Universitas Hasanuddin  
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## MODUL MATA (Tutorial 5&6)

### SPECIAL SENSE SYSTEM OPHTHALMOLOGY MODULE

#### CASE 1

A 66 year old man was diagnosed as Senile Cataract + Diabetic Retinopathy ( ODS ), based on these findings :

**History:** A chief complain of decreased vision on both eyes, aware since  $\pm$  8 months ago and worsened for the past 4 weeks. Vision appears to be white, hazy smoke-like and seems to be clearer during night time. There was no history of using spectacles for distant vision, and neither of red eyes or trauma of the eye balls. There is a history of hypertension for about 10 years with improper treatment, diabetic mellitus is not known and neither in family history.

**Physical findings:** General state : Mild / Good nutrition / Conscious

- **Vital signs :**BP = 180/90 mmHg; **Pulse** = 80 x/mnt, **Breathe**= 20x/mnt; **Temp** = 36,7° C
- **Ophthalmology findings :**  
VOD = 3/60; could not be corrected    VOS= 1/60; could not be corrected
- Anterior Segment :

Eye	OD	OS
Palpebra	Normal	Normal
Cilia	Normal	Normal
Bulbar conjunctiva / Palpebral conjunctiva	Normal/ Hyperemic(-)	Normal/ Hyperemic(-)
Cnea	Clear	Clear
COA	Normal	Normal
Iris	Dark brown, crypt(+)	Dark brown, crypt(+)
Pupil	Round, central, light reflex (+)	Round, central, light reflex (+)
Lens	Opaque	Opaque, dense

- Posterior Segment :
  - FOD : fundus reflex (+), Optic nerve : fine edge, CDR 0,3, A/V : 1/3, Macula : fovea reflex(+), peripheral retinal : dot-blot hemorrhage 4 quadrant
  - FOS : fundus reflex (+), Optic nerve : fine edge, CDR 0,3, other details are difficult to evaluate due to dense cataract.
- Lab findings, biometry

Diagnose :ODS Mature Senile Cataract + Diabetic retinopathy

- Treatment plan :
  - Cataract extraction + IOL implant ( Intra Ocular Lens ) ODS
  - control blood glucose and pressure

**EACH STUDENTS ARE ASSIGNED TO :**

- 1. OUTLINE A MIND MAP OF SENILE CATARACT.**
- 2. DESCRIBE RISK FACTORS, PATHOPHYSIOLOGY OF SENILE CATARACT**
- 3. DESCRIBE CLINICAL MANIFESTATION OF CATARACT, INCLUDING SIGNS AND SYMPTOMS**
- 4. DESCRIBE TREATMENTS, POSSIBLE COMPLICATIONS AND ITS PROGNOSIS**
- 5. PRESENT AND DISCUSS THIS CASE IN CLASS**

**PROBLEM BASED LEARNING MODULE**  
**SHORT OBJECTIVE ORAL CASE ANALYSIS EXAM**  
**SPECIAL SENSE SYSTEM**

**CASE 2**

A 20 year old woman was diagnosed with anterior uveitis, due to:

***History taking :***

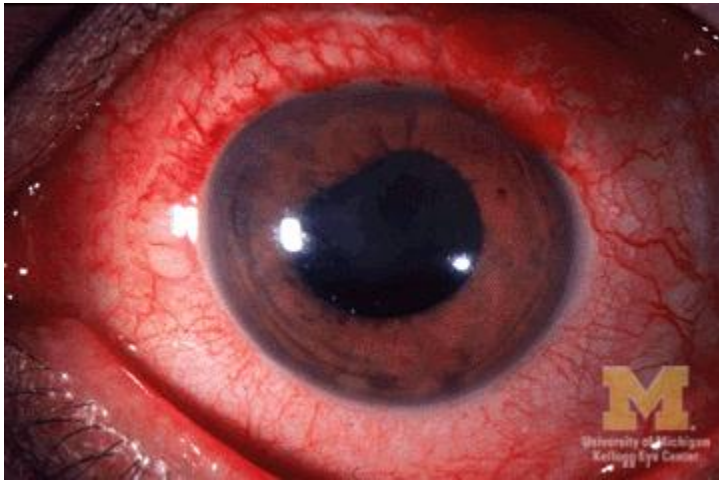
Major complaint was red and painful right eye, which since 1 week prior to visit, first symptom was mild pain which developed progressively until admitted. She also complaint of excessive tearing, glare and blurred vision on her right eye. No previous history of trauma, systemic illness nor ocular surgery. No history of spectacle uses and other ocular diseases.

