OCOS Pathology Symposium

8 Hours of CE

Sunday, 9/13
8am – 4pm

Raj Rathod, MD: Tumors in the Eye
Milliu Liu, OD: Urgent or Not?
George Salib, MD: Laser Assisted Cataract Surgery & Premium IOLs
Betsy Nguyen, MD: Glaucoma Boot Camp - Clinical Pearls
Lisa Garbutt, MD: Ocular Trauma
Jeffrey Joseph, MD: Eyelid & Periocular Lesions - Optometric Evaluation & Management
John Lee, OD: Basics of ICD-10 for Optometrists
Jerry Sebag, MD: Curing Vitreous Floaters Safely & Effectively - A New Paradigm is Born
NVISION Doctors (TBA): Advanced LASIK & Cataract Procedures
Peter Joston, MD: Update on Glaucoma
Juancho Remulla, MD: Diabetic Retinopathy & AMD Update
Ramin Tayani, MD: Finesse in Oculoplastic Surgery

Oakley Headquarters Theater
Sign-in begins at 7:15am | Breakfast & Lunch provided
$85 OCOS Members | $95 COA | $120 Non-COA & At the Door
RSVP now at www.ocos.org
Hello fellow colleagues,

I hope everyone is having a great summer. I can not believe we are heading into August already as the year is flying by. I would like to welcome 36 new members to the Orange County Optometric Society. We are excited for you to join our family and can not wait to meet everyone at future meetings, continuing education events, community projects and local grassroots advocacy efforts. Since many of our new members are recent graduates I would like to revisit history and give a little background about OCOS and how optometry has changed over the years.

OCOS was established in 1959 and was one of the original local society part of the California Optometric Association. In 1966, optometrists were permitted to perform contact tonometry. By 1986, optometrists were able to prescribe glasses/contacts, perform vision therapy, dilate eyes and diagnosis ocular pathology. In 2000, a COA sponsored bill was passed that allowed optometrists to treat ocular conditions, remove foreign bodies, and insert punctal plugs. It is important to remember that a similar bill did not pass in 1993. In 2008, a second therapeutics bill passed that made glaucoma treatment possible. The scope of optometry has expanded greatly in the last 20 years which allows us to provide better care to our patients and increase access to a greater number of patients in need. However, without the relentless advocacy efforts of all the current and past optometrists and the COA, we would not be where we are today. This is where you come in. We need to work together to ensure that profession of optometry continues to advance so that we can practice to fullest extent possible. I implore all new and current members to be active within the society and recruit others to join the fight! Please contact myself or any other board member if you would like be more involved.

Sincerely,

Danny Ngo, O.D.
President 2015-2016 😎
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Orange County Retina Group is excited to be a sponsor of the Orange County Optometric Society. Since our inception in 1971, our goal has been to provide the best retinal care for patients in our community of Orange County. Our physicians, who have trained at the best institutions in the country, have academic expertise and years of clinical skills in retinal surgery.

To maintain our commitment to retina care, we have participated in over 50 clinical trials, and have at our disposal both current intravitreal therapies in addition to next-generation pharmacologic medications such as Fovista, Gevokizumab and Chroma, a new drug for dry AMD. We have a unique retinal laboratory with electrophysiology, MAIA microperimetry, and mfERG testing. We have upgraded each of our five offices with state-of-the-art equipment including Heidelberg SD-OCT scanners, SLO fluorescein angiography, and Multispot Pattern Laser Treatment of Diabetic Retinopathy. Our surgeons operate at many of our local medical centers including St. Joseph’s, CHOC, Hoag and St. Jude’s as well as surgical centers such as Pacific Surgicenter and Barranca. We perform surgeries with the latest small-incision vitrectomy equipment including the Alcon Constellation, B&L Stellaris and DORC EVA, which was FDA approved last month.

Our retinal specialists are available 24/7 for retinal emergencies. Orange County Retina accepts many of the major insurances, IPAs and HMOs in our local area. Our practice takes pride in medical education, as our doctors are clinical faculty at UC Irvine, Ketchum and Western Universities. Recently, we started a residency program for optometric retinal training. We thank you for entrusting your patients’ care to the specialists at Orange County Retina.

