Happy New Year!

May 2013 bring you good health and continued success!
For better or for worse, we can all now breathe a huge sigh of relief that the election is over. Election years can be very stressful but yet entertaining. I was listening to the radio and a broadcaster likened it to the Super Bowl of politics; and I kind of agree with that. We are not only talking about which way the country goes but also the manner in which states will trend as well. As California goes so does the rest of the country is what I say.

One thing is for sure, California is leading the way in implementing the Affordable Care Act. About two years ago, even before the Supreme Court upheld the law, California was underway in forming the health care exchanges. And now that the election is over the ACA is here to stay. Many of you will see changes in your practice as an estimated 4 million new people will be integrated into the health care system and as VSP is allowed to compete in the exchanges too. We don’t really know how it will impact us but certainly there will be change.

Change can be a good thing. In these times of change I urge you to keep an open mind and to be optimistic. Optometry has seen change in the past and through the peaks and the valleys we have persisted and I for one will not let go of my resolve. Rightly so, I believe optometry should be called on to receive this flood of new recipients with open arms and be the gate keeper to the health care system. Many of us have already been doing this meanwhile providing excellent care for our patients as well as providing the appropriate referral. It is our time to shine my friends; let us be seen, heard, and poised.

Lastly, I want to thank all the members and our industry colleagues who attended our annual OCOS Holiday Mixer. For those who didn’t attend, this is our way of celebrating the holiday season with some fun and food in a very relaxed social gathering. For all those who did attend thank you for you continued support of optometry and in believing in the future of the profession. Without the support of the industry and the membership we’d all probably feel like we were on a deserted island. The camaraderie was electric that night and the atmosphere festive. Thank you and see you next year.

Chris Vargas, OD
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Laser cataract surgery is something that we could have only dreamed of in the past. I can recall countless times my patients would ask me if cataract surgery is done with a laser. “No, Ms. Durgendorf, we do it with something called phacoemulsification.”

It is simply amazing how far we have come in terms of technology for cataract surgery. From the days when cataract surgery involved sandbagging our patients’ heads (no, I never actually did that!), to now using a laser in cataract surgery and sending them home an hour later with a clear shield is truly incredible. On top of that, the lens technology is so advanced that we can have our patients see better than what they ever saw without glasses and with a broader range than what they had before surgery. What a wonderful time it is to be an eye doctor! I am thankful every day that I have the opportunity to give my patients the benefits of all of this new technology.

The LensX laser made by Alcon is the first laser that was FDA approved in this country for laser cataract surgery. I recently became the first surgeon in the Western United States to use the latest updated version of the LensX, and what a difference it has made in my practice.

First of all, what does this laser do in “refractive cataract surgery”? It is a femtosecond laser like the same laser we use to make a corneal flap with all-laser LASIK. We program the laser, based on the preoperative measurements and an intraoperative real time Optical Coherence Tomographer (OCT) built into the laser, to do the following: The main incision, secondary incision, astigmatic keratotomies, capsulotomy and lens fragmentation. It does these with a new level of precision and reproducibility that was previously unseen at the hands of even the most experienced cataract surgeons.

You might be asking does this laser really make a difference? It certainly does, and it is truly an exciting innovation. In a series of recent clinical studies performed by Zoltan Nagy, MD, all anterior capsulotomies created with the LenSx® Laser achieved accurate centration and intended diameter, with no radial tears or adverse events seen. Only 10% of manual capsulorhexes achieved a diameter accuracy of +/- 0.25 mm. Why is this important? With accurate centration and precise intended diameters of the capsulotomy, the IOL can be more consistently situated within the capsular bag and have an adequate rim of capsule surrounding the lens so as to minimize posterior capsular opacification and more consistently hit our refractive targets. This translates into happier patients.

The astigmatic corrections are likewise extremely precise in shape and depth, something that even the most experienced surgeons cannot say about their limbal relaxing incisions despite their best efforts to make a perfect arc. These accurate astigmatic keratotomies can be made at whatever diameter and depth we choose, and can be opened up at the slit lamp if needed for more astigmatic correction if needed. This can be especially useful for our premium lens patients and even our toric lens patients who have a little bit of residual astigmatism. It essentially allows us to fine tune our surgeries even more!

The performing of the incisions precisely ensures that
they are always made exactly to specifications, and the lens fragmentation helps us to reduce the amount of phaco energy used in order to extract the cataract. This can be especially useful in more dense cataracts and in those patients who have Fuch’s dystrophy, but it is also helpful in all patients since the less energy used means faster healing times and better vision (since the cornea will clear up faster).

What are the exam components needed when considering referring/comanaging a patient for laser cataract surgery? Basically, the same as for a regular cataract surgery, such as K’s, refraction, vision, etc. In our office, we would perform the biometry with the Lenstar machine or Ascan if the cataract were too dense. If needed, we would also perform a corneal topography.

