OCOS MEETING
June 23, 2014
6:30 - 9:00 pm

2 CE Hours
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Dr. Tom Tooma:
Dysfunctional Lens Syndrome

Dr. Franklin Lusby:
Updates from ASCRS 2014

Dr. Jonathon Pirnazar:
IOLs...Different Strokes for Different Folks

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Dear Colleagues,

The days are longer and the warmer which means summer is officially here! Your OCOS board is working hard to bring you great CE and quality events this year. First off, I would like to welcome our new board members who were installed at our last CE dinner: Maggie Jan (Secretary), Krystal Nguyen (Membership co-chair), and Thanh Mai (Public Relations). I am excited to work with every one and bring great things to our society.

Have you read your Government Affairs Weekly updates? Your COA dollars are hard at work in Sacramento. As we speak, the Advanced Procedures bill SB 492 is still on the table authored by our own Senator Ed Hernandez. We are in the second year of this bill and we need YOUR help to pass it through. Contact your local state representatives and let them know who you are and what you do! Also, on the legislative table are bills on: children’s vision, Medi-cal provider rate increase, and early prescription refills. These are issues that we run into on a regular basis in our practices and COA is working on our behalf to keep optometry at the forefront.

Our next big event is the Pathology Symposium with 7 hours of great CE. I encourage you to attend, bring a colleague, and let them know why you’re in OCOS member. Membership begins with ME and grows outward. Thank you for your membership and for choosing to further our profession.

Sincerely,  
Isabell Choi, OD

Upcoming OCOS Meetings:

August 10 - Pathology Symposium
October 14 - Membership Drive
December 9 - Holiday Mixer

Perceptions
Orange County Optometric Society

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“It has been my pleasure to work in cooperation with family eye doctors for over 15 years” - Tom Tooma, MD, Founder
NVISION Laser Eye Centers has announced an agreement with Avellino Labs USA to be the first in the nation to offer a new genetic test that can detect both the Avellino Corneal Dystrophy (ACD) gene as well as another genetic mutation, Granular Corneal Dystrophy type 1 (GCD1).

GCD1 and ACD, also known as GCD2, are characterized by small translucent dots, or granules, resembling crushed bread crumbs that form in the various layers of the cornea. Similar to GCD2, GCD1 typically develops slowly. However, should a patient with GCD1 undergo vision correction surgery (e.g. LASIK, LASEK, PRK), he or she is at extreme risk of experiencing eventual blindness if they have the genetic mutation.

With the Avellino DNA Dual Test, a patient can now simultaneously determine if he or she has GCD1 or GCD2 prior to undergoing LASIK, avoiding the risk of post-surgery vision complications.

“The Avellino DNA Test for LASIK Safety has been a vital tool for our physicians to have access to in order to ensure the safety of our patients,” said Dr. Tom Tooma, founder of NVISION Laser Eye Centers. “We’re excited to offer our physicians and patients the new Avellino DNA Dual Test. Our patients can now go into LASIK treatment with the confidence they are protected against unwanted outcomes.”

“The Avellino DNA Dual Test is easy and safe. The test involves a simple mouth swab to determine whether a person carries either of these genetic mutations. Within 24 to 48 hours, the results are provided to our doctors to share with our patients,” concludes Tooma.

“NVISION Laser Eye Centers has been a valuable customer to our company since the launch last year,” said Avellino Lab USA COO Scott Korney. “Having NVISION offer the latest Avellino DNA Test for LASIK Safety demonstrates their commitment to providing its patients with the most innovative care.”

About Avellino Lab USA

Avellino Lab USA has developed the first and only commercially available testing system, the Avellino DNA Dual Test for LASIK Safety, for Granular Corneal Dystrophy type 1 (GCD1) and Granular Corneal Dystrophy type 2 (GCD2), also known as Avellino Corneal Dystrophy (ACD). The company’s proprietary genetic diagnostics system provides fast, safe and affordable evaluations of an individual’s genetic predisposition to GCD1 and/or GCD2. With the Avellino DNA Dual Test, Avellino Lab USA is able to positively identify, with high accuracy, a patient’s GCD status. Based on the test’s results, patients and their physician can make an informed decision when considering vision correction surgery.
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The partners of Harvard Eye Associates (HEA) are pleased to announce their affiliation with Alicia Surgery Center (ASC) in Laguna Hills. HEA was established by Roger Ohanesian, MD, in 1974 and specializes in the treatment of cataracts, glaucoma, corneal and retinal disorders, as well as plastic surgery of the eyelids and LASIK. "Since 1986, we have done our surgeries at a smaller facility in San Clemente," explains Ohanesian, "but as our practice has grown, we have been looking for a larger surgery center and one that is more central in South Orange County. In 1986, we had two surgeons at HEA, and now we have eight surgeons in every subspecialty of ophthalmology." HEA has two offices: one in Laguna Hills, across from Saddleback Hospital, and another in San Clemente. This surgery center will be a huge convenience for HEA’s many patients from Laguna Hills, Irvine, and North Orange County.

