

# Ocular Emergencies

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## What Classifies an Emergency?

- Ocular complaints
- Vision complaints
- Systemic complaints

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## Optometrists & Emergencies

- How many people visit urgent care/ER for ocular problems?
- Optometrists are best suited to handle eye emergencies
  - Urban/suburban setting
  - Rural setting
  - Going to urgent care vs optometrist
  - Integrated health care model

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## Office Protocols of emergencies

- Triage training
  - Same day/asap appointments
  - Within 24 hours
  - At earliest convenience
  - At a future date
- Document, Document, Document
- Importance

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## Taking call as an optometrist

- Required by state? Required by insurance panels?
- Value to the patient

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Let's get to some cases!

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### Case #1

- 43 year old male, mechanic
- **HPI:** "battery acid exploded into right eye", immediately felt pain
- -no improvement after irrigation with tap water
- (+) pain 9/10 severity
- (+) photophobia
- (+) blurry vision
- (+) watering

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### History

- **Medical history:** hypothyroidism
- **Medications:** levothyroxine
- **Allergies:** Penicillin (hives)
- **Ocular history:** unremarkable  
LEE 4mo ago, glasses full time, daily disposal CLs prn
- **Social history:** 5 drinks/week, "social smoker"

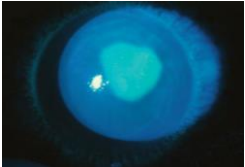
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### Entrance Testing

- **BCVA:** 20/400 OD NIPH; 20/20 OS
- **Pupils:** PERRLA, (-)APD
- **Confrontational VF:** grossly full, inconsistent responses in OD
- **EOMs:** Full & Smooth OU, (-)nystagmus
- **IOP:** (iCare) 12 mmHG OD, 12 mmHG OS

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	OD	OS
<b>Lids &amp; Lashes</b>	Erythematous upper & lower lid	Normal
<b>Conjunctiva/Sclera</b>	2+ injection; 1+ chemosis	White & Clear
<b>Cornea</b>	See photo	Clear
<b>A/C</b>	Deep & Quiet	Deep & Quiet
<b>Iris</b>	Green, Grossly normal	Green, WNL
<b>Lens</b>	Clear	Clear



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### Posterior Pole Findings

	OD	OS
<b>Vitreous</b>	Clear	Clear
<b>Optic nerve</b>	Pink, healthy rim 0.2/0.2 C/D ratio	Pink, healthy rim 0.3/0.3 C/D ratio
<b>Macula</b>	Flat & clear	Flat & clear
<b>Retina</b>	No breaks/tears	No breaks/tears


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### What do you do next?

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### pH of Tears

- At arrival: 6
- After irrigation of normal saline (15min)
- **What is the normal range for tears?**



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### Diagnosis

Differential Diagnosis:

- Corneal abrasion (mechanical trauma, foreign body, etc)
- Corneal Infections (viral, bacterial, fungal)

**What is your Diagnosis?**

Diagnosis:  
Corneal chemical Burn OD

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### Types of Chemical Burns

- **Neutral (Pepper Spray)**
- **Acidic**
  - Bind with tissue proteins causing coagulation → stops further penetration
  - Usually less harmful
  - Exception: hydrofluoric acid
- **Alkali**
  - Lipophilic → penetrate ocular tissues more quickly & deeper
  - Penetrates corneal stroma via saponification of fatty acids in cellular membranes
  - Damaged Stromal Tissue → proteolytic enzymes released → liquefactive necrosis

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Acidic Agents (pH <4)	Alkali Agents (pH >10)
Sulfuric Acid (Car batteries)	Ammonia (cleaning agents, fertilizers, refrigerants)
Acetic Acid (Vinegar)	Lye (drain & oven cleaners, air bags)
Hydrochloric Acid (swimming pool cleaner)	MgOH (Firework sparklers, flares)
Nail polish	Lime (plaster, mortar, cement, white wash)
	Mixed cement
	Ammonia

