



**STATE BOARD OF OPTOMETRY**  
2450 DEL PASO ROAD, SUITE 105, SACRAMENTO, CA 95834  
P (916) 575-7170 F (916) 575-7292 [www.optometry.ca.gov](http://www.optometry.ca.gov)



Continuing Education Course  
Approval Checklist

Title: **Orbital Trauma**

Provider Name: Kasra Eliasieh

Completed Application

Open to all Optometrists?  Yes  No

Maintain Record Agreement?  Yes  No

Correct Application Fee

Detailed Course Summary

Detailed Course Outline

PowerPoint and/or other Presentation Materials

Advertising (optional)

CV for EACH Course Instructor

License Verification for Each Course Instructor

Disciplinary History?  Yes  No



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## CONTINUING EDUCATION COURSE APPROVAL

## APPLICATION

**\$50 Mandatory Fee****\$50 Paid**

Pursuant to California Code of Regulations (CCR) § 1536, the Board will approve continuing education (CE) courses after receiving the applicable fee, the requested information below and it has been determined that the course meets criteria specified in CCR § 1536(g).

In addition to the information requested below, please attach a copy of the course schedule, a detailed course outline and presentation materials (e.g., PowerPoint presentation). Applications must be submitted 45 days prior to the course presentation date.

Please type or print clearly.

Course Title	Course Presentation Date
<i>Orbital Trauma</i>	<input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

## Course Provider Contact Information

Provider Name		
<i>Kasra</i>	<i>Eliasich</i>	—
(First)	(Last)	(Middle)

Provider Mailing Address
Street <i>1265 Church St.</i> city <i>San Francisco</i> State <i>CA</i> Zip <i>94114</i>

Provider Email Address <i>eliasichand@gmail.com</i>
---

Will the proposed course be open to all California licensed optometrists?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
Do you agree to maintain and furnish to the Board and/or attending licensee such records of course content and attendance as the Board requires, for a period of at least three years from the date of course presentation?	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO

## Course Instructor Information

Please provide the information below and attach the curriculum vitae for each instructor or lecturer involved in the course. If there are more instructors in the course, please provide the requested information on a separate sheet of paper.

Instructor Name		
<i>Kasra</i>	<i>Eliasich</i>	—
(First)	(Last)	(Middle)

License Number <i>A132S13</i>	License Type <i>MID</i>
-------------------------------	-------------------------

Phone Number <i>(330) 848 4755</i>	Email Address <i>eliasichand@gmail.com</i>
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I declare under penalty of perjury under the laws of the State of California that all the information submitted on this form and on any accompanying attachments submitted is true and correct.

  
Signature of Course Provider

*4/28/17*  
Date

Attention Board of Optometry.

To whom it might concern,

Along with this letter you will find CV's from all three doctors, CE applications, Summaries, Outlines, and Presentation materials. I apologized for the information being a little late but one of the doctors was Out of town and I didn't get his presentation information until much later.

Let me know if you need any other information.

Hedy Rodriguez

Batra Vision Medical Group

[hedyr@batravision.com](mailto:hedyr@batravision.com)

## Orbital Trauma Summary

Examining the Trauma Patient. Make sure cardiopulmonary and neurologic status is stable. Obtain focused history. Take into account the age and mental status.

Evaluation of eye precedes exam of soft tissue and bone. Inspect eyelids and facial skeleton. Orbital Roof Fractures are more common in children since frontal sinuses haven't pneumatized. Often involves brain and cribriform plate.

Zygomaticomaxillary Complex Fractures (ZMC) usually caused by blow to cheek, usually by fist.

Renee Le Fort described pillars of resistance to define strongest regions of facial skeleton. All Le Fort fractures involve the pterygoid plates (where maxillary sinus attaches to skull)

Intraorbital Foreign Bodies should be suspected in all cases of orbital trauma when there is a cutaneous wound. CT Scan, MRI is contraindicated for suspected metal foreign bodies. BB pellets usually made from non-ferromagnetic materials, but they are often *contaminated* with ferromagnetic materials. Wood may be difficult to visualize.

Traumatic Optic Neuropathy. Frontal bone trauma causes shearing injury to nerve. Similar to treatment for head injury patients, rationale is to reduce post-traumatic inflammation and edema. No randomized studies have shown effectiveness.

CRASH study in 2004 (Corticosteroid Randomization After Significant Head Trauma) showed head injury patients treated with steroids had significantly elevated risk of death as compared with placebo.

Orbital Trauma  
Kasra Eliasieh, M.D.  
Oculofacial Plastic Surgery  
[eliasiehmd@gmail.com](mailto:eliasiehmd@gmail.com)

- Topics
    - Examining the trauma patient
    - Orbital (blowout) Fractures
    - Orbital Roof Fractures
    - Zygomaticomaxillary Complex Fractures (ZMC)
    - Naso-Orbito-Ethmoid Fractures (NOE)
    - Le Fort Fractures
    - Retrobulbar Hemorrhage
    - Intraorbital Foreign Bodies
    - Traumatic Optic Neuropathy
  - Examining the Trauma Patient
  - Obtain focused history
    - Mechanism of injury
- Fall - what height? mechanism?
- Assault - was instrument used? (foreign body)
- Take into account the age and mental status
- Skepticism for histories: children or inebriated patients
- PMH, PSH, allergies
  - Symptoms - vision loss? hypesthesia? diplopia? bite? N/V?
  - **Last NPO?**
- Examining the Trauma Patient
  - Make sure cardiopulmonary and neurologic status is stable
  - Evaluation of eye precedes exam of soft tissue and bone
    - Prevent further eye injury as result of manipulation of surrounding tissues
    - Check for RG, hyphema, lacerations, VH
    - Check vision/pupils/APD. If vision is decreased but eye exam is normal, consider traumatic optic neuropathy
  - Examining the Trauma Patient
  - Photo documentation!
  - Inspect eyelids and facial skeleton
  - Signs of facial fractures (obtain CT scan)
    - Limited EOM
    - Hypesthesia of infraorbital nerve
    - Enophthalmos (may not be manifest if swelling/hemorrhage)
    - Epistaxis
    - Subcutaneous emphysema (sinus continuity - no nose blowing!)
    - Deformity (telecanthus, globe ptosis, flat malaria eminence, rim discontinuity “step-off”)
    - Trismus, malocclusion of teeth
  - Orbital Blowout Fractures
    - Lamina papyracea and/or orbital floor (usually no other bones involved)

- Intraorbital pressure increases due to blunt trauma, fracturing the bones
- Orbital contents pushed into maxillary and/or ethmoid sinuses
- If recoil, orbital tissues can become entrapped in fracture site, causing restrictive strabismus (usually in children)
- Orbital Blowout Fractures
- Signs
  - Echymoses and edema (may be absent in kids)
  - Diplopia with limitation of EOMs (forced ductions? IOP?)
  - Enophthalmos (masked initially)
  - Globe ptosis
  - Hypesthesia of cheek/teeth
  - Emphysema of eyelids/orbit
- Orbital Blowout Fractures
  - Surgery usually performed ASAP, within 2 weeks.
  - May start PO steroids to hasten resolution of edema
  - Indications for Repair

Diplopia with limitation in EOMs 7-10 days after injury. Positive forced duction test.

>2mm enophthalmos within 2 wks

>50% of orbital floor

- Orbital Blowout Fractures
- Children

- Special attention required
- “Greenstick type fracture” entraps orbital tissue
- “White-eyed” blowout

Under 18yo with insignificant trauma C/O pain or diplopia

Quiet exam except for

Restriction of EOM

Nausea/vomiting or bradycardia with EOM

- If muscle is entrapped, non-treatment may result in fibrosis and permanent restriction
- Requires immediate repair, at most within 24hrs
- Orbital Roof Fractures
  - More common in children since frontal sinuses haven't pneumatized.
  - Often involves brain and cribriform plate
  - Neurosurgery consult
  - In adults, frontal sinus acts as “crumple zone”
  - Surgical intervention indicated when displaced
  - Surgery performed in conjunction with neurosurgery
- Zygomaticomaxillary Complex Fractures (ZMC)
  - Usually caused by blow to cheek, usually by fist
  - Fractures occur at:

ZF suture

ZM suture

Orbital floor/maxillary sinus (ZS Suture)

Zygomatic arch

- Zygomaticomaxillary Complex Fractures (ZMC)

- Findings
  - Flattening of malar eminence
  - Step-off deformity
  - Lateral canthal dystopia
  - Lower lid retraction
  - Globe ptosis
  - Enophthalmos
  - Trismus (depression of arch against temporalis)
  - Diplopia (uncommon)
- Caused by direct trauma to the glabella
  - Force of impact causes collapse of bridge of nose
  - Ethmoids crushed
  - Nasal bones and frontal processes of maxilla splay outward, creating telecanthus
- Sequelae
  - Telecanthus
  - Nasal dorsum flattening
  - Traumatic NLDO
- Renee Le Fort described pillars of resistance to define strongest regions of facial skeleton
  - All Le Fort fractures involve the pterygoid plates (where maxillary sinus attaches to skull)
  - Separates lower maxilla from midface and cranium
  - Results in malocclusion
  - Pyramid shaped
  - Involves anterior orbit: nasal, lacrimal, maxillary bones, medial orbital floor
  - Craniofacial dysjunction
- Entire facial skeleton detached from cranium
- Involves medial wall, lateral wall, floor
  - Signs
  - Acute proptosis
  - Decreased vision
  - Afferent pupillary defect
  - Restriction of eye movements
  - Elevated intraocular pressure (tonopen)
  - 40mmHg
  - Management
  - Immediate lateral canthotomy and cantholysis
  - Central retinal artery occlusion of 105 min or longer showed irreversible optic nerve damage in monkeys.
  - Treatment aimed at lowering orbital and ocular pressure to protect the optic nerve
  - Intraorbital Foreign Bodies should be suspected in all cases of orbital trauma when there is a cutaneous wound.
    - CT Scan. MRI is contraindicated for suspected metal foreign bodies

BB pellets usually made from non-ferromagnetic materials, but they are often *contaminated* with ferromagnetic materials

Wood may be difficult to visualize

- Indications to remove foreign body:
  - Most metallic substances, except for copper and iron, remain relatively inert (observation).
  - Wood: reservoir for microbes due to porous nature, early excision is necessary.
  - Plastic and glass: inert, but sharp edges may cause significant morbidity and may require removal.
- Traumatic Optic Neuropathy
  - Direct injury

Orbital laceration

Bone fragment

- Indirect injury

Frontal bone trauma causes shearing injury to nerve

- R/O globe injury in pts with vision loss in trauma patients
- If no other cause for decreased vision, suspect TON
- Management

Starting in 1980s, “megadose” steroids (IV methylprednisolone 30mg/kg followed by infusion)

Similar to treatment for head injury patients, rationale is to reduce post-traumatic inflammation and edema

No randomized studies have shown effectiveness

CRASH study in 2004 (Corticosteroid Randomization After Significant Head Trauma) showed head injury patients that were treated with steroids had significantly elevated risk of death as compared with placebo

High dose steroids no longer indicated

- Management

Optic canal decompression

Similar to rationale for steroids, decompresses nerve

Most commonly performed via endoscope trans-sphenoidally

IONTS (International Optic Nerve Trauma Study) showed no additional benefit of surgical decompression or steroids compared with observation

May have benefit if performed immediately after observed vision loss from trauma

# Auge des Menschen.

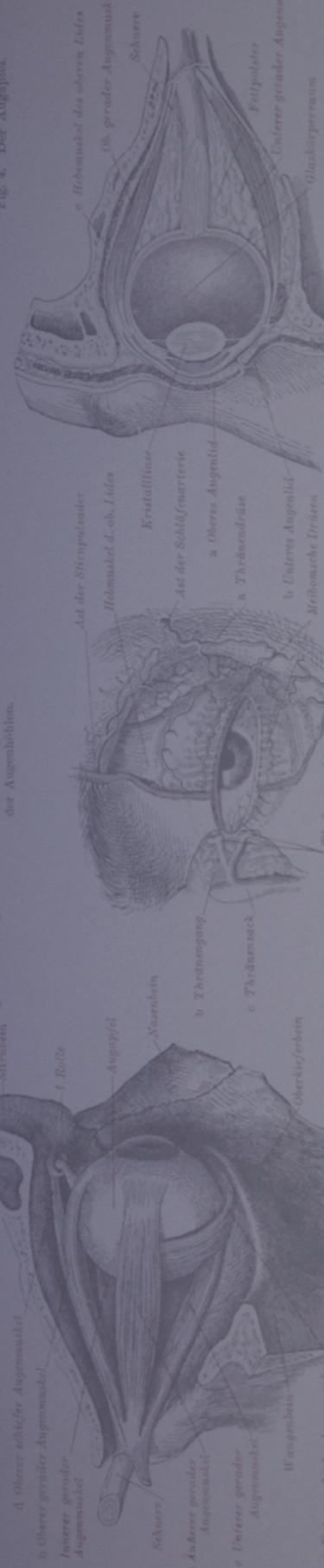


# Orbital Trauma

Kasra Eliasieh, M.D.

Cosmetic and Reconstructive Oculofacial Plastic Surgery  
[dreliasieh@silkisseyesurgery.com](mailto:dreliasieh@silkisseyesurgery.com)

Strikeln Fig. 1. Das Auge mit den Sehnerven von oben, nach Entfernung des Dacryos.



# Auge des Menschen.

# TOPICS

- Examining + know trauma in front of you
- Orbital (blowout) Fractures
- Orbital Roof Fractures
- Zygomaticomaxillary Complex Fractures (ZMC)
- Naso-Orbito-Ethmoid Fractures (NOE)
- Le Fort Fractures
- Retrobulbar Hemorrhage
- Intraorbital Foreign Bodies
- Traumatic Optic Neuropathy

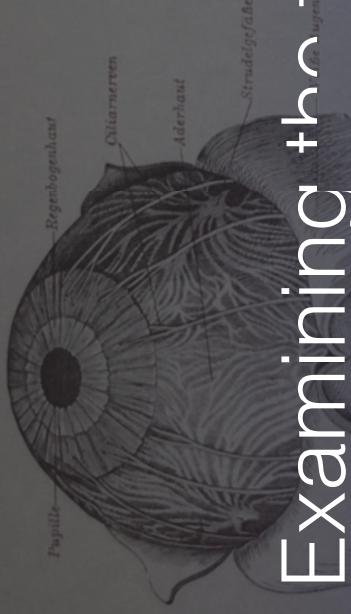


Fig. 8. Das Auge und seine Schutzorgane.

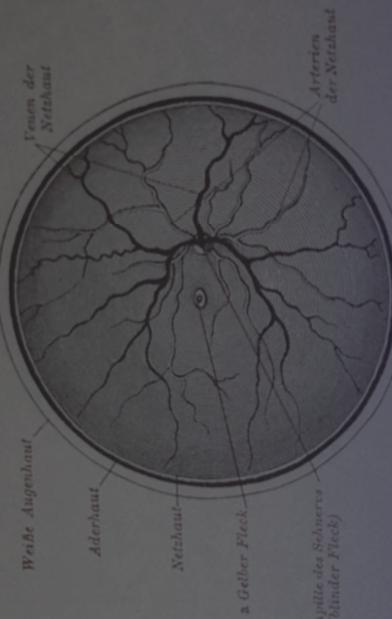


Fig. 7. Hauptdarstellung der Netzhaut.



## Zygomaticomaxillary Complex Fractures (ZMC)

Fracture through the zygomaticomaxillary complex (ZMC) leads to enophthalmos.

Fracture through the naso-orbito-ethmoid (NOE) leads to epiphora.

Fracture through the orbital roof leads to cerebrospinal fluid leak.

Fracture through the orbital floor leads to orbital cellulitis.

Fracture through the maxilla leads to facial nerve palsy.

Fracture through the ethmoid leads to epiphora.

Fracture through the sphenoid leads to CSF leak.

Fracture through the orbital roof and floor leads to enophthalmos.

Fracture through the orbital roof and floor leads to orbital cellulitis.

Fracture through the orbital roof and floor leads to CSF leak.

Fracture through the orbital roof and floor leads to facial nerve palsy.

Fracture through the orbital roof and floor leads to epiphora.

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Fracture through the orbital roof and floor leads to epiphora.

Zum Artikel zugegr.



Fig. 7. Hauptdarstellung der Netzhaut.

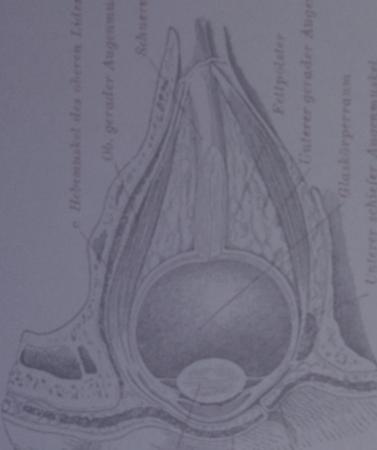


Fig. 7. Hauptdarstellung der Netzhaut.



Fig. 7. Hauptdarstellung der Netzhaut.



Fig. 7. Hauptdarstellung der Netzhaut.

Zum Artikel zugegr.

Zum Artikel zugegr.

Bibliographisches Institut in Leipzig.

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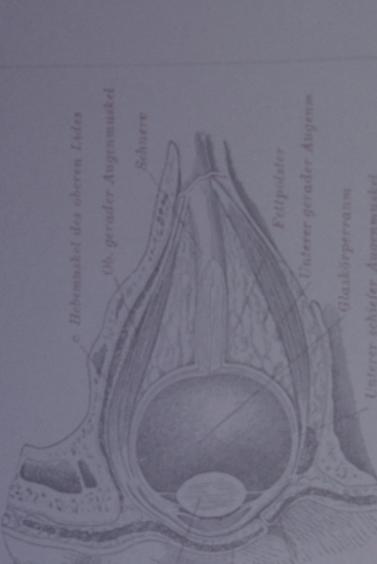


Fig. 7. Hauptdarstellung der Netzhaut.



