ASS. PROF. ZHICHAO WU

Wave 2026

D2-S1

MCQS

Geographic Atrophy – Updates on Clinical Management in a New Era

Q.1) What is the most appropriate terminology for classifying a person with bilateral large drusen?
a) Dry AMD
b) Early AMD
c) Intermediate AMD
d) Late Atrophic AMD

Q.2) Which of the following is not a distinctive characteristic of a geographic atrophy (GA) lesion on colour fundus photographs?
a) Sharply delineated margins
b) Perilesional hyperpigmentation
c) Roughly round or oval shape
d) Increased visibility of the choroidal vessels (compared to surrounding regions)

Q.3) Which of the following is not a distinctive feature of GA on OCT B-scans?.
a) Thinning of the inner nuclear layer (INL)
b) Loss of the photoreceptor ellipsoid zone (EZ)
c) Attenuation and disruption of the retinal pigment epithelium (RPE)
d) Choroidal signal hypertransmission

Q.4) What did the OAKS and DERBY trials of pegcetacoplan for GA show?
a) No significant treatment effect on GA progression
b) Significant slowing of GA growth only
c) Significant slowing of GA growth and VA loss only
d) Significant slowing of GA growth, VA loss, and reading speed decline

Q.5) What type of ocular-related adverse event(s) were seen at least twice as often with pegcetacoplan than sham treatment in the OAKS and DERBY trials?
a) None
b) Retinal vasculitis only
c) Exudative neovascular AMD only)
d) Retinal vasculitis and exudative neovascular AMD

Q.6) What did post hoc analyses of the OAKS trial show with pegcetacoplan for slowing the onset of absolute scotomas on all four points (central 1x1mm region) on microperimetry?

a) Slowing by <10%
b) Slowing by 10-20%
c) Slowing by 20-30%
d) Slowing by ≥30

Q.7) How much was GA growth slowed with avacincaptad pegol in the GATHER2 trial?

a) <10%
b) 10 to 20%
c) 20 to 30%
d) ≥30%

Q.8) What type of ocular-related adverse event(s) were seen at least twice as often with avacincaptad pegol than sham treatment in the GATHER2 trial?

a) None
b) Retinal vasculitis only
c) Exudative neovascular AMD only
d) Retinal vasculitis and exudative neovascular AMD

Q.9) Which drugs for GA are approved by the Therapeutics Goods Administration in Australia?

a) None
b) Syfovre (pegcetacoplan) only
c) Izervay (avacincaptad pegol) only
d) Syfovre (pegcetacoplan) and Izervay (avacincaptad pegol)

Q.10) Which of the following are recommendations for the care of those with GA by the Optometry Australia Clinical Practice Guide for AMD?

a) Optometrists should refer patients with GA interested in further advice or considering treatment to an ophthalmologist
b) Colour fundus photography, OCT and/or fundus autofluorescence imaging is recommended for all patients with GA. If not available, patients should be offered a referral to an appropriate practitioner for imaging
c) Patients with GA should be reviewed at least every 6 months
d) All the above

STEVE LESLIE

Wave 2026

D2-S2

MCQS

Concussion-Related Vision Symptoms & Dysfunctions

Q.1) People who have suffered one or more concussions will typically:
a) Show signs of damage on C T scans of the brain
b) Show signs of damage on standard MRI scans of the brain
c) Show signs of damage on both standard MRI and CT scans of the brain
d) Not show any signs of damage on standard MRI or CT scans of the brain

Q.2) Concussion (mild TBI) can be caused by:
a) Assault / domestic violence
b) Bicycle /skateboard / Scooter accidents
c) Sport
d) Falls, trips and slips
e) All of the above events

Q.3) Of people who suffer a concussion
a) 10% will have associated vision or oculomotor problem
b) 50% will have associated vision or oculomotor problems
c) 9 out of 10 will have associated vision or oculomotor problems
d) All will have associated vision or oculomotor problems

Q.4) Studies have shown the most common vision problem in people who have experienced one or more concussions is:
a) Vertical and/or horizontal misalignment (phoria)
b) Accommodative dysfunctions
c) Pursuit impairment
d) Saccadic impairment
e) Convergence insufficiency

Q.5) Pattern glare condition in people with a history of concussion causes:
a) Palinopsia
b) Visual motion hypersensitivity
c) Sensitivity to flickering light and visual patterns
d) Pursuit eye movement dysfunction

ASS. PROF. ZHICHAO WU

Wave 2026

D2-S3

MCQS

Artificial Intelligence in Eye Care – What Should You Be Aware Of?