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Acidic Agents (pH <4)	Alkali Agents (pH >10)
<b>Sulfuric Acid (Car batteries)</b>	Ammonia (cleaning agents, fertilizers, refrigerants)
Acetic Acid (Vinegar)	Lye (drain & oven cleaners, Drano, air bags)
Hydrochloric Acid (swimming pool cleaner)	MgOH (Firework sparklers, flares)
Nail polish	Lime (plaster, mortar, cement, white wash)
	Mixed cement
	Ammonia

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### pH Levels of Common Household Cleaners



Cleaner	pH Level
Chlorine Bleach	11 ~ 15
Tub & Tile Cleaner	11 ~ 15
Borax	10
Mild Dish Soap	7 ~ 8
Vinegar	3
Toilet Bowl Cleaner	1 ~ 5

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### Irrigation

- damage can happen within 5 minutes
- begin immediately after splash occurs
- irrigate over CLs
- eye wash station, shower, outdoor hose
- pH levels often normalize within 30min of continuous irrigation (at least 32oz)
- triaging

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### Treatment & Management

- Stabilize ocular surface pH
- Slit Lamp Examination
  - Lids, cornea, limbus, conjunctiva, adnexa
- IOP

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### Treatment Goals

- **prevent infection** → broad-spectrum antibiotic
- **promote re-epithelialization** → debridement
- **control inflammation** → steroid
- **minimize sequelae** → cycloplegic, anti-glaucoma therapy

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### Roper-Hall Classification

Grade	Prognosis	Cornea	Conjunctiva/Limbus
I	Good	Corneal epithelial damage	No limbal ischemia
II	Good	Corneal haze, iris details visible	<1/3 limbal ischemia
III	Guarded	Total epithelial loss, stromal haze, iris details obscured	1/3 to 1/2 limbal ischemia
IV	Poor	Cornea opaque, iris and pupil obscured	>1/2 limbal ischemia

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### Grade I Treatment

- Steroid (1% prednisolone acetate qid)
- Topical antibiotic ung (erythromycin qhs to qid)
- Preservative-free artificial tears
- Cycloplegic for pain

Grade	Prognosis	Cornea	Conjunctiva/Limbus
I	Good	Corneal epithelial damage	No limbal ischemia

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### Grade II & III Treatment

- Topical antibiotic (fluoroquinolone) qid
- Topical steroid q1hr while awake (may need to taper)
- Long-acting cycloplegic (1% atropine)
- Oral pain medication prn
- Oral doxycycline to reduce corneal melting through MMP inhibition
- Oral vitamin C (1,000-2,000 mg) qid
- Sodium ascorbate drops (10%) while
- Preservative-free artificial tears prn
- Debridement of necrotic tissue
- Amniotic membrane

Grade	Prognosis	Cornea	Conjunctiva/Limbus
II	Good	Corneal haze, iris details visible	<1/3 limbal ischemia
III	Guarded	Total epithelial loss, stromal haze, iris details obscured	1/3 to 1/2 limbal ischemia

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## Grade IV Treatment

- Stem cell transplantation
- Penetrating keratoplasty
- Keratoprosthesis
- Tenoplasty to re-establish limbal vascularity

IV Poor Cornea opaque, iris and pupil obscured >1/2 limbal ischemia

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## Long Term Complications

- poor vision
- corneal scarring
- xerophthalmia
- dry eyes
- symblepharon
- glaucoma
- uveitis
- cataract
- adnexal abnormalities (lagophthalmos, entropion, ectropion and trichiasis)

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## Case 1: 43 yo male

- **Treatment**
  - 0.3% ciprofloxacin qid
  - Erythromycin ung qhs
  - 1% pred acetate q2hr
  - 1% cycloplegic tid
- **Follow-up**
  - RTC 1 day
  - Complete resolution 6 days
  - BCVA after resolution: 20/20

