Presumed optic neuritis management in A+E

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Most senior doctor in casualty to assess history and signs : ***is this really optic neuritis???***

→ *Take complete medical and system history*

Compatible clinical presentation?

→ retro-ocular pain / pain on eye movements,

→ subacute reduction of vision: visual acuity/ field defect/ reduced colour vision (progressing over days - up to 2 weeks) with an RAPD.

→ Mild optic swelling *or* normal optic nerve head on ophthalmoscopy.

"Typical" at presentation

(ie: compatible clinical presentation in absence of atypical red flags)

Review in 2 weeks A+E :
Onset of recovery with **improvement in pain and visual function ?**

No → **Urgent neuro-ophthalmology opinion <24 h** +/-
"Optic neuropathy" bloods & Urgent MRI orbits + brain with contrast

Yes → **Referral to neuro-ophthalmology**

"Atypical" red flags at presentation

VA below 6/60 (counting fingers or less)

No pain or intense pain/intense headaches

Pale discs with no previous known history of demyelintion/MS

Age > 45 years or < 15 years

Bilateral

Marked papillitis with presence of haemorrhages, exudates or pallor *

Positive history of immunosuppression or autoimmune disease, ongoing systemic symptoms suggesting Inflammation, current or recent infection, other acute neurological symptoms

Pain persisting > 2/52

Vision loss progressing over 2 weeks since onset

→ **Urgent neuro-ophthalmology opinion <24 h** +/-
"Optic neuropathy" bloods & Urgent MRI orbits + brain with contrast

*On fundoscopy. 1/3 of typical retrobulbar optic neuritis have a **mild i**psilateral optic nerve swelling; the other 2/3 have a normal –looking optic nerve on presentation. ***Florid papillitis with any haemorrhages/ exudates is NOT a feature of typical (ie, demyelinating) optic neuritis.***