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**References:** 1. In a randomized, subject-masked clinical study at 20 sites with 252 patients; significance demonstrated at the 0.05 level; Alcon data on file, 2009. 2. Rappon J. Center-near multifocal innovation: optical and material enhancements lead to more satisfied presbyopic patients. *Optom Vis Sci.* 2009;86:E-abstract 095557. 3. In a randomized, subject-masked clinical trial at 6 sites with 47 patients; significance demonstrated at the 0.05 level; Alcon data on file, 2008. 4. Based on a third-party industry report, 12 months ending October 2012; Alcon data on file.

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## ASCRS welcomes ODs during IOMED program

By **Gretchyn M. Bailey, NCLC, FAAO**  
Editor in Chief, Content Channel Director

**San Francisco**—At the recent American Society of Cataract and Refractive Surgery (ASCRS) meeting, optometrists joined ophthalmologists for the Integrated Ophthalmic Managed Eyecare Delivery Model (IOMED) track. The track consisted of three panel discussions during an afternoon session followed by a reception, plus 13 additional courses chosen for Council on Optometric Practitioner Education (COPE) approval.

The three panel discussions involved ODs as both panelists and moderators. Topics included new technology, practice management, and managing cases in an integrated setting. COPE-approved topics were mainly clinical in nature, such as post-LASIK ectasia, IOL power calculations, and corneal topography and imaging.

"I think the symposium went very well," says IOMED task force Chairperson Stephen S. Lane, MD, of St. Paul, MN. "I'm very upbeat and excited about it. All feedback has been positive. From an attendance standpoint, we always would like to see a greater number, but for a first go-round, it was excellent. The highlights are the participation and the fact that ASCRS made a significant effort to reach out to this group of ODs, who responded quite well. To see the support and participation in the event was most gratifying."

The next step is growing the IOMED portion of the meeting with the help of ODs who attended this year's meeting. In addition, the IOMED task force will be upgraded to a full standing committee of ASCRS. The IOMED

See **ASCRS** on page 5



Creating an IOMED committee shows the commitment of ASCRS to the integrated concept, says IOMED task force chairperson Stephen S. Lane, MD.

## SCCO to become Marshall B. Ketchum University

By **Gretchyn M. Bailey, NCLC, FAAO**  
Editor in Chief, Content Channel Director

**Fullerton, CA**—The Southern California College of Optometry (SCCO) is adding a physician assistant program and will be known, as of July 1, as Marshall B. Ketchum University. Stanley Woo, OD, will become dean of optometry, and Daniel May, MD, will lead the new physician assistant program. Current SCCO President Kevin Alexander, OD, will manage the new university structure.

"When I started at SCCO in 2008, we began

a process of futuring," says Dr. Alexander. "We looked at demographics, changes in healthcare reform, changes in education, and everything that would potentially impact us. We concluded that we're not in the optometry education business. We're really in the healthcare education business. From an education standpoint, particularly as we look at the new schools established in larger medical centers and comprehensive medical campuses, we asked ourselves, 'What is the future of the standalone, independent college of anything?' In our case, it's a college of optom-

See **SCCO** on page 5

INSIDE: Special Section

PRACTICE  
MANAGEMENT

Starts on page

20





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**References:** **1.** Dumbleton KA, Richter D, Jones LW. Compliance with lens replacement and the interval between eye examinations. *Optom Vis Sci.* 2012;89 (E-abstract 120059). **2.** Dumbleton K, Woods C, Jones L, et al. Patient and practitioner compliance with silicone hydrogel and daily disposable lens replacement in the United States. *Eye & Contact Lens.* 2009;35(4):164-171. **3.** Yeung KK, Forister JFY, Forister EF, et al. Compliance with soft contact lens replacement schedules and associated contact lens-related ocular complications: The UCLA Contact Lens Study. *Optometry.* 2010; 81(11):598-607. **4.** Dumbleton K, Woods C, Jones L, et al. Comfort and Vision with Silicone Hydrogel Lenses: Effect of Compliance. *Optom Vis Sci.* 2010;87(6):421-425.

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In partnership with our readers, we will achieve mutual success by:

- Being a forum for optometrists to communicate their clinical knowledge, insights, and discoveries.
- Providing management information that allows optometrists to enhance and expand their practices.
- Addressing political and socioeconomic issues that may either assist or hinder the optometric community, and reporting those issues and their potential outcomes to our readers.

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## ASCRS

Continued from page 1

committee will include 4 ODs, 4 MDs, an OD co-chair, and an MD co-chair. Says Dr. Lane: "Creating a committee shows the commitment of ASCRS to this concept. The committees are part of ASCRS and are integral in the determination of how things are run—not just from an educational standpoint, but politically as well. ASCRS takes this very seriously and has every intention of making it bigger."

IOMED task force member David Geffen, OD, of San Diego, agrees that a wider range of optometrists should attend an integrated care delivery meeting. "Integrated means you are serving patients together," he says. "Even people on the panel have different opinions about what that means. This program is trying to move optometry forward. ODs and MDs need each other. There are bigger battles, like managed care and Medicare. We can fight those battles better together instead of being divided."