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# Examining the Trauma Patient

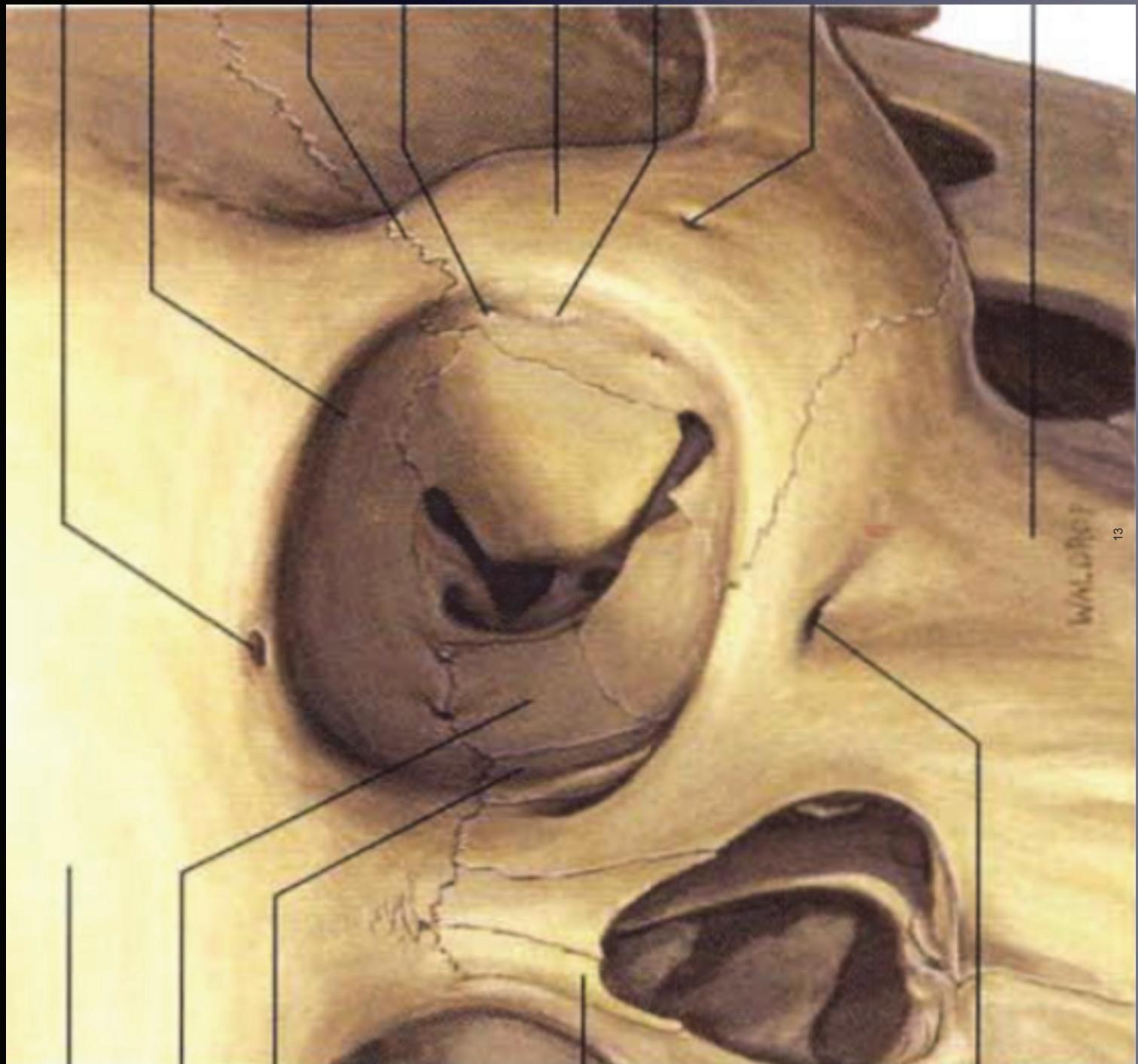
- Obtain focused history
- Mechanism of injury
  - Fall - what height? mechanism?
  - Assault - was instrument used? (foreign body)
  - Take into account the age and mental status
- Skepticism for histories: children or inebriated patients
- PMH, PSH, allergies
- Symptoms - vision loss? hypesthesia? diplopia? bite? N/V?
- **Last NPO?**

# Examining the Trauma Patient

- Make sure cardiopulmonary and neurologic status is stable
- Evaluation of eye precedes exam of soft tissue and bone
- Prevent further eye injury as result of manipulation of surrounding tissues
- Check for RG, hyphema, lacerations, VH
- Check vision/pupils/APD. If vision is decreased but eye exam is normal, consider traumatic optic neuropathy

# Examining the Trauma Patient

- Photo documentation!
- Inspect eyelids and facial skeleton
- Signs of facial fractures (obtain CT scan)
  - Limited EOM
  - Hypesthesia of infraorbital nerve
- Enophthalmos (may not be manifest if swelling/hemorrhage)
- Epistaxis
- Subcutaneous emphysema (sinus continuity - no nose blowing!)
- Deformity (telecanthus, globe ptosis, flat malaria eminence, rim discontinuity “step-off”)
- Trismus, malocclusion of teeth

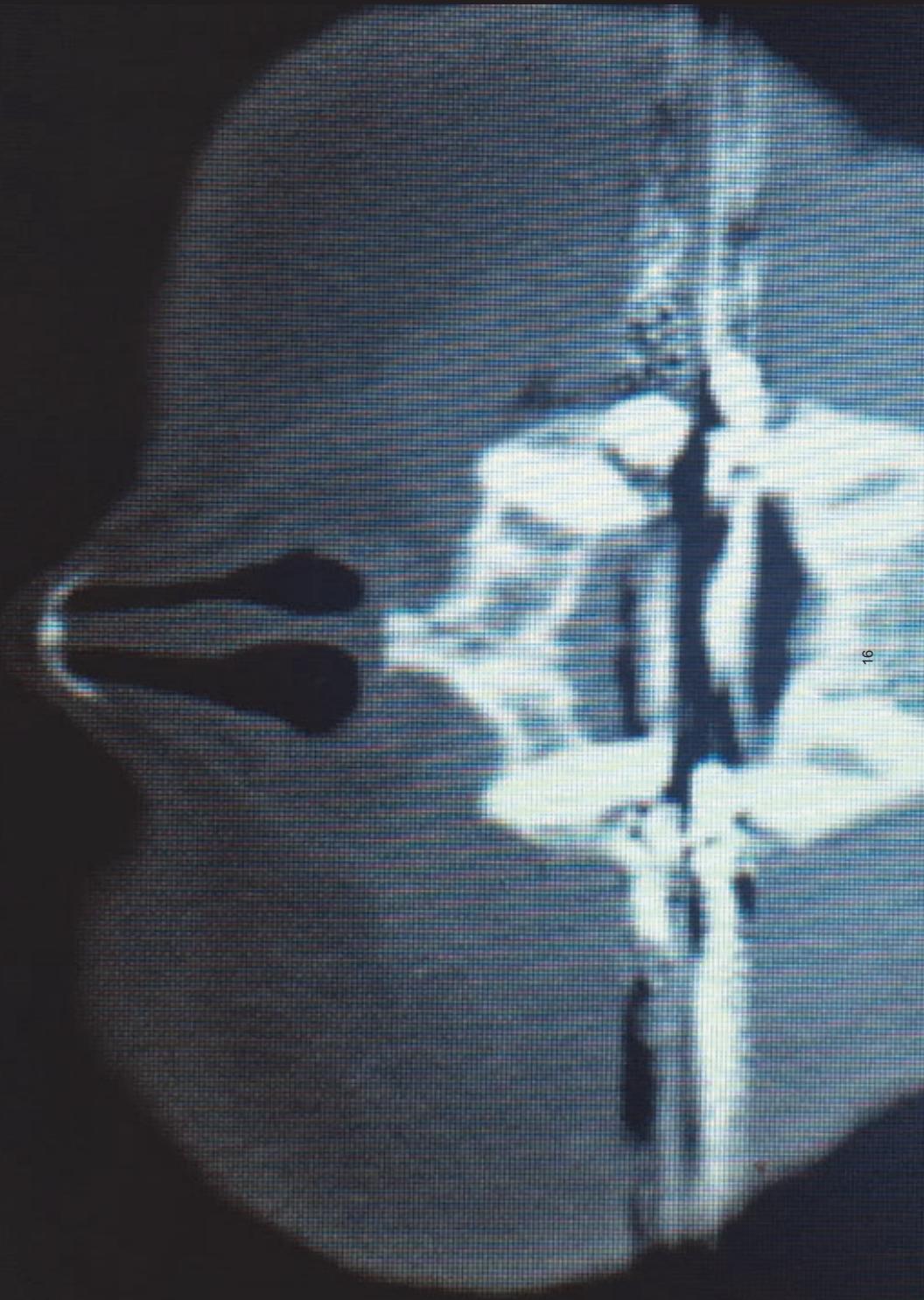


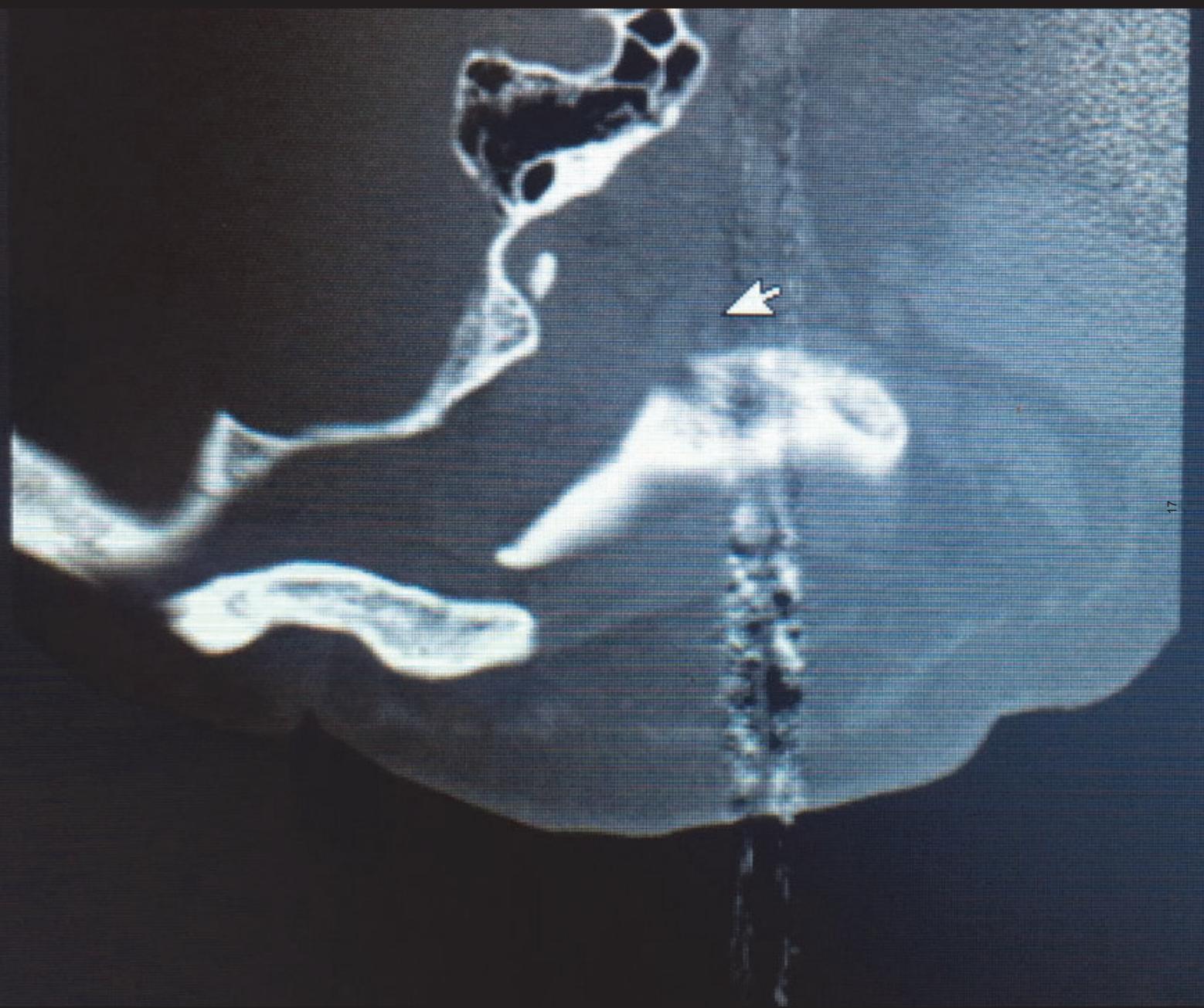
# Orbital Blowout Fractures

- Lamina papyracea and/or orbital floor (usually no other bones involved)
- Intraorbital pressure increases due to blunt trauma, fracturing the bones
- Orbital contents pushed into maxillary and/or ethmoid sinuses
- If recoil, orbital tissues can become entrapped in fracture site, causing restrictive strabismus (usually in children)

# Orbital Blowout Fractures

- Signs
- Echymoses and edema (may be absent in kids)
- Diplopia with limitation of EOMs (forced ductions? IOP?)
- Enophthalmos (masked initially)
- Globe ptosis
- Hypesthesia of cheek/teeth
- Emphysema of eyelids/orbit







N Gellrich

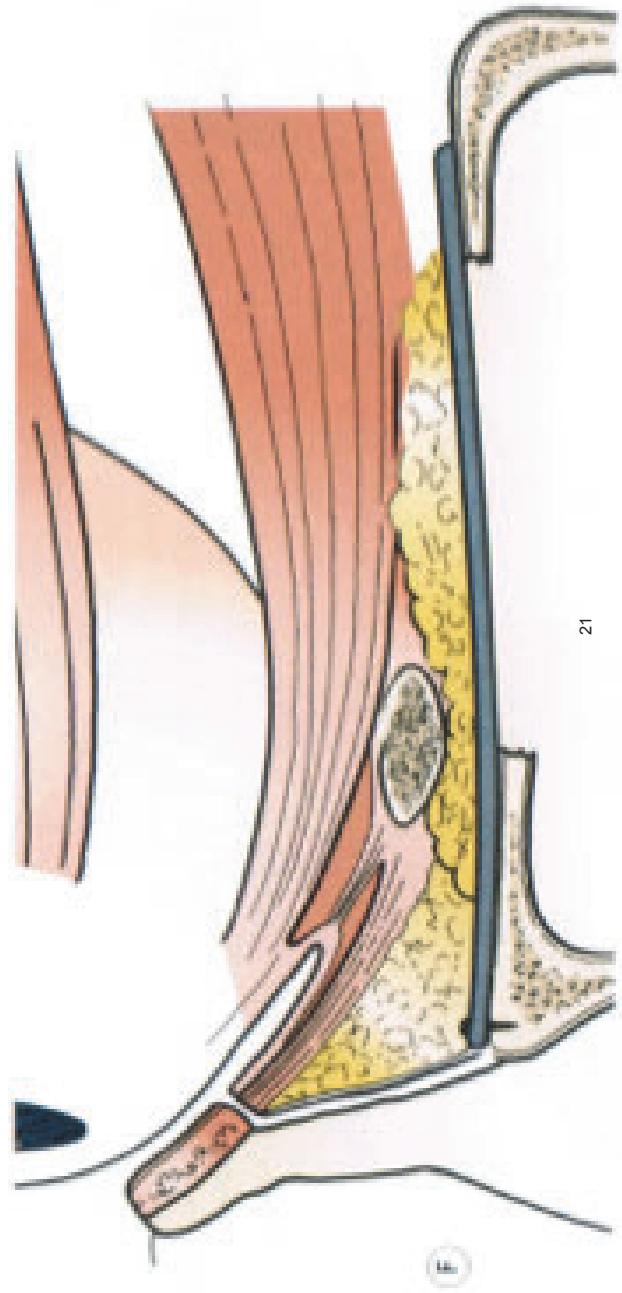
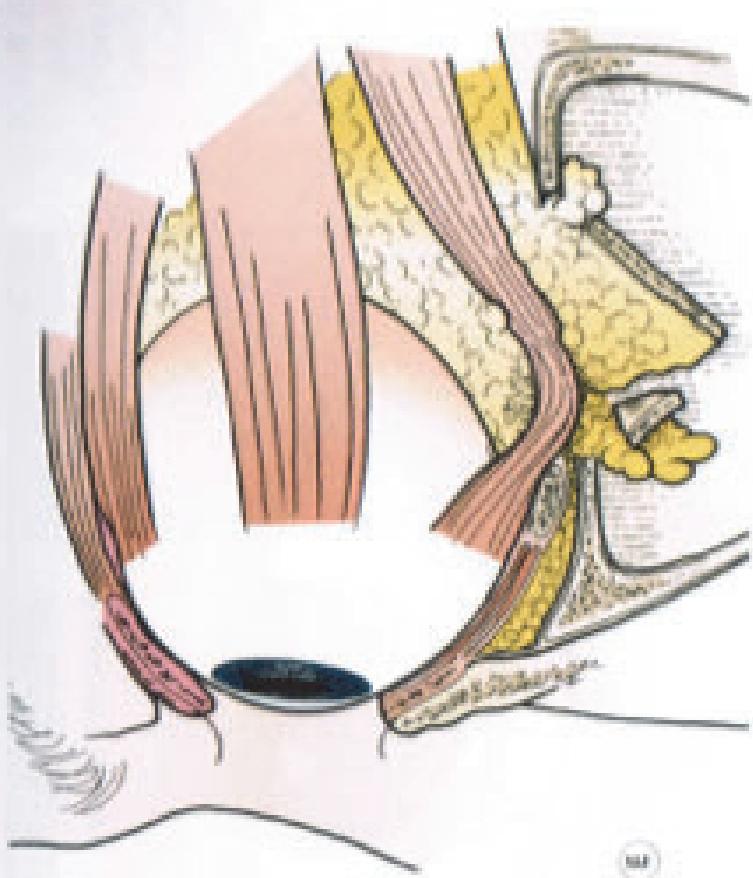


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N Gellrich

# Orbital Blowout Fractures

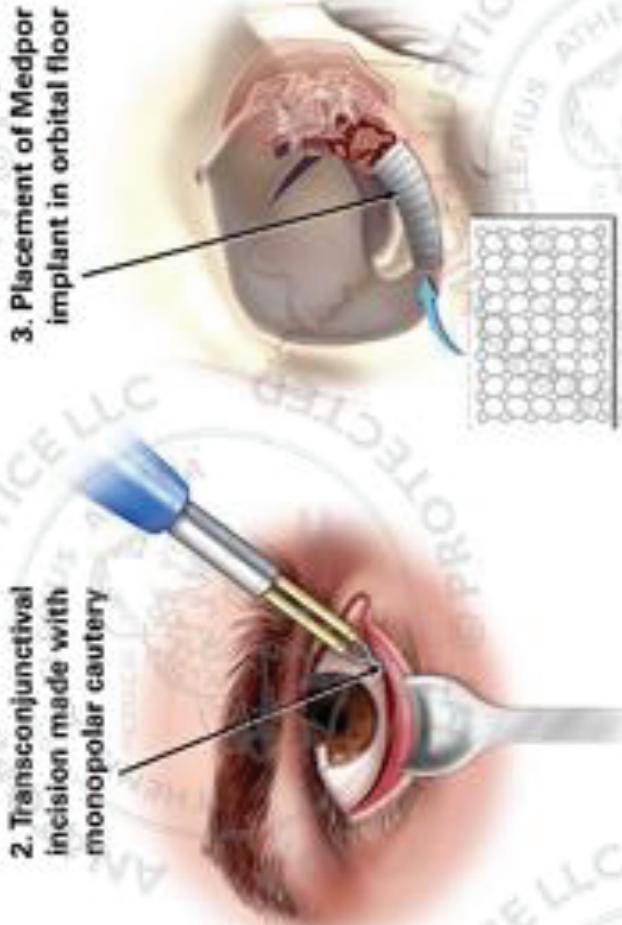
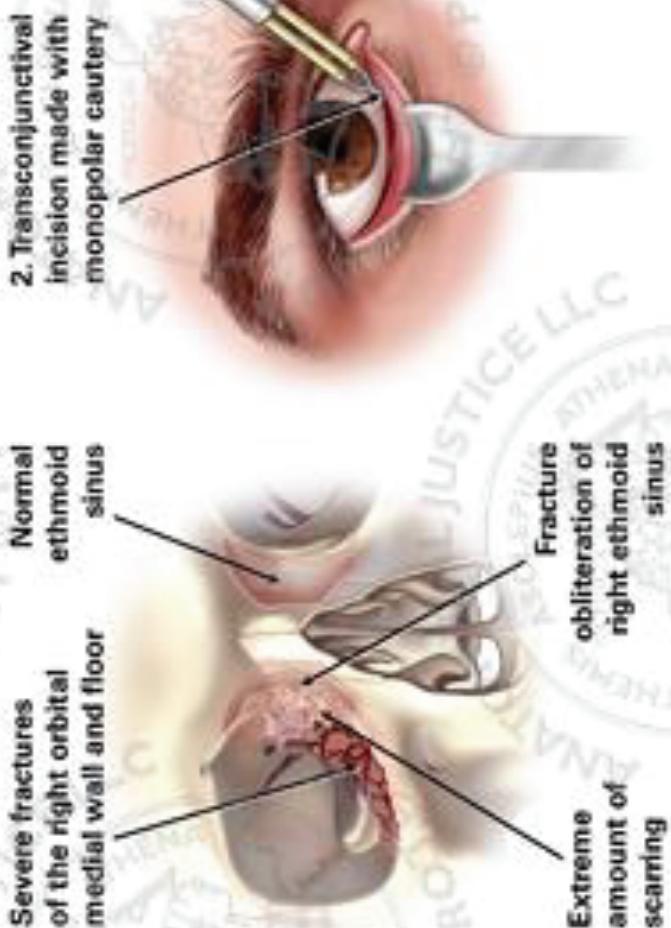
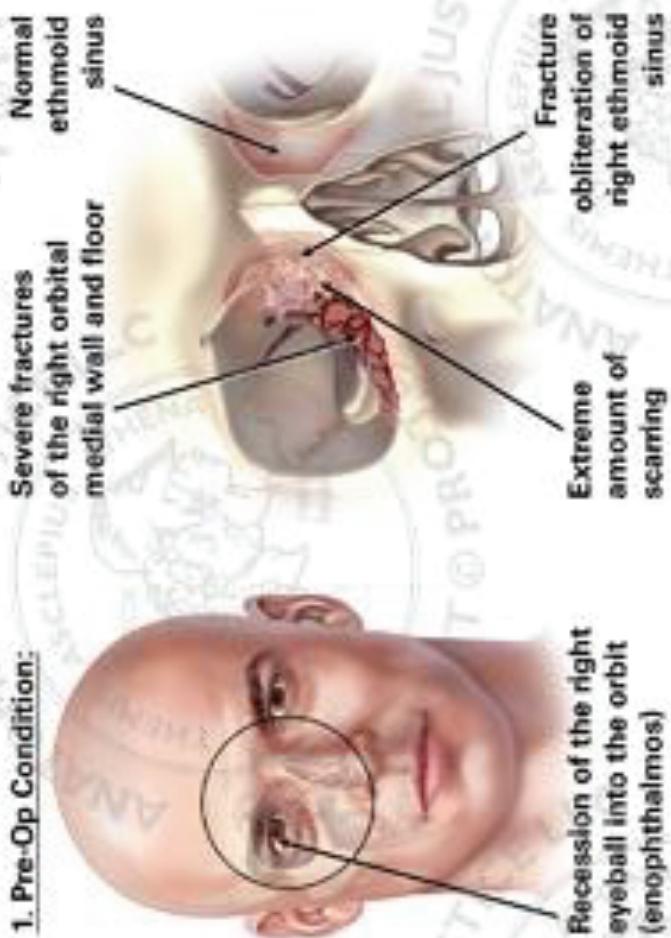
- Surgery usually performed ASAP, within 2 weeks.
- May start PO steroids to hasten resolution of edema
- Indications for Repair
  - Diplopia with limitation in EOMs 7-10 days after injury. Positive forced duction test.
  - >2mm enophthalmos within 2 wks
  - >50% of orbital floor



