The following document outlines the current process for consulting the Maine Eye Center for Maine Medical Center/Brighton First Care patients. The guidelines and information provided on this document are developed by the department of emergency medicine at Maine Medical Center and the Maine Eye Center. The information is believed, but not guaranteed to be correct. It is intended to be a reference for Maine Medical Center clinicians and is not intended to replace providers’ clinical judgment or definitive consultation.

The Maine Eye Center is happy to discuss patients from 8a-10p. For comments or suggestions regarding these guidelines, please contact Jeff Holmes, MD at holmej@mmc.org

**Consult Maine Eye Center during 8a-10p, Transfer to Boston (Mass Eye and Ear or New England Eye Center at Tufts) during Off Hours for Emergent Care:**
1. Open Globe
2. Retrobulbar hematoma
3. Primary acute angle closure glaucoma

**Admit to Internal Medicine/Family Medicine with Optional Ophthalmology Consultation:**
1. Orbital cellulitis
2. Ophthalmia neonatorum (Newborn conjunctivitis)

**Immediate Ophthalmologic Consultation; CDU in off hours with Ophthalmology consult in AM:**
1. Corneal Ulcer
2. Complicated Hyphema
3. Corneal Perforation
4. Endophthalmitis
5. Severe hyperacute conjunctivitis and gonococcal conjunctivitis (i.e. corneal involvement)
6. Central retinal artery occlusion
7. Severe chemical/thermal injury
8. Central retinal vein occlusion and branch retinal vein occlusion
9. Eyelid laceration

**(+/-) Phone consultation with Ophthalmology to Optimize Treatment, Follow Up in at Maine Eye Center Office in AM:**
1. Corneal ulcer (small, peripheral ulcer)
2. Mild hyperacute/gonococcal conjunctivitis (severe cases require IV antibiotics)
3. Retinal detachment
4. Corneal foreign body
5. Corneal Abrasion
6. Corneal Laceration
7. Minor chemical/thermal injury
8. Small, uncomplicated hyphema
9. Herpetic Keratitis or eye changes WITH herpetic rash on cranial nerve 5 distribution
10. Vitreous hemorrhage
11. Posterior vitreous detachment
12. Keratitis

**Delayed Referral to Maine Eye Center (within one week):**
1. Orbital Wall fractures (no entrapment or roof fracture)
2. Traumatic Iritis
3. Scleritis

**Follow up Maine Eye Center prn:**
1. Corneal Abrasion
2. Conjunctivitis
3. Episcleritis
Consult Maine Eye Center during 8a-10p, Refer to Boston (Mass Eye and Ear or Tufts University Medical Center) During Off Hours:

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<th>Diagnosis</th>
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<th>Consultation</th>
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| Open globe | - Surgical exploration and repair  
- Ct of brain and orbits to rule out intraocular foreign body in most cases  
- NPO, antiemetic agents, tetanus, elevate HOB, eye shield  
- Systemic antibiotics within 6 hours of injury | Office Hours 8a-10p  
Consult Ophthalmologist on call for Maine Eye Center |
| Retrobulbar hematoma (Isolated trauma only and trauma surgery chooses not to admit) | - Pain, decreased vision, inability to open eyelids due to severe swelling  
- Proptosis with resistance to repulsion, tense eyelids  
- A lateral canthotomy should be done by the emergency physician as a temporizing measure before definitive decompression.  
- Treatment of increased intraocular pressure includes oral carbonic anhydrase inhibitor, topical beta-blocker, and intravenous (IV) mannitol.  
- Re-evaluate eye pressures after treatment and monitor for improvement | Office Hours 8a-10p  
Consult Ophthalmologist on call for Maine Eye Center |
| Retrobulbar hematoma (Isolated trauma only and trauma surgery chooses not to admit) | Off Hours 10p – 8a  
Options include immediate transfer vs CDU AM ophthalmology evaluation and operative management |
| Primary acute angle closure glaucoma | - Pain, blurred vision, colored halos around lights, frontal headache, N/V, conjunctival injection; fixed, mid-dilated pupil  
- Emergent ophthalmologic consultation  
- Intraocular pressures less than 50 mm Hg can be managed without IV medications  
- Topical therapy with β-blocker (eg. timolol 0.5%), α2-agonist (e.g., brimonidine 0.15%), prostaglandin analogs (lantoprost 0.005%), and CAI’s (dorzlamide 2%) should be initiated immediately. In urgent cases, three rounds of these medications may be given, with each round being separated by 15 minutes  
- Topical steroid (prednisolone acetate 1% every 15 minutes for four doses) should be given.  
- Recheck the IOP and visual acuity in one hour. If IOP does not decrease and vision does not improve, repeat topical medications and give mannitol 1-2 g/kg IV over 45 minutes | Office Hours 8a-10p  
Consult Ophthalmologist on call for Maine Eye Center |
| Primary acute angle closure glaucoma | Off Hours 10p – 8a  
Options include immediate transfer vs CDU for AM evaluation and operative management (CDU only if canthotomy performed and patient eye pressures improved, otherwise transfer) |
| Primary acute angle closure glaucoma | • Pressures improved post management appropriate for AM follow up  
• Transfer for laser treatment if pressures remain >40mm Hg after 3 hours of treatment |
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<th>Diagnosis</th>
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<tr>
<td>Orbital cellulitis</td>
<td>- Red eye, pain, blurred vision, double vision, pain with extraocular movements</td>
<td>Office Hours 8a-10p&lt;br&gt;If ophthalmology consultation desired, consult Ophthalmologist on call for Maine Eye Center</td>
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<td>- Broad spectrum IV antibiotics to cover&lt;br&gt;Gram-positive, gram – negative and anaerobic organisms</td>
<td>Off Hours 10p – 8a&lt;br&gt;Rarely requires transfer - Options include immediate transfer vs CDU for AM evaluation and definitive management.</td>
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<td>- Consider inpatient ophthalmology consult&lt;br&gt;- Early surgical drainage of paranasal sinuses by ENT specialist if sinusitis present (more common in adults)</td>
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<td>Ophthalmia neonatorum</td>
<td>- Purulent, mucopurulent, or mucoid discharge from one or both eyes in the first month of life with diffuse conjunctival injection&lt;br&gt;- Etiologies include Neisseria gonorrhoeae, Chlamydia trachomatis, Staphylococci (including MRSA), streptococci, and Gram-negative species, herpes simplex virus&lt;br&gt;- Perform gram stain and culture&lt;br&gt;- Treatment based on suspected organism&lt;br&gt;- Admit for antibiotics or consider AM office follow up with Maine Eye Center&lt;br&gt;- Consider CDU</td>
<td>Office Hours 8a-10p&lt;br&gt;If ophthalmology consultation desired, consult Ophthalmologist on call for Maine Eye Center&lt;br&gt;Off Hours 10p – 8a&lt;br&gt;Options include admission, CDU or AM office visit</td>
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<td>Diagnosis</td>
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<td><strong>Corneal ulcer</strong></td>
<td>- Large, vision threatening ulcers (&gt; 1.5 mm in diameter) and central ulcers should be referred to ophthalmologist immediately</td>
<td>Office Hours 8 – 10 p</td>
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<td>- Consider CDU admission if patient unable to self-administer antibiotics, high likelihood of noncompliance or large corneal ulcer</td>
<td>Consult Ophthalmologist on call for Maine Eye Center</td>
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<td>- Initiate broad spectrum ex. Vigamox Q1h</td>
<td>Off Hours 10p – 8a</td>
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<td>Consider CDU or AM office visit</td>
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<tr>
<td><strong>Complicated hyphema</strong></td>
<td>- Consider hospitalization for noncompliant patients, patients with bleeding diathesis or blood dyscrasia</td>
<td>Office Hours 8 – 10 p</td>
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<td>- Patients with other severe ocular or orbital injuries and patients with concomitant significant IOP</td>
<td>Consult Ophthalmologist on call for Maine Eye Center</td>
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<td>- Elevation head of bed, place eye shield, atropine 1% solution b.i.d. to t.i.d. or scopolamine 0.25% b.i.d. to t.i.d.</td>
<td>Off Hours 10p – 8a</td>