Q.1) How have deep learning models for detecting referable diabetic retinopathy (DR) been typically developed?

a) By using collected information about clinical risk factors (e.g., HbA1c, duration of diabetes) to predict humans have labelled as referable DR or not

b) By automatically processing images to derive features deemed important by experts to predict what humans have labelled as referable DR or not.

c) By automatically extracting features from the images to predict what humans have labelled as referable DR or not.

d) By automatically learning from vast amounts of images without human input to determine what referable DR should be.

Q.2) Which of the following best describes what "oculomics" is?

a) A field that uses ocular imaging to detect eye diseases.

b) A field that uses ocular imaging to provide insights into systemic health.

c) A field that uses ocular imaging to predict a person's demographic characteristics.

d) A field that uses ocular imaging to predict a person's genetic profile.

Q.3) What is Optometry Australia's position on who can be responsible for clinical decisions in eye care?

a) Health professionals

b) Autonomous AI models

c) Non-clinical staff, guided by AI tools

d) Any of the above

Q.4) How do current AI tools approved by the Therapeutic Goods Administration (TGA) for detecting eye diseases most typically work?

a) By asking you to upload your patient history and examination notes, to estimate the likelihood of different eye diseases being present.

b) By asking you to describe what features you see on retinal images, to derive a clinical diagnosis and referral suggestion.

c) By analysing retinal images, to determine the presence of eye diseases based on specific definitions used during its training process (e.g., referable AMD).

d) By segmenting disease features or highlighting areas-of-interest on the image, to assist you with clinical decision-making.

Q.5) What are some key questions to ask when seeking to understand the performance of an AI tool for detecting eye diseases?

a) Was it externally evaluated?

b) How does it compare to clinicians or human experts?

c) Has it been shown to work effectively for the population that I wish to use it for?

d) All the above.

DR ROHAN HUGHES

Wave 2026

D2-S4

MCQS

Before the Blur: Identification & Management of Pre-Myopia

Q.1) Which factor is the single best predictor that a child is likely to develop myopia?

a) Refractive error
b) Number of parents that are myopic
c) Ethnicity
d) Accommodative lag
e) Near esophoria

Q.2) What is the refractive definition of pre-myopia as defined by the International Myopia Institute?

a) <= +1.00 DS to > -0.50 DS
b) <= +0.75 DS to > -0.50 DS
c) <= +0.50 DS to > -0.50 DS
d) <= +0.25 DS to > -0.50 DS
e) Plano to > -0.50 DS

Q.3) True or False: The refractive threshold for pre-myopia may be ~1.00 D higher for children of East Asian ethnicity.

a) True
b) False

Q.4) Which of the following children would be predicted to develop myopia by 11 years of age?

a) 9 year old, refraction of +1.25 D
b) 9 year old, refraction of +1.00 D
c) 9 year old, refraction of +0.75 D
d) 9 year old, refraction of +0.50 D
e) 9 year old, refraction of +0.25 D

Q.5) Which of the following clinical tests should be performed to accurately assess an individual's risk of myopia development?

a) Cycloplegic refraction
b) Heterophoria
c) Accommodative convergence (AC/A)
d) Accommodative posture (lag/lead)
e) All of the above

Q.6) Which of the following behaviours increase the risk of myopia?

a) Spending 30 minutes outdoors per day
b) Spending 2 hours outdoors per day
c) Reading books for 20 minutes each night before bed
d) Using a near working distance of 40 cm
e) Sleeping 9 hours per night

Q.7) Which of the following should you recommend for a child with pre-myopia?

a) Increase time outdoors
b) Take regular breaks during near work
c) Ensure adequate working distance during near work
d) Review in 6 months
e) All of the above

Q.8) For a 9-year-old child, which of the following refractive shifts over the past year would concern you the most regarding their potential for myopia onset?

a) +1.75 DS to +1.50 DS
b) +1.50 DS to +1.25 DS
c) +1.25 DS to +1.00 DS
d) +1.00 DS to +0.25 DS
e) +0.75 DS to +0.50 DS