# JOHN DOE

## Right Orbital Floor and Medial Wall Fractures with Surgical Implant Repair

### 1. Pre-Op Condition:

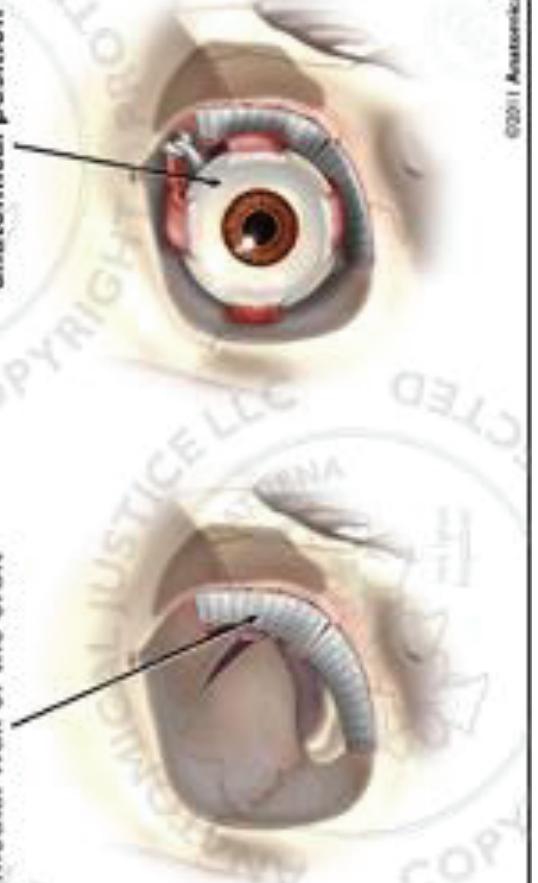


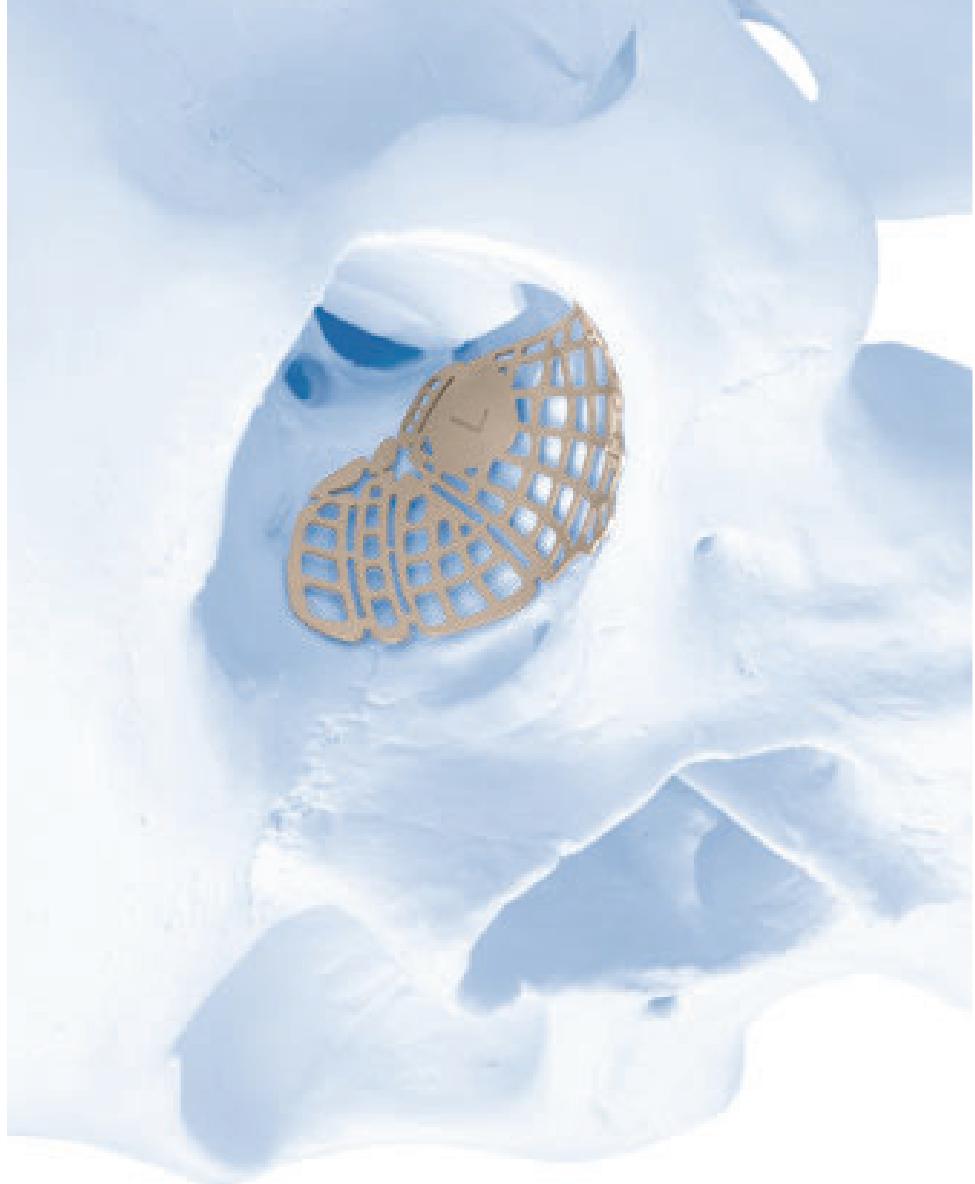
4. Incision made through the plica semilunaris with scissors

5. Fragments and sinus mucosa removed from the right ethmoid sinuses

6. A second Medpor implant placed in the medial wall of the orbit

7. Post-Op Condition:  
Enophthalmos reduced and eyeball restored to normal anatomical position





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# Orbital Blowout Fractures

- Children
  - Special attention required
  - “Greenstick type fracture” entraps orbital tissue
  - “White-eyed” blowout
- Under 18yo with insignificant trauma C/O pain or diplopia
  - Quiet exam except for
  - Restriction of EOM
  - Nausea/vomiting or bradycardia with EOM
- If muscle is entrapped, non-treatment may result in fibrosis and permanent restriction
- Requires immediate repair, at most within 24hrs

# Orbital Blowout Fractures

- 12yo boy with no past medical history, was jumping on a trampoline earlier this evening when his knee struck his left eye. There was no loss of consciousness.
- He immediately complained of left eye pain, worse with eye movements. Had minimal periorbital swelling.
- Normal visual acuity, but he complained of binocular diplopia. He vomited 30 minutes after injury.



Spin: 2  
Tilt: -0

L



F 27  
Noncontrast

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W: 2500 L: 500  
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Zoom=161%

23:00:36 -  
PriorS=0

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Tilt: -0

L

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28  
Mammogram

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FOV: 18.2cm x 18.2cm

R

# Orbital Blowout Fractures

- Patient underwent urgent orbital fracture repair with release of entrapped periocular tissue including the inferior rectus.



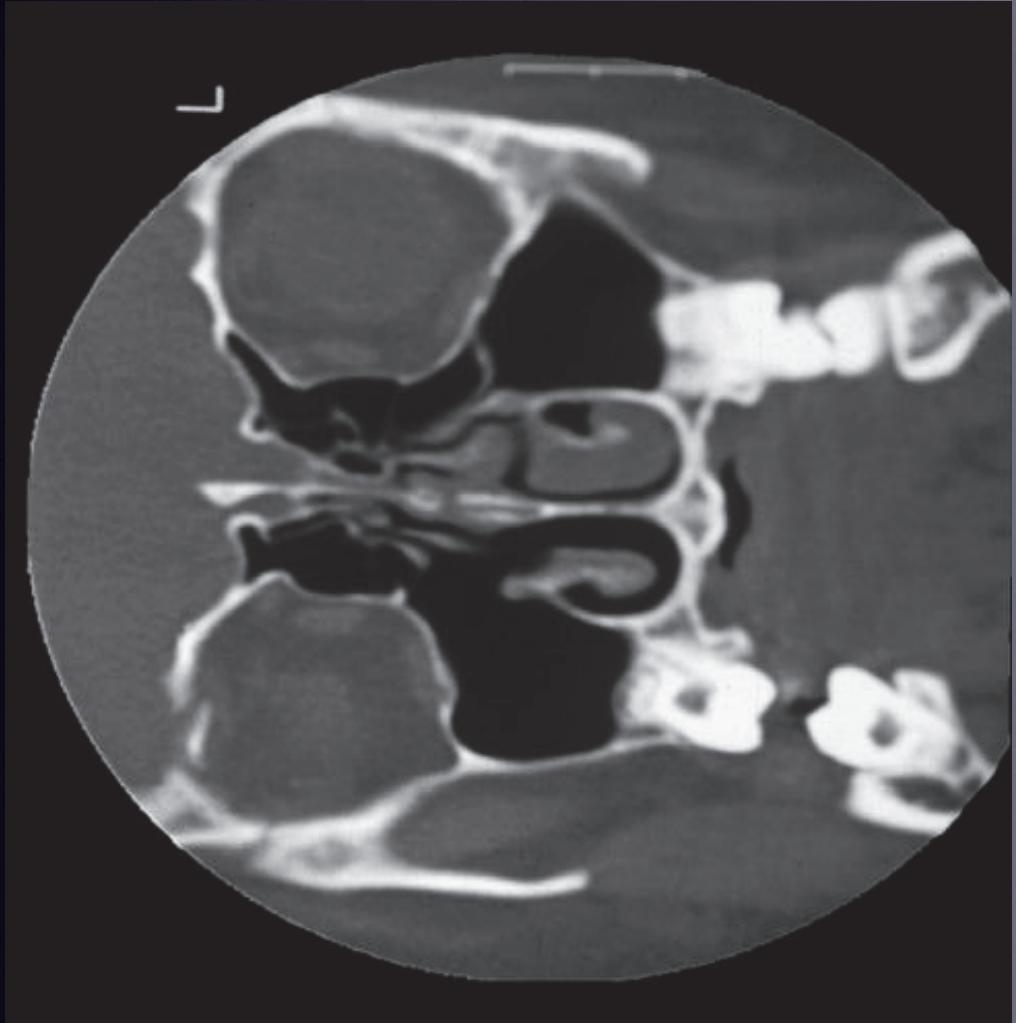




# Orbital Roof Fractures

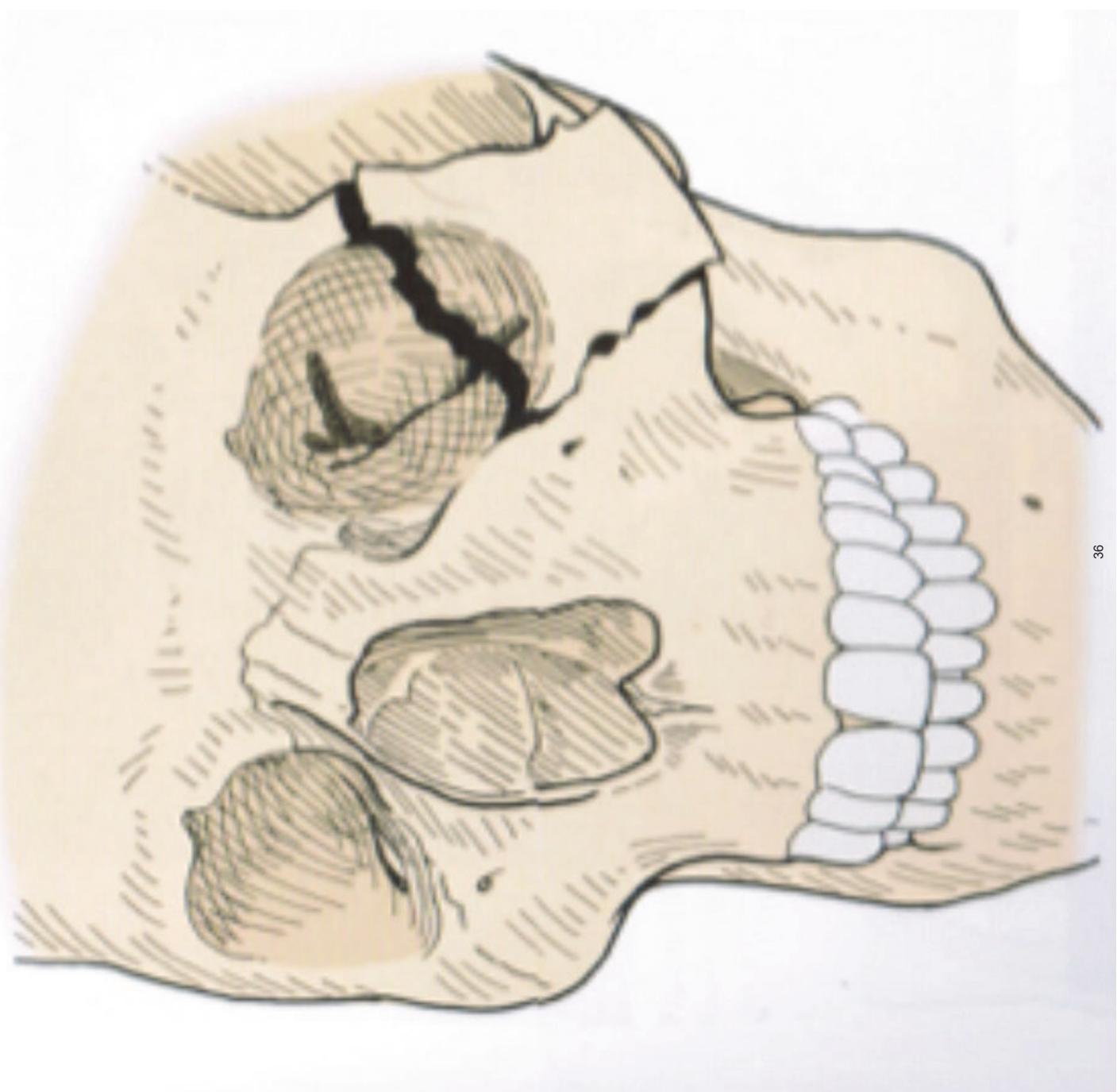
- More common in children since frontal sinuses haven't pneumatized. Often involves brain and cribriform plate
- Neurosurgery consult
- In adults, frontal sinus acts as "crumple zone"
- Surgical intervention indicated when displaced
- Surgery performed in conjunction with neurosurgery

# Orbital Roof Fractures



# Zygomaticomaxillary Complex Fractures (ZMC)

- Usually caused by blow to cheek, usually by fist
- Fractures occur at:
  - ZF suture
  - ZM suture
- Orbital floor/maxillary sinus (ZS Suture)
- Zygomatic arch