Alicia Surgery Center is a new, state-of-the-art facility located on Alicia Parkway, near the 5 Freeway. It was built two years ago by Om Chaurasia, MD, GI specialist of Mission Viejo. "I am very pleased to associate with this excellent ophthalmology group," said Chaurasia. Alicia Surgery Center is 7,500 square feet, with three surgery suites and a procedure room. Edward Kim, MD, a partner at HEA, adds: "ASC will be a center that specializes in ocular surgery. It will have a femtosecond (laser) for cataract surgery and the best equipment for performing cataract and other ocular procedures. According to Diana Kersten, MD, a partner at Harvard Eye Associates, "The location and the beautiful facility couldn’t be better for our group." John Hovanesian, MD, HEA partner, says, "Our experienced nurses and staff will be brought over to work in the new center, and we expect a seamless transition in late April 2014."

25211 Paseo de Alicia, Suite 100
Laguna Hills, CA 92653
For more information about Alicia Surgery Center please visit www.AliciaSurgery.com.
WaveTec Vision's ORA System is "significantly more accurate" than traditional solutions in predicting intraocular lens (IOL) power selection in challenging eyes with prior refractive surgery, according to a recent peer-reviewed article in the journal *Ophthalmology*.

WaveTec Vision's ORA System with VerifEye, the leading intraoperative wavefront measurement technology for cataract surgeons, optimizes data during cataract surgery to calculate IOL power. It is the technology of choice for the nation's leading cataract surgeons who use the ORA System to provide critical feedback and guide premium IOL selection.

The study titled, "Intraoperative Refractive Biometry for Predicting Intraocular Lens Power Calculation after Prior Myopic Refractive Surgery," was authored by Tsontcho Ianchulev, MD, MPH; Kenneth J. Hoffer, MD, FACS; Sonia H. Yoo, MD; David F. Chang, MD; Michael Breen, OD; Thomas Padrick, PhD; and Dan B. Tran, MD. is the largest peer-reviewed, published study of intraoperative aberrometry to date. It demonstrates the efficacy of this new technology in one of the most challenging cataract patient populations -- those with prior LASIK procedure where lens power estimation is particularly difficult.

According to Sean Ianchulev, MD MPH, Associate Clinical Professor at UCSF, primary author of the study, "This study provides remarkable validation for the evolution of intraoperative biometry. The ORA System reflects the culmination of a decade-long research effort which has now matured and provides true benefit and superior outcomes to patients and surgeons. I personally cannot imagine refractive cataract surgery without it."

In the study, WaveTec's ORA System was used to obtain aphakic refractive measurements intraoperatively and then to calculate the IOL power. Comparative effectiveness analysis of IOL power determination was done against three conventional clinical practice methods: surgeon best preoperative choice (determined by the surgeon using all available clinical data), the Haigis L, and the Shammas IOL formulas.

In 245 eyes (215 first eyes and 31 second eyes) IRB using ORA achieved the greatest predictive accuracy. Sixty-seven percent of eyes were within ±0.5 D and 94% of eyes were within ±1.0 D of the IRB's predicted outcome. This was significantly more accurate than the other preoperative methods. Study participants included patients with a history of myopic LASIK or photorefractive keratectomy who underwent intraoperative refractive biometry (IRB) for IOL power estimation.

"Acknowledgement by the peer-review community is a further reflection of the data and clinical success we are seeing from ORA surgeons worldwide," said Tom Frinzi, WaveTec Vision's President and CEO. "Determining IOL power estimation in challenging eyes with prior LASIK/photorefractive keratectomy is a persistent and growing challenge for surgeons. We're glad to have a solution for them."

**About WaveTec Vision**
A privately held company, WaveTec Vision is the leader in intraoperative wavefront measurement technology for cataract surgeons, providing on-demand information that increases the precision of cataract surgery so patients achieve their best possible vision. Based in Aliso Viejo, Calif., WaveTec manufactures the proprietary ORA System that delivers optimal cataract surgery results for demanding patients and the skilled surgeons who serve them. For more information, visit www.wavetecvision.com.
**ONLY THE LATEST SURGICAL TECHNOLOGIES**

Coastal Vision uses only the latest surgical technologies to ensure the very best outcomes. Our excimer laser is part of the fastest refractive surgery platform available in the U.S.

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It has been more than three years now since I bought my practice from a retiring ophthalmologist here in Laguna Hills, and a year and a half since I closed my optical shop. When I first got here, part of the office space was set aside as an optical shop. Where I worked before in Van Nuys for eight years prior, they also had a rather large optical shop, so I was used to the idea of having one in office although I had never owned one. So why did I close it, and what effect did this have on my practice?