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## Staff Triaging

- -Preliminary irrigation take place on site immediately
- -irrigate eye for 20-30min before coming to office
- -irrigate over contact lenses
- -bring container of chemical or MSDS card
- -Time is critical
- -Document, document, document

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## Corneal Burn Clinical Pearls

- Stabilize pH (acidic vs alkaline)
- Thorough case history & examination
- Watch IOP
- Prevent infection
- Control Inflammation
- Minimize sequelae

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## Case #2

- 56 year old male
- **HPI:** "right eye hurts", began 1-2 week ago
- -thinks he scratched eye after removing contact lenses
- (+) pain 2/10 severity
- (+) photophobia
- (+) blurry vision
- (+) watering

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### History

- **Medical history:** Anxiety, Depression, HTN, neuropathy (feet)
- **Medications:** lisinopril, Effexor, Xanax
- **Allergies:** NKDA
- **Ocular history:** unremarkable LEE 5 years ago, Monthly MF contact lenses
- **Social history:** 1-2 drinks/week, non-smoker

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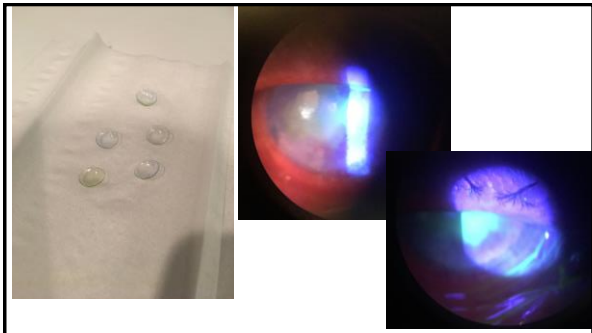
### Entrance Testing

- **BCVA:** HM @ 4ft OD NIPH; 20/30 OS
- **Pupils:** PERRLA, (-)APD
- **Confrontational VF:** grossly full OU
- **EQMs:** Full & Smooth OU, (-)nystagmus
- **IOP:** (iCare) 17 mmHG OD, 16 mmHG OS

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	OD	OS
<b>Lids &amp; Lashes</b>	Normal	Normal
<b>Conjunctiva/Sclera</b>	3+ injection	Trace Injection
<b>Cornea</b>	Contact Lens Diffuse edema Central epi defect Neovascularization (0.5mm I & N)	Contact Lens
<b>A/C</b>	Hazy View	Deep & Quiet
<b>Iris</b>	Brown, Grossly normal	Brown, WNL
<b>Lens</b>	Trace NS	Trace NS

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### Posterior Pole Findings

	OD (Hazy View)	OS
<b>Vitreous</b>	Quiet-no cells	Quiet-no cells
<b>Optic nerve</b>	Pink, healthy rim 0.3/0.3 C/D ratio	Pink, healthy rim 0.3/0.3 C/D ratio
<b>Macula</b>	Flat & clear	Flat & clear
<b>Retina</b>	No breaks/tears	No breaks/tears

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### Diagnosis

- **Differential Diagnosis**
  - corneal abrasion
  - corneal infiltrate

**What's your diagnosis?**

**Diagnosis**  
Corneal ulcer secondary to contact lens over wear

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## Sterile vs Infectious Infiltrate

Sterile	Infectious
Smaller lesion (<1mm)	Larger lesion (>1mm)
Peripheral location	Central location
Minimal epithelial damage	Significant epithelial defect
No mucous discharge	Mucopurulent discharge
Less pain or photophobia	Pain & photophobia
No or minimal A/C reaction	Anterior chamber reaction
No lid involvement	Lid edema, hypopyon

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## Infectious Infiltrates

- **Viral**=adenovirus, EKC, HSV, HZO
- **Bacterial**=Staphylococcus, Streptococcus, Pseudomonas
  - Contact lenses: *Pseudomonas aeruginosa*
  - *Staphylococcus aureus*
- **Fungal**
- **Protozoan**=*Acanthamoeba*