As far as contraindications, the most important one would be significant corneal scarring or thinning that might interfere with the laser treatment. Poorly dilating pupils might preclude us from using the laser for the capsulotomy and lens fragmentation, but we could still do the astigmatic treatment(s) and incisions.

Who is a good candidate for the LensX laser? Basically, most anyone who is undergoing a cataract surgery or clear lens extraction would benefit from this precise and innovative technology. With patient expectations at an all-time high, it is nice to be able to offer the best in vision rehabilitation to our patients, translating to increased levels of satisfaction among them (and more of their referrals!). At the Orange County Eye Institute, we are proud to offer this service to our patients, and I have seen increasing numbers of them taking advantage of this advancement. For information on comanaging laser cataract surgery, feel free to contact us anytime.
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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.
Technology has always played a critical role in eye care. Looking back at just the past ten years, cataract surgery alone has seen some monumental breakthroughs such as the premium intraocular lens implant, which can help some patients reduce or eliminate the need for glasses after cataract surgery. Now, comprehensive ophthalmologists are able to utilize another advancement in technology during cataract surgery to help patients with mild to moderate open-angle glaucoma (OAG), the iStent® Trabecular Micro-Bypass (from Glaukos Corporation). The iStent® was the co-creation of local Glaucoma Specialist, Richard Hill M.D. of Orange County Glaucoma.

Recently the iStent® received approval from the FDA, making it not only the smallest known implant ever approved by the FDA, but also the only implant approved for the treatment of mild-to-moderate open-angle glaucoma. Although the device is extremely small, measuring only a millimeter in length, iStent increases fluid outflow to safely lower eye pressure by creating a trabecular micro-bypass into Schlemm’s canal. iStent is indicated for cataract patients with open-angle glaucoma, and is implanted during cataract surgery to reduce intraocular pressure in adults currently treated with glaucoma medications. This procedure has the potential to reduce a patient’s reliance on medications, since many OAG patients are burdened with the inconvenience and expense of using two or more different types of drops everyday to control their eye pressure.

As an approved FDA Research Study Center, Harvard Eye Associates has always been on the forefront of medicine and was chosen among 27 sites nationwide to participate in the study for iStent®. Since the FDA study began, investigator Dr. Roger Ohanesian has seen tremendous success from the device for dozens of his patients and those of other investigators while participating in educational conferences and meetings. “Implantation of iStent® can be performed ab interno during cataract surgery using the same instruments and postoperative medications. Utilizing a micro-invasive procedural technique, iStent helps eliminate the need for sutures while sparing eye tissue that would be damaged using traditional, more invasive tube shunts and trabeculectomies.” said Dr. Ohanesian, noting also that use of the device will not limit future treatment options for maintaining your vision. Now that the iStent® has received FDA approval, all surgeons at Harvard Eye Associates can offer this device to patients.
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Pharmacologic Vitreolysis Cure of Macular Hole with a Single Injection of Ocriplasmin at the VMR Institute in Huntington Beach: Prospective 3D Analysis of Structure and Function

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Presented at the 45th annual meeting of The Retina Society in Washington D.C.
October 4, 2012

Disclosures:
Dr. Sebag is consultant and shareholder of ThromboGenics, LLC
Drs. Sadun and Fink have proprietary interest in the 3D-TAG technology.

Recent advances in ophthalmic diagnostic technology have improved the way vitreo-retinal diseases are diagnosed and monitored from a structural standpoint, but there are still limitations in the ability to assess function. Three Dimensional Threshold Amsler Grid (3D-TAG) was developed to quantitate macular function by combining Amsler grid with contrast sensitivity testing at 5 levels of contrast between the grid lines and the background. 3D-TAG has previously been shown to correlate well with automated perimetry while being both faster and yielding a higher spatial resolution. Unlike simple visual acuity, which tests only the central 4 degrees of vision, 3D-TAG measures a 25-degree field. This test has been used to characterize numerous diseases such as glaucoma, age-related macular degeneration, diabetic macular edema, and various optic neuropathies. 3D-TAG has the added benefit of providing quantitative indices that can be used to follow changes in visual function over time, such as the absolute percent magnitude lost, which incorporates all five tested contrast levels to calculate the cumulative percent of visual field lost. Utilizing this index provides an objective and reproducible way to measure changes in disease severity on a functional level as well as quantify the response to therapy.

Vitreo-macular adhesion (VMA) is presently treated surgically with pars planar vitrectomy and membrane peeling, often with chromodissection. Although effective, this surgical approach is not without inherent risks and costs. Recent developments in pharmacologic vitreolysis may obviate the need for surgery. One agent that is about to be approved by the FDA is ocriplasmin.