Communication is key in an integrated practice, says Norfolk, VA, optometrist Walt

Whitley, who was part of the case management panel. "I was honored to be part of that panel, and the biggest takeaway from the meeting is the trust involved between OD and MD," he says. "There will be integrated eye care in some form. We need to keep working on our relationships with other doctors, whether they're ophthalmologists or primary-care practitioners. We're all going to have to work together to meet our patient care needs."

Members of the IOMED task force met with a group of optometrists who have been unhappy with the exclusion of private-practice optometrists from the meeting. Says Dr. Lane: "We had a nice dialogue. We understand the issues that private-practice optometrists have. We understand that many of them would like to attend. We are going to look for potential ways to include more optometrists. There's a lot of common ground for them to participate, and we'll try to work with this group to see where there are some common things we can share."

In related news, the American Optometric Association (AOA) recently announced the

launch of an integrated eyecare project team. This team will analyze models of care and set out the elements essential to developing an ideal system that is efficient, productive, and patient-centric.

"The main focus of our project team will be to analyze existing models of integrated care and to define those elements that result in integrated care teams that deliver high quality, efficient patient care," Iselin, NJ, optometrist Christopher Quinn, project team chair, said in a statement. "Over the past several years, ASCRS and several prominent ophthalmologists have been promoting their version/vision of 'integrated eye care.' Unfortunately, in my understanding, their model takes a very limited perspective of the potential benefits of integrated eye care delivery, focusing on the benefit to individual ophthalmologists. Optometry's vision for how our professions can work together will be focused on better patient care and outcomes." **ODT**

(See "Certain ODs welcome to participate in new ASCRS integrated program" in the February issue for more details on IOMED.)

## SCCO

Continued from page 1

etry. In addition, there's a real drive to create interprofessional opportunities so people are working as a team to take care of patients."

Dr. Alexander believes there is great value in diversifying SCCO's interests, adding programs, and making the school larger. Plans are in the works to add a third program to the university.

"It's not about making money," he says. "I don't know anybody that is making money on educational enterprise. If you're doing well, you're breaking even, and it's paying for itself."

The school began its expansion with a physician assistant program because such a program would open doors for the school within the medical community. Dr. Alexander believes that partnering with a medical school would not be in the best interests of the optometry school.

"On a large medical campus, the medical school is the top dog," he says. "It gets the funding and preferential treatment. An optometry program with only a few hundred students... how significant will that be? Within a week [of our announcement of the physician assistant program], I got phone calls from hospital administrators saying, 'We'd like to work with you.' That never happened before."

Dr. Alexander is considering other changes as well. He's very interested in creating an MBA program for ODs and a Master of Public Health (MPH) degree program. The school is in the process of partnering with California State University, Fullerton, to offer graduate-level opportunities to those students. The campus will likely see a new building after the third program is added.

"Creating the university isn't the end point," he says. "It's creating the structure so we can add the programs we want. Every program has a strategic value in enhancing the optometric program, and each program elevates the opportunities for optometric education." **ODT**

## In Brief

### FDA approves Alcon's Simbrinza for glaucoma

**Basel, Switzerland**—Novartis International AG/Alcon has received FDA approval of Simbrinza suspension, a new beta blocker-free, fixed-dose combination therapy for glaucoma patients. Simbrinza suspension is indicated for reducing elevated IOP in patients with primary open-angle glaucoma or ocular hypertension.

The new ophthalmic suspension offers many treatment possibilities because of its strong efficacy and ability to decrease elevated IOP by 21%-35%, according to study results. Also, it is the only available, fixed-dose combination therapy for glaucoma in the US without a beta blocker.

Simbrinza suspension combines a carbonic anhydrase inhibitor (brinzolamide 1.0%) with an alpha 2 adrenergic receptor agonist (brimonidine Tartrate 0.2%) in one multi-dose bottle, helping to reduce the medication burden for glaucoma patients. Patients are to administer one drop of Simbrinza into the affected eye(s) TID.

FDA approval of Simbrinza is based on data from two pivotal Phase III clinical trials with approximately 1,300 patients. The studies evaluated the safety and efficacy of a fixed-dose combination of Brinzolamide 1.0% and Brimonidine 0.2%, administered TID, compared to separate TID dosing of one or the other component. Both studies met their primary endpoint and demonstrated that Simbrinza is statistically superior compared to either component regarding mean IOP at month 3 for all time points. In both studies, Simbrinza achieved a 5mm Hg to 9mm Hg reduction from baseline to month 3. Patients' mean IOP at baseline was 22mm Hg to 36mm Hg. **ODT**

# It's all about service



**Ernest L. Bowling,  
OD, MS, FAAO,  
Chief Optometric Editor**

I recently bought a new truck. It's nothing fancy, a bare-bones pickup truck. I looked far and wide, did extensive research, haggled with different dealerships, and narrowed the selection to a couple of choices. Now, while my wife will tell you I made my selection based on its crimson color (Roll Tide!), my deciding factor was the dealership's service department. The people there cared for my old jalopy for years, and I trust them with my vehicles.

Customer service is something that seems to have fallen by the wayside these days. Perhaps it's society's fixation on cost alone. The optical business isn't immune. There has been a proliferation of online optical retailers with attractive pricing that definitely attracts some patients. Yet, you can't judge a product or service by cost alone.