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<td>- Use topical steroids (eg. prenisolone acetate 1% q.i.d. to q1h) if any suggestion of iritis (eg. photophobia, deep ache, ciliary flush)</td>
<td>Consider CDU or AM office visit</td>
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<td>- Refer to definitive text/consultation for treatment of increased IOP</td>
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<td><strong>Corneal perforation</strong></td>
<td>- Most often 2nd to infectious breakdown (other causes include trauma, inflammatory conditions, environmental exposures)</td>
<td>Office Hours 8 – 10 p</td>
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<td>- Treatment is surgical (or tissue adhesives for non-operative patients)</td>
<td>Consult Ophthalmologist on call for Maine Eye Center</td>
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<td>- Emergent Ophthalmology consultation; CDU in off hours</td>
<td>Off Hours 10p – 8a</td>
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<td>Consider CDU or AM office visit</td>
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<td><strong>Endophthalmitis</strong></td>
<td>- Patients most at risk are those with recent ocular surgery or injection (other risk factors are severe bacterial keratitis or ulceration)</td>
<td>Office Hours 8 – 10 p</td>
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<td>- Likely present with red swollen painful eye post (recent or remote) glaucoma surgery</td>
<td>Consult Ophthalmologist on call for Maine Eye Center</td>
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<td>- Usually presents with hypopion (yellow hyphema)</td>
<td>Off Hours 10p – 8a</td>
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<td>- Immediate ophthalmology consultation</td>
<td>Consider CDU or AM office visit</td>
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<td><strong>Severe hyperacute conjunctivitis and gonococcal conjunctivitis (i.e. corneal involvement)</strong></td>
<td>- Excessively purulent appearing eye</td>
<td>Office Hours 8 – 10 p</td>
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<td>- Emergent referral to ophthalmology for moderate/severe cases</td>
<td>Consult Ophthalmologist on call for Maine Eye Center</td>
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<td>- Ceftriaxone 1 g IM as single dose</td>
<td>Off Hours 10p – 8a</td>
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<td>- Swab culture with gram stain</td>
<td>Consider CDU or AM office visit</td>
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<td>- Outpt treatment after Rocephin IM includes topical antibiotics, saline solution for conjunctival irrigation</td>
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<td>- Consider testing or treating presumptively for concomitant Chlamydia trachomatis infection with oral doxycycline, tetracycline, or erythromycin or single dose of 1 g of azithromycin</td>
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| Central retinal artery occlusion | Severe painless vision loss that occurs over seconds: markedly reduced visual acuity with prominent afferent pupillary defect; on fundoscopic exam, retina appears edematous with pale-grey appearance, may possibly see a fovea “cherry red spot”  
- Immediate ophthalmic consultation  
- Ocular massage  
- Lower IOP after consultation with ophthalmologist  
- Consider Timoptic and paracentesis  
- Work up includes STAT ESR, CRP and Carotid US  
- NOTE: Treatment and disposition are time dependent, symptoms present longer than 90min are unlikely to respond to interventions and are less emergent | Consult Ophthalmologist on call for Maine Eye Center  
Off Hours 10p – 8a  
Options include TIA workup in CDU plus AM evaluation and definitive management for eye. |
| Severe chemical/thermal injury | Based on degree of chemosis, corneal cloudiness and conjunctival blanching  
- Thorough irrigation with Morgan Lens for chemical burns  
- Confirm neutral pH for chemical burns after adequate irrigation  
- Severe chemical injury requires urgent ophthalmologic follow up (based on degree of corneal cloudiness and sclera whitening)  
- Mild thermal injuries can be left unpatched with antibiotic ointment and seen in 1-2 days  
- Cyloplegic drop for ciliary body spams and pain  
- Oral analgesics, tetanus | Office Hours 8 – 10 p  
Consult Ophthalmologist on call for Maine Eye Center  
Off Hours 10p – 8a  
AM office visit at Maine Eye Center |
| Central retinal vein occlusion and branch retinal vein occlusion | Painless vision loss with hemorrhage of retinal vessels in a pt with co-morbidities (DM, HTN)  
- No effective treatment in ED  
- Check pressure and refer for AM follow up  
- Urgent follow up | Office Hours 8 – 10 p  
Consult Ophthalmologist on call for Maine Eye Center  
Off Hours 10p – 8a  
AM office visit |
| Eyelid laceration | Refer to ophthalmology/plastic surgery to repair if:  
1. Lacerations involving lid margins  
2. Lacerations involving the canalicular system. Injury to the canalicular system should be suspected in any laceration involving the medial lower eyelid area  
3. Lacerations involving the levator or canthal tendons.  
4. Laceration through the orbital septum. Orbital fat protrudes through septal lacerations into the wound. Because eyelids have no subcutaneous fat, the appearance of fat in a lid laceration confirms this diagnosis. These wounds are associated with a high incidence of globe penetration and intraorbital foreign bodies.  
5. Lacerations with tissue loss.  
6. Full thickness (on lid margin) or involving deeper structures or involving oculopastics or structures involving canaliculus  
   The Emergency Physician can repair:  
1. Simple horizontal  
2. Oblique partial thickness lid lacs  
   - Close with 6-0 or 7-0 nylon interrupted; remove in 3-5 days | Office Hours 8 – 10 p  
Consult Ophthalmologist on call for Maine Eye Center  
Off Hours 10p – 8a |
**(+/-) Phone consultation with Ophthalmology to Optimize Treatment, Follow Up in at Maine Eye Center**