Q.9) What is the minimum number of hours per week that a child with pre-myopia should be advised to wear peripheral defocus (HAL/Stellest) spectacles?

a) 10
b) 20
c) 30
d) 40
e) 50

Q.10) Which of the following myopia control treatments could you consider prescribing for a child with pre-myopia?

a) 0.05% atropine eye drops
b) Peripheral defocus spectacles
c) Repeated red light therapy
d) A or B only
e) A, B, or C

DR ROHAN HUGHES

Wave 2026

D2-S4 MCQS

"Defining Success in Myopia Management"

Q.11) "Myopia management" is defined by which of the following?
a) Myopia correction
b) Myopia control
c) Monitoring of refraction and axial length
d) All of the above

Q.12) What should be the refractive target for myopia progression in a child undergoing myopia control?
a) No change
b) -0.25 D or less per year
c) -0.50 D or less per year
d) -0.75 D or less per year

Q.13) What should be the axial elongation target in a child undergoing myopia control?
a) <0.05-0.10 mm per year
b) <0.10-0.15 mm per year
c) <0.15-0.20 mm per year
d) <0.20-0.30 mm per year

Q.14) Which of the following statements is true regarding monitoring axial length using a growth curve for a patient undergoing myopia control?
a) Axial length following the same percentile over time indicates poor myopia control
b) Axial length moving to a lower percentile over time indicates excellent myopia control
c) Axial length moving to a higher percentile over time indicates excellent myopia control
d) Growth curves are not useful for tracking myopia control

Q.15) What is the best approach for a patient continuing to exhibit rapid myopia progression and axial elongation during monotherapy myopia control treatment?
a) Prescribe a combination treatment
b) Switch to an alternative treatment with greater efficacy
c) Nothing, the patient is likely a poor responder to treatment
d) A or B

DR CHARLOTTE MCKNIGHT

Wave 2026
D2-S5
MCQS

A PBS Update

Q.1) For Medicare card holders without a concession card, the maximum cost of PBS-listed medications is:
a) $7.70
b) $25
c) $31.60
d) Frozen by the government for five years

Q.2) For Medicare card holders with a concession card, the maximum cost of PBS-listed medications is:
a) $6.80
b) $25
c) $31.60
d) Frozen by the government for five years

Q.3) Which medication cannot be PBS-prescribed as 2 x 5rpt?
a) Latanoprost (Xalatan)
b) Paraffin ointment (PolyVisc)
c) Hydrocortisone ointment (Hycor)
d) Hyaluronate sodium (Hylo-Forte)
e) Brinzolamide and timolol (Azarga)

Q.4) Which steroid eye drops are available on the PBS?
a) Fluoromethalone (FML)
b) Dexamethasone (Maxidex)
c) Prednisolone acetate (Prednefrin forte)
d) All of the above
e) None of the above

Q.5) Which of the following is not true:
a) Aciclovir ointment is available on the PBS for a Restricted indication
b) Ofloxacin drops are available on the PBS with an Authority approval
c) Hylo-forte is available on the PBS with streamlined Authority code 15559
d) Hylo-forte is available on the PBS with streamlined Authority code 6172
e) Cellufresh is available on the PBS with streamlined Authority code 6172

DR CHARLOTTE MCKNIGHT MARK LUCEY

Wave 2026

D2-S6

MCQS

Cosmetics & Eye Health

Q.1) Which of the following is not a potentially toxic preservative used in cosmetics:

a) Benzalkonium chloride
b) Formaldehyde-releasing compounds
c) Parabens
d) Phenoxyethanol
e) Chloroform
f) Chlorphenesin

Q.2) Which of the following is not true:

a) After three months of use, bacteria can be grown from 35% of mascaras
b) With ongoing use, 79% of mascaras are positive for Staphylococcus aureus and 13% are positive for Pseudomonas aeruginosa
c) Makeup sponges and brushes can act as reservoirs for bacterial growth
d) Microbes breed in skin oils, skin debris and moisture on makeup applicators
e) Washing or disinfecting makeup applicators is recommended once a month
f) Applying makeup with clean fingers avoids contamination from makeup applicators

Q.3) Which of the following is not a potential adverse effect from eyelash growth serums containing prostaglandin-analogues?

a) Conjunctival hyperaemia
b) Skin pigmentation
c) Iris pigmentation
d) Itch
e) Trichiasis
f) Malar hypertrichosis
g) Increased intraocular pressure