Has your practice encountered any of these scenarios?

A patient returns to your office with a pair of spectacles purchased online and wants your staff to adjust them "because they don't fit right."

A patient complains that he or she is not seeing adequately out of a pair of glasses pur-

chased online and wants you to "check them."

A phone shopper wants to know if your office would measure her PD "because the place where I got the exam didn't, and I want to order my glasses online."

Of course, in all three examples, the patients want this service for free!

I am quite certain most ophthalmic professionals are alike in this way: We will bend over backward to ensure that our patients are happy and satisfied with materials purchased in our offices. There is a service component to the fitting, measuring, and dispensing of eyewear that is not considered by patients when they purchase online. Optical dispensing requires fitting measurements that must be initially obtained in person by a trained professional, then the spectacles must be properly adjusted at dispensing. There is a tremendous amount of patient education along the entire process, discussing lens and frame types, and marrying the patient's needs with his or her frame desires.

Online vendors can't do these personal services.

That service aspect has a time value and therefore a dollar value. Who determines the value of that service? You do—the business owner. Online vendors surely don't feel these services are important. Like the old saying goes, no one is going to value your service if you don't first. Time is money. For years, we've operated on the policy of taking care

of whoever comes through our door, and that included free repairs and adjustments without really monitoring where the person obtained his glasses. We always thought it was good public relations, built goodwill, and resulted in future business. That's my fault. Like I said earlier, if we don't value our services, no one else will. By doing free repairs and adjustments for anybody who walked through the door, we were actually devaluing our own materials and services. I mean, why purchase your materials here if you know we're going to care for your eyewear no matter where you got them?

Regardless of how you feel about online eyewear retailers, the wise thing to do is develop your office policies now—if you haven't already—on how to handle information and service requests when your office isn't providing the eyewear. Be prepared to discuss your policies and concerns with patients and out-of-the-practice clients asking about buying eyewear online. Above all, never apologize for the fees you charge. You set the value of your service, and if you don't value it, no one else will.

Aren't you worth every penny?

How does your practice handle service requests from non-customers? I am interested to hear your policies and how you enforce them. Drop me a line at [drbowling@windstream.net](mailto:drbowling@windstream.net). **ODT**

## Optometry at the ASCRS meeting



**Gretchyn M. Bailey, NCLC,  
FAAO  
Editor in Chief, Content Channel  
Director**

I just returned from spending some time in San Francisco at the American Society of Cataract and Refractive Surgery (ASCRS) Integrated Ophthalmic Managed Eyecare Delivery Model (IOMED) symposium. Whew, that's a mouthful.

I saw a room full of ODs and MDs learning side by side. I saw several sessions featuring both ODs and MDs on panels. In fact, ODs moderated the panel sessions.

The practice management strategies session was quite interesting to hear. A show of hands indicated that mainly MDs were in the audience during this session. In addition to

other presenters on the panel, two MDs shared how their practices were set up to include optometrists in the patient-care delivery system. Plus, one MD noted that the optometrists in his practice were partners in the practice, not just employees. Moving forward, I'd like to see more discussion around how to partner with optometrists instead of how to employ them.

The final panel discussion in the half-day symposium exemplified the driving force behind this meeting. Titled "Challenging Cases in an Integrated Eyecare Setting: How We Manage Them," this panel featured Howard Fine, MD, and Derek Cunningham, OD, as moderators. On the panel were Jeff Azus, OD; Stephen Lane, MD; and Walt Whitley, OD. Dr. Cunningham presented a small summary of each case, and Drs. Whitley and Azus discussed how they would manage these patients. Drs.

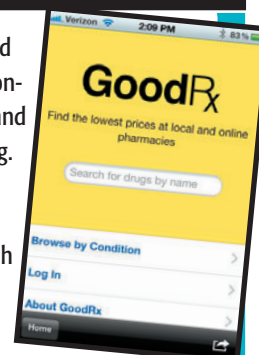
See **ASCRS** on page 8

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—Kirk Smick, OD  
Morrow, GA





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**Please see Brief Summary of the full Prescribing Information on adjacent page.**

**RESTASIS® (Cyclosporine Ophthalmic Emulsion) 0.05%****BRIEF SUMMARY—PLEASE SEE THE RESTASIS® PACKAGE INSERT FOR FULL PRESCRIBING INFORMATION.****INDICATIONS AND USAGE****RESTASIS®** ophthalmic emulsion is indicated to increase tear production in patients whose tear production is presumed to be suppressed due to ocular inflammation associated with keratoconjunctivitis sicca. Increased tear production was not seen in patients currently taking topical anti-inflammatory drugs or using punctal plugs.**CONTRAINDICATIONS****RESTASIS®** is contraindicated in patients with known or suspected hypersensitivity to any of the ingredients in the formulation.**WARNINGS AND PRECAUTIONS****Potential for Eye Injury and Contamination**

To avoid the potential for eye injury and contamination, be careful not to touch the vial tip to your eye or other surfaces.

