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A Day in the Life in the Wills ER

By Samara Hamou, MS1 | Faculty Reviewer: Christine Chung, MD



Entry to the emergency room; located on the first floor of the Jefferson Hospital for Neuroscience.

The Wills Eye Hospital — among the greatest eye hospitals in the country — is a force to be reckoned with. Located in Center City Philadelphia, the eight-story tall brick facility will capture your attention as you stroll down Walnut Street. The entrance to the Wills Eye Emergency Room (ER), however, is less apparent to the average city-goer. Located directly across from the Hospital, the red and blue entrance sign may go unnoticed to the unsuspecting passer. However, for those who require expert eye care in a timely fashion, the Eye Emergency Room is a signal for the invaluable services provided by the doctors and trainees inside.

The Wills Eye ER is one of only three emergency rooms in the country dedicated exclusively to emergency eye care. It is available 24 hours a day, 365 days a year, and serves over 1600 patients each month. The hospital's world-renowned reputation uniquely attracts patients throughout the Eastern Seaboard who seek access to the world-class expertise and emergent eye care available at Wills.

As a first-year medical student at SKMC, I was fortunate to catch a glimpse of what goes on behind the scenes during a typical day in the Wills ER. There are five exam rooms and one triage room. Acute eye emergencies account for about 60% of the visits, with the rest comprising of non-emergent visits. Patients come in on their own volition, or are referred from local urgent care, primary care services, their ophthalmologist or ER's as far away as Lehigh Valley. All patients are triaged by a registered nurse upon presentation, a process that starts with visual acuity and vital signs. On my particular visit, the attending physician, Dr. Christine A. Chung, then performed a pupil exam to clear the patient for dilation in preparation for a full eye exam. If cleared, a first- or second-year ophthalmology resident will gather a history and conduct a full ocular exam consisting of color testing, confrontational visual field testing, motility, applanation tonometry, slit lamp, and dilated fundus exam. The patient is then seen a second time by the attending ophthalmologist for final review. After completing the patient work up, the resident and attending team discuss the findings, and together create a diagnostic assessment and treatment plan. Depending on the diagnosis and nature of the case, the patient is either discharged, sent for further imaging, or admitted.

I was amazed at the myriad of patients I witnessed throughout the several hours I spent observing in the Wills ER. Encounters ranged from something as straight-forward as a superficial foreign body requiring removal and treatment with topical drops, to complex ocular pathology such as cavernous sinus hemangioma requiring an intense work-up and further testing. I



A typical exam room in the Wills Eye ER.

distinctly recall three patients that came through which left quite an impression on me.

Case 1: A 70-year-old man presented after falling the prior day while carrying bags of gardening soil. Since he was holding the bags of soil, he was unable to stop his fall and fell directly on his face. Upon arrival, his blood pressure (BP) was elevated to 200/120. He reported good BP control on his home anti-hypertensive medications, but admitted to forgetting his regular dose that morning. Ocular examination quickly revealed that he had a full thickness corneal laceration requiring urgent repair (Figure 1). After starting IV antibiotics, the Wills ER was able to admit him to the Jefferson Hospital for Neuroscience for stabilization of his BP prior to surgery. The patient was then scheduled for open-globe repair at Wills Eye the following day.

Case 2: A 75-year-old man recovering from COVID-19, diagnosed three weeks earlier, presented with debilitating headaches, elevated BP and tunnel vision. These symptoms led the patient to see an optometrist, who found a "poor visual field" and promptly referred him to the Wills Eye ER. A confrontational visual

field performed by the ophthalmology resident on initial evaluation revealed a right upper quadrant homogenous field defect. The slit lamp exam and fundus exam were unrevealing, and the patient was scheduled for a brain MRI to confirm the working diagnosis of a subacute stroke. Unfortunately, an MRI workup takes several hours to complete, and the nature of the emergency room does not always allow you to follow a patient to completion.

Case 3: A 54-year-old man with a history of recent shingles presented with a chief complaint of double vision (diplopia) for the past month. His medical history was significant for uncontrolled diabetes, well-controlled hypertension, and hypercholesterolemia. A Three-Step Test was performed (Figure 2), and the etiology of his diplopia was determined to likely be a unilateral cranial nerve IV palsy. The residents presumed that this palsy could be due to microvascular ischemia from uncontrolled diabetes or from his recent shingles infection. He was sent for an MRI which showed no intracranial mass, hemorrhage, or acute infarct, and was consistent with microangiopathy. The patient was advised to follow up



Figure 1. Anterior ruptured globe enhanced with yellow fluorescein dye, subconjunctival hemorrhage, and surrounding ecchymoses.

with a neuro-ophthalmologist for his diplopia, and with a comprehensive ophthalmologist to monitor the incidental diabetic retinopathy found on dilated fundus exam.

It became evident to me that the Wills Eye residents are essential for running the ER. The residency program itself is one of the most competitive and largest in the country, and accepts a total of 8 residents each year. Residents complete various 6-week rotations in comprehensive and subspecialty clinics, the emergency room, consult service at Jefferson, and the operating room at Wills Eye Hospital. An ophthalmology attending supervises the residents during the week, and an ER attending covers overnight and during the weekend. I had the privilege of working with Dr. Kaylene Carter (PGY-2) who shared that the most rewarding part of her Wills Eye experience so far has been working with amazing co-residents from around the country. When asked about the most challenging part of residency so far, she reflected upon the “steep learning curve with a high volume of patients in the ER that definitely takes some adjusting to.”

Across the many patient encounters that day, I was able to appreciate how ocular symptoms can serve as presenting signs of systemic diseases that often involve multiple organ systems, especially the brain. I witnessed first-hand the meaning behind the cliché expression “the eye is the window to the soul”, which could not be more evident throughout the various diagnoses made during my time shadowing Dr. Chung and the talented Wills Eye residents.



Figure 2. Dr. Bonnie Sklar (PGY-3) using various sets of prisms to quantify diplopia severity after performing the Parks Three-Step Test, a diagnostic test used to identify which muscle is paretic in the case of an acquired hypertropia.

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