

IS08**Orbital surgery: a conceptual approach**

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Orbital surgery and even oculoplastic surgery are almost unknown concepts in the minds of medical students before the start of the Ophthalmology rounds. And yet, this is an unusually important segment of ophthalmology. Without eyelids, lacrimal system, extraocular muscles, and orbital neurovascular structures commonly named protective apparatus, there can be no normal visual and eye motility function. In other words, the protective apparatus of the eye is necessary to fulfill two fundamental functions of the ophthalmic apparatus: the function of sight and articular function; both of which allows us to see one perfect image with two eyes. Apart from its protective role, orbital cavity is a „home“ to many different pathological conditions related to systemic diseases e.g. thyroid associated orbitopathy, lymphoma, IgG 4 related disease, granulomatous polyangiitis, neurofibromatosis, sarcoidosis, rheumatoid arthritis, Sjogren syndrome etc. Some conditions require surgical along with conservative treatment. From the perspective of other branches of ophthalmology, orbital surgery is a hard core, bloody surgery which carries a burden not so often seen in ophthalmology. Visual loss and serious systemic complications are not unusual and must be properly managed. Orbital bony decompression is one, such procedure. There are several different surgical approaches combining one, two, three or four wall orbital fracturing. The basic principle is to relieve orbital compression and decrease orbital pressure to avoid ischemic damage of the optic nerve and other orbital structures. By fracturing orbital walls the surgeon allows “overflow” of excessive orbital tissues to adjacent intracranial spaces like paranasal sinuses and temporal fossa. The result is decreased orbital and intraocular pressure, remodeling of the orbital content and thus optic nerve and other orbital structures ischemic injury relief. Orbital bony decompression is most performed as an urgent procedure and can be a solution for any kind of orbital compressive and compartment syndrome regardless of etiology. In skillful hands it is a safe, quick, and effective procedure.

IS09**Differential diagnosis of vertigo**

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Vertigo is an illusion of movement of the body or the environment. It is a symptom that can be caused by central (cerebrovascular insult (CVI), tumors, multiple sclerosis) or peripheral (Meniere disease, labyrinthitis, benign paroxysmal positional vertigo (BPPV)) origin. Vertigo is a common nonspecific complaint in patients attending the emergency department. Careful history taking and examination are required to distinguish vertigo from other nonrotational types of dizziness such as presyncope, disequilibrium and lightheadedness. Once we have determined that our patient suffers from vertigo it is important to differentiate if it is of central or peripheral origin. Central causes are suspected in patients with associated neurological symptoms such as one-sided muscle weakness, headache, dysarthria or confusion. Risk factors for vascular disease must also be taken into consideration. Peripheral vertigo is often associated with nausea and vomiting and in some cases with hearing loss (Meniere disease, labyrinthitis). Vertigo triggered by a change in the position of the head is often caused by BPPV or of cervicogenic origin. In conclusion, vertigo is a common symptom that is often caused by harmless conditions. However, serious diseases such as CVI must be excluded. Clinical history taking and physical examination is crucial in differential diagnosis of vertigo.