**Use with Contact Lenses****RESTASIS®** should not be administered while wearing contact lenses. Patients with decreased tear production typically should not wear contact lenses. If contact lenses are worn, they should be removed prior to the administration of the emulsion. Lenses may be reinserted 15 minutes following administration of **RESTASIS®** ophthalmic emulsion.**ADVERSE REACTIONS****Clinical Trials Experience**

Because clinical trials are conducted under widely varying conditions, adverse reaction rates observed in the clinical trials of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice.

In clinical trials, the most common adverse reaction following the use of **RESTASIS®** was ocular burning (17%).

Other reactions reported in 1% to 5% of patients included conjunctival hyperemia, discharge, epiphora, eye pain, foreign body sensation, pruritus, stinging, and visual disturbance (most often blurring).

**Post-marketing Experience**The following adverse reactions have been identified during post approval use of **RESTASIS®**. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish a causal relationship to drug exposure.

Reported reactions have included: hypersensitivity (including eye swelling, urticaria, rare cases of severe angioedema, face swelling, tongue swelling, pharyngeal edema, and dyspnea); and superficial injury of the eye (from the vial tip touching the eye during administration).

**USE IN SPECIFIC POPULATIONS****Pregnancy****Teratogenic Effects: Pregnancy Category C**Adverse effects were seen in reproduction studies in rats and rabbits only at dose levels toxic to dams. At toxic doses (rats at 30 mg/kg/day and rabbits at 100 mg/kg/day), cyclosporine oral solution, USP, was embryo- and fetotoxic as indicated by increased pre- and postnatal mortality and reduced fetal weight together with related skeletal retardations. These doses are 5,000 and 32,000 times greater (normalized to body surface area), respectively, than the daily human dose of one drop (approximately 28 mcL) of 0.05% **RESTASIS®** twice daily into each eye of a 60 kg person (0.001 mg/kg/day), assuming that the entire dose is absorbed. No evidence of embryofetal toxicity was observed in rats or rabbits receiving cyclosporine at oral doses up to 17 mg/kg/day or 30 mg/kg/day, respectively, during organogenesis. These doses in rats and rabbits are approximately 3,000 and 10,000 times greater (normalized to body surface area), respectively, than the daily human dose.

Offspring of rats receiving a 45 mg/kg/day oral dose of cyclosporine from Day 15 of pregnancy until Day 21 postpartum, a maternally toxic level, exhibited an increase in postnatal mortality; this dose is 7,000 times greater than the daily human topical dose (0.001 mg/kg/day) normalized to body surface area assuming that the entire dose is absorbed. No adverse events were observed at oral doses up to 15 mg/kg/day (2,000 times greater than the daily human dose).

There are no adequate and well-controlled studies of **RESTASIS®** in pregnant women. **RESTASIS®** should be administered to a pregnant woman only if clearly needed.**Nursing Mothers**Cyclosporine is known to be excreted in human milk following systemic administration, but excretion in human milk after topical treatment has not been investigated. Although blood concentrations are undetectable after topical administration of **RESTASIS®** ophthalmic emulsion, caution should be exercised when **RESTASIS®** is administered to a nursing woman.**Pediatric Use**The safety and efficacy of **RESTASIS®** ophthalmic emulsion have not been established in pediatric patients below the age of 16.**Geriatric Use**

No overall difference in safety or effectiveness has been observed between elderly and younger patients.

**NONCLINICAL TOXICOLOGY****Carcinogenesis, Mutagenesis, Impairment of Fertility****Carcinogenesis:** Systemic carcinogenicity studies were carried out in male and female mice and rats. In the 78-week oral (diet) mouse study, at doses of 1, 4, and 16 mg/kg/day, evidence of a statistically significant trend was found for lymphocytic lymphomas in females, and the incidence of hepatocellular carcinomas in mid-dose males significantly exceeded the control value.In the 24-month oral (diet) rat study, conducted at 0.5, 2, and 8 mg/kg/day, pancreatic islet cell adenomas significantly exceeded the control rate in the low dose level. The hepatocellular carcinomas and pancreatic islet cell adenomas were not dose related. The low doses in mice and rats are approximately 80 times greater (normalized to body surface area) than the daily human dose of one drop (approximately 28 mcL) of 0.05% **RESTASIS®** twice daily into each eye of a 60 kg person (0.001 mg/kg/day), assuming that the entire dose is absorbed.**Mutagenesis:** Cyclosporine has not been found to be mutagenic/genotoxic in the Ames Test, the V79-HGPRT Test, the micronucleus test in mice and Chinese hamsters, the chromosome-aberration tests in Chinese hamster bone-marrow, the mouse dominant lethal assay, and the DNA-repair test in sperm from treated mice. A study analyzing sister chromatid exchange (SCE) induction by cyclosporine using human lymphocytes *in vitro* gave indication of a positive effect (i.e., induction of SCE).**Impairment of Fertility:** No impairment in fertility was demonstrated in studies in male and female rats receiving oral doses of cyclosporine up to 15 mg/kg/day (approximately 2,000 times the human daily dose of 0.001 mg/kg/day normalized to body surface area) for 9 weeks (male) and 2 weeks (female) prior to mating.**PATIENT COUNSELING INFORMATION****Handling the Container**

Advise patients to not allow the tip of the vial to touch the eye or any surface, as this may contaminate the emulsion. To avoid the potential for injury to the eye, advise patients to not touch the vial tip to their eye.