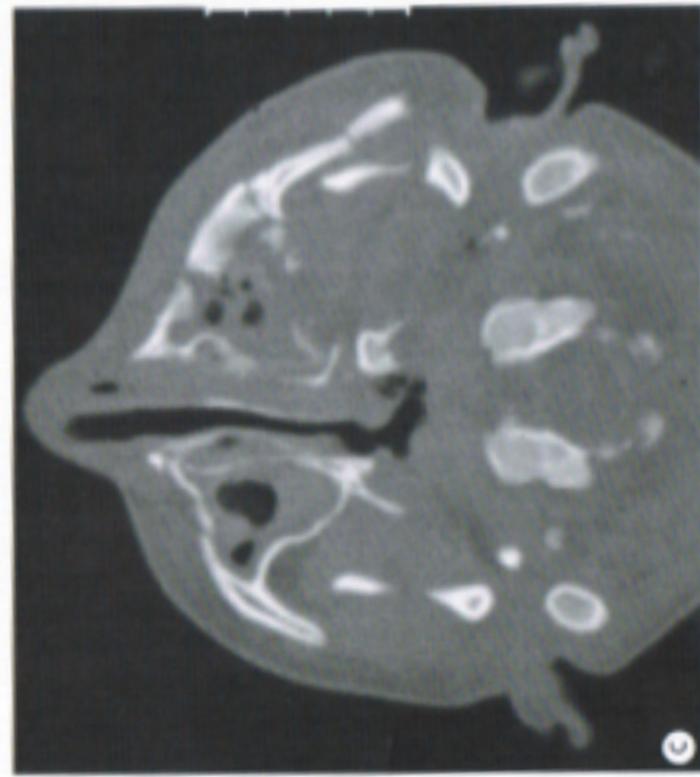
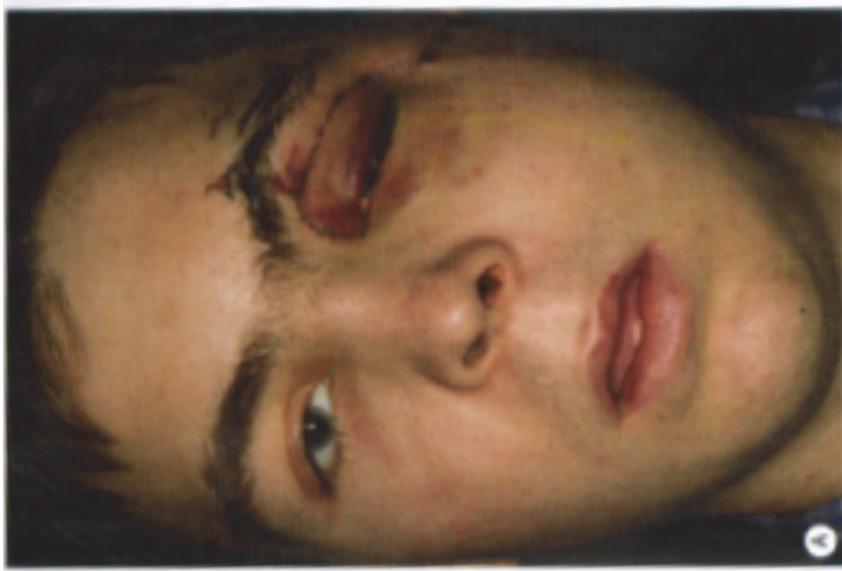
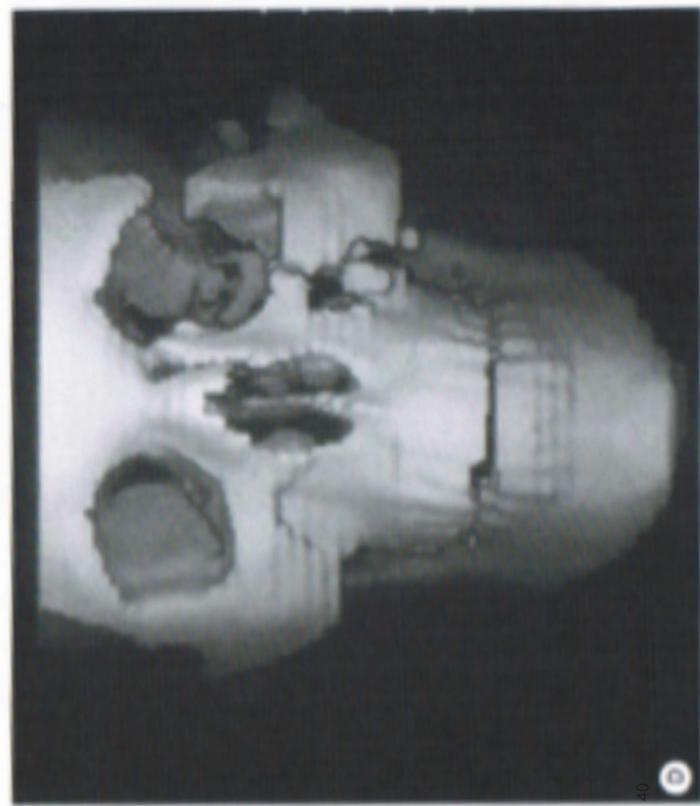


# Zygomaticomaxillary Complex Fractures (ZMC)

- Findings
  - Flattening of malar eminence
  - Step-off deformity
  - Lateral canthal dystopia
  - Lower lid retraction
  - Globe ptosis
  - Enophthalmos
  - Trismus (depression of arch against temporalis)
  - Diplopia (uncommon)





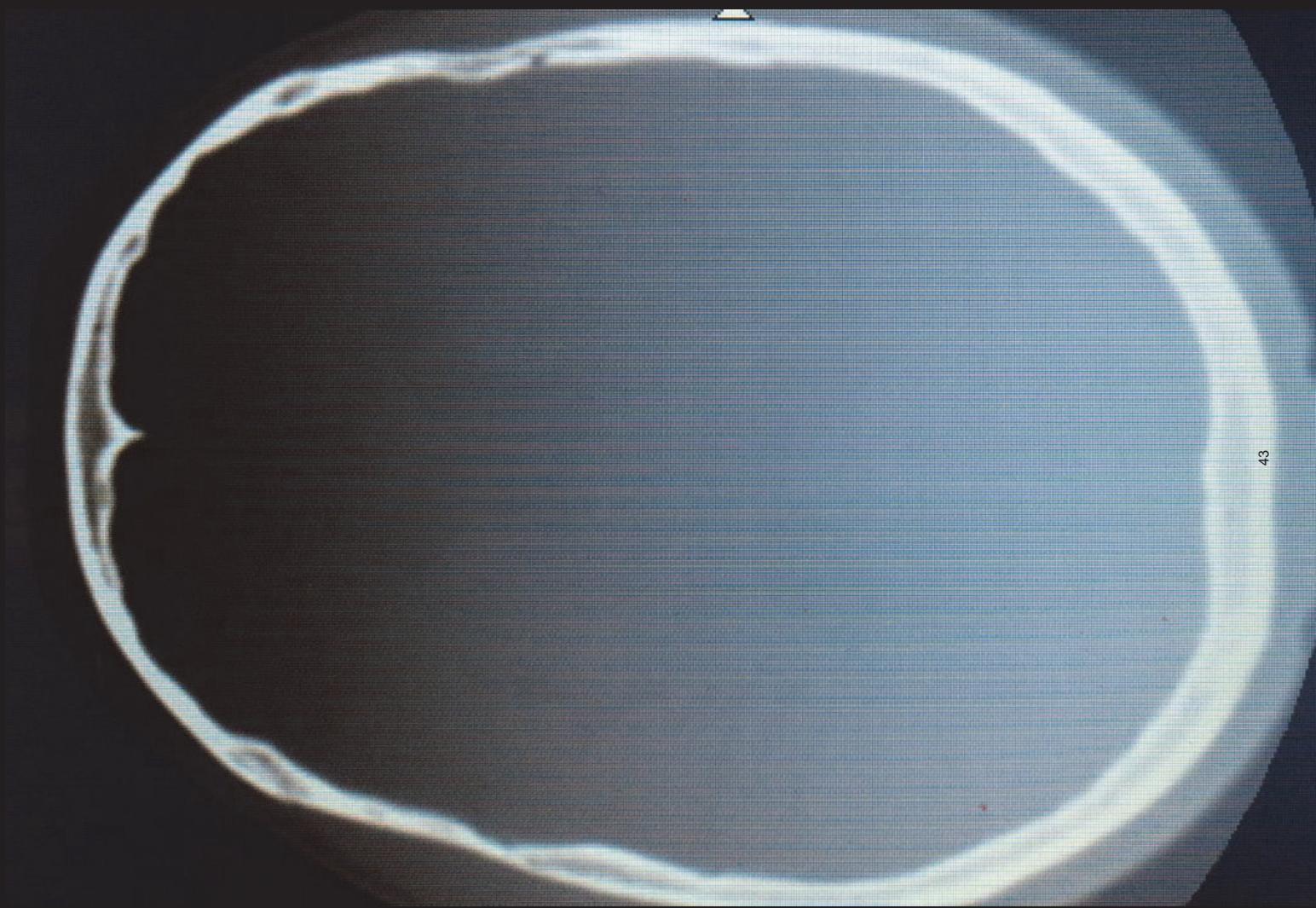


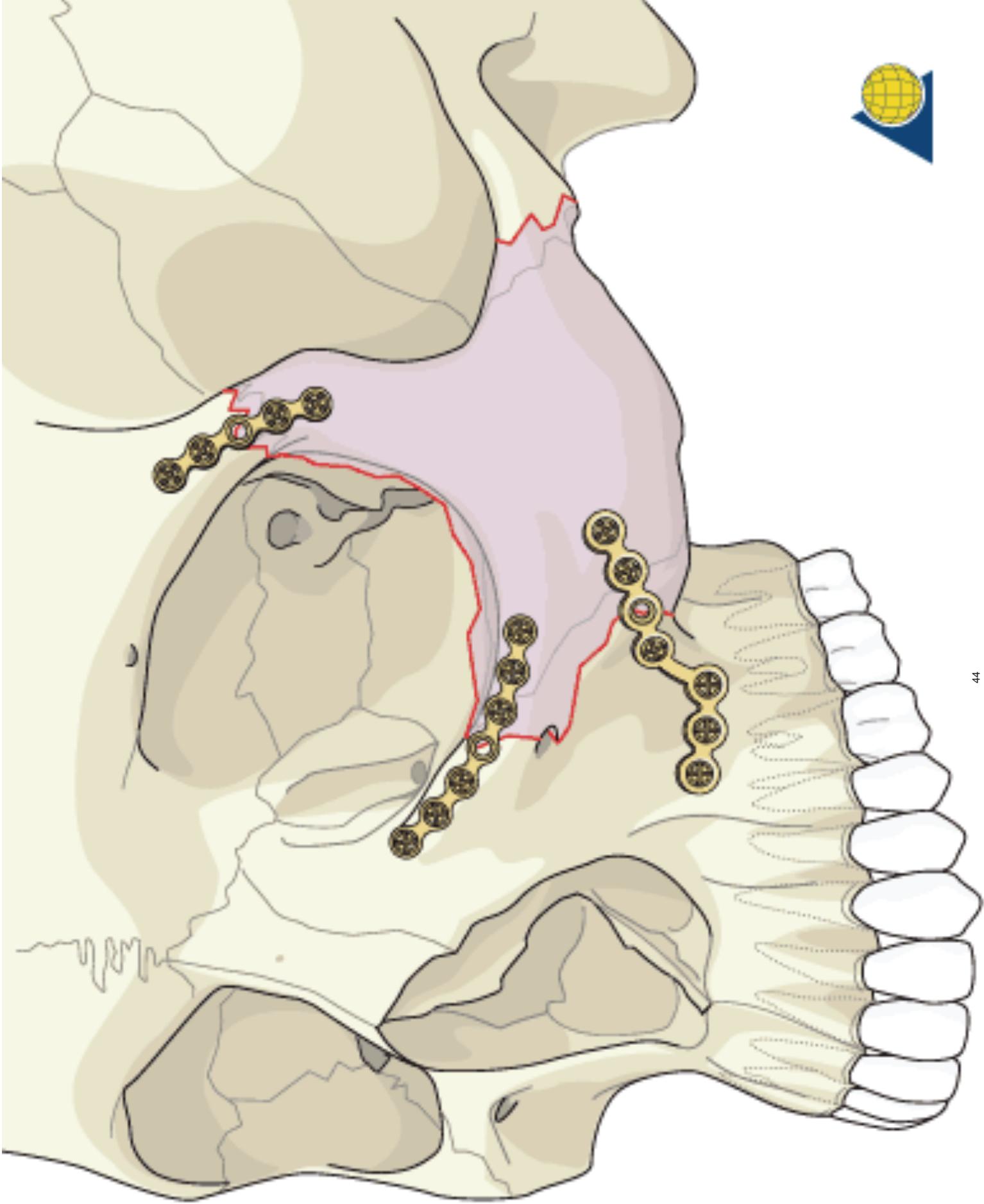


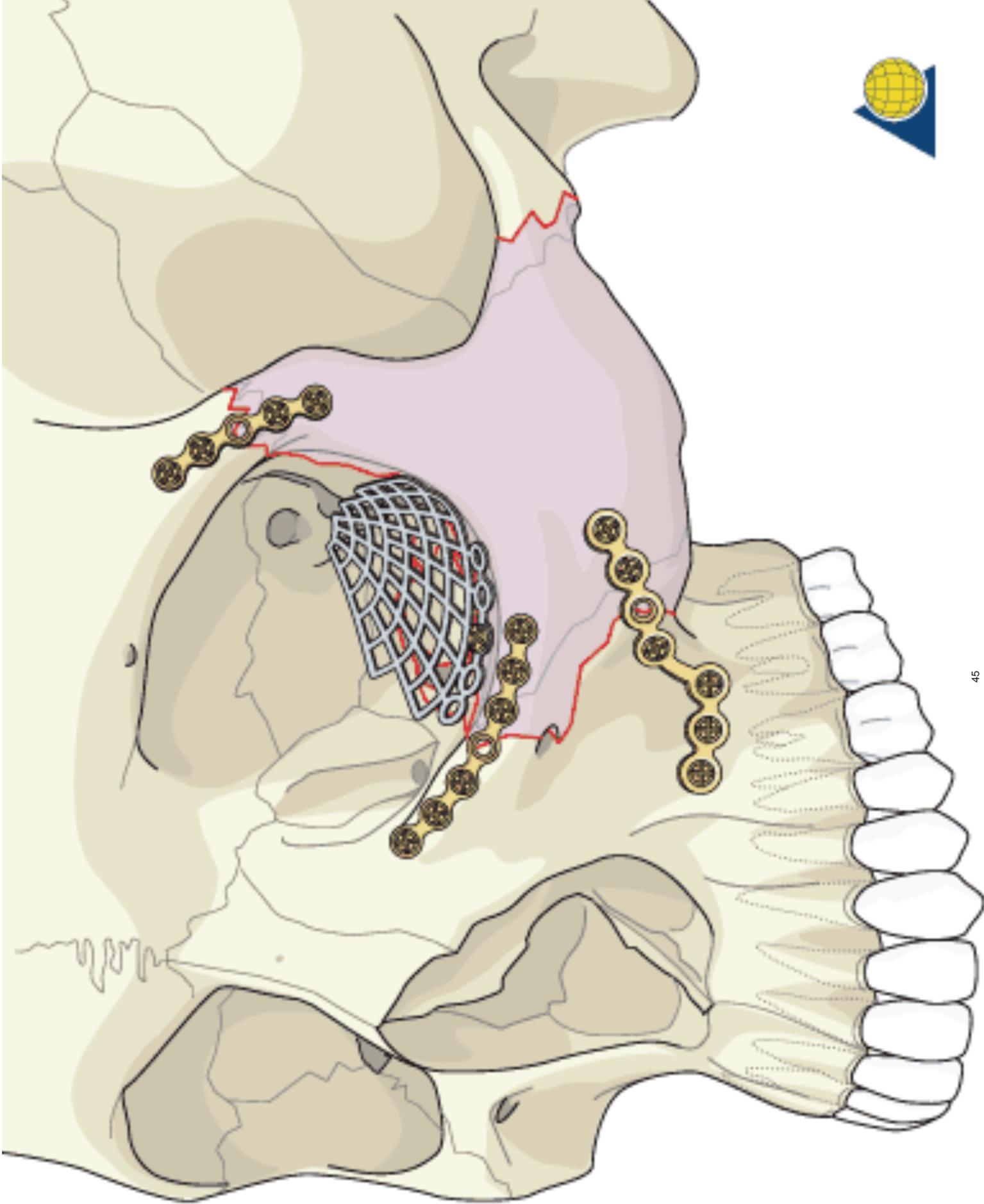
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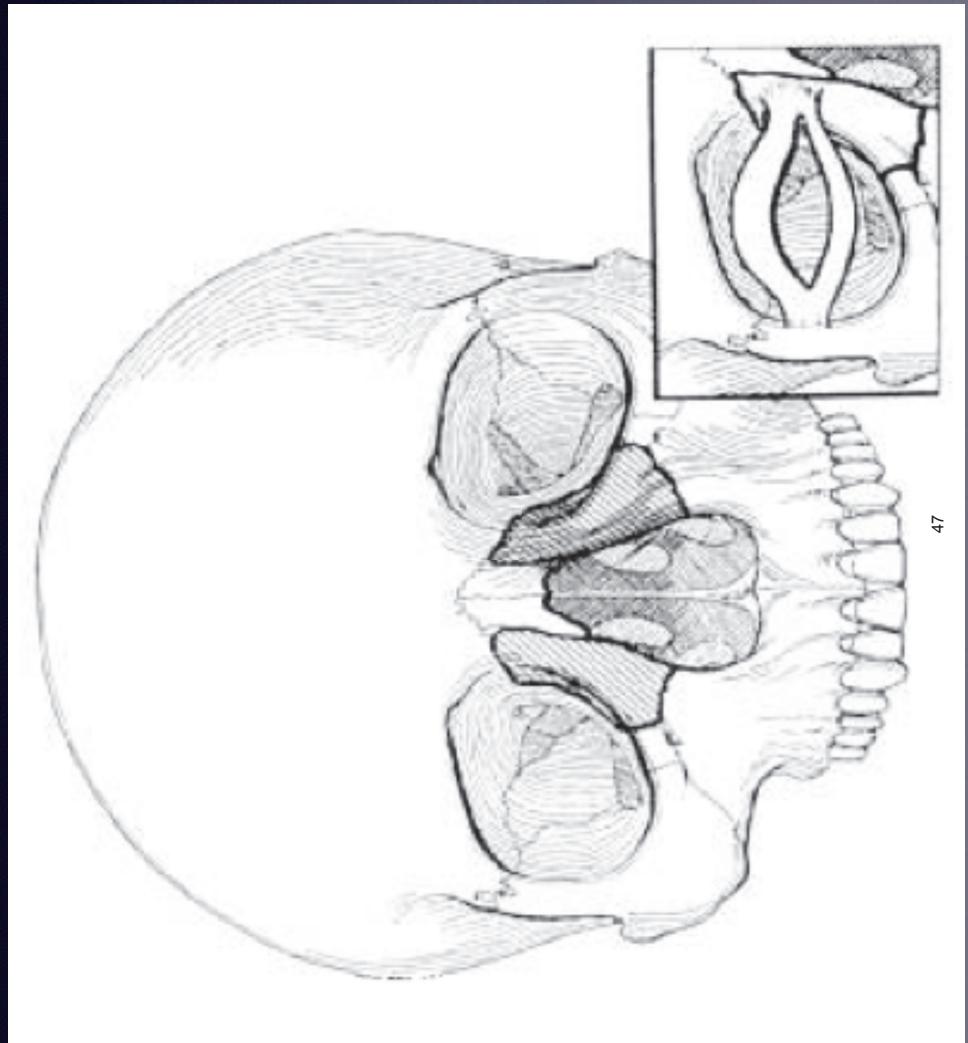


# Naso-orbito-ethmoid (NOE) Fracture

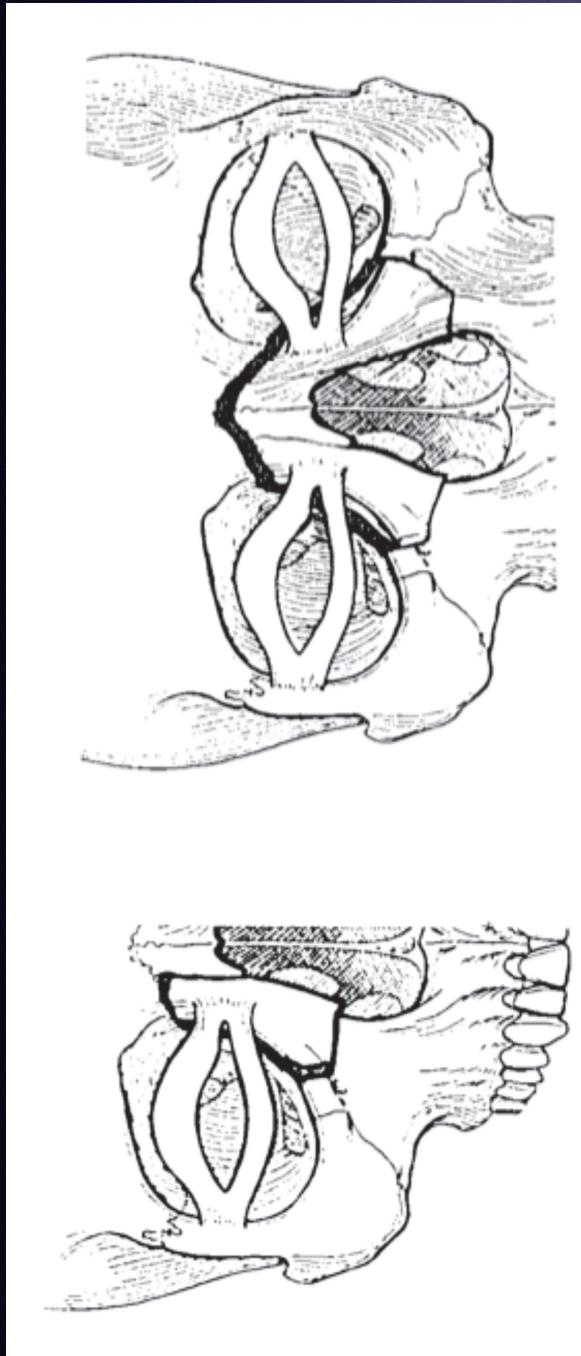
- Caused by direct trauma to the glabella
- Force of impact causes collapse of bridge of nose
- Ethmoids crushed
- Nasal bones and frontal processes of maxilla splay outward, creating telecanthus