**Office in AM:**

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| Corneal ulcer (Small peripheral ulcers) | - Pain, photophobia, tearing, red eye  
- An ulcer exists if there is stromal loss with an overlying epithelial defect that stains with fluorescein  
- Broad spectrum antibiotics  
- Next day follow up | Office Hours 8 – 10 p  
Consult Ophthalmologist on call for Maine Eye Center  
Off Hours 10p – 8a  
Options include CDU for AM evaluation or AM office visit |
| Mild hyperacute/gonococcal conjunctivitis (severe cases require IV antibiotics) | - Red eye, copious discharge that accumulates quickly  
- Patients should be questioned about urethral or vaginal discharge or other symptoms of STD’s  
- Ceftriaxone 1 g IM as single dose  
- Swab culture with gram stain  
- Outpatient treatment after Rocephin IM includes topical erythromycin ointment, saline solution for conjunctival irrigation  
- Consider testing or treating presumptively for concomitant Chlamydia trachomatis infection with oral doxycycline, tetracycline, or erythromycin or single dose of 1 g of azithromycin | Office Hours 8 – 10 p  
Consult Ophthalmologist on call for Maine Eye Center  
Off Hours 10p – 8a  
AM office visit at Maine Eye Center |
| Retinal detachment | - Floaters and flashers  
- Potential field loss  
- Use ultrasound/fundoscopic exam to diagnose  
- Keep NPO after midnight for Early AM office follow up | Office Hours 8 – 10 p  
Consult Ophthalmologist on call for Maine Eye Center  
Off Hours 10p – 8a  
Options include immediate transfer for macula threatening detachments vs NPO with early AM office visit |
| Corneal foreign body | - Attempt to first remove with moistened cotton swab, then tip of 25 gauge needle  
- Antibiotic ointment or drops  
- Cycloplegic agent prn for ocular discomfort if significant photophobia  
- Emergent referral if any corneal laceration, positive seidel test, evidence of corneal ulcer or infiltrate, deeply embedded foreign body, hypopyon or significant anterior chamber reaction  
- Referral if not removed or residual rust ring  
- 24-48 hour referral for all other retained FB’s not removed  
- Simple foreign bodies successfully removed in ED may not need ophthalmology referral | Office Hours 8 – 10 p  
Consult Ophthalmologist on call for Maine Eye Center  
Off Hours 10p – 8a  
Consider AM office visit |
| Corneal abrasion | - Large abrasions in visual axis should be examined the next day  
- Small peripheral abrasions can be followed up 2-5 days prn | Office Hours 8 – 10 p  
Consult Ophthalmologist on call for Maine Eye Center |