**Pemeriksaan Fisik :** Keadaan Umum : Sakit sedang / Gizi baik/ sadar

- Vital sign : TD = 120/80; Nadi = 80x/mnt; Pernapasan= 20x/mnt; Suhu= 37,1°C
- Pemeriksaan Oftalmologi :
  - Visual Acuity :
    - OD : 3/60 Counting finger
    - OS : 20/20
  - Intraocular Pressure : OD : Tn      OS : Tn
  - Segmen Anterior :

<b>Structures of the eye</b>	<b>OD</b>	<b>OS</b>
Palpebra	Normal	Normal
Cilia	Normal	Normal
Konjungtiva bulbi/ Konjungtiva palpebral	Hyperemis, conjunctival injection (+), pericorneal injection (+)	Normal/ normal
Cornea	Slightly hazy,diffuse	Clear

	Keratic Precipitate (+)	
COA	AC (+), flare grade (+2)	Normal
Iris	Bombae Segmental posterior synechiae	Brown, crypte(+)
Pupil	Irregular shape	Round, light reflex(+)
Lens	Clear	Clear



**Posterior segment :**

FOD : Due to unclear media, posterior segment could not being evaluated

FOS : red reflex (+), fine edges of optic nerve, CDR normal, fovea reflex (+).

Laboratory findings : Leucocytosis ( 14.000 /ul ), elevated ESR/LED

Diagnose : Anterior Uveitis

**STUDENTS ARE ASSIGNED TO :**

- 1. OUTLINE A MIND MAP FOR THE CASE ABOVE**
- 2. DESCRIBE THE ETHIOLOGY AND PATHOPHYSIOLOGY OF THE CASE**
- 3. DESCRIBE CLINICAL MANIFESTATION OF ANTERIOR UVEITIS, INCLUDING ITS SIGNS AND SYMPTOMS**
- 4. DESCRIBE THE DIFFERENTIAL DIAGNOSE OF ANTERIOR UVEITIS**
- 5. DESCRIBE ITS MANAGEMENT AND PROGNOSIS**
- 6. PRESENT AND DISCUSS THIS CASE IN A GROUP**

## SPECIAL SENSE SYSTEM OPHTHALMOLOGY MODULE

### CASE 3 :

Seorang Wanita 60 tahun didiagnosis dengan Glaukoma absolut berdasarkan :

Anamnesis :

Kedua mata tidak bisa melihat yang dialami sejak 6 bulan yang lalu, awalnya pasien sering merasa sakit kepala sejak 2 tahun yang lalu, kemudian penglihatan kabur pada kedua mata dan perlahan – lahan tidak bisa melihat, riwayat mata merah (+), gatal (-), berair (+), kotoran mata berlebih (-), nyeri (-), silau (-), berair (+). Riwayat berobat (-), Riwayat operasi (-), Riwayat penyakit yang sama dalam keluarga(-), Riwayat HT (-), Riwayat DM (-).

Pemeriksaan Fisik :

#### A. Visus

VOD : 0

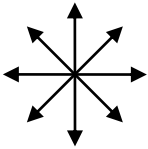
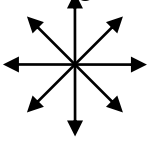
VOS : 1/-

#### Tonometri :

TOD = 0/5,5 = 0/7,5 = 2/10 = 59,1 mmHg

TOS = 0/5,5 = 0/7,5 = 2/10 = 59,1 mmHg

PEMERIKSAAN	OD	OS
Palpebra	Edema (-)	Edema (-)
Apparatus Lakrimalis	Lakrimasi (+)	Lakrimasi (+)
Silia	Normal	Normal
Konjungtiva	Hiperemis (-)	Hiperemis (-)

Bola mata	Normal	Normal
Mekanisme muskular	Normal ke segala arah : 	Normal ke segala arah : 
Kornea	Jernih	Jernih
Bilik Mata Depan	Dangkal	Dangkal
Iris	Coklat, kripte (+)	Coklat, kripte (+)
Pupil	Bulat, mid dilatasi (-), RC (-)	Bulat, sentral, mid dilatasi RC (-)
Lensa	Keruh	Keruh

#### A. Oftalmoskopi

FOD : refleks fundus (+), papil N.II batas tegas, CDR 1,0, a/v = 2/3, nasalisasi (+), makula refleks fovea (+) kesan normal, retina perifer kesan tipis.

FOS : refleks fundus (+), papil N.II batas tegas, CDR 1,0, a/v = 2/3, nasalisasi (+), makula refleks fovea (+) kesan normal, retina perifer kesan tipis.



**STUDENTS ARE ASSIGNED TO :**

- 1. OUTLINE A MIND MAP FOR THE CASE ABOVE**
- 2. DESCRIBE THE ETHIOLOGY AND PATHOPHYSIOLOGY OF THE CASE**
- 3. DESCRIBE CLINICAL MANIFESTATION OF ABSOLUTE GLAUCOMA, INCLUDING ITS SIGNS AND SYMPTOMS**
- 4. DESCRIBE THE DIFFERENTIAL DIAGNOSE OF ABSOLUTE GLAUCOMA**
- 5. DESCRIBE ITS MANAGEMENT AND PROGNOSIS**
- 6. PRESENT AND DISCUSS THIS CASE IN A GROUP**