# Naso-orbito-ethmoid (NOE) Fracture

## Central Fragment

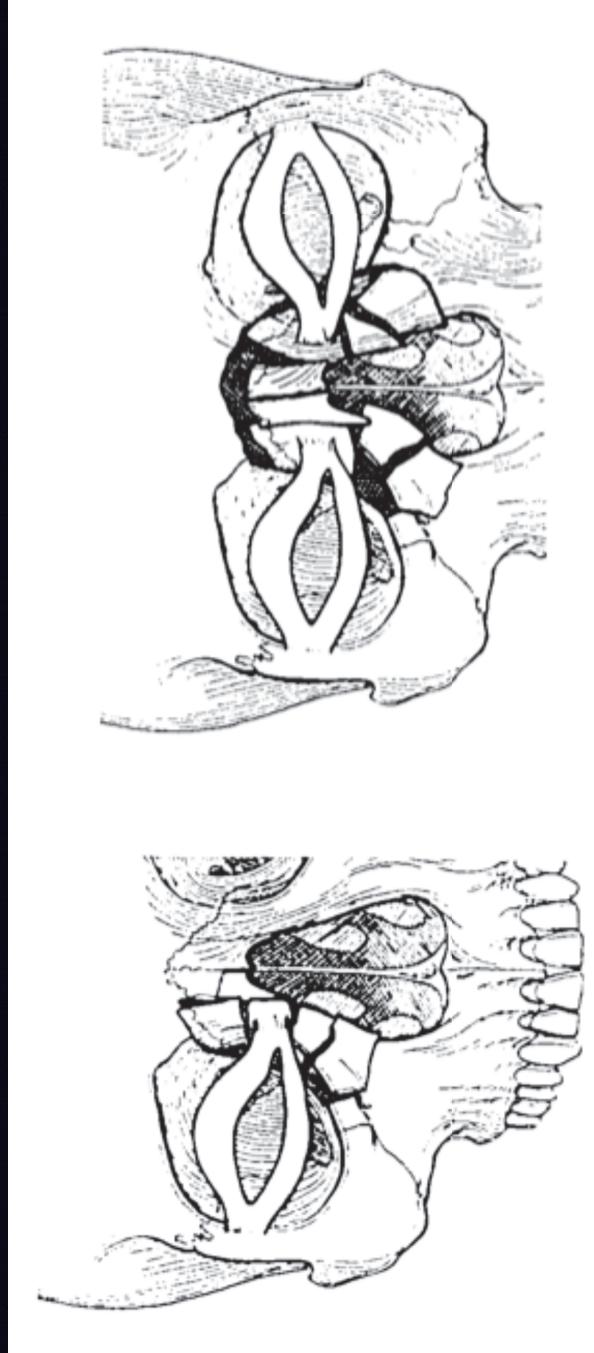


# Naso-orbito-ethmoid (NOE) Fracture Type I



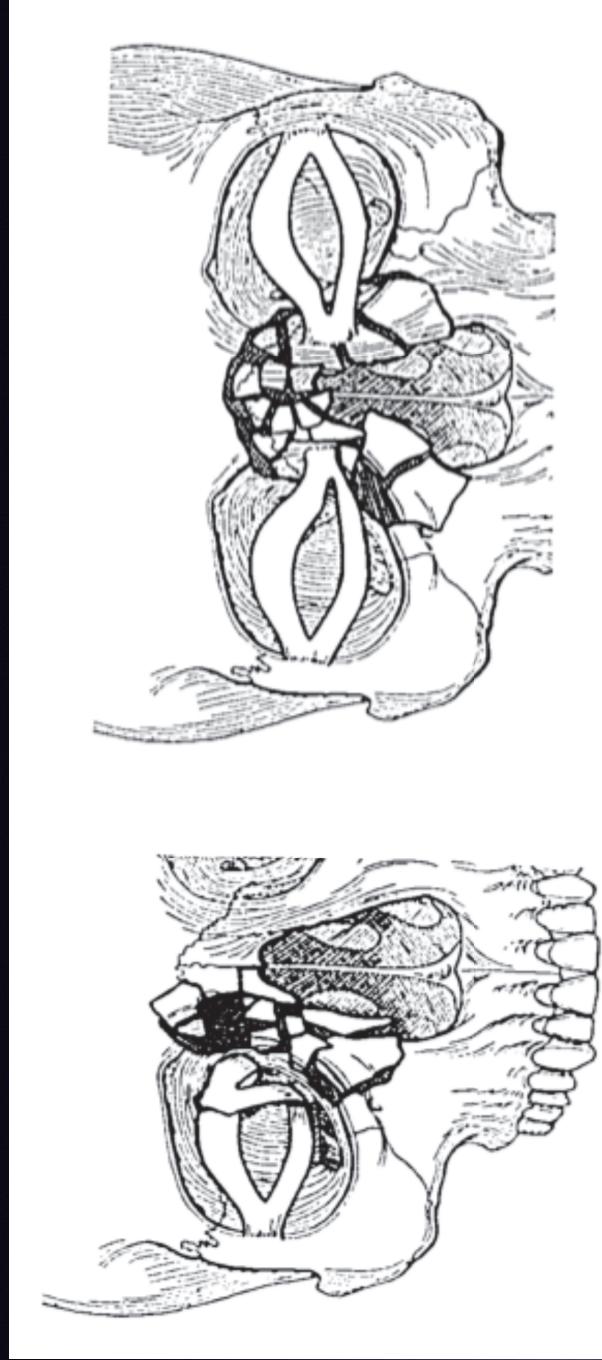
Single segment fracture

# Naso-orbito-ethmoid (NOE) Fracture Type II



Comminuted central fragment, unininvolved medial canthal insertion

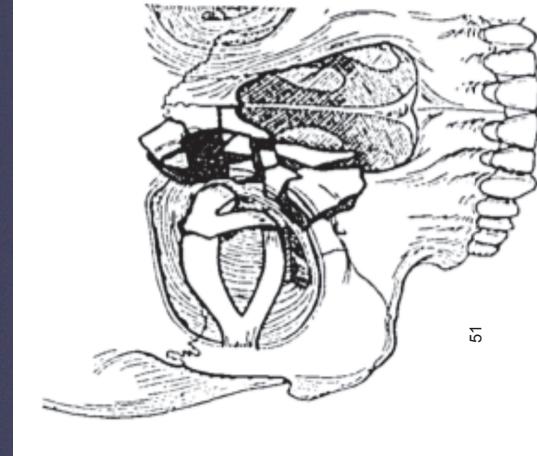
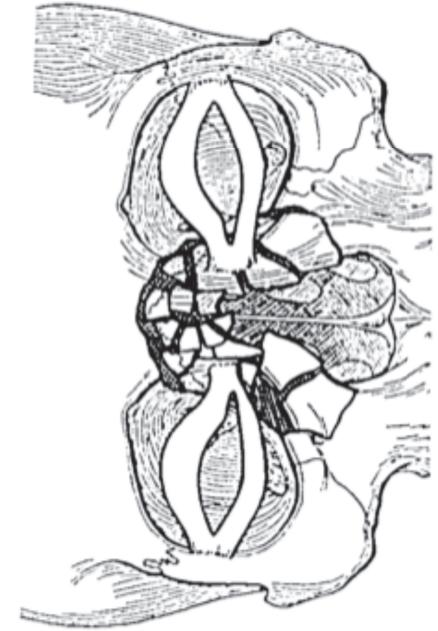
# Naso-orbito-ethmoid (NOE) Fracture Type III



Comminuted central fragment involving medial canthal insertion

# Naso-orbito-ethmoid (NOE) Fracture

- Sequalae
- Telecanthus
- Nasal dorsum flattening
- Traumatic NLDO



# Naso-orbito-ethmoid (NOE) Fracture Presentation

Telecanthus



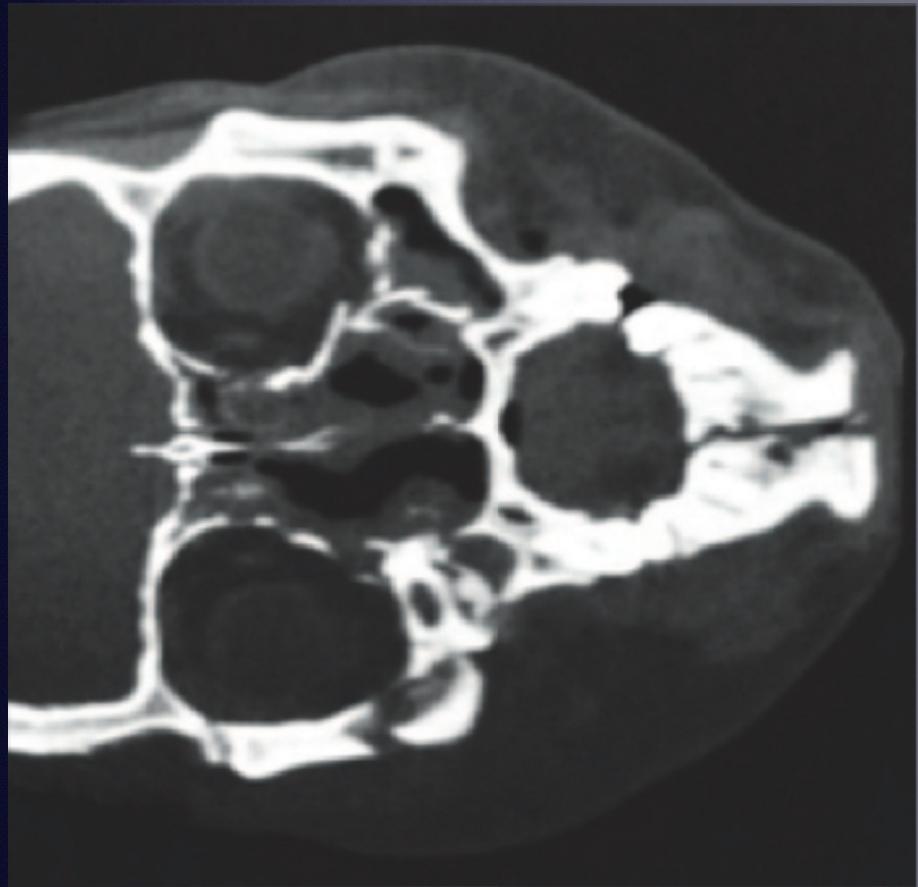
# Naso-orbito-ethmoid (NOE) Fracture Presentation

Loss of nasal dorsal height

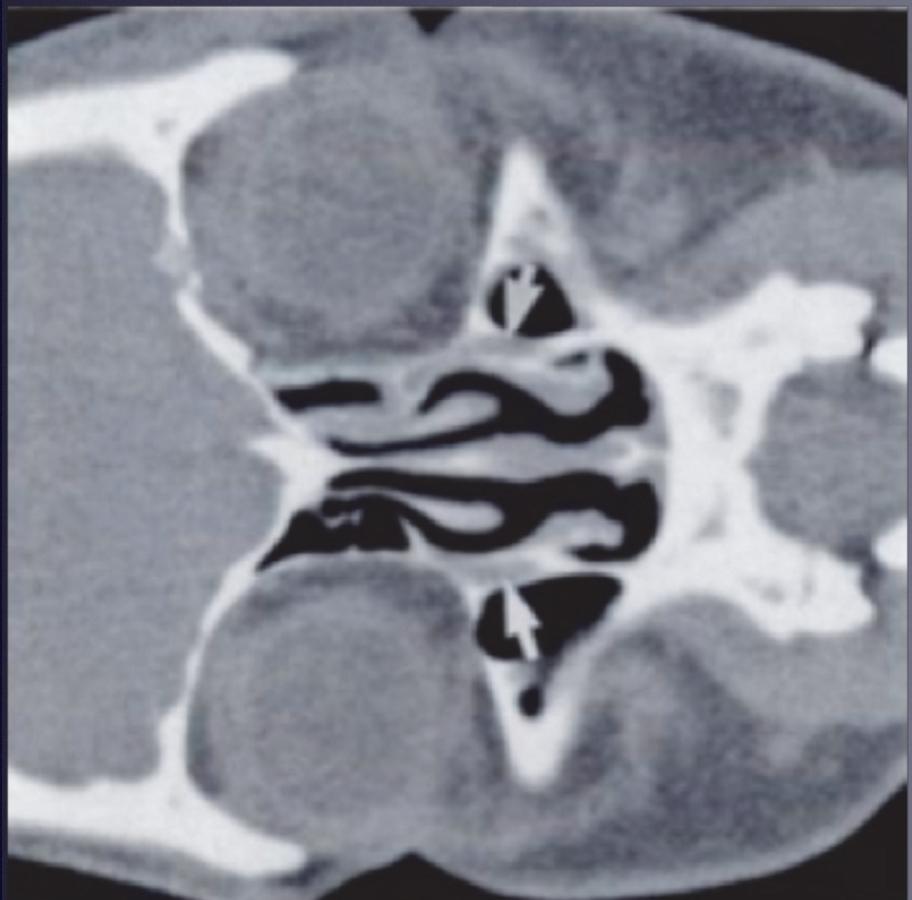


# Naso-orbito-ethmoid (NOE) Fracture Presentation

Nasolacrimal Duct Obstruction

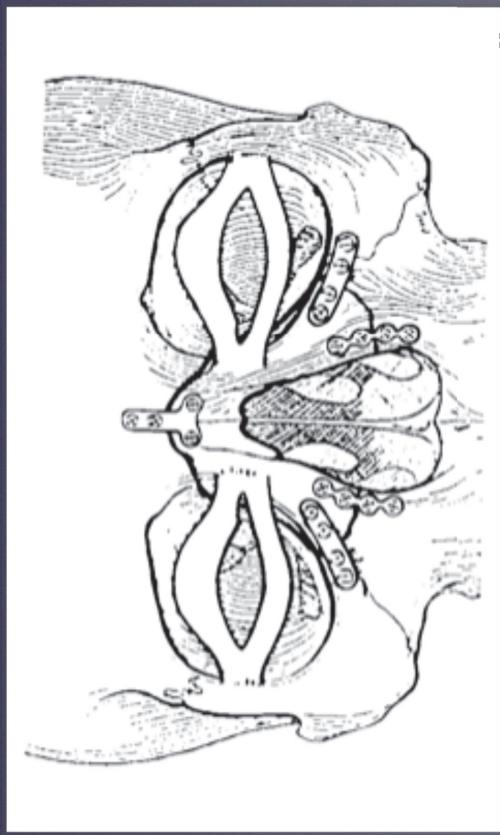
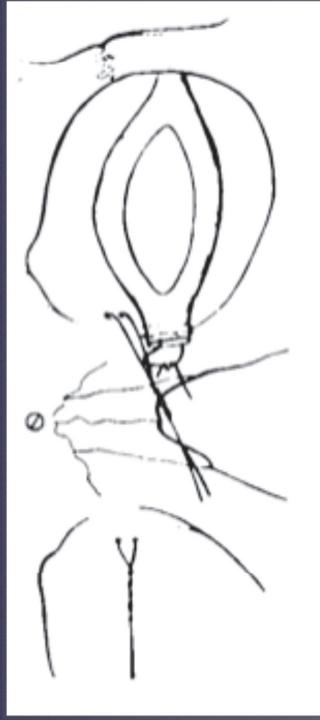


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# Naso-orbito-ethmoid (NOE) Fracture Management

- Early (within 2 weeks) fracture repair associated with lower incidence of NLDO.
- Early repositioning of bone fragments, especially the attachment to medial canthus, prevents obstruction of lacrimal sac and canaliculi.



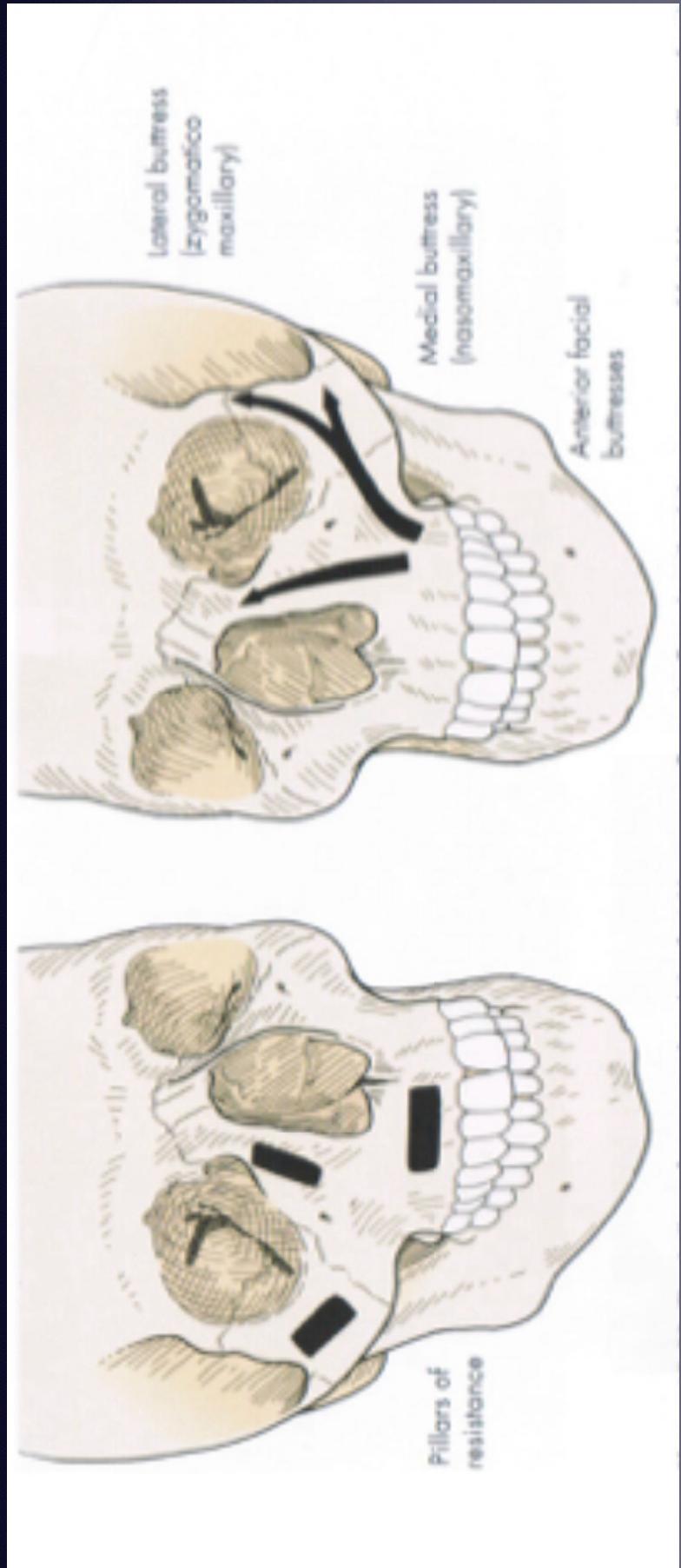
# Traumatic Nasolacrimal Duct Obstruction

## Diagnosis

- Often, early signs of NLDO (epiphora, dacryocystitis) are caused by post-traumatic edema and spontaneously resolve after several months
- Early probing can indicate apparent obstruction in an intact lacrimal system
- Delayed probing (up to 6 months) of lacrimal duct upon resolution of edema and soft tissue injuries permits definitive evaluation of obstruction

