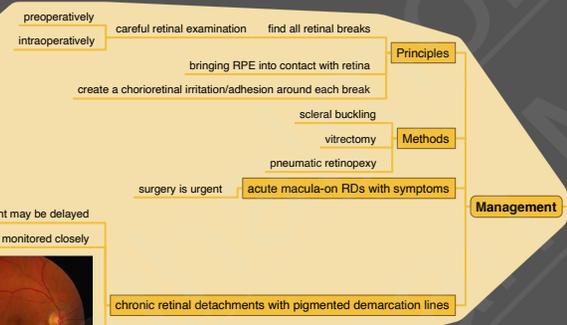
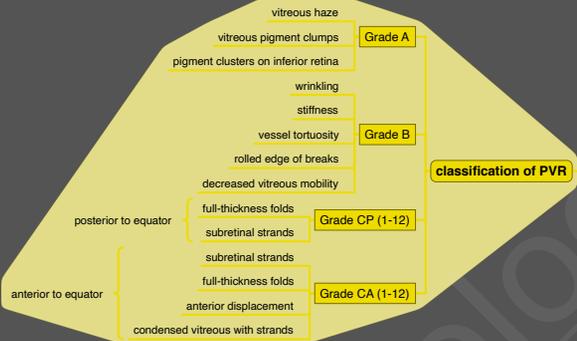
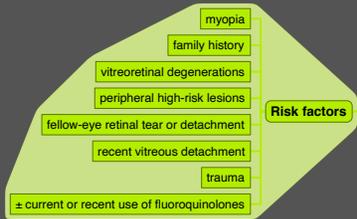


Rhegmatogenous Retinal Detachment



annual incidence 12.6/100,000 persons in a primarily white population

photopsias, floaters 1/2

if no break can be found, rule out all other causes of retinal elevation

intraocular pressure is usually lower occasionally higher

Shafer sign "tobacco dust" (pigmented cells) in anterior vitreous 70%

retina detaches progressively from periphery to optic disc

convex retinal borders and contours

corrugated retinal appearance especially in recent retinal detachments

retina undulates with eye movements

retina may appear smooth and thin

chronic RRD demarcation lines

macrocysts

shifting fluid may occur uncommon more typical of serous RD

90--95%

Rules to Find the Primary Break

Rule 1: Superior temporal or nasal detachments: In 86%, the primary break lies within 1 1/2 clock-hours of the highest border.

Rule 2: Total or superior detachments that cross the 12 o'clock meridian: In 95%, the primary break is at 12 o'clock or in a triangle, the apex of which is at the ora serrata, and the sides of which extend 1 1/2 clock-hours to either side of 12 o'clock.

Rule 3: Inferior detachments: In 95%, the higher side of the detachment indicates on which side of the disc an inferior break lies.

Rule 4: "Inferior" bullous detachment: Inferior bullae in a rhegmatogenous detachment originate from a superior break.

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most common cause of failure after RRD repair

RPE, glial, and other cells grow on both inner and outer retinal surfaces and on vitreous face, forming membranes

membranes contract and cause

- fixed retinal folds almost always indicate an RRD
- equatorial traction
- detachment of nonpigmented epithelium from pars plana
- generalized retinal shrinkage
- reopening of causative retinal breaks or formation of new breaks
- tractional RD