**Use with Contact Lenses****RESTASIS®** should not be administered while wearing contact lenses. Patients with decreased tear production typically should not wear contact lenses. Advise patients that if contact lenses are worn, they should be removed prior to the administration of the emulsion. Lenses may be reinserted 15 minutes following administration of **RESTASIS®** ophthalmic emulsion.**Administration**

Advise patients that the emulsion from one individual single-use vial is to be used immediately after opening for administration to one or both eyes, and the remaining contents should be discarded immediately after administration.

**Rx Only**

Based on package insert 71876US15

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# ASCRS

Continued from page 6

Fine and Lane chimed in with their impressions.

At the start of the session, Dr. Fine said, “I have never worked in an integrated setting, but I am 100% convinced that this is going to be the future.” At times he didn’t appear quite so convinced as he grilled the ODs on the panel about their experience and knowledge, stating that the MDs in the audience needed to believe in the ODs working with them.

However, the interaction among Drs. Azus, Fine, Lane, and Whitely showed eye care at its finest by discussing what was best for the patient in question, how to more efficiently utilize ophthalmology and optometry in a

combined setting, and ultimately make sound clinical decisions.

By contrast, in another session Bithika Kheterpal, MD, appeared to be more interested in ensuring that any optometrist she works with follows prescribed triage guidelines. Don’t get me wrong, knowing when to punt is important for any optometrist, regardless of practice setting. But claiming that quality of care is dependent on MD presence (“The more available the ophthalmologist, the higher the quality of care”) may not smooth the path to integrated patient care.

This meeting was a good first step on the road to better collaboration between optometry and ophthalmology. I hope next year’s meeting builds on what took place in San Francisco, with a big emphasis on partnering, not employing. **ODT**

## To the Editor

# Online tech training for busy practices

I’m *hugely* in favor of trained technicians. I trained my first tech and paid for all her certification training through the American Optometric Association. She earned certified paraoptometric (CPO), certified paraoptometric assistant (CPOA), and certified paraoptometric technician (CPOT) designation. A year after she got her CPOT, she left for another practice; her leaving was unrelated to her CPOT.Now I find myself with a new tech, Jackie. I don’t have time to do the training by myself anymore, so I found this wonderful program offered through Madison Area Technical College of Madison, WI. It’s an online optometric technician program, [http://madisoncollege.edu/optometric-technician-online-pro-](http://madisoncollege.edu/optometric-technician-online-pro-gram)*gram*, designed for people currently working as staff in a practice. The doctor (or optician, if there is one) acts as the mentor and is in charge of making sure the student knows how to do the practical tasks. But the lectures and coursework are done online.

This has been a really cool process. Jackie is almost done with her first of a projected four semesters. I like that Jackie is having someone other than me teach her, although I am “supervising.” I ask her for a weekly summary of what she has been working on, so I know she is keeping up with the program. The program isn’t cheap—about \$400 per course, not including books—but so far I think it’s very worth it.

**Viktoria Davis, OD**  
Madelia, MN



# Prescribing toric contact lenses

Your patients look to you for the best vision correction options

Astigmatism is not a disease. Many of our patients have been told they have “stigmatism” and equate this term with familiar eye diseases, such as glaucoma and macular degeneration.

Unfortunately, some patients have been told they can't wear contact lenses (CLs) “because of my astigmatism.” That response gives the doctor an opportunity to explain that astigmatism is not a disease but a refractive error that distorts vision and reduces visual clarity. That opportunity is definitely present because an estimated 45 million Americans have significant astigmatism.<sup>1</sup> Patients may not wear soft toric lenses because they think astigmatism precludes CL wear.

Perhaps the patient had a bad experience with older versions of toric lenses, or he or she may not know CLs are available for astigmats.



## By Ernie Bowling, OD

Dr. Bowling is in solo private practice in Gadsden, AL, and is chief optometric editor of *Optometry Times*.

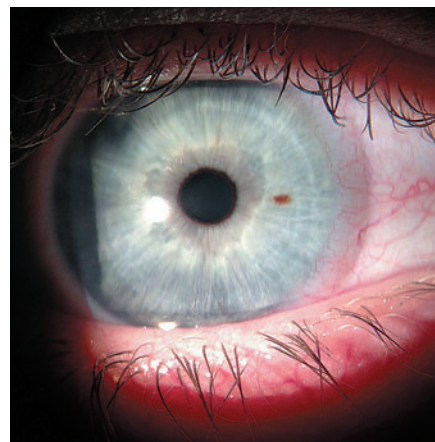
## Timing is everything

This gives the progressive optometrist an opportunity to gain a patient's loyalty by providing sharper, crisper vision with toric lenses. Toric lenses are available for most every prescription, from low astigmats to high astigmats, in both hydrogel and silicone hydrogel materi-

als. It is important to educate your astigmatic patients from the outset that their prescription is more challenging to fit, and more than one lens type

may need to be tried. Get off to a good start by conducting a subjective refraction. The most important data points include the amount of cylinder power in relation to the sphere power, the total amount of astigmatism, and the cylinder axis. If a patient presents with an outside prescription, take the time to verify that it is correct. This small investment of your time on the front end can save you some time and frustration down the road. Always err on the lesser side of the patient's need with cylinder power. For instance, if the patient's refractive cylinder power is -1.00 DC, choose a diagnostic lens with -0.75 DC as opposed to one with a -1.25 DC.

