JILLIAN CAMPBELL

Wave 2026

# PRE-RECORDING 1

## MCQS

**MCQS – Advance Access Only for WAVE. Please submit answers online before 11.59pm AWST 23rd March**
**OR if you want a 7 Day Extension to complete ALL MCQS – opt in online for the extra time.**
**The following 10 MCQS are from the presentation on Jillian Campbell Pre-recording 1 @ WAVE 2026.**

**Interesting Contact Lens Cases: What They Taught Me.**

**Q.1) In unilateral paediatric aphakia following congenital cataract surgery, what is the primary reason contact lenses are preferred over spectacles?**
a) Reduced risk of infection
b) Improved cosmesis
c) Reduced aniseikonia and anisometropia
d) Lower maintenance

**Q.2) In paediatric aphakia, which factor most influences rapid refractive change in the first two years of life?**
a) Tear film instability
b) Axial elongation
c) Corneal scarring
d) Posterior capsular opacification

**Q.3) When fitting a contact lens in an aphakic infant, what is the most appropriate strategy for power selection?**
a) Full distance correction with no overcorrection
b) Undercorrect to stimulate accommodation
c) Overcorrect for near to support visual development
d) Prescribe emmetropia

**Q.4) Following congenital cataract surgery in an infant, the most significant long-term risk requiring ongoing monitoring is:**
a) Keratoconus
b) Retinal detachment
c) Secondary glaucoma
d) Corneal ectasia

**Q.5) A patient with advanced keratoconus requiring rigid optics is scheduled for cataract surgery. Why may prolonged rigid lens optics washout not be necessary?**
a) Keratometry is unaffected in advanced keratoconus
b) Perfect IOL power accuracy is less critical if rigid lenses will be resumed
c) Axial length compensates for corneal instability
d) Toric IOLs correct irregular astigmatism

**Q.6) In recurrent corneal erosion with irregular optics, scleral lenses improve function primarily by:**
a) Increasing corneal rigidity
b) Masking posterior corneal irregularity
c) Creating a fluid reservoir that protects the epithelium
d) Increasing tear osmolarity

**Q.7) Which factor most strongly influences whether scleral lens wear is safe in a post graft eye?**
a) Central corneal thickness
b) Patient comfort
c) Endothelial cell density
d) Base curve selection

**Q.8) A 70 year old patient with a 30 year old penetrating keratoplasty presents with reduced tolerance to scleral lenses. Specular microscopy shows an endothelial cell count of 700 cells per $mm^2$. After 6 hours of scleral wear, microcystic oedema is observed. What is the most likely limiting factor?**
a) Tear reservoir thickness
b) Mechanical trauma from the lens edge
c) Reduced endothelial reserve
d) Inadequate Dk of the lens material

**Q.9) In a patient with failing penetrating keratoplasty but preserved anterior corneal architecture, which surgical option may preserve structure and accelerate rehabilitation?**
a) Repeat penetrating keratoplasty
b) Deep anterior lamellar keratoplasty
c) DSEAK or DMEK
d) Intracorneal ring segments

**Q.10) When deciding whether to proceed with scleral fitting in a high-risk graft that is the patient's only seeing eye, the most appropriate clinical framework is:**
a) Maximise best corrected visual acuity
b) Avoid all corneal contact
c) Balance endothelial reserve against functional necessity
d) Prioritise topographic symmetry