# Le Fort Fractures

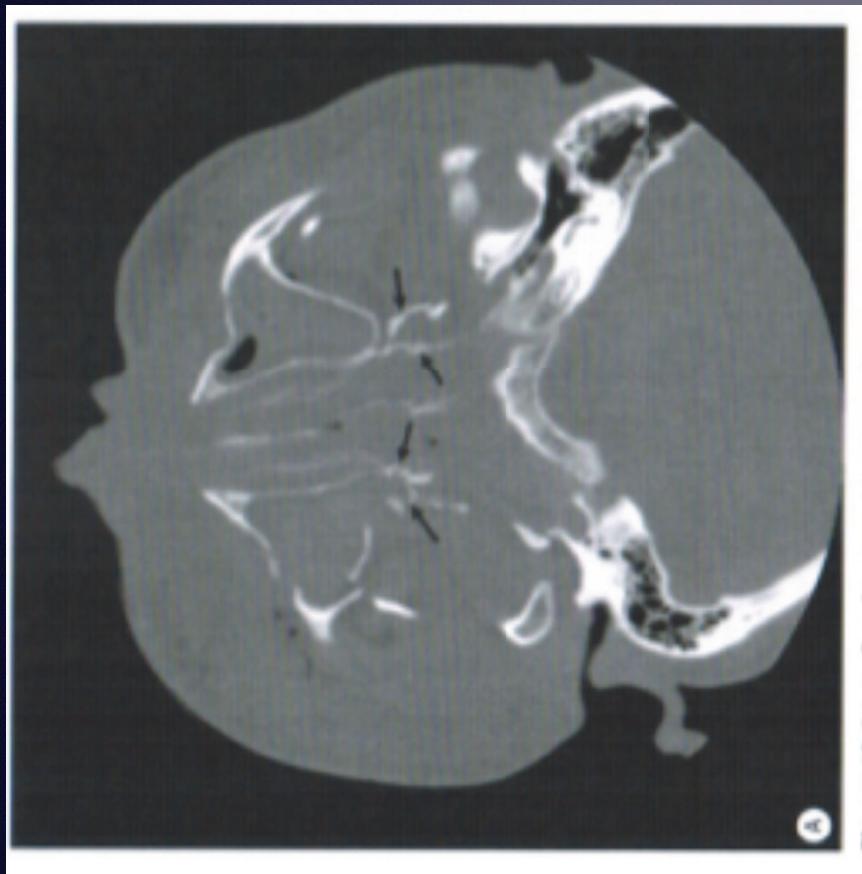
- Renee Le Fort described pillars of resistance to define strongest regions of facial skeleton



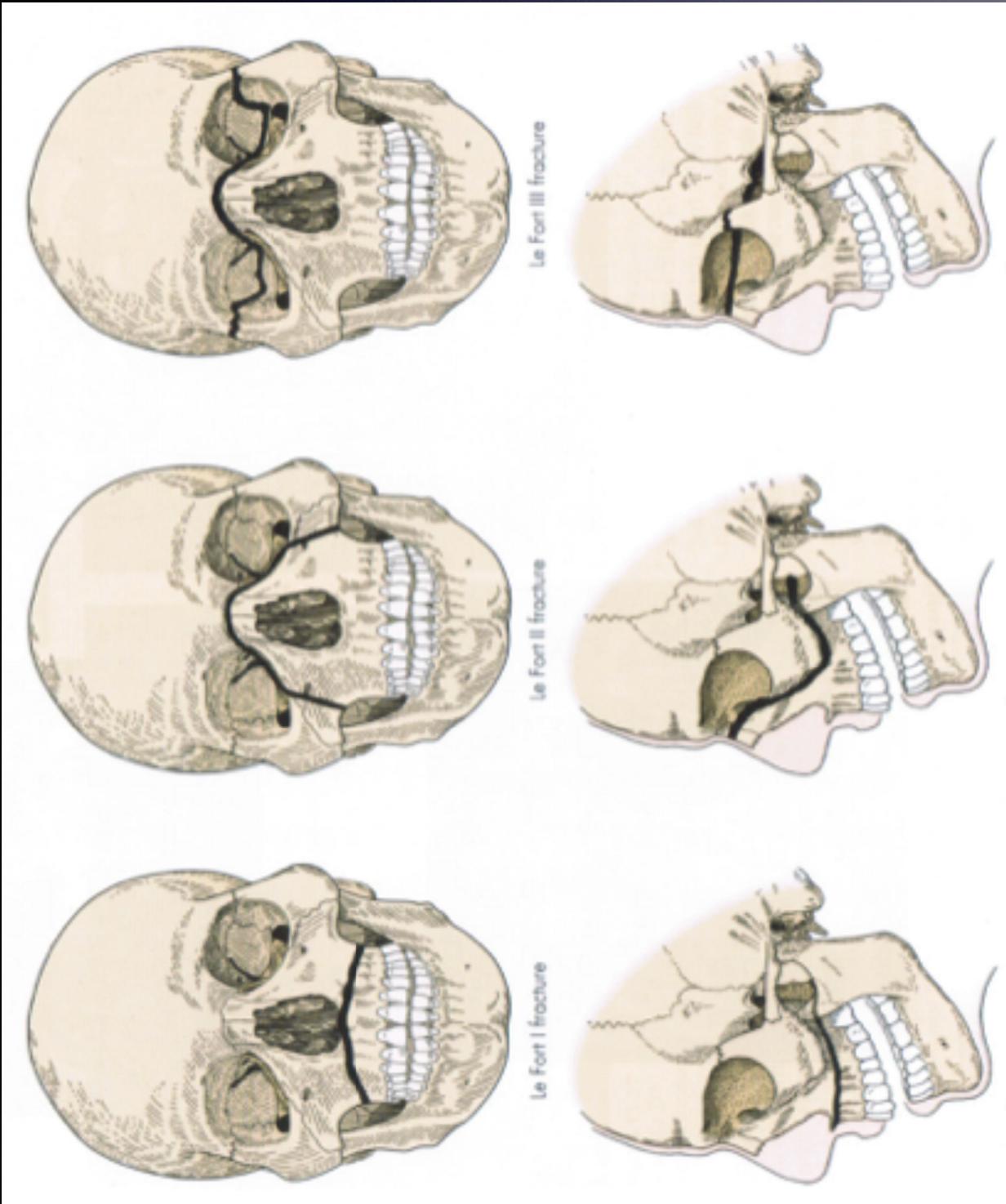
- Facial fractures tend to occur in patterns between these pillars

# Le Fort Fractures

- All Le Fort fractures involve the pterygoid plates (where maxillary sinus attaches to skull)



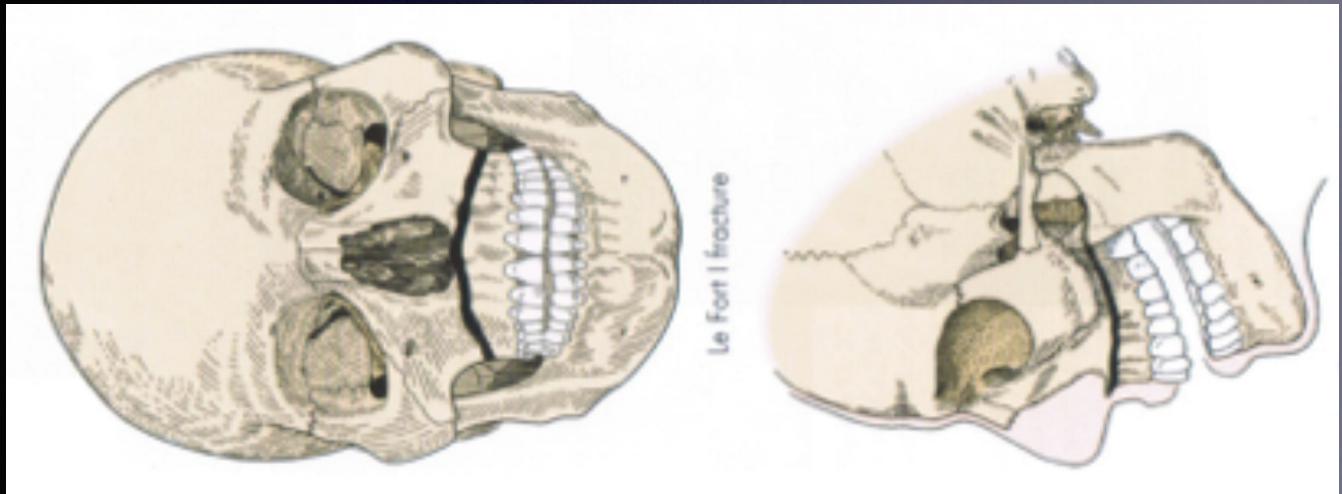
# Le Fort Fractures



\*May occur bilaterally or unilaterally

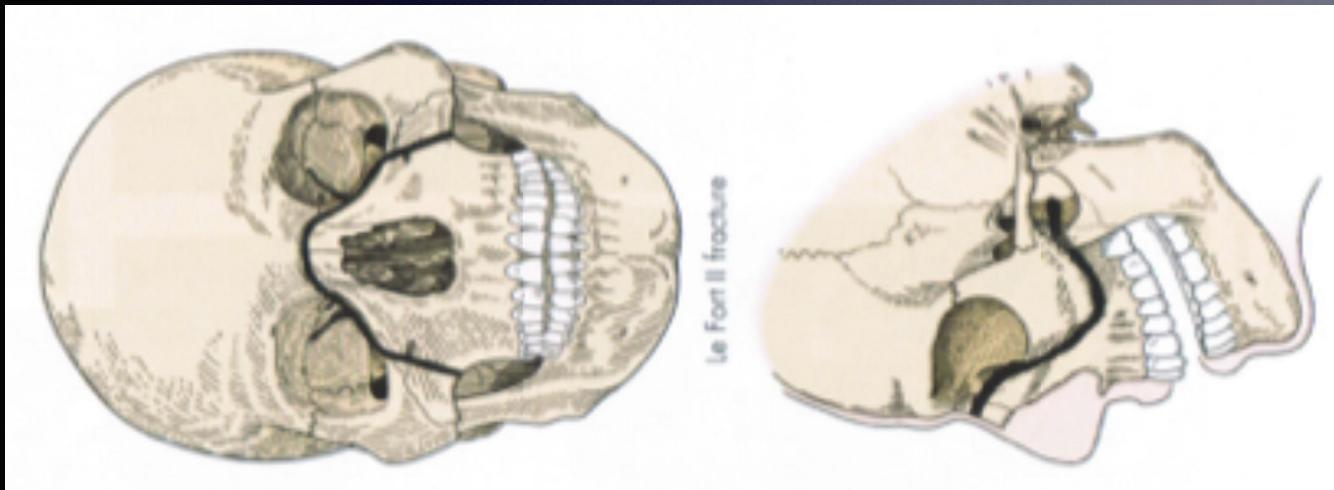
# Le Fort Type I

- Separates lower maxilla from midface and cranium
- Results in malocclusion



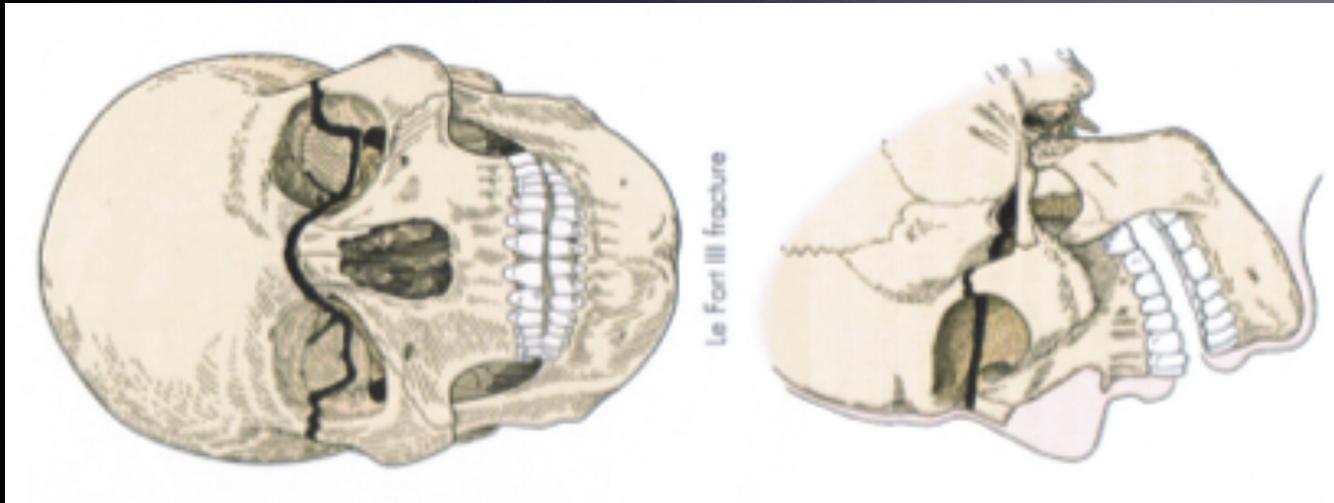
# Le Fort Type II

- Pyramid shaped
- Involves anterior orbit: nasal, lacrimal, maxillary bones, medial orbital floor

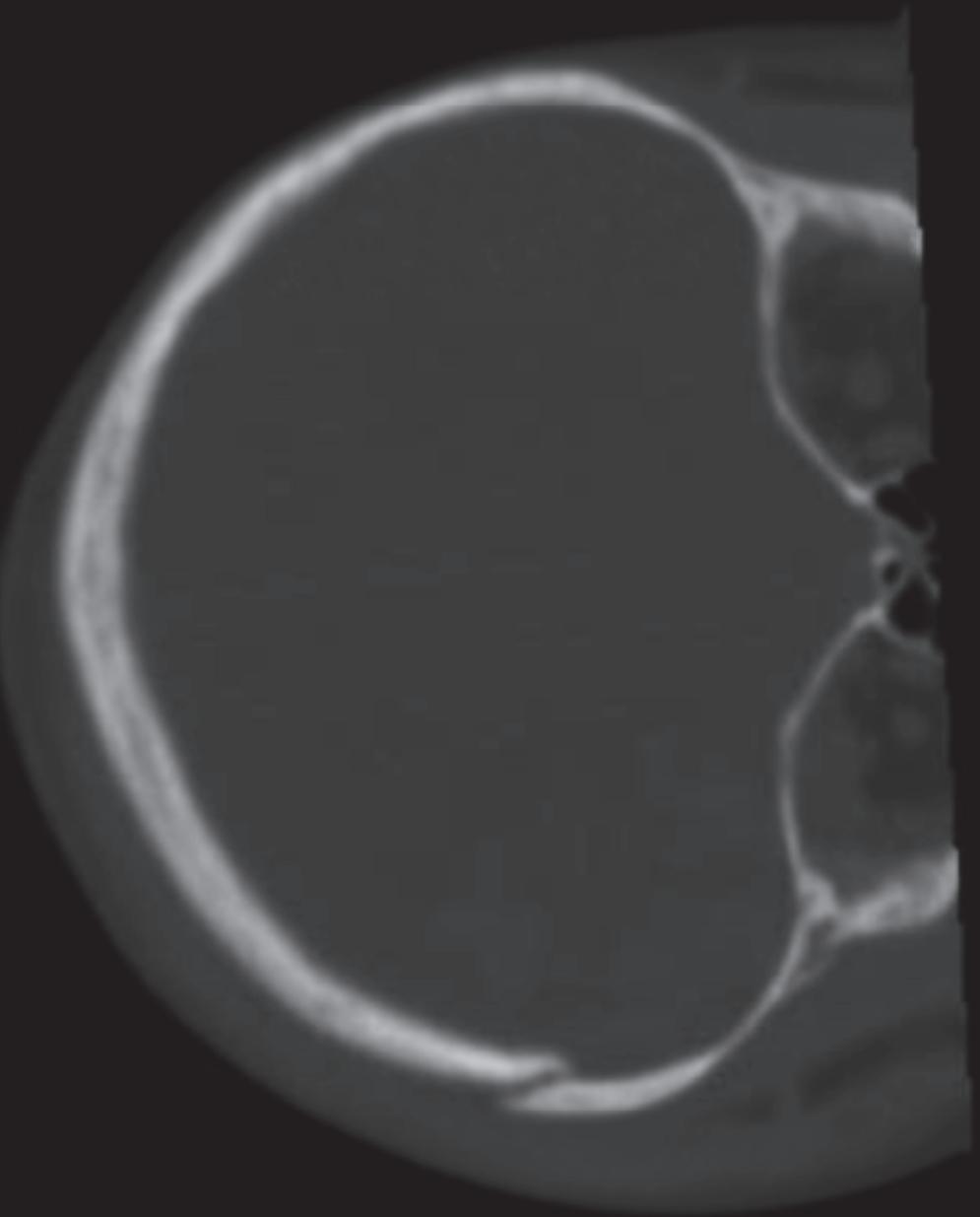


# Le Fort Type III

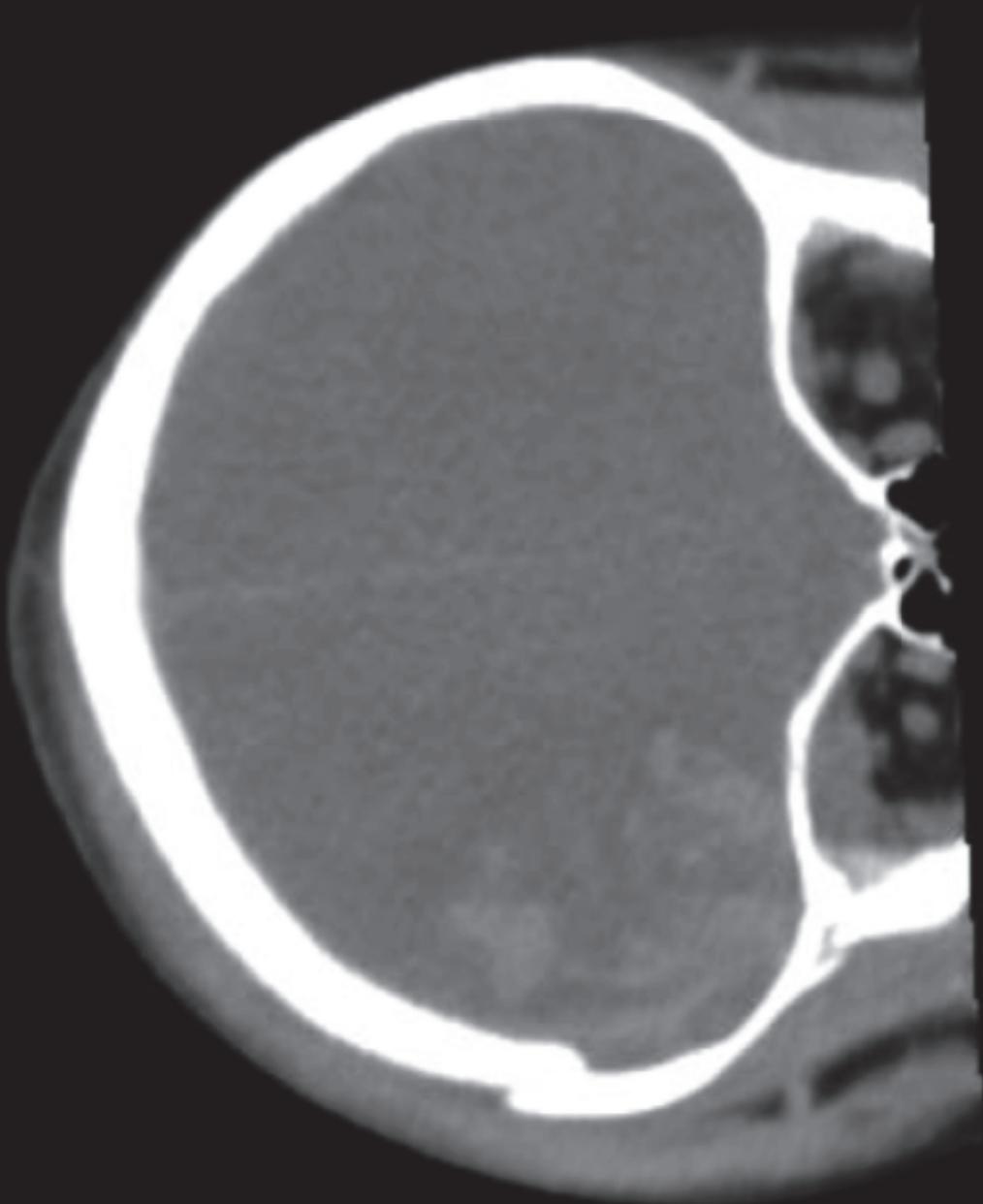
- Craniofacial dysjunction
- Entire facial skeleton detached from cranium
- Involves medial wall, lateral wall, floor