Demonstrate the patient's cylindrical correction in the phoropter. Show the patient what the full spherocylindrical correction looks like, then present the spherical equivalent and listen for his or her response. More often than not, the patient appreciates the increased clarity of the cylindrical correction, making this a good point to explain the value of a toric CL. In fact, it is this necessary dialogue with your patient about toric lenses that adds time to the patient visit, not the actual CL fitting itself. Yet all toric lenses need time to settle. One way to speed this process along is to position the laser markings into their



**Toric contact lenses are a great option for your low astigmat patients. (Photo courtesy of Ernie Bowling, OD)**

proper alignment when applying the lens to the eye, which will reduce the distance the lens has to travel to stabilize. Be a critical observer as well as a critical listener. Signs such as injected eyelid margins and excessive blinking may be harbingers of eyelid disease or concomitant dry eye, which need to be addressed for a successful CL fit.

Keep in mind: You deserve to be compensated for this increased level of skill and expertise. Modify your fee schedule to incorporate differing levels of service with the appropriate fee charges.

Consumer polls and surveys reveal a large, enthusiastic, yet underserved, astigmatic population. These patients are just waiting to be introduced to toric soft CLs. After all, your patients are looking to you for their best vision correction options. Today's toric CL designs have been refined to yield consistent, clear vision. Toric lens fitting does not require significantly more chair time, and their cost is no longer prohibitive.

Educating your patients about all of their vision correction options is imperative. For your astigmatic patients, that warrants a discussion about toric soft CLs. **ODT**

## REFERENCES

1. Miller J. It takes one to know one: Reasons to fit more toric lenses. *Contact Lens Spectrum*, February 2011. [www.clspectrum.com/articleviewer.aspx?articleid=105186](http://www.clspectrum.com/articleviewer.aspx?articleid=105186). Accessed April 8, 2013.

You deserve to be compensated for this increased level of skill and expertise. Modify your fee schedule to incorporate differing levels of service with the appropriate fee charges.

There may be some doctor bias factored into this as well. The old school of thought was that soft toric CLs were difficult to fit, yielded inconsistent vision, and lacked reproducibility in the manufacturing process to the point where no two toric lenses were alike.

# Explore the mechanism of macular hole formation

Case study provides insights on roles VMT, VMA play in MH development

A 56-year-old black female attended to clinic for a 6-month follow-up of macular hole (MH) OD with mild vitreous traction at the macula OS. Aside from the MH and minimal refractive correction, the ocular history is unremarkable. She has been systemically treated for hypertension and diabetes for 20 years. Examination revealed best-corrected visual acuity of 10/400 OD and 20/25 OS. At that time, an OCT baseline was performed. The figures show baseline fundus photographs taken 3 months earlier (See Figure 1).

Considering Figure 1 and looking at the OS, vitreomacular adherence (VMA) is very apparent on OCT. Much of what has been learned about the vitreomacular interface has been the convergence of histologic, clinical, and imaging infor-

## Procedure recommended

At a further follow-up visit approximately 3 months later, a retinal consultation was obtained. At this time, surgery to relieve the vitreomacular traction (VMT) OD was recommended, and the patient accepted.

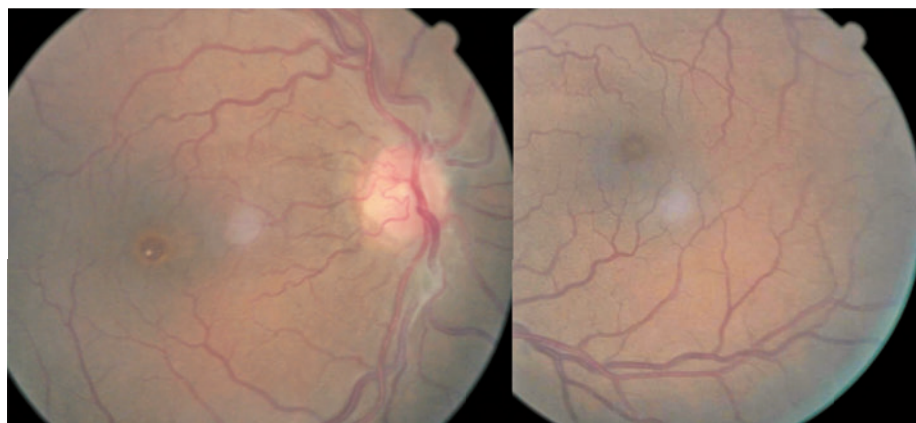
Following vitrectomy and release of VMT, the patient was seen and imaged. In addition to the vitrectomy procedure, a cataract extraction with placement of a posterior-chamber IOL was performed. The post-operative macular image showed the fovea and macula resumed appropriate anatomical contour. Looking closely, the photoreceptor layer is absent, which resulted in no improvement in visual acuity (Figure 4). High-definition scans show this clearly (Figure 5). The obscuration in the upper portion of the reflectance image is the gas bubble placed to facilitate MH closure.