**Contact Lens patient=treat as infectious until proven otherwise**

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## Non-infectious infiltrates

- Marginal corneal infiltrates
- Contact lens-induced acute red eye (CLARE)
- Contact lens-induced peripheral ulcer (CLPU)
- Infiltrative keratitis

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## Culturing

- **When to Culture:**
  - Large, central ulcer
  - unresponsive to treatment
  - post-surgical, monocular, or immunocompromised
  - 3-2-1 Guideline: 3mm size, 2+ ulcers, 1mm visual axis
- Best to perform culture before initiating treatment**
- "Quick culture"**: sterile swab placed in prepared (thioglycolate) broth and sent to lab to be placed on nutrient plates

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## Treatment

- **Antibiotic**
  - Fluoroquinolones: Gram - & +
  - Aminoglycosides: Gram -
  - Polymyxin-B: Gram -
  - Other: erythromycin (G+, some G-), bacitracin (G+), azithromycin (G + & -)
- **Steroid**
- **Amniotic Membranes**

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## Amniotic Membranes

- derived from placentas
- amniotic membrane (AM)=inner layer of the fetus membranes
- AM contains: structural proteins, specialized proteins, cytokines, growth factors
- MOA poorly understood
- faster healing, less pain, less scarring, less inflammation
- ocular history
  - 1940 & 1992
  - 700+ peer-reviewed publications on ocular use

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## Amniotic membrane properties

- Anti-inflammatory
- Anti-fibrotic
- Anti-angiogenic
- Anti-microbial
- Promotes epithelization
- Pro-healing
- Provides matrix for cell migration/proliferation

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## Case: 56 yo male Corneal Ulcer

- **Treatment**
  - 0.3% ciprofloxacin q30min
  - 1% cycloplegic in office
  - Prokera Slim Amniotic Membrane
  - RTC 1 day

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## Follow-up

- **1-Day:** Prokera Slim 80% dissolved
  - replaced with new Prokera
  - Continue topical antibiotic q30min
  - RTC 1 day
- **4-day:** 2<sup>nd</sup> Prokera dissolved
  - resolved infiltrate
  - 2+ SPK cornea
  - Taper topical antibiotic to qid
  - Start 1% pred acetate q2hr
  - copious PF ATs
  - RTC 2 days

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## Follow-up

- **6-Day:**
  - 1+ SPK
  - D/C topical antibiotic
  - Decrease 1% pred acetate qid & increase PF ATs
  - RTC 3 day
- **10-day:**
  - trace SPK
  - BCVA 20/25-
  - IOP stable
  - small central epithelial scar

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## Corneal Ulcer Clinical Pearls

- Infectious vs Non-infectious
- Be aggressive
- Don't forget about amniotic membranes



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## Case #3

- 67 year old, Caucasian male
- **HPI:** "can't see out of right eye", started 2 days ago
- (-) pain
- (+) headache-right side of head
- (+) blurry vision-right eye only
- (+) fatigue, pain around back of neck X 2 wks, scalp tenderness
- (-) jaw pain/claudeication

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## History

- **Medical history:** unknown, LME 10+ yrs ago
- **Medications:** none
- **Allergies:** NKDA
- **Ocular history:** unremarkable  
LEE 2017, cataracts
- **Social history:** (-)EtOH, non-smoker

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## Entrance Testing

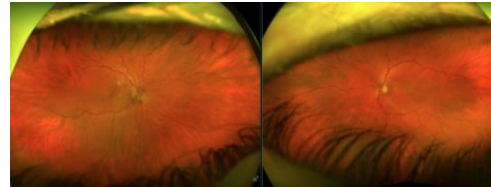
- **BCVA:** HM @ 4 ft OD, 20/30 OS
- **Pupils:** PERRLA, (+)APD OD
- **Confrontational VF:** restricted OD, grossly full OS
- **EQMs:** Full & Smooth OU, (-)nystagmus
- **IOP:** (NCT) 10 mmHG OU