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<th>Emergency Instructions</th>
<th>Office Hours</th>
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<td><strong>Corneal laceration</strong></td>
<td>- R/o perforated globe&lt;br&gt;- Urgent ophthalmologic consultation for partial thickness&lt;br&gt;- Cover with metal eye shield&lt;br&gt;- Partial thickness lacerations treat with cycloplegic agents, topical antibiotics, tetanus&lt;br&gt;- NPO after midnight</td>
<td><strong>Off Hours 8p – 8a</strong>&lt;br&gt;Consult Ophthalmologist on call for Maine Eye Center&lt;br&gt;<strong>Off Hours 10p – 8a</strong>&lt;br&gt;Consider AM office visit at Maine Eye Center</td>
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<td><strong>Minor chemical/thermal Injury</strong></td>
<td>- Thorough irrigation with Morgan Lens for chemical burns&lt;br&gt;- Confirm neutral ph for chemical burns after adequate irrigation&lt;br&gt;- Severe chemical injury requires urgent ophthalmologic follow up&lt;br&gt;- Mild thermal injuries can be left unpatched with antibiotic ointment and seen in 1-2 days&lt;br&gt;- Cycloplegic drop for ciliary body spams and pain&lt;br&gt;- Oral analgesics, tetanus</td>
<td><strong>Off Hours 8p – 8a</strong>&lt;br&gt;Consult Ophthalmologist on call for Maine Eye Center&lt;br&gt;<strong>Off Hours 10p – 8a</strong>&lt;br&gt;Consider CDU or AM office visit at Maine Eye Center</td>
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<td><strong>Small, uncomplicated hyphema</strong></td>
<td>- If traumatic, screen for other significant signs of trauma (corneal laceration/abrasion, perforated globe)&lt;br&gt;- Cycloplegic to help minimize pain and discomfort&lt;br&gt;- Prednisolone acetate 1% QID&lt;br&gt;- Protective eye shield</td>
<td><strong>Off Hours 8p – 8a</strong>&lt;br&gt;Consult Ophthalmologist on call for Maine Eye Center&lt;br&gt;<strong>Off Hours 10p – 8a</strong>&lt;br&gt;Consider AM office visit</td>
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<td><strong>Herpetic Keratitis OR eye changes WITH herpetic rash on cranial nerve S distribution</strong></td>
<td>- Dermatomal pain, paresthesias, skin rash or discomfort&lt;br&gt;- May be preceded by headache, fever, malaise, blurred vision, eye pain and red eye&lt;br&gt;- Initiate oral antiviral&lt;br&gt;- Viroptic drops or vidarabine ointment&lt;br&gt;- 24 hour follow up with ophthalmologist&lt;br&gt;- Severe cases may require admission for IV antiretroviral therapy&lt;br&gt;- Follow up Maine Eye Center in AM</td>
<td><strong>Off Hours 8p – 8a</strong>&lt;br&gt;Consult Ophthalmologist on call for Maine Eye Center or refer for follow up&lt;br&gt;<strong>Off Hours 10p-8a</strong>&lt;br&gt;Consider CDU or AM office visit</td>
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<td><strong>Vitreous hemorrhage</strong></td>
<td>- Sudden, painless loss of vision or sudden appearance of black spots, cobwebs or haze in vision&lt;br&gt;- Partial to complete obstructed view to fundus&lt;br&gt;- Screen for retinal detachment with ultrasound&lt;br&gt;- No emergent treatment</td>
<td><strong>Office Hours 8 – 10 p</strong>&lt;br&gt;Contact Ophthalmologist on Call for Maine Eye Center or refer for follow up&lt;br&gt;<strong>Off Hours 10p – 8a</strong>&lt;br&gt;Consider CDU or AM office visit</td>
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<td><strong>Posterior vitreous detachment</strong></td>
<td>- May present as “Flashers/floaters”&lt;br&gt;- Use ultrasound/fundoscopic exam to r/o retinal detachment&lt;br&gt;- <em>Patients with a new posterior vitreous detachment should have prompt evaluation (24-48 hours) by an ophthalmologist to rule out these surgically amenable complications.</em></td>
<td><strong>Office Hours 8 – 10 p</strong>&lt;br&gt;Contact Ophthalmologist on Call for Maine Eye Center or refer for follow up&lt;br&gt;<strong>Off Hours 10p – 8a</strong>&lt;br&gt;AM office visit</td>
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| Keratitis | - No specific treatment is indicated for posterior vitreous detachment unless it is accompanied by a retinal break, vitreous hemorrhage, or retinal detachment. | - If patient wears contact lens, instruct the patient to remove and temporarily discontinue wearing.  
- If infectious etiology suspected, thorough exam by ophthalmologist to r/o corneal ulcer.  
- Next day ophthalmology follow up.  