5 yo boy, fall from 2 story window



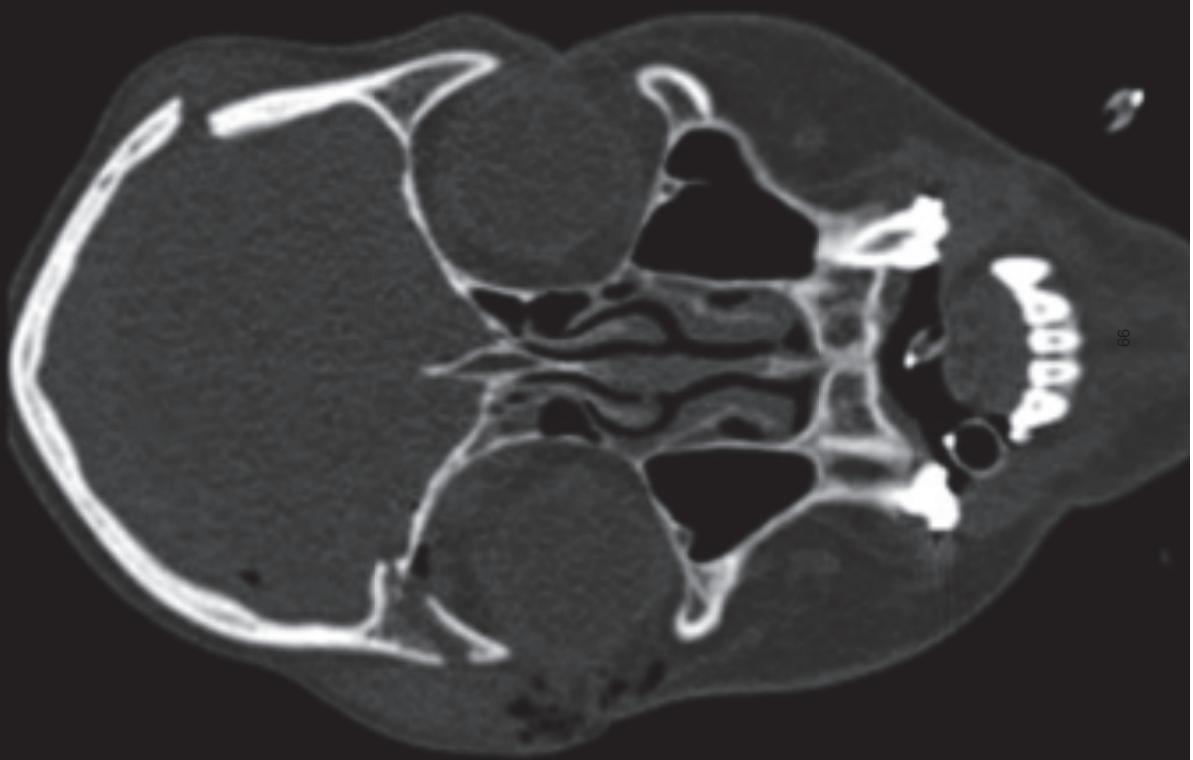
5 yo boy, fall from 2 story window



# Orbital Hemorrhage (Retrobulbar Hemorrhage)

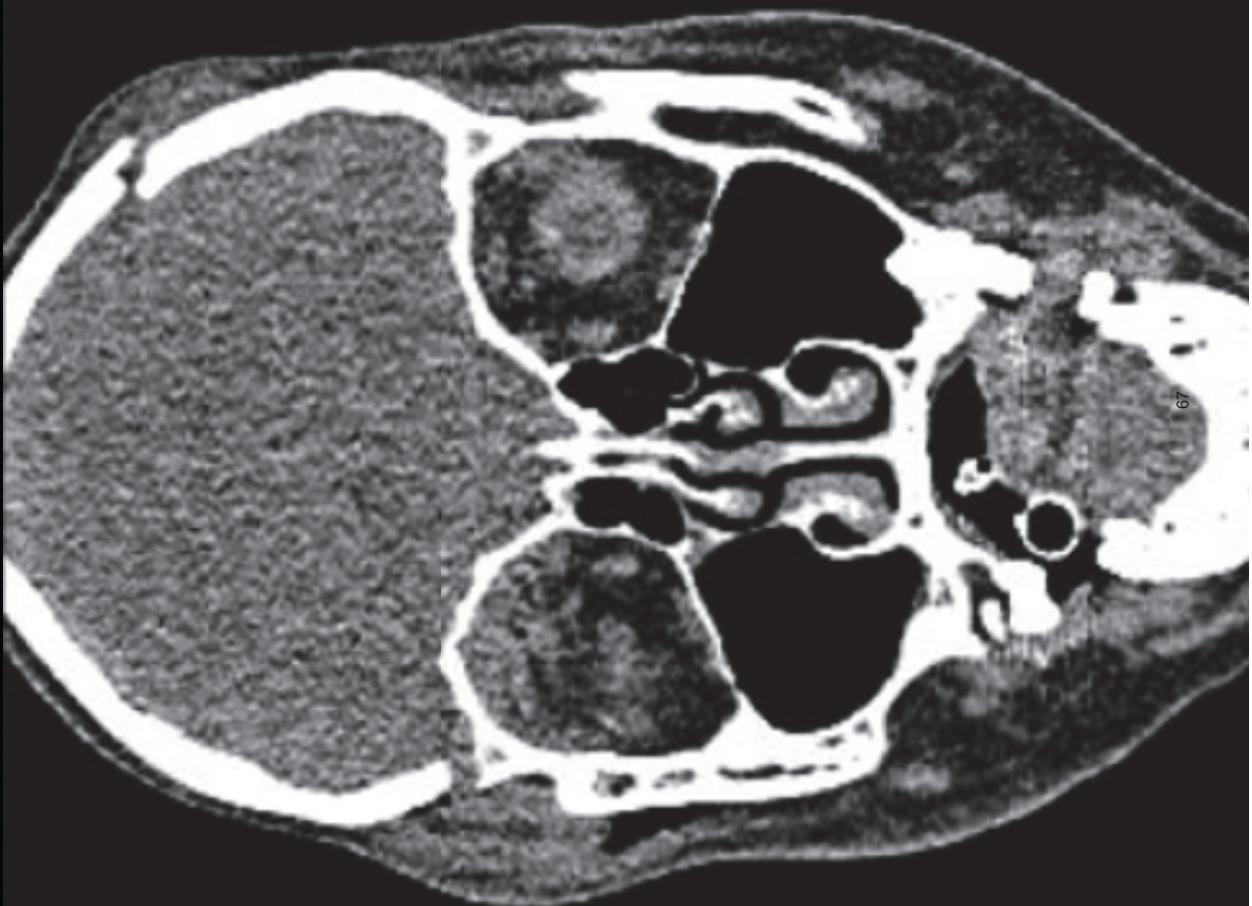
- Signs
  - Acute proptosis
  - Decreased vision
  - Afferent pupillary defect
  - Restriction of eye movements
- Elevated intraocular pressure (tonopen)
  - 40mmHg

11 yo boy, head trauma, 20ft fall



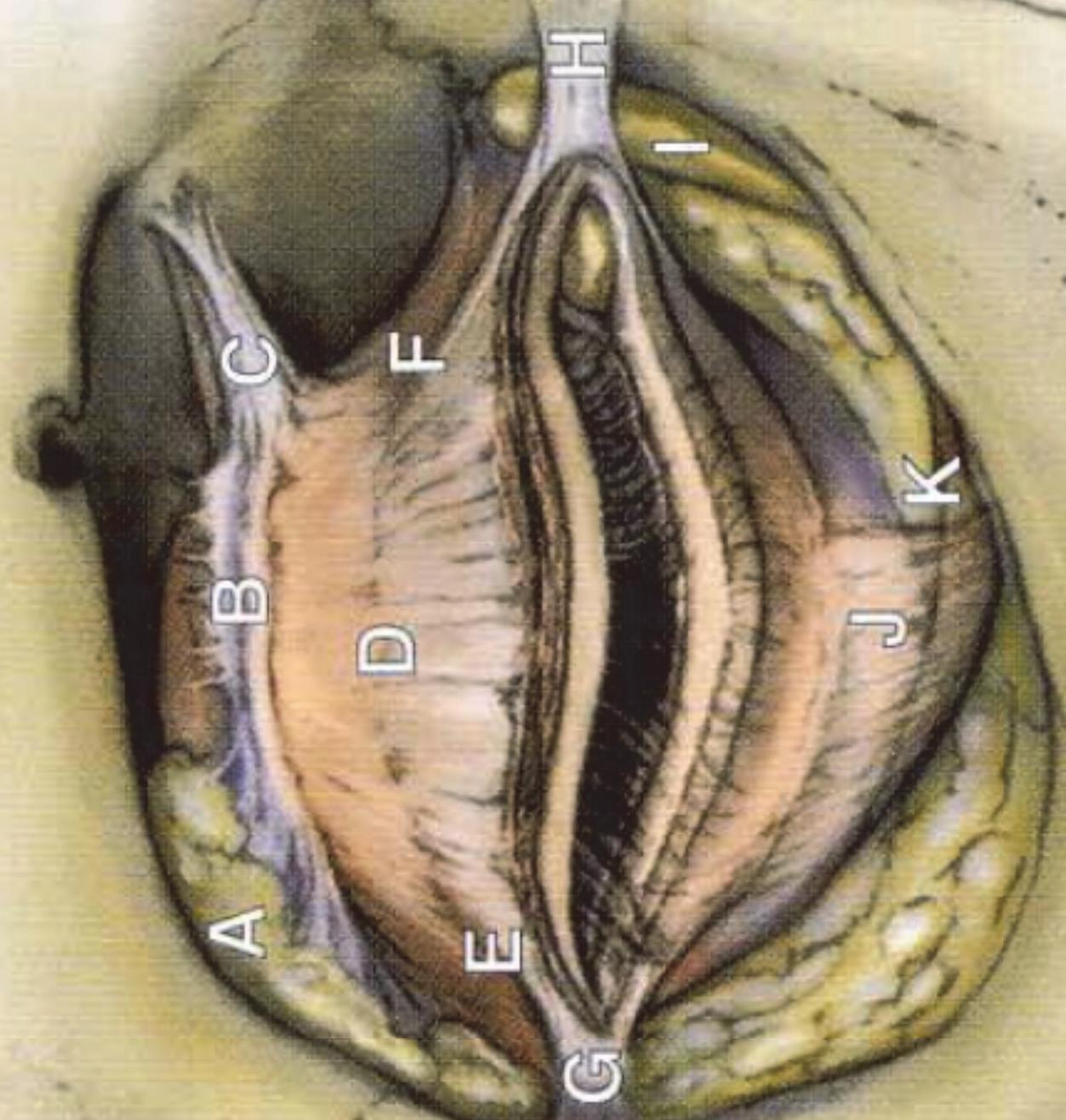
66

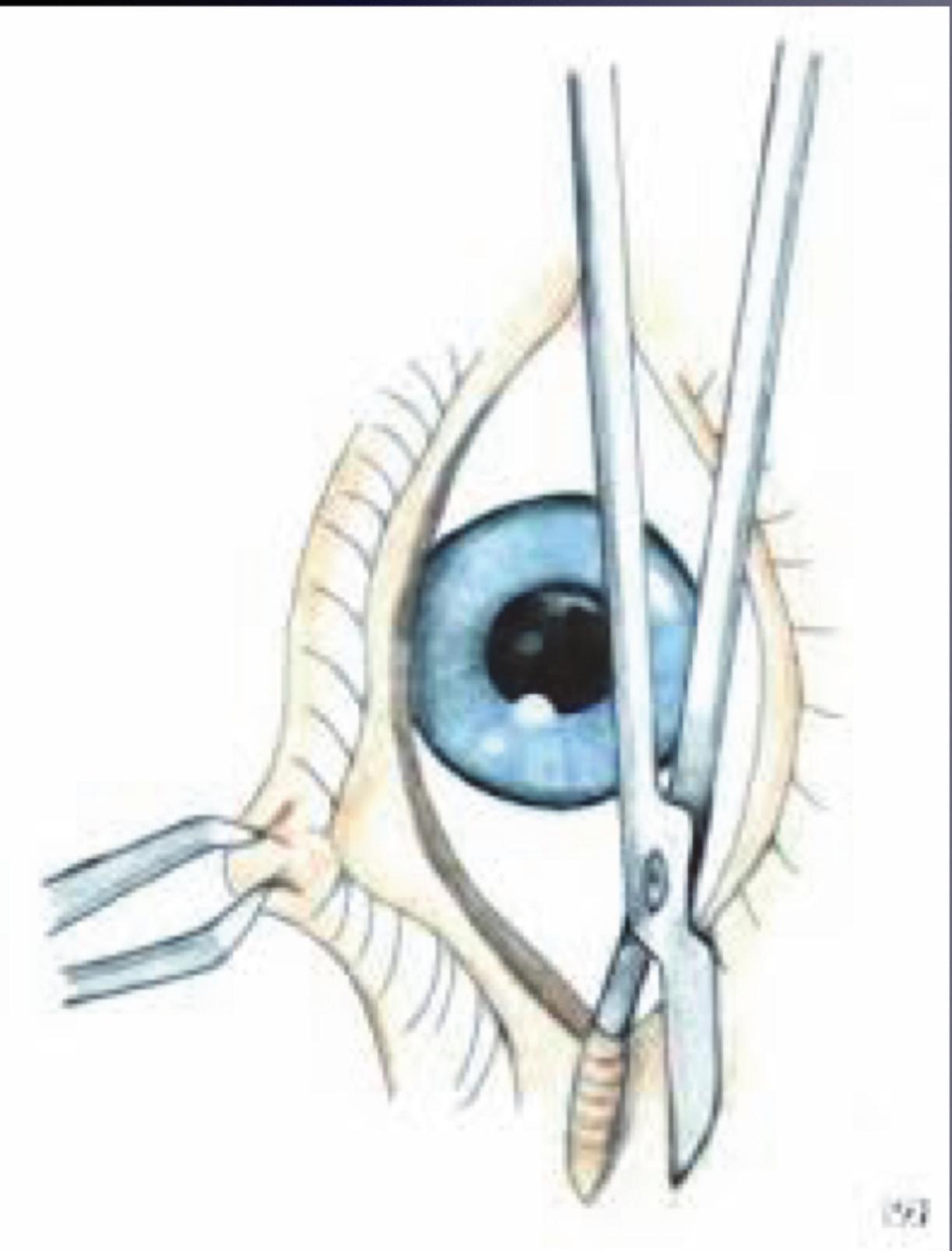
11 yo boy, head trauma, 20ft fall

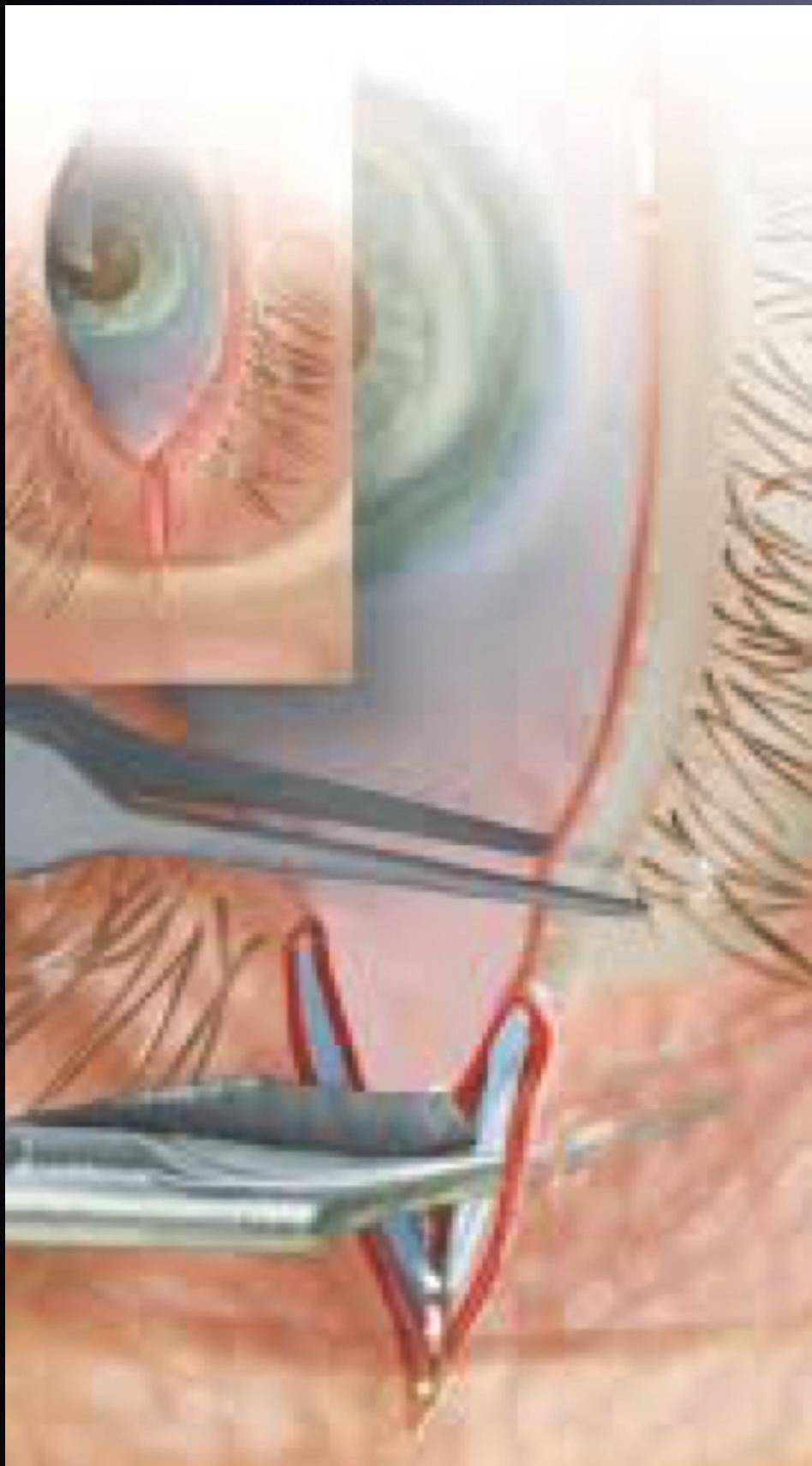


# Orbital Hemorrhage (Retrobulbar Hemorrhage)

- Management
  - Immediate lateral canthotomy and cantholysis
  - Central retinal artery occlusion of 105 min or longer showed irreversible optic nerve damage in monkeys.
  - Treatment aimed at lowering orbital and ocular pressure to protect the optic nerve







# Intra-orbital Foreign Bodies

- Should be suspected in all cases of orbital trauma when there is a cutaneous wound.
- CT Scan. MRI is contraindicated for suspected metal foreign bodies
  - BB pellets usually made from non-ferromagnetic materials, but they are often *contaminated* with ferromagnetic materials
  - Wood may be difficult to visualize

# Intra-orbital Foreign Bodies

- Indications to remove foreign body:
  - Most metallic substances, except for copper and iron, remain relatively inert (observation).
  - Wood: reservoir for microbes due to porous nature, early excision is necessary.
  - Plastic and glass: inert, but sharp edges may cause significant morbidity and may require removal.