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	OD	OS
<b>Lids &amp; Lashes</b>	Normal	Normal
<b>Conjunctiva/Sclera</b>	Trace injection	Trace Injection
<b>Cornea</b>	Clear	Clear
<b>A/C</b>	Deep & Quiet	Deep & Quiet
<b>Iris</b>	Brown, WNL	Brown, WNL
<b>Lens</b>	2+ NS	2+ NS

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## Posterior Pole Findings



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## Diagnosis

- **Differential Diagnoses:**
  - Headache/migraine
  - NAION, AAION, Optic Neuritis, papilledema or pseudotumor cerebri
- **What's your Diagnosis?**
- **Diagnosis:** Arteritic ischemic optic neuropathy (AION) - Giant Cell arteritis (GCA)
- **3 Criteria for (American College of Rheumatology) Classification of GCA:**
  - Age of onset >50yrs or older
  - Onset of new headache
  - Temporal artery abnormality (tender or reduced pulsation)
  - Elevated ESR (>50mm/hr Westergren)
  - Abnormal artery biopsy showing necrotizing vasculitis with predominant monocular cell infiltration or granulomatous inflammation

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## Treatment

- **ER** → CBC, ESR, CRP, FBS, FTA-ABS, ANA
  - ESR >100mm/hr
  - CRP 33mg/L
  - Normal neuroimaging
  - Order Temporal Artery Biopsy
- **Rheumatology consult**
- **Vascular Surgeon** → Temporal Artery Biopsy confirmed GCA
- **Neuroimaging** → rule out intracranial process
- **Steroids** → IV - 1g methylprednisolone sodium succinate X 3 days then 80mg oral prednisone

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### 1 week follow-up

- Resolution of headaches, pain, fatigue
- No change in optic nerve edema
- Vision decreased to LP
- Rheumatology for GCA management

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### 2 week follow-up

- Resolved optic nerve edema, improved perfusion
- VA: NLP OD - no improvement to-date, 20/30 OS

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### Giant Cell Arteritis

- Most common vasculitis adults >50 years
- Incidence 18 per 100,000; Women 4X more likely
- Highest prevalence in Caucasians (Scandinavian or Northern European decent)
- Granulomatous inflammatory vasculopathy affecting medium & large sized arteries
- External carotid branches, ophthalmic, vertebral, distal subclavian & thoracic aorta
- >50 yo, females > males
- **Goal: recognize & treat GCA before AION occurs**

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### Symptoms

- Headache/scalp tenderness
- Temple artery tenderness
- Neck pain
- Weight loss
- Jaw claudication
- Weakness
- Fatigue
- Tongue/scalp necrosis
- Unexplained fever

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### AAION (arteritic anterior ischemic optic neuropathy)

- Most common cause of severe vision loss from GCA
- Infarction of short posterior ciliary arteries that supply optic nerve
- 1 in 5 GCA patients will develop monocular vision loss related to AAION
- 1/3 patients amaurosis fugax present as sign of impending AION
- Vision loss severe & responds poorly to treatment
- If untreated, 50% lose vision in fellow eye within days to weeks of onset
- **TRUE OCULAR EMERGENCY**

- **Acute phase → ON appear swollen & pale, flame hemes**
- **Later → no edema, optic atrophy sets in**

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Arteritic AION	Non-arteritic AION
"older" patient population	"younger" patient population
Female > male	No relation
HA, scalp tenderness, jaw claudication	Occasional orbital pain
Better VA	Worse VA
FFA: choroidal & disc filling delay	Disc filling delay
Poor prognosis for recovery; fellow eye 95% cases	3 line VA improvement in 43% cases; fellow eye <30% cases
Urgent corticosteroid treatment	Doubtful role of corticosteroids