## By Leo Semes, OD, FAAO

Dr. Semes is a professor of optometry at the University of Alabama-Birmingham. He is a founding member of the Optometric Glaucoma Society and a founding fellow of the Optometric Retina Society.

mation. It has been recognized for more than 3 decades that residual VMA following posterior vitreous detachment is the cause of MH formation. Looking at the OCT studies of the patient's OD, this becomes apparent (Figure 2). The OS showed only VMA in the OD on OCT (Figure 3).



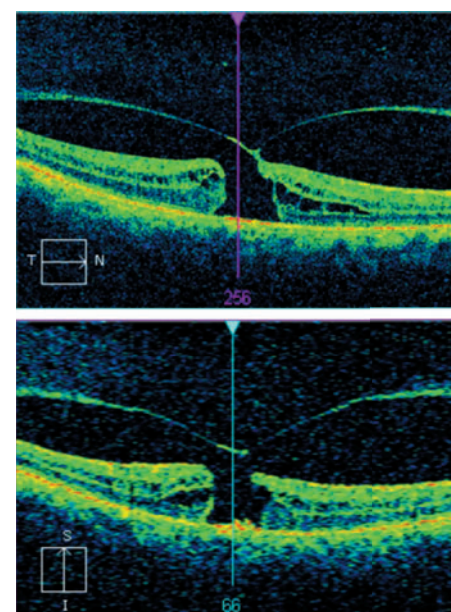
**Figure 1.** Fundus photographs of the OD and OS. While the OD shows a small, well-defined macular hole, the OS gives the appearance of a macular hole, a condition called a macular pseudohole. (Photos courtesy Leo Semes, OD, FAAO)

## Likelihood of developing a macular hole in the fellow eye

The patient's question in such cases is: What is the likelihood of macular hole formation in the currently uninvolved eye? The risk of macular hole formation in such situations is about 3% per year over the next 5 years. This has been termed Stage 0 MH.

When any meridian of the OCT shows traction on both sides of the macula, it supposedly increases risk of MH formation. In the patient's case, it suggests that she deserves close surveillance and awareness of the symptoms of MH formation. Given the outcome of the surgery, this is the most reassuring aspect of this case.

See **Macular hole** on page 12



**Figure 2.** OCT studies of the OD. In the cross-sectional sample images, both the vertical and horizontal sections demonstrate (1) attachment between the hyaloid face of the detached vitreous; (2) cystic spaces within the retina; (3) loss of photoreceptors, and (4) intact retinal pigment epithelium. Note that the vertical section (bottom) shows a region above the macula that is completely free from vitreo-macular traction. The thickened portion of the hyaloid face represents a pseudo-operculum or a small portion of macular tissue which has become atrophic but remains adherent to the hyaloid face of the vitreous. The former is more likely considering the fundus appearance as well as the imaging study results. (Photos courtesy Leo Semes, OD, FAAO)



# YOUR PATIENTS SAY

## Lens care makes a difference

Listen to your patients.  
I did, and I learned a lot.

**A**fter I asked my patients to try OPTI-FREE® PureMoist® Multi-Purpose Disinfecting Solution, I was intrigued by what they said. I was so intrigued that I started writing down what they said.

I first experienced OPTI-FREE® PureMoist® almost 2 years ago during a post-market patient comparison survey sponsored by Alcon. At the initial visit, patients filled out a questionnaire about their experiences with their current contact lens solution. Some patients were using another product manufactured by Alcon, and some patients were using competitors' products. Patients were then given a bottle of OPTI-FREE® PureMoist® and told to use it for the next 2 weeks before answering another questionnaire.



Christopher Stansbury, OD

For the next 6 months, I would consistently dispense OPTI-FREE® PureMoist® to my contact lens patients, instruct them to use it, and inform them that I would be asking about their experiences when they returned for follow-up. I will present the most frequently reported comments from this informal survey along with the science to support the validity of each comment.

**"Now that I have been using OPTI-FREE® PureMoist®, I can wear my contact lenses for an extra hour or two at the end of the day without them drying out or feeling uncomfortable."**

Why is dryness or end-of-day discomfort a big concern for patients? To find out, let us first look at the kind of contact lenses we are prescribing.