Timothy You, MD • Sanford Chen, MD • Rajiv Rathod, MD, MBA
Eugene Chang, MD, MBA • John Maggiano, MD • Millie Liu, OD • Margret Yu, OD
Background

Hydroxychloroquine, known also by the brand name Plaquenil, was first used as an antimalarial drug but has since gained widespread use in treating various autoimmune diseases, including systemic lupus erythematosus and rheumatoid arthritis. It is estimated that in America alone, more than 150,000 patients are on long-term therapy. A derivative of chloroquine - which it largely replaced - hydroxychloroquine was thought to be safer, as it does not cross the blood-retinal barrier. Retinal toxicity due to Plaquenil is relatively rare, estimated at 1 percent after five years and rising with continued therapy. However, the retinopathy, described as a bull’s-eye, is untreatable and tends to progress even after cessation of the drug. Moreover, rates of toxicity may be higher than estimated as screening techniques have been refined to detect more cases. More effective screening measures utilizing multimodal imaging techniques are now being employed to elicit early signs of toxicity.

Clinical Features

Difficulty in diagnosing toxicity arises from the fact that patients are often asymptomatic with preservation of visual acuity. When toxicity is present, and likely more advanced, individuals may report difficulty with night vision, glare or paracentral scotomas that interfere with reading. The classically described bull’s-eye retinopathy, characterized by a ring of retinal pigment epithelium degeneration often sparing the foveal center, is a late finding indicative of advanced damage. Relying only on clinical exam is therefore insufficient for detecting toxicity.

Screening and Dosing

New monitoring guidelines were published in early 2011, by an American Academy of Ophthalmology Task Force. Patients are classified as either low risk or high risk. High risk patients include the following features: duration of usage > 5 years, cumulative dose > 460 grams, daily dose > 400 mg/day, age greater > 60 years, high fat level body habitus, renal or liver dysfunction. A baseline examination is recommended prior to initiation of treatment or at any time during treatment if no previous examination has been performed to identify any potential high risk characteristics. Annual examination is then followed with the assistance of ancillary testing to help identify early signs of toxicity.

Caution must be followed with dosing regimens. Traditionally, most patients were automatically initiated on a standard dose of 400mg / day. However, this may be too high for those patients of shorter stature. Dosing is therefore recommended based on ideal body weight, rather than actual body weight.

Ancillary Testing

Advances in imaging technology have aided in the early detection of toxicity before clinically evident damage results. In addition to complete examination, macular perimetry testing is still recommended (HVF 10-2 or microrperimetry). Additionally, SD-OCT is routinely used due to its wide availability and its resolution of structural changes in the various retinal layers. The now classic sign of toxicity is the “flying saucer” sign, which results from an intact foveal outer retina next to a loss of perifoveal ellipsoid layer. An even earlier, more subtle sign of toxicity may be thinning of the inner retina.

Though not 100% sensitive, fundus autofluorescence (FAF) can be a useful adjunct as it measures RPE health. Early signs may show a ring of hyper autofluorescence. This modality is also useful for tracking changes once toxicity has already developed, as continued RPE loss can be seen even after cessation of the medication.

(Continues on page 6)
Multifocal ERG can provide an objective measure of retinal function localized to the macula. Serial testing can be very sensitive to detecting early changes in retinal response. Currently, its use is limited by availability and patient cooperation.

Orange Count Retina Diagnostic Center

By employing a multifaceted approach to screening patients on Plaquinil therapy, the doctors and staff at Orange County Retina provide a complete evaluation using all of the recommended modalities to diagnose early toxicity and prevent significant vision loss in our patients. We have seen many cases of toxicity recently as a result of our diagnostic techniques and have recommended discontinuation of Plaquinil treatment to prevent significant morbidity. The following case highlights some of the findings from a patient in our own practice.