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## ESR

- Measures height of RBC's settling out of plasma per hour
- Male Norm: age/2
- Female Norm: age + 10 /2

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## GCA Ocular Manifestations

- Cranial nerve involvement (CN VI) → diplopia
- Cotton wool spots
- Central Retinal artery occlusion (CRAO)
- Visual Field defect (altitudinal, arcuate, cecentral scotoma)
- Choroidal infarction
- Nystagmus/internuclear ophthalmoplegia
- Rare=anterior segment neovascularization/ocular ischemic syndrome

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## GCA

- **Actemra (tocilizumab)** =2017 FDA expanded & approved use of subcutaneous Actemra (tocilizumab) to treat adults with GCA
  - subcutaneous
  - First FDA approved therapy specific to this type of vasculitis
- **Polymyalgia Rheumatica (PMR)**
  - Systemic autoimmune disease
  - Shoulder & hip girdle pain
  - 50% GCA patients also have PMR
  - Controversy: GCA & PMR separate or different manifestations of same disease

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## GCA Clinical Pearls

- **Thorough case history**
- **Prompt treatment=start tx before lab results are back**
  - If aggressive steroid tx initiated within first 24hrs of onset of visual symptoms, 50% chance of vision improvement
  - Temporal biopsy should be done within 1 week of starting steroid tx
  - Beware of normal labs
    - 15-30% patients with (+) temporal artery biopsies have normal ESR
    - Biopsy temporal artery 5-9% false negative rate due to skip lesions

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## Ocular Emergency Basics

- Emergent vs Urgent
- Vision vs Life Threatening
- Acute vs Chronic
- Progressive vs Stable
- Proper Documentation

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## Triaging

- Staff Responsibility
  - Worth the training & revisit it
  - Never offer a diagnosis or treatment plan
- Doctor Responsibility
- Document Everything!

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### Case #4

- 18 yo female athlete
- **HPI:** "pain & blurry vision in OD", hit in face with soccer ball 1 day ago
- (+) mild pain
- (+) photophobia
- (+) blurry vision
- (-) CT scan at ER: no orbital fractures

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### History

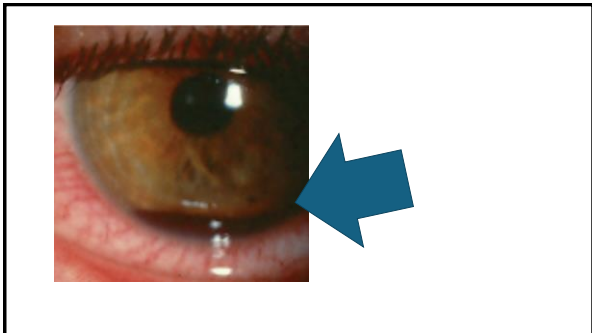
- **Medical history:** seasonal allergies
- **Medications:** Flonase prn
- **Allergies:** no medications
- **Ocular history:** unremarkable LEE 1yr ago
- **Social history:** (-)EtOH, non-smoker

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### Entrance Testing

- **BCVA:** 20/40 OD PH 20/25; 20/20 OS
- **Pupils:** PERRLA, (-)APD
- **Confrontational VF:** FTFC OU
- **EOMs:** Full & Smooth OU, (-)restrictions, (-)nystagmus
- **IOP:** (iCare) 13 mmHG OD, 14 mmHG OS

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	OD	OS
<b>Lids &amp; Lashes</b>	Ecchymosis	Normal
<b>Conjunctiva/Sclera</b>	1+ injection; temporal SCH	White & Clear
<b>Cornea</b>	1+ SPK; (-)edema	Clear
<b>A/C</b>	1+ cells 0.5mm inferior hyphema	Deep & Quiet
<b>Iris</b>	Hazel, (-)TIDs	Hazel, WNL
<b>Lens</b>	Clear	Clear