This report describes 3-D structural and functional changes in a patient with macular hole who was successfully cured by pharmacologic vitreolysis with a single injection of ocriplasmin at the VMR Institute in Huntington Beach. The patient was followed prospectively for 15 months.
Case Report:

S. C. is a 62 year old woman who presented with blurred vision and distortions in the right eye of three months duration. Best-corrected ETDRS visual acuity was 20/200 in the right eye and 20/20 in the left eye. There was anomalous posterior vitreous detachment with vitreous adhesion to the macula and optic disc (Figure 1). OCT/SLO (OPTOS, Southborough, Mass) also detected tractional cysts and measured central macular volume (central 1 mm ETDRS region) = 0.32μL [normal = 0.16μL11]. The linear distance of vitreomacular adhesion was 515 μM in the horizontal and 525 μM in the vertical axis. 3D-TAG testing revealed a central cylindric defect (Figure 2 top) with 2.24 absolute percent magnitude lost. Under topical anesthesia, the patient underwent intravitreal injection of Ocriplasmin (ThromboGenics, LLC) at the VMR Institute in Huntington Beach. Table 1 shows the progression of quantitative structural (3D-OCT/SLO) and functional (visual acuity and 3D-CTAG) indices over time.

One week after injection, the patient had decreased metamorphopsia and visual acuity of 20/40-2 in the treated eye. At 2 weeks post-injection 3D-OCT/SLO imaging revealed resolution of vitreous-macular and vitreopapillary adhesion. Macular volume had decreased to 0.22 μl (31.25% improvement from pre-injection level) and nearly all cystic spaces had resolved. Repeat 3D-CTAG evaluation revealed a smaller central cylindric defect (Figure 2) with a 0.66 absolute percent magnitude lost (nearly 4-fold improvement from pre-injection level). At six months post-injection the macular volume was 0.21 μl and 3D-TAG measured an absolute percent magnitude lost of 0.65. At 15 months macular volume improved to 0.15 μl and the macula appeared normal (Figure 3B).

Discussion:

This case demonstrates the utility of 3D-TAG in assessing macular dysfunction and its recovery following resolution of vitreo-macular adhesion and cure of a macular hole by ocriplasmin pharmacologic vitreolysis, performed under topical anesthesia at the VMR Institute in Huntington Beach. The functional improvement quantitated by 3D-TAG mirrored the structural improvement measured by 3-D imaging. The relative percent improvement in central macular volume over the first 2 weeks was 31% (0.32 μl to 0.22 μl) while the 3D-TAG percent magnitude lost improved nearly 4-fold (2.24 to 0.66). Similarly, at 6 months the central macular volume had improved slightly more to 0.21 μl (34% overall improvement) and the absolute percent magnitude lost showed a similar small improvement to 0.65 (400% overall). Both volumetric measurements showed that while major improvement occurred in the first two weeks after treatment, there were residual structural and functional deficits present 6 months after the injection.

Previous studies2,3,4,5,12, have shown the value of 3D-TAG in various pathologies with greater sensitivity in detecting wet AMD as compared to traditional Amsler grid testing12. This case demonstrates that 3D-CTAG correlates well with structural changes in the macula and would thus provide enhanced characterization of maculopathies undergoing pharmacologic vitreolysis as well as surgical therapies.
Figure 1. Combined SD-OCT/SLO of Vitreo-Macular Adhesion (Pre-treatment)

3D SD-OCT/SLO imaging prior to treatment demonstrates vitreous attachment to both the macula and optic disc (OD). The macula is elevated by traction caused by the vitreous membrane opening a central dehiscence [See Fig 3A].

Figure 2. 3D-CTAG Plots of Central Visual Field Function

Changes in macular function (i.e., Amsler grid and contrast sensitivity) are plotted over time by 3D-CTAG graphs. The top left corner shows the central visual abnormality at presentation, while the bottom right represents the abnormality at 6 months. In these graphical representations of the central visual defects, the x- and y-axes represent the area of visual field tested by Amsler grid, while the z-axis represents contrast sensitivity.
Pre-treatment OCT-SLO of Macular Hole

Fig 3B
15 months after pharmacologic vitreolysis with a single injection of ocriplasmin at the VMR Institute in Huntington Beach

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NVISION Laser Eye Centers is now enrolling patients with Keratoconus and Post Refractive Surgery Ectasia in our Collagen Cross Linking Clinical Trial. Collagen Cross Linking in the United States has not been FDA approved.

Collagen Cross Linking has been shown, in multiple peer reviewed scientific journal articles, to slow down, and in most cases stop the progression of Keratoconus and Post Refractive Surgery Ectasia, as well as to decrease myopia and astigmatism and improve the corneal irregularity resulting in improved uncorrected and best corrected vision in a significant number of eyes treated.

