

FIGURE 1. Patient A

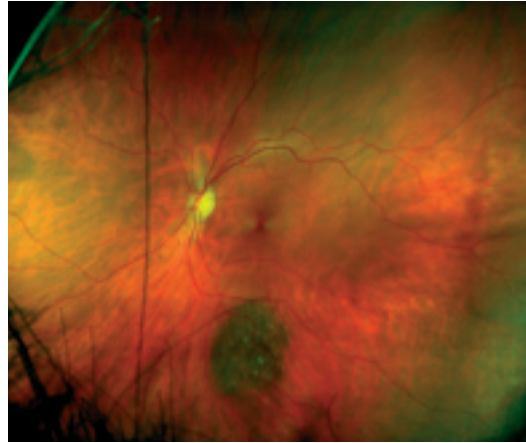


FIGURE 2. Patient B

IRRESPECTIVE of how one arrives at the correct spelling, one of my most feared fundus findings is that of presumed naevi (nevi).

Days and nights trawling through Kanski as an undergraduate did not prepare me for what I was about to see. No amount of understanding that choroidal melanin was brownish in colour as compared to the retinal pigment epithelium which is black helped. Could I really say with 100 per cent confidence the lesion was flat, with a greyish appearance and a less demarcated edge than of a retinal lesion such as a congenital hypertrophy of the retinal pigment epithelium (CHRPE)?

Did geographic patches of orange pigment overlying the naevi represent an early sign of a malignant transformation?

Generally, the fields showed nothing, and dilation with binocular indirect ophthalmoscopy helped little in differentiation. Usually, erring on the side of caution, I referred, often using such vague phrases as 'routine examination' 'not seen at previous examination', 'flat brown pigmented lesion', 'an immediate referral re-presumed naevus'.

Above are two images (Figures 1 and 2) – what would you do?

Patient A: age 70+ reports for 12-month examination. The lesion had not been seen before despite five previous visits.

Patient B: age 51 with a previous history of skin cancer. Presented for second opinion as couldn't see through progressive power lenses. I referred both.

RETINAL SCANNING/IMAGING

I had invested in the latest technology for retinal scanning/imaging and in front of me were two naevi, the very lesions it was possible to miss during routine direct ophthalmoscopy. The first major benefit of this imaging system was the ability to refer the condition by email. Within 12 hours I had consultant confirmation that indeed these were naevi.

The recommendation was that I should see the patient at six-monthly intervals and any change in size be reported to

Naevi or not nevi? Now that's a question

In the second of our case studies highlighting the advantages of the Optomap scanning laser ophthalmoscope system, **Simon Falk** describes how it may help with choroidal pigmented lesions

the ophthalmologist. The second major benefit is the ease with which the lesion may be measured by the software, making it possible to detect even minor size changes of such lesions over time. Both lesions have now been imaged three times and no change detected.

IMAGE SPLITTING

The huge advantage offered by the Optomap is the splitting of the image into two components: the deep choroidal layers and the neuro-sensory layers. This easily identifies choroidal lesions which very often may not be seen by direct ophthalmoscopy. It is clear the lesion is only present in the deep layers (as shown by

the colour separation of Figures 3 and 4).

I feel a lot more confident in my management of this common lesion. Studies suggest anywhere between 10 and 30 per cent of the fair-skinned population will have a choroidal naevus, which may be a surprise if only direct ophthalmoscopy is used, but less of a shock to those using indirect methods or scanning laser ophthalmoscopy where the lesions are much easier to detect.

Obviously, referral of all of these would bring the health service to its knees, but a systematic approach of electronic information transfer and accurate measurement makes for a better clinical result.

◆ *Optometrist Simon Falk practises in Leeds*

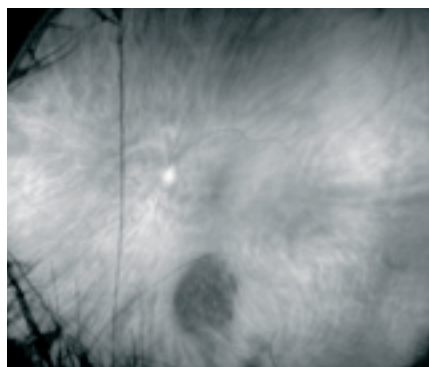


FIGURE 3. Red separation

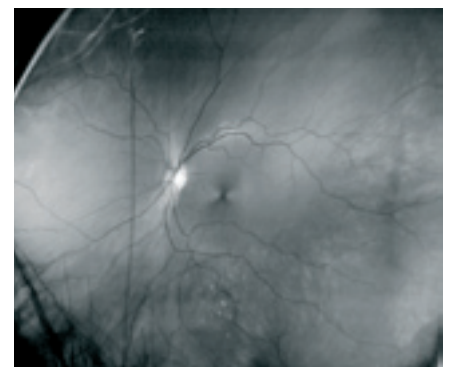


FIGURE 4. Green separation