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### Posterior Pole Findings

	OD	OS
<b>Vitreous</b>	Quiet-no cells	Quiet-no cells
<b>Optic nerve</b>	Pink, healthy rim 0.2/0.2 C/D ratio	Pink, healthy rim 0.3/0.3 C/D ratio
<b>Macula</b>	Flat & clear	Flat & clear
<b>Retina</b>	No breaks/tears (-)commotio retinae	No breaks/tears

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### Diagnosis

- 1) Traumatic hyphema
- 2) Secondary traumatic iridocyclitis

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### Treatment

- 1% cyclopentolate TID OD
- 1% prednisolone acetate q2hr OD
- Limit physical activity
- Sleep with head elevated
- Avoid ASA
- RTC 1 day

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### Hyphema

- Rupture of iris & ciliary body vessels
  - Direct, concussive forces cause mechanical tearing of fragile vasculature of iris or angle
  - Concussive trauma creates rapidly rising intravascular pressure resulting in rupture
- Incidence: 17 per 100,000
- 39.2% athletic injuries, 9.9% work-related injuries
- 30% present with increase in IOP
  - Anterior Synechiae formation
  - Increased outflow resistance & fibrosis of TM
  - Secondary Glaucoma=weeks to years after hyphema (20% of cases)
  - Sickle trait patients have greater risk for IOP (sickled RBC not as malleable)

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### Hyphema Etiology

- Blunt Trauma
- Intraocular surgery
- Iris neovascularization
- Venous occlusion
- Iris melanoma
- Keratouveitis complication (herpes zoster)
- Blood disorder complication (leukemia, hemophilia, von Willebrand disease, ethanol/aspirin/warfarin use)

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### Hyphema Grading

- **Microhyphema**=blood cells suspended in c
- **Grade 1**=blood filling <1/3 of chamber
- **Grade 2**= 1/3 to 1/2 chamber
- **Grade 3**= >1/2 chamber
- **Grade 4**= chamber completely filled
- **Eight-ball**

The diagram illustrates five stages of hyphema grading using cross-sectional diagrams of the eye. 
 1. **Microhyphema**: Circulating red blood cells. 
 2. **Grade I**: ≤ 1/3 anterior chamber vol. 
 3. **Grade II**: 1/3 - 1/2 anterior chamber vol. 
 4. **Grade III**: > 1/2 anterior chamber vol. 
 5. **Grade IV**: Total anterior chamber vol. "Eight ball hyphema".

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### Hyphema Treatment Goal

- Decrease inflammation
- Enhance blood resorption
- Minimize complications
  - Secondary glaucoma
  - Corneal staining
  - Beware of rebleeding

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### Consider referral if...

- Significant corneal blood staining
- Hyphema fails to reduce to <50% of A/C volume within 8 days
- IOP greater than 60mmHG X 2 days
- 8-ball hemorrhage
- IOP elevated in patient with sickling disorder

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### Other treatment options

- Limbal paracentesis & blood aspiration
- AC washout
- Oral antifibrinolytic medication
- Hospitalization if bed rest orders not followed

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### Case 4 Follow-up

- **Watched daily until hyphema resolved**
- **Day 6**
  - Hyphema & Uveitis resolved
  - Steroid Taper started

#### 6 weeks

- No rebound inflammation
- gonio=no angle recession
- BCVA 20/20
- no lasting ocular damage to-date

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### Exam Clinical Pearls: Blunt Trauma

- Pupils-PERRLA? APD? Iris sphincter or dilator muscle damage?
- EOM-Restriction?
- Anterior Chamber-Hyphema? Uveitits?
- Iris-Iridodylasis? TIDs?
- Cornea-abrasion? Laceration? Seidels?
- Lens-subluxation?
- Vitreous-hemorrhage?
- Retina-commotio retinae? Retinal break/tear/detachment?
- IOP
- Gonio-Angle Recession (perform 6 wks after initial trauma)

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# Thank you!

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