Our study differs from most studies in that we will be performing an **Epithelium On Technique** which we believe will significantly reduce healing time and discomfort as well as reduce the chance of an infection or haze that may result from a 9mm epithelial defect, which is typically performed in an **Epithelium Off technique**. The other area of difference is the length of time the eye is exposed to the UV light. In our study it will be for only 5 minutes since the UV light intensity is 6X that of other studies requiring UV light exposure time of 30 minutes. Needless to say, 5 minutes of a speculum in one’s eye is much more comfortable.

A pre-operative evaluation similar to that performed for LASIK consults is all you need to do.

**Inclusion Criteria**
The following criteria will be used to determine if you are a candidate for the clinical trial:

**Criteria for Individuals with Keratoconus**
- Subjects who have one or both eyes that meet the following criteria will be considered candidates for this study:
  - 12 years of age or older
  - Signed written informed consent
  - Willingness and ability to comply with schedule for follow-up visits
  - Contact lens removal prior to evaluation and treatment
  - Candidates must also have two of the following criteria (6.1.6 through 6.1.8)
    - Presence of central or inferior steepening on the Pentacam or Orbscan map consistent with Keratoconus.
    - Axial topography consistent with keratoconus
    - Steepest keratometry (Kmax) value ≥ 47.00 D

**Criteria for Individuals with Ectasia**
1. History of having undergone a keratorefractive procedure and meet two of the following criteria:
   a) Steepening by topography, either Pentacam or Orbscan
   b) Thinning of cornea
   c) Shift in the position of thinnest portion of cornea
   d) Change in refraction with increasing myopia
   e) Development of myopic astigmatism
   f) Development of irregular astigmatism
   g) Loss of BSCVA

**Exclusion Criteria**
Participants meeting any of the following criteria will be excluded from this protocol:
- Eyes classified as either normal, atypical normal
- Corneal pachymetry ≤ 350 microns at the thinnest point measured by Pentacam in the eye to be treated
- A history of chemical injury or delayed epithelial healing in the eye to be treated.
- Pregnancy (including plan to become pregnant) or lactation during the course of the study
- A known sensitivity to study medications
- Patients with nystagmus or any other condition that would prevent a steady gaze during the treatment
- Inability to cooperate with diagnostic tests.
- Patients with a current condition that, in the investigator’s opinion, would interfere with or prolong epithelial healing.
- Taking Vitamin C (ascorbic acid) supplements within 1 week of the cross-linking treatment.
- Patients who are unable to remain supine and tolerate a lid speculum for an extended period of time.
A Rubric for Expressing Regret to Patients

Health care is more complex now than ever before, and refractive surgery mirrors the trend. Intertwined in that complexity is the doctor-patient relationship. Although patients expect great clinical skills and superb outcomes from their surgery, they also expect their doctors to say the right thing at the right time in nearly every situation. However, what a doctor thinks is said and what a patient needs to hear may be significantly different. One area where there is a great deal of social science attended to an issue has to do with expressing regret to patients. And, there are all manner of instances and circumstances where a direct expression of regret may help our patients.

So, how do we go about expressing regret? There are five steps in the process, and they are easy to remember. Each step begins with an “r” word. First, recognition. Is this the right time to express regret? In general, too soon is better than too late, but finding the perfect time is often elusive. Second, regret. It is often helpful to have the beginning of the expression memorized, “I regret that...” These three words can springboard into a more specific statement to the patient. Third, responsibility. “I am going to do what I can to make things better for you. If I believe someone else might be more qualified to help you than me, I will either consult with another doctor, or refer you to another doctor, but in the interim I will stay with you until this is better for you.” Fourth, remedy. Don’t say something to a patient that you cannot support with clarity. The patient will remember every detail of what you say when you offer remedy. So, if you don’t know what you believe the remedies are that are available for the patient, then say something like, “I am not sure what to do right now, but give me a day to sort this out and perhaps talk to another doctor, and I will get back to you tomorrow. What would be a good time to call you?” It is important to be direct and not vaporous in any manner. So, if you need more time to organize a remedy for the patient, then take the time. Do not hurry. Finally, and not always appropriate, but if the circumstances lend themselves to it, consider the fifth step, realignment. Here you are suggesting that the patient can help you understand more about what has occurred, so that other patients might benefit by either preventing the circumstances from happening in the future, or making things a bit better for patients if these circumstances were to occur again.

Using these 5 steps in expressing regret is easy. You can write them on a note card or a piece of paper and go over them before you express regret to a patient. Preparation is important, and in fairness it will seem awkward in the beginning as you work through the skills and techniques. However, what we believe you will find is that as you begin communicating in this way with patients, they will certainly benefit and you will have greater confidence in engaging with them in what otherwise may seem like a daunting and uncertain task. When all is said and done, the patient will benefit from what you do and how you do it, and that is the best result you could hope for in expressing regret.

John Potter, OD, MA & Bill Tullo, OD
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