Case

A 67-year-old woman presented for evaluation of possible Plaquinil toxicity. She had no significant visual complaints. She had been on the medication for 12 years for rheumatoid arthritis at a dose of 400mg/day, for a cumulative dose of over 1750 grams. She was five feet, one inch in stature with a body weight of 165 pounds. Her funduscopic examination was essentially unremarkable.

**OCT shows characteristic parafoveal loss of outer retinal structures along with a “flying saucer” sign:**

(Continues on page 7)
Multifocal ERG shows depression of the waveform in the parafoveal ring pattern:

RPE changes are highlighted by autofluorescence imaging and microperimetry shows corresponding ring scotomas:

(Continued from page 6)
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I have learned over the years that it does not matter how good of an eye doctor you are if you do not have the right team to help you do the job to the patient’s complete satisfaction. At the Orange County Eye Institute, we certainly have an excellent team that works well together with one goal in mind: to give the best possible care and experience for the patient. It all boils down to showing the patient that you truly care for their health, happiness and satisfaction. Competence is expected and a given if they are in your office...they wouldn’t have even shown up if they didn’t believe you were a competent provider. What happens once they pass through your doors is all that matters from that point on. It is this (hopefully!) short time period in your office that could potentially build or destroy your reputation and practice.

Let’s focus on the basics—The team. Have you looked at your team lately? Do you have someone working with you that you dread having there? Do you cringe every time one of your staff says something to you or the patient? Maybe it is a colleague of yours. Do you have an enthusiastic and knowledgeable practice manager/administrator (or do you do the job)? Is your front office staff cheerful and patient? Is your back office efficient and friendly? Is your team cohesive or are they islands of discord and division?

It is critical to have an effective, competent, friendly, and unified team. Without this, your team’s morale will sink, not to mention your patients’ opinion of you. Let’s look at several factors that can affect this:

- **Mood**: How frustrating is it for anyone to work alongside a colleague or employee that is always in a bad mood or whose moods mimic the weather? I personally cannot tolerate moodiness in the workplace—it simply does not belong there. If they are moody, the manager or doctor should talk to them and let them know their behavior is setting a bad tone for the office.

- **Work Ethic**: Working hard no matter who is watching you and whether you are being watched is of paramount importance. If someone is not pulling their weight in the office, then this certainly will anger their fellow colleagues/employees and kill morale. One must be diligent in their work and not just going through the motions to pass the time. Metrics can be measured in order to ensure the work is being performed.

- **Competence**: If the member of the team simply does not have the knowledge to do their job competently, they need to receive the proper training. It is neither fair to the employee nor the patient to put someone in a position when they have not been adequately educated on how to do the job.

- **Willingness to help**: In order for the team to be truly a team, all members must cheerfully and willingly help each other out as necessary for the greater good of the office and the patient. Cross training between front office and back office is very helpful in this regard so that they can help each other out. At no time should someone say “that is not my job!” This expectation of mutual help should be clearly explained to everyone.

- **Empathy/Caring**: If your team does not genuinely feel and express empathy and care for the patients, then they are simply in the wrong business. We all gravitated to this field through our desire to be of help and do good for our society. We should work with like-minded people. This can’t always be taught, so if someone fails to display this trait early on, consider replacing them with someone that does.
From the moment a patient walks into your office, they should be made to feel welcome. The front office check-in person should warmly greet the patient by name. The waiting area should be clean and pleasant, and they should not wait too long there despite its name (I recommend no more than 10-15 minutes after their appointment time). The back office person or the doctor should then cheerfully attend to the patient, efficiently and professionally performing the patient’s exam, testing and taking care of their needs. Offering water to the patient is a nice touch I have found to be effective and greatly appreciated, especially in these hot summer months!

Despite being the best eye doctor around, your patients will leave your practice and spread bad news about your care if they are not satisfied with their care.

You have to do your part as well! The exam should be as thorough and as comfortable as possible. Many of my patients have commented on the fact that my exam was the most thorough one they have ever received. They truly admire that and have a greater sense of confidence in you as a clinician as well as a person. It is critical to ask the patient if you have answered all of their questions to their satisfaction towards the end of the visit so as not to let the patient feel they have been shortchanged of any time or attention during their visit with you. Pat them warmly on their shoulder or shake their hand as you say goodbye, and then direct them to the check-out area.