L 7



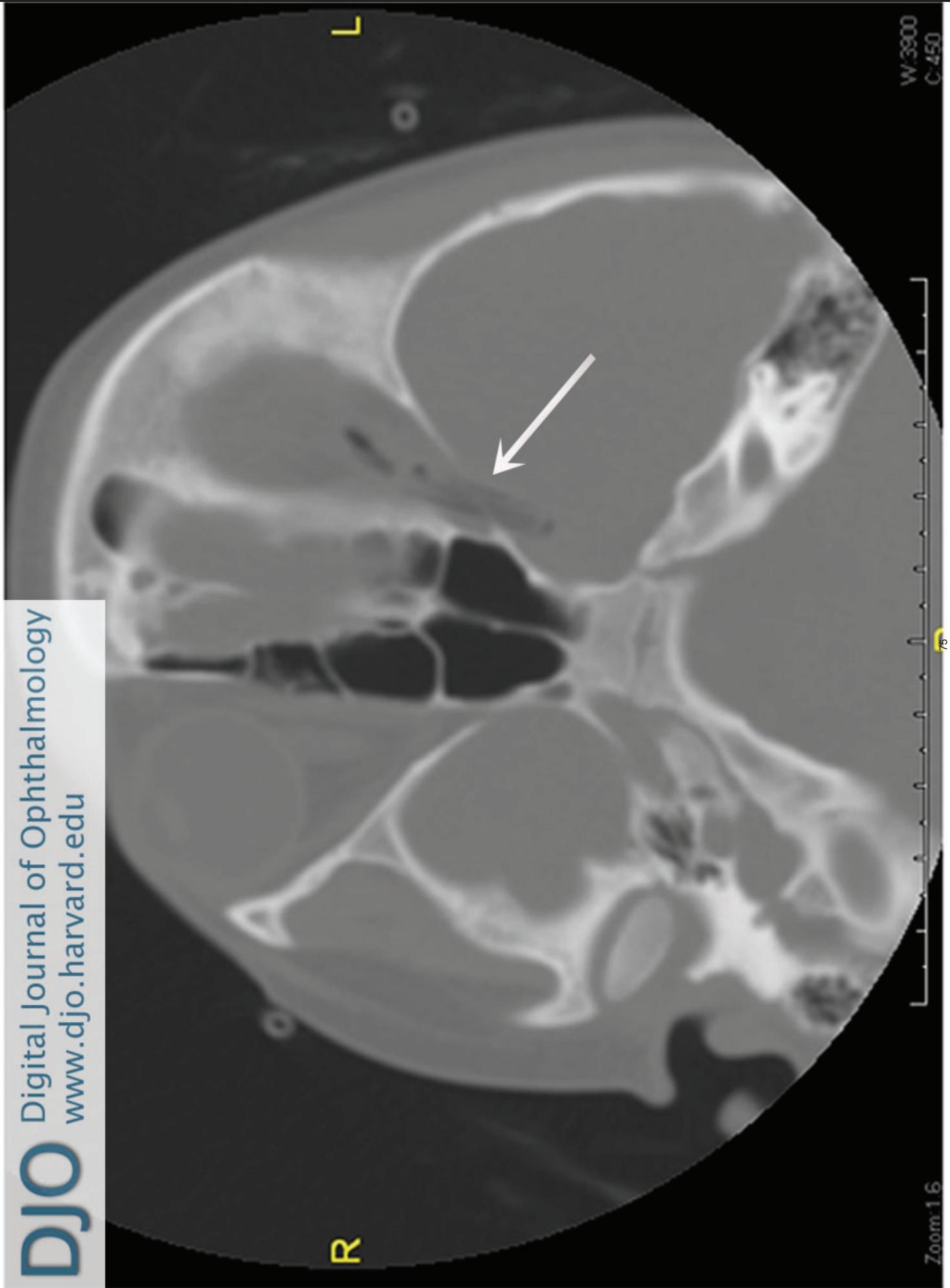
University of Michigan  
Kellogg Eye Center

PS

CV

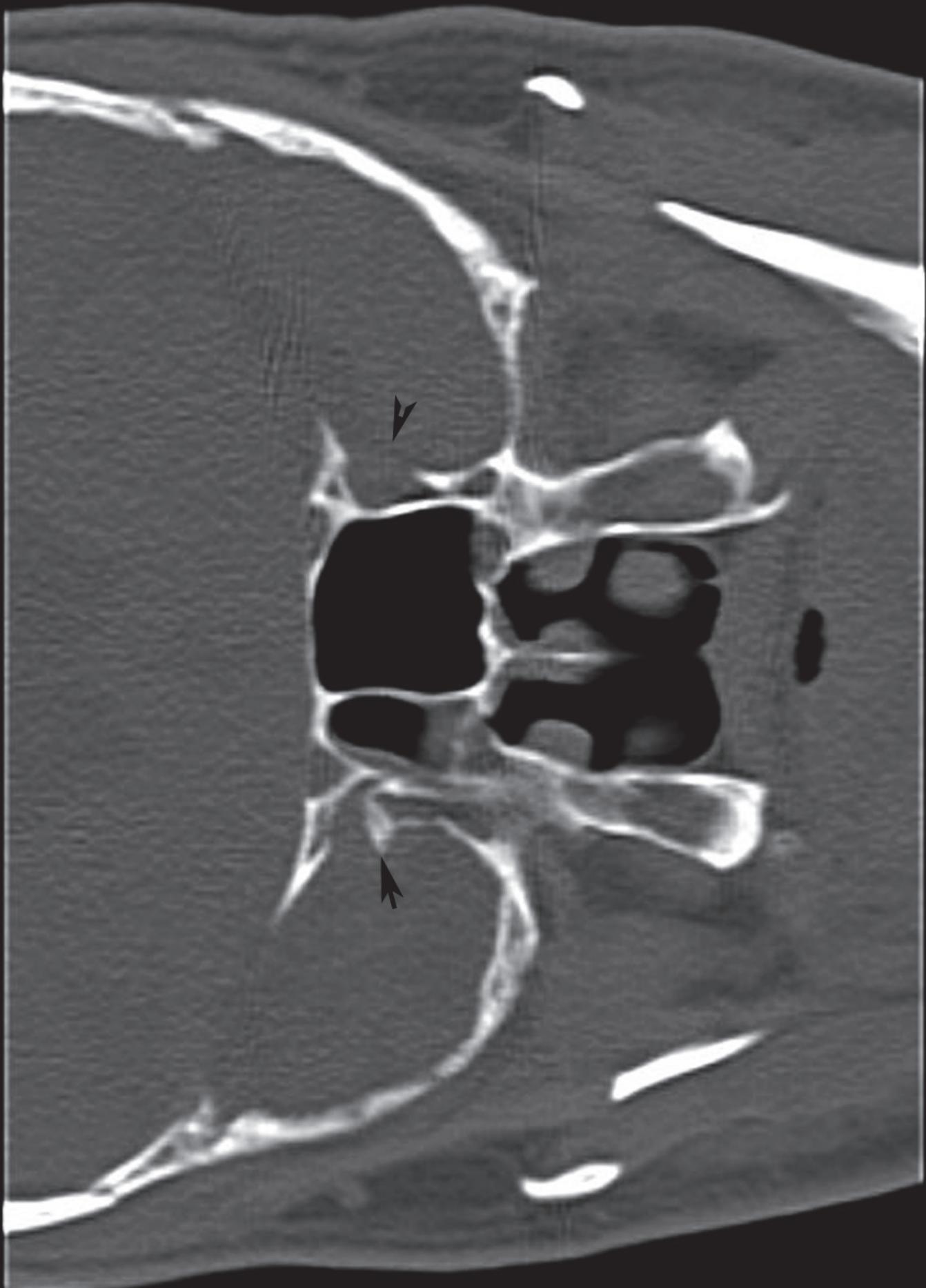
CV 120  
SA 120

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Filt: T4.0  
0.8s /HE+ 15:26:04/07.80  
V:2000 L:400



# Traumatic Optic Neuropathy

- Direct injury
  - Orbital laceration
  - Bone fragment
- Indirect injury
  - Frontal bone trauma causes shearing injury to nerve
  - R/O globe injury in pts with vision loss in trauma patients
  - If no other cause for decreased vision, suspect TON



# Traumatic Optic Neuropathy

- Management
  - Starting in 1980s, “megadose” steroids (IV methylprednisolone 30mg/kg followed by infusion)
  - Similar to treatment for head injury patients, rationale is to reduce post-traumatic inflammation and edema
  - No randomized studies have shown effectiveness
  - CRASH study in 2004 (Corticosteroid Randomization After Significant Head Trauma) showed head injury puts that were treated with steroids had significantly elevated risk of death as compared with placebo
    - High dose steroids no longer indicated

# Traumatic Optic Neuropathy

- Management
  - Optic canal decompression
  - Similar to rationale for steroids, decompresses nerve
  - Most commonly performed via endoscope trans-sphenoidally
  - IONTS (International Optic Nerve Trauma Study) showed no additional benefit of surgical decompression or steroids compared with observation
  - May have benefit if performed immediately after observed vision loss from trauma

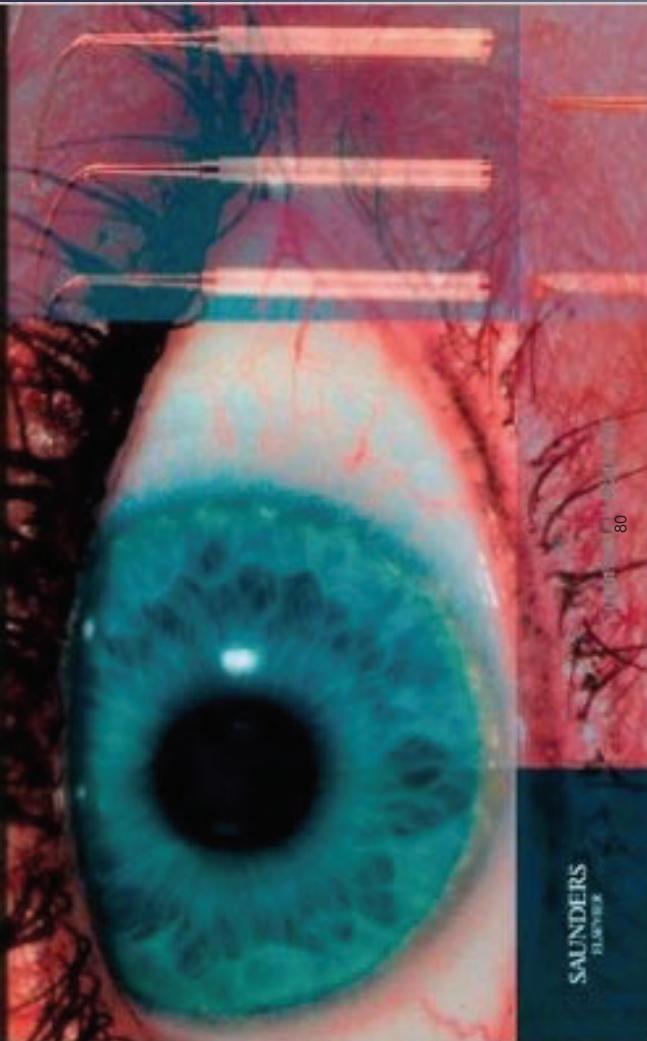
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JEFFREY A. NERAD

# *Techniques in Ophthalmic Plastic Surgery*

A PERSONAL TUTORIAL

Contains DVD



SAU NDERS  
S A U N D E R S

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## Kasra Eliasieh, M.D.

Phone: (415) 799-8800  
Email: eliasiehmd@gmail.com

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### EDUCATION/TRAINING

Undergraduate (10/98-08/02)	University of California, Davis. B.S. in Neurobiology, Physiology, and Behavior. <i>Cum Laude</i> Davis, CA
Medical (08/03-06/08)	University of California, Davis School of Medicine, M.D. Sacramento, CA
Internship (07/08-06/09)	St. Mary Medical Center, Department of Internal Medicine Long Beach, CA
Residency (07/09-06/12)	The New York Eye and Ear Infirmary, Department of Ophthalmology New York, NY
Fellowship (07/12- 06/14)	Wilmer Eye Institute, Johns Hopkins Hospital, Baltimore, MD Division of Cosmetic and Reconstructive Oculoplastic Surgery American Society of Ophthalmic Plastic and Reconstructive Surgery (ASOPRS) Fellowship Fellowship Director: Dr. Shannath Merbs

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### BOARD CERTIFICATIONS

07/14	American Society of Ophthalmic Plastic and Reconstructive Surgery (ASOPRS) – Eligible
06/14	American Board of Ophthalmology

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### MEMBERSHIPS

07/12 - Current	American Society of Ophthalmic Plastic and Reconstructive Surgery (ASOPRS) - Eligible
07/09 - Current	American Academy of Ophthalmology

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### WORK EXPERIENCE

01/15 - Current	Director	San Francisco Oculofacial Plastic Surgery
01/15 - Current	Oculoplastics Consultant	UCSF Benioff Children's Hospital, Oakland
01/15 - Current	Clinical Instructor	Oculoplastics Division, Highland Hospital, Oakland
01/15 - Current	Oculoplastics Consultant	Batra Vision Medical Group, San Leandro

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### RESEARCH

#### Publications

Liets LC, **Eliasieh** K, van der List DA, Chalupa LM. Dendrites of rod bipolar cells sprout in normal aging retina. Proceedings of the National Academy of Sciences. August 2006, Vol. 103, No. 32, pp. 12156-12160.

**Eliasieh** K, Liets LC, Chalupa LM. Cellular reorganization in the human retina during normal aging. Investigative Ophthalmology and Visual Science. June 2007, Vol. 48, No. 6, pp. 2824-2830.

Graue-Hernández EO, Mannis MJ, **Eliasieh** K, Greasby T, Beckett L, Bradley J, Schwab IR. Salzmann Nodular Degeneration. Cornea. March 2010, Vol. 29, No. 3, pp. 283-289.

Gutmark R, **Eliasieh** K, Rivera-Michlig R. A case of bilateral trochleitis in Adult-onset Still's disease. Seminars in Arthritis and Rheumatism. April 2014, Vol. 43, No. 5, pp. 689-691.

**Eliasieh K**, Grant M, Mahoney N, Merbs S. Use of bicanalicular stents with intra-lacrimal sac fixation suture for punctal and canicular stenosis. *Pending Submission.*

**Eliasieh K**, Grant M, Mahoney N, Merbs S. Postural effects on lower eyelid position. *Pending Submission.*

### **Textbook Chapters**

Zoumalan C, **Eliasieh K**, Lelli Jr. GJ. Chapter: Instrumentation in Ophthalmic Plastic Surgery. Smith and Nesi's Ophthalmic Plastic and Reconstructive Surgery. Black EH, Nesi FA, Calvano CJ, Gladstone GJ, Levine MR (Editors). 3rd edition. 2013

**Eliasieh K**. Chapter: Trichiasis. Master Techniques in Ophthalmic Surgery. Roy FH (Editor). *In Press*

**Eliasieh K**. Chapter: Intra-orbital Foreign Bodies. Master Techniques in Ophthalmic Surgery. Roy FH (Editor). *In Press*

### **Abstracts**

**Eliasieh K**, Liets LC, van der List DA, Chalupa LM. Dendrites of Rod Bipolar Cells Sprout in the Aging Retina. The Association for Research in Vision and Ophthalmology (ARVO), May 2006, Ft. Lauderdale, FL.

Kashyap Y, Dorairaj SK, **Eliasieh K**, Nezgoda JT, Teng CC. Evaluation of Laser Iridotomy Performed by Residents in a Teaching Institution. The Association for Research in Vision and Ophthalmology (ARVO), May 2010, Ft. Lauderdale, FL.

**Eliasieh K**, Dorairaj SK, Kashyap Y, Nezgoda JT, Teng CC. Evaluation of Argon Laser Peripheral Iridoplasties Performed by Residents: Does It Really Work? Association for Research in Vision and Ophthalmology (ARVO), May 2010, Ft. Lauderdale, FL.

**Eliasieh K**, Zoumalan C, Gentile R, McCormick S, Milman T, Maher E. The Spectrum of Periocular Atypical Mycobacterial Infections: A Case Series. The American Society of Ophthalmic Plastic and Reconstructive Surgery (ASOPRS) Fall Scientific Symposium, Oct. 2010. Chicago, IL.

**Eliasieh K**, Fitzgerald C, Merbs S, Rivera-Michlig R. Bilateral Müller muscle-conjunctiva resection in a patient with oculosympathetic spasm. The American Society of Ophthalmic Plastic and Reconstructive Surgery (ASOPRS) Fall Scientific Symposium, Nov. 2013. New Orleans, LA

---

### **INVITED LECTURES**

Howard Hughes Medical Institute (HHMI) Annual Medical Fellows Conference, May 2006. Chevy Chase, MD.  
*Aging and Plasticity of the Retina*

25<sup>th</sup> Annual Wilmer (Johns Hopkins Medical Institute) Current Concepts in Ophthalmology, December 2012, Baltimore, MD  
*Management of Nasolacrimal Duct Trauma*

26<sup>th</sup> Annual Wilmer (Johns Hopkins Medical Institute) Current Concepts in Ophthalmology, December 2013, Baltimore, MD  
*Complications of the Anophthalmic Socket*

73<sup>rd</sup> Annual Wilmer (Johns Hopkins Medical Institute) Resident's Association Clinical Meeting, June 2014, Baltimore, MD  
*Postural Effects on Lower Eyelid Biometrics*

The American Society of Ophthalmic Plastic and Reconstructive Surgery (ASOPRS) Fall Symposium, Oct 2014, Chicago, IL  
*Bicanalicular silicone intubation with intra-lacrimal sac fixation suture for punctal and canicular stenosis*

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### **HONORS**

- 1998 Integrated Studies Honors Program, UC Davis
- 1998 Regents Scholarship, UC Davis
- 2005 Howard Hughes Medical Institute Research Fellowship
- 2007 Nominated for AOA (Top 25% of class)

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## ADDITIONAL EXPERIENCE

**Research**

- 12/01-06/02      University of California, Davis Department of Neurobiology, Physiology, and Behavior  
*Student Researcher*, The role of dopaminergic amacrine cells in the stratification of retinal ganglion cell axons during development. Preceptor: Leo M. Chalupa, PhD
- 06/05-06/06      Howard Hughes Medical Institute  
*Research Fellow*, Reorganization of neural circuitry in mouse and human retina in context of age related vision loss. Preceptor: Leo M. Chalupa, PhD, University of California, Davis

**Leadership**

- 2004-2006      Physiology and Neuroanatomy Instructor, UC Davis School of Medicine
- 2007      Co-Director- Willow Project Homeless Clinic, UC Davis School of Medicine
- 2007      Co-Director- Ophthalmology Student Interest Group, UC Davis School of Medicine

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**OTHER LANGUAGES** Fluent in Spanish and Persian (Farsi)

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**INTERESTS** Photography, film, silkscreen printing, bicycling

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**REFERENCES** Shannath Merbs, MD, PhD – ASOPRS Fellowship Director  
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Baltimore, MD 21287  
[smerbs@jhmi.edu](mailto:smerbs@jhmi.edu)      (410) 955-1113