Intending on being a premier ophthalmology office, I decided to upgrade all of my equipment, and so I bought the latest and greatest diagnostic equipment available after having researched it extensively. As things progressed for me in this office here, I realized that I was a little short of space, and my optical shop wasn't giving me all the benefits I thought I should have.

After looking at the numbers, it appeared that my optical shop was really acting as a convenience for my patient but was not helping my bottom line. Not only that, while most patients were happy, there was a significant minority of patients who had issues with their glasses—this would take up precious chair time. I had to decide whether to modernize the optical or not, and whether to invest more in frame selection. I also had to determine how to best manage the optical shop or possibly outsource its management. If I didn't do all of this, sales would likely stagnate further.

It had always been my goal to work closely and collaboratively with optometrists. I worked closely with an optometrist at my previous practice, and I had a very collegial relationship with her, as I have with other colleagues. With our increasing population as well as its aging, the time demands on ophthalmologists and optometrists are going to increase exponentially. In order to meet the needs of our patients, we are going to have to work together in an efficient and collaborative manner. In order to do so, we have to be certain that whoever we send our patients to or work closely with will take as good care of our patients as we do. It all boils down to trust, knowledge, bedside manner, and skill.

I informally polled local optometrists as I met them in the community and at optometric society meetings. While some said that whether an ophthalmologist had an optical shop or not did not really affect their referrals as long as they trusted the doctor, a majority suggested that they would refer more patients to someone who did not have an optical shop. I heard stories of ophthalmologists keeping patients who had been referred to them and selling them glasses. This obviously would put a damper on any such relationship. I also studied this business model nationally, and it appeared that not having an optical shop was a definite advantage in establishing an optometric referral network.

So I decided to close my optical shop. Without one, I knew it would help me to gain the trust of local optometrists referring their patients to me. Of course, this would not be the only factor in their determining whether to refer a patient to me, but it certainly would not be a deterrent. I had to first show that I am a capable and excellent ophthalmologist and surgeon, then I had to get to know them and gain their trust.

So how has closing my optical shop affected my practice?

Let's first start the negatives of closing the optical shop:

1. Some of my patients complain that they no longer have the convenience of shopping for glasses at my office.
2. I have had some loss of revenue from not selling glasses.
3. I'm no longer getting any freebies from optical labs and manufacturers.
4. I am no longer visited by friends and relatives who want cheap glasses or contact lenses.
5. I am no longer a VSP provider, which caused some of my younger patients not to return.

How about the positives of closing my optical shop?

“I can now refer my patients to optometrists in the local community so that my patients can get glasses and contact lenses from their optical shops. This of course helps to build relationships with local colleagues.”
1. I was able to gain enough space in my office to create a state-of-the-art diagnostic Center complete with Spectralis OCT, Galilei topographer, Lenstarbiometer (like an IOL Master), autorefractor and autolensometer, retinal camera, visual field machine, and FDT. I am able to offer these diagnostic services for my patients and for those patients who are referred to me. This has definitely raised my level of care that I can offer to patients.

2. I was able to close the contact lens fitting room and convert it into another workup room, complete with a digital refraction system from Topcon, which certainly added a wow factor to the overall patient experience and helped with the efficiency of the office.

3. I was able to convert the optician’s office into a surgery scheduling office, which greatly enhanced the overall surgery scheduling process for our patients. Having a dedicated office for this purpose certainly gives patients more comfort and confidence in proceeding with surgery.

4. I no longer have to worry about patient complaints about their glasses or contact lenses. This has freed up an enormous amount of time which I can use in examining more patients.

5. I can now refer my patients to optometrists in the local community so that my patients can get glasses and contact lenses from their optical shops. This of course helps to build relationships with local colleagues.

6. I have experienced a large increase in optometric referrals to my office for both diagnostic purposes as well as for ophthalmic evaluations. I even had to pick a new color chart for these patients in order to remind me to send them back to the referring optometrist once I have finished caring for this patient.

So, overall, I am very pleased with my decision to close my optical shop. While I was hesitant at first because of possible losses of revenue, I've actually experienced the opposite effect. I have been able to concentrate more on the medical and surgical aspects of ophthalmology, while I have also been able to enhance my relationships with my optometric colleagues. Ophthalmologists and optometrists working closely together is really a must if we are to give our patients the best care possible, and I am looking forward to the future of collaborative eyecare in this great country of ours!