If your team is not working well together, then adequate training and counseling is of utmost importance to get the best results. Your office manager (or you) should be acutely aware of whether the team is cohesive or not and take actions to make it so. Sometimes, unfortunately, this can lead to letting someone go at the office. If this is necessary, then do so quickly without delaying the inevitable—for the greater good of the group and even for that employee who might be better suited in another field. If the practice sinks because of one bad apple, no one will get a paycheck!

It is amazing to me how much difference management can have on any business. I recently came back from a trip to San Diego and visited two nationally recognized restaurant chains (not fast food!). They should have both been very busy on a Friday and Saturday night, but neither was. The food was not bad, but items were not brought to the table correctly or in a timely fashion. The waiter did not attend to the table adequately. The atmosphere seemed disorganized and chaotic at best despite not being crowded. What a bad impression this left on our group. The management must not have been doing their job correctly at either place. Can you imagine what your patients are thinking if they also have a similar experience in your office?

The bottom line is that you need a good team to get the job done. Despite being the best eye doctor around, your patients will leave your practice and spread bad news about your care if they are not satisfied with their care. Remember the wise words of Baymax in Big Hero 6: “I cannot deactivate until you say you are satisfied with your care.” What words of wisdom to carry with us as we work to have the best team in place to take care of our patients together in one unified and cheerfully caring front.

Many of my patients come to me from other practices, and their most common complaint is about the service or the feeling of being in a big box store or factory when they went to that other office. Our practice focuses on excellent and highly advanced care with a personalized touch that you would find in a small town—and I am so proud of my team. If you have any questions, please feel free to contact me at gsalibmd@oceyeinstitute.com.
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Astigmatism in the cataract patient can be managed by either limbal relaxing incisions (LRIs) or toric intraocular lenses (IOLs). Manual LRIs with a blade are relatively simple to perform; however, they are not as precise as the individual wound healing responses can lead to variable corrections. However, with the introduction of the Femtosecond laser in cataract surgery, limbal relaxing incisions made with the laser are more precise and predictable in regard to both placement and depth of the incisions. The use of the laser for astigmatism management gives the patient the best possible chance for excellent uncorrected distance visual acuity following cataract surgery. In fact, surgeons can only charge patients for Femtosecond laser surgery per CMS guidelines if astigmatism correction is performed. Naturally, measuring the patient’s pre-operative astigmatism is key, and various measurements are taken into account, including the patient’s refraction, topography, and keratometry by IOL Master. “On the table,” real-time intraoperative astigmatism can be measured by Alcon’s ORA system, guiding placement and power of a toric IOL and/or determining if the LRIs had the desired effect.

The platform of toric IOLs offered by both AMO and Alcon provides state-of-the-art technology in providing patients with the most effective method of treating astigmatism. The Alcon Acrysof Toric IOLs also offer aspheric optics that enhance image quality by reducing spherical and higher order aberrations and increasing contrast sensitivity.

Candidates for the Acrysof Toric IOLs are those patients who desire spectacle independence for distance vision and less than +2.5D of corneal astigmatism. The FDA first approved lenses with corneal powers of +1.0D, +1.5D, and +2. In recent years, additional higher powers have been released to control astigmatism from +2.5 to +4.0D. Clinical studies for FDA approval showed that >94% of patients achieved uncorrected distance visual acuity of 20/40 or better with 87% of patients achieving less than 1.0D of residual cylinder. Furthermore, there was less than 4 degrees of rotation at post-operative month 6 with 97% of patients < 10 degrees of intended axis.