Q.4) Which of the following is not a potential adverse effect from botulinum toxin in the aesthetic setting:

a) Upper eyelid ptosis
b) Reduced lacrimal function
c) Brow ptosis
d) Lagophthalmos
e) Ectropion
f) Monocular diplopia

Q.5) Which of the following is not true regarding hyaluronic acid filler used aesthetically:

a) Filler can be seen on MRI more than 10 years after injection
b) In Australia nurse practitioners can prescribe and administer fillers
c) Unwanted aesthetic effects from fillers are more common than true adverse events
d) Filler around the eyes lasts longer than filler elsewhere in the face, due to reduced anti-hyaluronidase activity

e) Tissue ischaemia and retinal artery occlusion are possible immediate adverse complications
f) Nodules and masses that occur as late complications of filler injection appear at the site of the original injection

MARK LUCEY

Wave 2026
D2-S6
MCQS

Third Time is the Charm

Q.6) According to TFOS DEWS III (2025), which of the following best describes the updated definition of dry eye disease?
a) A disease of tear film instability only, independent of symptoms.
b) A multifactorial, symptomatic disease characterized by a loss of homeostasis of the tear film and/or ocular surface
c) Primarily an aqueous deficiency disease with secondary evaporation
d) A rare ocular condition affecting only elderly individuals

Q.7) In the TFOS DEWS III tiered diagnostic algorithm, which minimal screening elements are required to confirm dry eye in a busy clinic?
a) Full OSDI, Schirmer, meibography
b) Impression cytology, tear proteomics, nerve imaging
c) OSDI-6 (≥4), noninvasive tear breakup time (<10 s) or osmolarity (≥308 mOsm), and ocular surface staining
d) In vivo confocal microscopy, tear cytokine levels

Q.8) TFOS DEWS III de-emphasizes rigid "stages" of dry eye (e.g., mild, moderate, severe) because:
a) There is no correlation between severity and symptoms
b) Dry eye disease is often dynamic, driven by overlapping, shifting mechanisms
c) It is easier to sell more products if one doesn't label a patient severe
d) The prior staging had legal implications

Q.9) For a patient whose predominant driver is meibomian gland dysfunction (MGD) and eyelid disease, which of the following is least appropriate as a first-line therapy?
a) Warm compress + lid hygiene
b) Intense pulsed light (IPL) therapy
c) Topical corticosteroid as monotherapy
d) Lid hygiene with Demodex targeted treatment

Q.10) Which of the following is true regarding neuromodulation therapies discussed in TFOS DEWS III?
a) They provide tear-conserving benefit by occluding the punctum
b) They stimulate production of various tear components (e.g. aqueous, lipids)
c) They replace all other therapies and are effective as monotherapy in all cases
d) They are the first-line therapy in mild dry eye

MARK LUCEY

Wave 2026

D2-S6

MCQS

Targeted Light & Energy Therapies for MGD-related Dry Eye: IPL, LLLT, and Radiofrequency

Q.11) Which energy-based modality currently has the strongest evidence base from systematic reviews for improving signs and symptoms of MGD?

a) Intense pulsed light (IPL)
b) Radiofrequency therapy (RF)
c) Low-level light therapy (LLLT)
d) Warm compress therapy

Q.12) Which patient phenotype is most likely to benefit from IPL as an adjunctive therapy?

a) Pure aqueous-deficient dry eye
b) Ocular rosacea with lid telangiectasia
c) Neurotrophic keratopathy
d) Acute infective blepharitis

Q.13) Radiofrequency (RF) therapy improves MGD outcomes primarily by:

a) Destroying obstructed meibomian glands
b) Liquefying inspissated meibum through controlled heating
c) Stimulating goblet cell proliferation
d) Increasing aqueous tear secretion

Q.14) Which factor represents a key safety consideration when providing IPL treatment?

a) Contact lens wear history
b) Central corneal thickness
c) Tear osmolarity level
d) Fitzpatrick skin type and photosensitising medications

Q.15) Energy-based therapies for MGD should be described to patients as:

a) First-line treatments replacing conventional therapy
b) Cosmetic procedures unrelated to dry eye care
c) Adjunctive interventions within staged dry eye management
d) Experimental treatments without supporting evidence

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