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The Ocular Surface and LASIK: Detection, Management, and Treatment

AUTHOR: Thomas D. Gilbert, O.D., FAAO

Detecting every single dry eye issue on every single patient can be extremely challenging. Every one of our patients will benefit from a diligent inspection of lids, lashes, conjunctiva, meibomian glands, cornea, and the tear film. Without an in-depth evaluation, a practitioner can overlook ocular surface issues and in turn recommend frequent use of artificial tears as opposed to a more effective medical and/or therapeutic treatment. When this occurs, we fail to treat the underlying problem. With dry eye patients, the key to a better vision is better tear film quality and quantity. Ultimately, it can make our contact lens, post-op laser vision, elderly, post-menopausal women, and patients in general have better quality and comfort of vision everyday.

Detecting symptoms of ocular surface disease during the patient history is the first step in the process of identification. Careful slit lamp evaluation will assist the process of uncovering conditions such as blepharo-conjunctivitis, meibomian gland dysfunction, frothy, oily lid margins, injected conjunctiva, and corneal haze or opacities.

Another effective tool in the discovery of ocular surface disease is the evaluation of the tear film. This is commonly done via the Tear Breakup Time (TBUT) evaluation with sodium fluorescein (NaFl). A clinician should visualize the tear film breakup to be equal or greater than 10 seconds. If it is observed to be less, there could be ocular surface implications. While you are observing the tear break up time, you can also evaluate presence of an ample tear prism. Patients with a low or no tear prism are also suspected to have dryness issues. Superficial Punctate Keratitis (SPK) can be easily observed with the TBUT NaFl stain at this time. All of these signs are helpful in determining the severity of the ocular surface disease and the treatment plan you will implement.

1. Warm compresses for 5 minutes morning and evening to increase circulation and melt the toothpaste colored, paraffin-like contents of the capped meibomian glands. The goal is to visualize the clear, oily meibum present in healthy meibomian gland secretions. This will help to prevent rapid evaporation of the tear film seen in patients with low tear break up times.

2. Follow the warm compresses with an antiseptic/antibacterial commercially available lid scrub to clean the oily lid margins and kill staph and strep bacteria present as normal lid flora.

3. Cyclosporine A (Restasis) instilled BID OU for 3-6 months depending on severity of the Dry Eye Syndrome (DES). Remind the patient that it takes a few weeks to reach effectiveness.

4. Artificial tears 8-10 times a day. Some patients may require preservative free artificial tears.

5. Omega 3 oral supplements added to the diet can be helpful in sustaining relief from dry eye symptoms.

6. In more severe cases involving blepharo-conjunctivitis, topical Azithromycin applied to the lid margins at bedtime as directed until it is resolved.

7. Also in some more severe cases, oral Doxycycline (20mg twice/day) for 6-8 weeks can be implemented to assist in the control of the ocular surface disease.

8. Lacrimal plugs can be used to improve tear quantity once the quality has been improved and any inflammation has been reduced.

(continued on next page)
In the past it was theorized that LASIK hinge location could be a factor in severity of dry eye post surgery. Some studies show that there was increased dryness post-operatively if the flap was hinged superiorly versus nasally. Today, with the utilization of femtosecond lasers for flap creation, we find that there is no significant difference when the flap is created in different positions when examined 6 months post-operatively. Other studies suggest that post-operative dryness can be minimized when the flap is created with a femtosecond laser as opposed to a microkeratome.

There is also evidence shown that the use of Cyclosporine A can be helpful in LASIK-associated dry eye and neurotrophic epitheliopathy. Corneal sensitivity returned more quickly as opposed to those that used artificial tears alone. UCVA at 3 and 6 months was also improved in patients that used Cyclosporine A. The reduction in inflammation following surgery and increased corneal sensitivity is hypothesized to be the reason for improved tear film. Improved tear film helps improve UCVA and resulted in greater refractive predictability in these cases at the 3 and 6 month post-op visits.

Cyclosporine A 0.05%, in the form of Restasis, may be an effective treatment for reducing the time needed for visual recovery after LASIK. Use of cyclosporine A was associated with overall better UCVA and faster recovery of UCVA.

Dry eye and ocular surface disease is a multi-factorial and complex issue. Consensus in treating dry eye patients more aggressively versus less is widely accepted and universal. The next time an ocular surface disease patient sits in your chair, especially before or after LASIK, take the time to fully assess the patient. Minutes spent caring for your patients pre-operatively can enhance their vision for a lifetime.

We are excited to announce that TLC Laser Eye Centers has launched a joint venture partnership with Harvard Eye Associates at our Laguna Hills location.

TLC brings your patients the very best in technology, surgical outcomes and a personal approach for both LASIK and refractive IOL's. TLC was founded on the philosophy of co-managing patients with Optometry, working with some of the most experienced surgeons while maintaining our strong commitment to our affiliate optometrists.

John A. Hovanesian, MD, FACS
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*CE Pending California Board of Optometry and CCOE approval
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