In 2013, Bausch and Lomb received FDA approval to launch its Trulign Toric IOL, which is a toric version of the Crystalens AO. This lens gives cataract patients with astigmatism a chance for reduced spectacle dependence not only distance, but also intermediate, and possibly even near tasks. It is thought that the polyamide loops/haptics provide better rotational stability resulting in 98% of patients achieving distance uncorrected visual acuity of 20/40 or better. It is available in 3 Toric powers of 1.25, 2.0 and 2.75. Alcon hopes to receive FDA approval this year to launch their ReSTOR Toric line, which will further expand our options in treating both presbyopia and astigmatism.
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DUBLIN, IRELAND (July 28, 2015) — First responders often work in conditions that can take a toll on their eyes. Exposure to heat, smoke, wind and dust may cause Dry Eye symptoms, such as irritated and painful eyes.¹ This is part of the day-to-day environmental challenges they must endure in order to do their job—saving lives. That is why today, Allergan is announcing the REFRESH AMERICA campaign to help our nation’s best perform and alleviate their discomfort from dry eye. Every purchase of specially-marked package in the REFRESH OPTIVE® product line between 8/1/15 – 7/31/16 will lead to donations of REFRESH® eye drops to select first responder groups nationwide. Allergan guarantees a minimum product donation with an approximate retail value of $250,000, regardless of the number of eligible products sold during the campaign period.

“We are pleased that we can offer comfort to first responders working in smoky and dusty conditions with quality eye care products,” said Brent Saunders, CEO, Allergan. “REFRESH® is the number one doctor recommended brand of artificial tears, and we hope this philanthropic program will provide much-needed relief to the men and women who keep us safe.”

Being in an environment with conditions that are severely dry, dusty and windy may result in development of Dry Eye symptoms.¹ REFRESH OPTIVE® Advanced Lubricant Eye Drops, also available in a preservative-free formula, provide long-lasting relief through an innovative, triple-action formula.

“There are an estimated 25 million Dry Eye sufferers in the United States.² More specifically, I see first responders in my practice who complain of eye dryness, burning and irritation brought on by environmental hazards like dust and smoke which are inherent to their work,” said Marguerite McDonald, MD, FACS, board-certified ophthalmologist, Ophthalmic Consultants of Long Island. “I recommend REFRESH OPTIVE® Advanced products to my patients because they are clinically proven to lubricate for Dry Eye relief, hydrate the eye surface cells and help protect your natural tears from evaporating.”

Allergan’s partnership with the U.S. First Responders Association will help designate where REFRESH® eye drop donations will do the most good for our nation’s best.

“I am thrilled that we are able to partner with Allergan for REFRESH AMERICA,” said Traycee Biancamano, CEO, U.S. First Responders Association. “As a first responder, I know first-hand the dedication first responders put into their jobs each and every day, as well as the risks they face. Allergan’s generous contribution is a great way to give back and take care of those who are saving lives.”

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Thanks to the dedicated support of the optometric community, Coastal Vision continues to grow. We are pleased to announce the opening of our newest, and centrally-located, Irvine office just off the 5 or the 405 in the Irvine Spectrum area.

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The Role of the Optometrist

Readers of this article know that optometrists provide two thirds of the primary eye care in this country. It should be noted that for many patients, the optometrist represents the only healthcare professional the patient will routinely see. Because of these factors, the responsibility of the optometrist often extends past their normal role and into a gray area where the comfort level of diagnosis and management can be more variable across the specialty. In my discussions with the many optometrists I have worked with, the identification and management of eyelid and periocular cancers falls into this category.

Challenges

The challenges associated with identifying and caring for potentially malignant lesions are not only faced by optometrists but all eye care providers. Variable past training and current clinical practice can mean some providers have limited didactic and clinical exposure to systemic issues such as cutaneous malignancy. Also, often the patient’s primary complaint does not involve the lesion but a refractive or ocular issue. After an eye care provider listens to the patient’s complaint, it can be easy to turn the lights off in the exam room and get right to the refraction or slit lamp examination to work on the problem at hand. While there are other challenges, the lack of exposure, comfort, or poor examination conditions cause many potentially malignant lesions to go unnoticed.

Your Unique Role

As your patient’s optometrist, you have a unique role and a unique set of skills that lend themselves to early identification of malignant lesions. The most important factor is that the patient is sitting in front of you. That is to mean, the short amount of time that the patient spends in your examination chair, may be the only opportunity he or she has to have this lesion identified by a healthcare professional. Additionally, as an eye care specialist, you have a unique understanding and familiarity with eyelid and periocular anatomy with the ability
to perform microscopic examination at the slit lamp. Your understanding of the
and ability to evaluate this area often surpasses non-eye physicians.