Office Hours 8 – 10 p.m.
Contact Ophthalmologist on Call for Maine Eye Center or refer for follow up.  

Off Hours 10 p.m. – 8 a.m.
Consider CDU or AM office visit. |
### Delayed Referral to Maine Eye Center (within one week):

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<tr>
<td><strong>Orbital Wall fractures (no entrapment or roof fracture)</strong></td>
<td>- Consult neurosurgery if roof fracture present or fracture extends into optic canal</td>
<td><strong>Office Hours 8a-10p</strong></td>
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<td>- 1-2 weeks with ophthalmology referral to look for persistent double vision or enophthalos after edema has subsided</td>
<td>If ophthalmology consultation desired, consult Ophthalmologist on call for Maine Eye Center</td>
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<td>- 1-2 weeks ophthalmology referral to check for accessory damage from blunt trauma such as angle recession and retinal detachment</td>
<td><strong>Off Hours 10p – 8a</strong></td>
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<td>- If fracture involves infected sinus, treatment consists of nasal decongestants, broad-spectrum oral antibiotics</td>
<td>Delayed referral to Maine Eye Center</td>
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<td>- Patients with orbital floor and medial orbital wall fractures should avoid blowing their noses and performing Valsalva maneuver to limit the extent of emphysema.</td>
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<td>- Surgical repair is only for persistent diplopia or cosmetic concerns and is generally not performed until swelling subsides in 7 to 10 days</td>
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<td><strong>Traumatic Iritis</strong></td>
<td>- Photophobia, redness, history of trauma</td>
<td><strong>Office Hours 8a-10p</strong></td>
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<td>- Conjunctival injection, perilimbal flush</td>
<td>If ophthalmology consultation desired, consult Ophthalmologist on call for Maine Eye Center</td>
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<td>- Anterior chamber cell and flare</td>
<td><strong>Off Hours 10p – 8a</strong></td>
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<td>- Long-acting cycloplegic agent for pain</td>
<td>Consider delayed referral to Maine Eye Center</td>
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<td>- Topical steroid (e.g. Prednisolone 1%) for inflammation</td>
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<td><strong>Scleritis</strong></td>
<td>- Severe and boring eye pain (most prominent eye feature), which may radiate to the forehead, brow, or jaw, and may awaken the patient at night</td>
<td><strong>Office Hours 8a-10p</strong></td>
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<td>- Refer for outpatient workup</td>
<td>If ophthalmology consultation desired, consult Ophthalmologist on call for Maine Eye Center</td>
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<td>- Oral NSAID</td>
<td><strong>Off Hours 10p – 8a</strong></td>
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<td>Delayed referral to Maine Eye Center</td>
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### References