

## PANOPTIC OPHTHALMOSCOPE TECHNIQUE

**Purpose of this bulletin:** To ensure practitioners understand that the **PanOptic technique** is not exactly the same as using the traditional Welch Allyn direct ophthalmoscope. There are subtle but critically important differences. By understanding the following concepts, you appreciate that this great new instrument does require some practice and technique adjustments in order to fully exploit its capabilities. ***This proactive in-service takes just a minute or two but is invaluable in ensuring a satisfied customer...***

- 1) **The 'red reflex' is essential to achieving the view.** Starting at level height with the patient from 6" away & 15 deg. off-center (temple side), you should find the red reflex and **SLOWLY follow it into the patient's eye** --- the reflex is the "lighthouse" which leads you into the eye and it is ***FAR MORE IMPORTANT*** with PanOptic than with a standard scope. Here's why:  
A standard scope floods the eye with light, and this flood remains no matter how close or far you are from the patient i.e. there is no pinpoint convergence effect as you approach & get close to the patient like there is with PanOptic.

PanOptic's light beam converges to a pinpoint at the pupil. If you lose track of the reflex you will almost certainly end up misaligned with the pupil because the whole system is less forgiving i.e. it is much easier to become misaligned because everything is now small -- a 2mm sized point of light and a 2mm sized pupil. Thus, ***without the red reflex as your guide, you will end up with a partial view or no view at all (blackness), simply because the light beam is not lined up with the pupil.***

Therefore, the "trip" from 6" away to making contact with the patient must be one that is ***slow, deliberate, and steady.*** This is the only way to maintain the red reflex and thus proper alignment with the pupil.

- 2) **The second essential rule is making contact with the eyecup.** In order to fully exploit the panoramic field-of-view capabilities of the PanOptic, one **MUST** be at the correct working distance, which means one must be touching the patient's brow with the eyecup. ***The 5X bigger view can actually only be achieved by COMPRESSING the eyecup about half it's length against the patient's brow*** (you can achieve a 3X bigger view by just touching, but compression is needed to fully exploit the view).
- 3) **Focusing adjustments should also be made slowly, deliberately, and precisely.** A small movement in the focusing wheel will result in a lot of focusing change (e.g. perhaps an 1/8 of an inch is about 3 diopters in focus change). Thus, after focusing the wheel across the room for your (the user's) vision, the adjustments for the blur once you are in the patient's eye should be minor **FINE TUNING** adjustments, not major moves of the wheel.
- 4) **You must "move" with the scope.**

The 5" long optical tube of the PanOptic requires you to move your head more when panning/moving around the back of the eye. You must also be cognizant of your wrist movements while panning to maintain alignment of the illumination and your line of sight. The motion with PanOptic is more like pivoting about a point, rather than just re-pointing the scope as with a traditional direct.