**Why Is It So Important?**

An aging American population leads to increased cumulative sun exposure and
with it, an increase in the incidence of cutaneous malignancy. One in five
Americans will develop some form of skin cancer. Of these skin cancers, five to
ten percent are periocular in location.

This is a particular issue for our patient population here in Southern California
who experience year round sun exposure due to the weather and high level of
outdoor activity. Currently, nonmelanoma skin cancers such as basal cell cancer
have the highest incidence of any cancer in the United States. Probably most
startling is the incidence of melanoma, the most fatal of sun related skin cancer.
It is currently the sixth most common cancer in men, and the seventh most
common cancer in women. Also, it is one of only three cancers in men that has
demonstrated an increasing mortality rate over time.

**When To Refer**

The threshold for referral may be different from one provider to the next. Several
factors such as one’s comfort in observing suspicious lesions over time or the
willingness of a patient to be referred to a specialist may affect this threshold. As
a general rule lesions that demonstrate one or more of the following features
usually raise enough clinical suspicion to merit biopsy.

- Size- recent onset or growth
- Color- varying pigment within a lesion
- Borders- poorly defined with surrounding induration
- Vascularity- telangiectasias or large “feeding” blood vessels
- Ulceration- or “scabbing” in the center
- Loss of lashes (or misdirection)
- Disruption of normal lid or cutaneous architecture- irregular margin
- Focal or unexplained inflammatory disease
Where to refer

As the lead oculoplastic surgeon at the Skin Cancer and Reconstructive Surgery (SCARS) Center of Newport Beach, I have extensive experience managing eyelid and periorcular cancer ranging from small common lesions to large complex, or locally invasive disease. My practice offers the benefit of multi-disciplinary sub-specialized care including Mohs surgery and on site dermatopathology. This means that your patient, whether he or she needs a simple biopsy, or extensive excision and reconstruction of a large complex cancer, will be able to receive the highest level of cutting edge, specialized care all in one location in Newport Beach.

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- Skin cancer
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 IOLs. 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.

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A Novel Combination Therapy for Patients with Dry Eye Disease: A Pilot Study

**Purpose:** To understand the efficacy of a proprietary daily Dry Eye Protocol on patients with established dry eye disease as diagnosed by the Ocular Surface Disease Index (OSDI), a 12-question survey validated for use in clinical trial to assess the severity of dry eye disease.¹

**Design:** Office-based, multi-center cohort study.

**Methods:** This four-week pilot study was to determine if subjects presenting with dry eye responded to a combined daily protocol of nutritional therapy via an oral triglyceride form Omega 3 supplement and the application of a moist, heated eye compress. See Table 1 for the protocol.

<table>
<thead>
<tr>
<th>Therapy</th>
<th>Product</th>
<th>Dosing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Omega 3 oral supplementation containing:</td>
<td>OcuSci Inc. Ultra Dry Eye TG™</td>
<td>3 softgels per day</td>
</tr>
<tr>
<td>2,430mg Omega 3 (1,515mg EPA,630mg DHA)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye Compress with moist heat 25 seconds in microwave</td>
<td>OcuSci Inc., Dry Eye Compress with HydroHeat™</td>
<td>5 minutes per day</td>
</tr>
</tbody>
</table>

Table 1

Patients were included in the study if their baseline OSDI was 23 or greater which is considered moderate dry eye.

**Side Effects:** There were no side effects reported and the four patients who did not complete the trial were due to non-compliance to the protocol.

**Results:** A total of 30 patients were enrolled between 18-75 years of age and 26 patients completed the four-week protocol. The patients on the Dry Eye Protocol showed significant improvement from baseline demonstrated by a decrease in OSDI scores by 54% on average with over half of the patients reported becoming asymptomatic of dry eye symptoms, See Table 2 for more detail.

<table>
<thead>
<tr>
<th>Results, n=26</th>
</tr>
</thead>
<tbody>
<tr>
<td>Variable</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td>Baseline OSDI</td>
</tr>
<tr>
<td>Follow Up OSDI</td>
</tr>
<tr>
<td>Asymptomatic Patients Follow Up OSDI (n=14)</td>
</tr>
</tbody>
</table>

Table 2

**Conclusion:** Daily use of the Dry Eye Protocol showed significant improvement in OSDI and should be considered as a first line therapy for patients with dry eye disease.

To learn more or request a sample of the Dry Eye Protocol visit [www.ocusci.com](http://www.ocusci.com)

Reference:
DRY EYE 30 Day Money Back Guarantee.

"87% of DES patients using Ultra Dry Eye TG and the Dry Eye Compress were asymptomatic in 30 days" - OSDI Dry Eye Study 2015

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What have we learned from oncology and OCT angiography?

It is now clear that intravitreal injections do not cure wet AMD and patients need almost life-long injections to control choroidal neovascularization. We now understand from the oncology literature that new blood vessel formation is comprised of angiogenesis and arteriogenesis. Angiogenesis is the sprouting of new capillaries while arteriogenesis is the dilation of pre-existing channels by active proliferation and remodeling of the vessel wall. Angiogenesis is highly VEGF dependent while arteriogenesis is not. Anti-VEGF agents injected into the eye are highly effective in resolving leaking blood vessels and halting the growth of new capillaries. However, once this occurs the remaining vasculature becomes more robust and remodels and arteriogenesis is stimulated.

After several cycles of anti-VEGF injections, the choroidal revascularization has the characteristic appearance of an overly trimmed tree with thick robust branches and only a few smaller sprouting branches. This is the equivalent of the mature choroidal neovascular membrane which has undergone repeated anti-VEGF injections. The OCT shows a dry macula but with a subretinal hyperreflective elevation.

OCT angiography is a technique which images blood flow in the retina without the need for contrast (Figure 1). It takes advantage of the difference in time of flight of light reflected by vascular cells flowing toward the OCT versus cells flowing away from the OCT. Its major advantage is the lack of vascular leakage and therefore the three layers of retinal blood vessels can be discriminated. Indeed OCT angiography confirms the anatomy of the mature choroidal neovascular membrane (Figure 2). We may now look forward to drugs which modify vasculogenesis and OCT angiography may become an important monitor of the clinical endpoint.

![Figure 1 Legend:](SSADA-Superficial SSADA-Deep)  
OCT angiography demonstrates multi-layering of fundus vessels without the use of contrast dyes.  
[Courtesy of Optovue, Inc.; http://www.optovue.com/products/angiovue/]

![Figure 2 Legend:](angioflow Enface)  
Exudative AMD with choroidal neovascularization.  
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Borish, Skeffington, Sullins, Rosenbloom. These are some of the names that are synonymous with excellence in Optometry. These were the doctors that were Optometric game changers. When they were in active practice, their colleagues knew how special they were and acknowledged their contributions to the profession. In 2015, we have our own set of Optometric game changers. One of those is Paul Karpecki, OD, FAAO.

Dr. Karpecki is a graduate of the Indiana University College of Optometry. He completed a fellowship in medical cornea and refractive surgery in Kansas City under the guide of refractive surgery pioneer and researcher, Daniel Durrie, MD. He was one of two Optometrists appointed to the Delphi International Society at the Wilmer Eye Institute at Johns Hopkins University. This group consisted of the top 25 dry eye experts from around the world tasked to develop clinical standards and recommendations for the treatment of dry eye.

Paul is the Chief Clinical Editor of the most widely read magazine in the profession, “Review of Optometry.” Some know him as being on advisory boards to our greatest Optometric corporations but little know about how much of his time that he has donated to the American Optometric Association, Kentucky Optometric Association, Optometric Council on Refractive Technology, the Ocular Surface Society of Optometry and many others.

With all of his work with emerging products and technologies, Dr. Karpecki has been at the forefront of delivering this information to the profession. His education series through the Review of Optometry called, “New Technologies and Treatments in Vision Care” enables him to lead his team of optometric experts to deliver high quality education around the United States.

Dry eye disease is of high interest to Dr. Karpecki. He continually presents it as one of the most researched and reported diseases that we address as Optometrists. While it is clearly a multi-factorial problem, he states that we have only a few commercially available drugs to address dysfunctional tear syndrome and ocular dryness. For this reason, Dr. Karpecki has actively involved himself in the advancement of all components of dry eye disease.

One of the newer drugs that Dr. Karpecki believes is going to make a difference in the dry eye marketplace is Lifitegrast ophthalmic solution 5.0%, a dry eye drug by Shire plc. In fact, in clinical trials, Dr. Karpecki has treated more patients than any other Optometrist worldwide with this new topical dry eye formulation. Back in April 2015, Shire released a statement which announced that the United States Food and Drug Administration (FDA) has accepted for filing the New Drug Application (NDA) for Lifitegrast and granted a Priority Review designation. Lifitegrast is an investigational treatment for dry eye disease in adults and, if approved, has the potential to be the first treatment indicated to address both signs and symptoms of the disease.

The FDA is expected to provide a decision on October 25, 2015, based on the Prescription Drug User Fee Act V action date.

According to fellow investigators “Lifitegrast is designed to immunomodulate a key pathway in the development and progression of dry eye. The inflammation associated with dry eye is largely mediated by T-cells which feature increased expression of intracellular adhesion molecule-1 (ICAM-1). Lifitegrast is an ICAM-1 decoy that blocks a key binding interaction between ICAM-1 and lymphocyte function-associated antigen-1 (LFA-1) expressed on the T cell surface. The blockade inhibits T-cell activation, adhesion, migration, proliferation and cytokine release in the eye, effectively down regulating inflammation and the resultant ocular surface disease.” In a study presented at the Annual Meeting of the American Academy of Ophthalmology, November 12, 2012 in Chicago, Illinois Shepard, et al. concluded that Lifitegrast ophthalmic solution 5.0% significantly reduced corneal fluorescein and conjunctival lissamine staining and improved symptoms of ocular discomfort and eye dryness compared with placebo when administered twice daily over 84 days. “For doctors that treat dry eye, this new formulation may have a huge impact in dry eye patient care. The doctors at TLC will be watching closely to see if Lifitegrast will be a game changer like Dr. Karpecki is in the dry eye world.”

Disclosure: Karpecki is a paid consultant to Shire Pharmaceuticals and received a research grant for involvement as a principal investigator in the lifitegrast phase 3 U.S. Food and Drug Administration clinical trials

On a personal note, I am honored to be able to work with someone as dedicated, selfless, and of such high moral fiber as Paul. His dedication to our beloved profession is obvious in the work he continues to do daily.

Thank you again for trusting TLC Laser Eye Centers with your patients.

All the Best!

Andy
Upcoming CE Opportunities

VMR Lecture Schedule 2015

7677 Center Avenue, Suite 400
7:00pm - 9:00pm
(Dinner available at 6:30pm)

10/07/2015  Fluorescein Video Angiography, Dr. Chong

11/18/2015  Diabetic Retinopathy, Dr. Chong

CE Credit:  2 Hours (CA State Board of Optometry)
Complimentary dinner included
$10 fee for CE

RSVP:  Mimi.N@VMRInstitute.com
       (714) 901-7777 x7

The San Fernando Valley Optometric Association presents ICD-10 CE:

https://www.eventbrite.com/e/icd-10-ce-sfvos-tickets-17818854674

-September 17, 2015 (Thursday)
-2 Hours of CE
-Topic will be ICD-10
-Space is limited, but we are encouraging doctors to purchase 2 tickets and bring a staff member
-Cost is $20 for members (including members of your society) and $40 for non-members
-The link below will have more information and allow them to RSVP! Need to RSVP online:

https://www.eventbrite.com/e/icd-10-ce-sfvos-tickets-17818854674

Oh, hello August

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Darlene Fidler, O.D.
Jenny Soo Hoo, O.D.
David Yoo, O.D.

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