The majority of contact lenses prescribed by eyecare practitioners today are silicone hydrogel (SiHy) materials.<sup>1</sup> SiHy contact lenses are renowned for their oxygen transmissibility, but they are inherently difficult to keep wet. The silicone within the matrix of the contact lens is hydrophobic and causes water on an untreated contact lens to bead up like a freshly waxed car. Manufacturers of SiHy contact lenses know that wettability can be a concern, so they use a variety of strategies to make their contact lenses more wettable including:

- Internal wetting agents
- Moisturizing lens packaging solutions
- Tailored hydrophilic side chains (a hydrogel coating that hides the Si ends)
- Plasma surface treatment

These strategies are effective to vary-

ing degrees, and with the exception of plasma treatment, some will dissipate over the life of the lens, resulting in diminished effectiveness.<sup>2,3</sup>

Another important point to consider is how SiHy contact lenses change once they are exposed to the ocular environment. The molecular structure of the contact lenses can actually change throughout a day of wear as the silicone side chains are free to rotate about the polymer main chain. When a patient removes a SiHy contact lens from a solution-filled case, the contact lens surface is mostly hydrophilic because the silicone side chains are buried within the matrix of the contact lens. Once the contact lens is exposed to the ocular environment, however, those side chains can rotate and migrate to the surface. There, they are exposed to air as the tear film breaks up between blinks, and the surface then becomes less wettable. Higher-modulus silicone hydrogel materials are highly cross-linked and thus have very few side chains, so rotation is limited in those materials. More loosely cross-linked materials are prone to rotation and potential wettability concerns.<sup>4</sup>

How does OPTI-FREE® PureMoist® enhance the wettability of SiHy contact lenses? It uses the HydraGlyde® Moisture Matrix (MM). The HydraGlyde MM is a block co-polymer made up of ethylene oxide (EO) and butylene oxide (BO). The EOBO co-polymer is unique in that one end, the ethylene oxide, is highly hydrophilic, while the other end, the butylene oxide, is highly hydrophobic. When a SiHy contact lens is soaked in OPTI-FREE® PureMoist® containing the EOBO co-polymer, the BO ends bind tightly to the silicone side chains, while the EO ends bind to any water in solution. This effectively encapsulates the SiHy contact lens in moisture and prevents the exposure of the hydrophobic ends. This capsule of moisture also acts as a depot of EOBO molecules, which are ready to bind to any newly exposed side chains that rotate and migrate during contact lens wear.

HydraGlyde MM works so well because it has a strong affinity for the hydrophobic regions of SiHy lenses, which effectively anchors the matrix to the contact lens. Once anchored to the contact lens, the HydraGlyde MM presents its hydrophilic EO ends, which keep the lens moist and comfortable from morning to night.<sup>5,6</sup>

**Dr. Stansbury** is part of a four-doctor group in southern West Virginia. He serves as a paid consultant to Alcon.

#### REFERENCES:

1. Campbell R. Clinical benefits of a new multipurpose disinfecting solution in silicone hydrogel and soft contact lens users. *Eye Contact Lens*. 2012 Mar;38(2):93-101.
2. Santos L, Rodrigues D, Lira M, et al. The influence of surface treatment on hydrophobicity, protein adsorption and microbial colonisation of silicone hydrogel contact lenses. *Cont Lens Anterior Eye*. Jul 2007;30(3):183-188.
3. Jacob J, Levett J, Edwards T, et al. Visualizing hydrophobic domains in silicone hydrogel lenses with Sudan IV. *Invest Ophthalmol Vis Sci*. 2012;53(7):3473-3480.
4. Tighe B. Silicone hydrogels: structure, properties and behaviour. In: Sweeney D, ed. *Silicone Hydrogels*. Second ed. Edinburgh: Butterworth Heinemann; 2004:1-27.
5. Davis J, Ketelson H, Shows A, Meadows D. A lens care solution designed for wetting silicone hydrogel materials. *Invest Ophthalmol Vis Sci*. 2010;51.
6. Lally J KH, Borazjani R, et al. A new lens care solution provides moisture and comfort with today's CLs. *Optician*. 2011;241(6296):42-46.

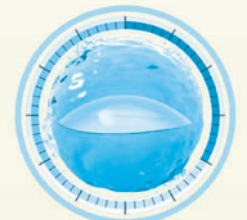
### HOW HydraGlyde® Moisture Matrix WORKS



HydraGlyde Moisture Matrix is an innovative, proprietary reconditioning agent that embeds on and within soft contact lenses for an outstanding lens-wearing experience.<sup>a-c</sup>



The resulting envelope of moisture helps form a unique barrier that reduces lipid deposition and removes protein deposits.<sup>a,b,d,e</sup>



The hydrophilic environment reduces friction, facilitates wetting, and provides moisture from morning till night.<sup>a-c,e,f</sup>

#### IMAGE REFERENCES:

- a. Data on file, Alcon Research Ltd.
- b. Lally J, Ketelson H, Borazjani R, et al. A new lens care solution provides moisture and comfort with today's contact lenses. *Optician*. 2011;241:42-46.
- c. Davis J, Ketelson HA, Shows A, Meadows DL. A lens care solution designed for wetting silicone hydrogel materials. ARVO Meeting Abstracts. 2010;51:3417.
- d. Campbell R, Kame G, Leach N, et al. Clinical benefits of a new multi-purpose disinfecting solution in silicone hydrogel and soft contact lens users. *Eye Contact Lens*. 2012;38(2):93-101.
- e. Senchyna M, Stauffer P, Davis J, et al. Characterization of a multi-purpose lens solution designed for silicone hydrogel materials. ARVO Meeting Abstracts. April. 2010;51:3426.
- f. Huo Y, Perry SS, Rygalov A, et al. Chemical and frictional analysis of silicone hydrogel lens surfaces. ARVO Meeting Abstracts. 2010;51:3422.

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## Macular hole

Continued from page 10

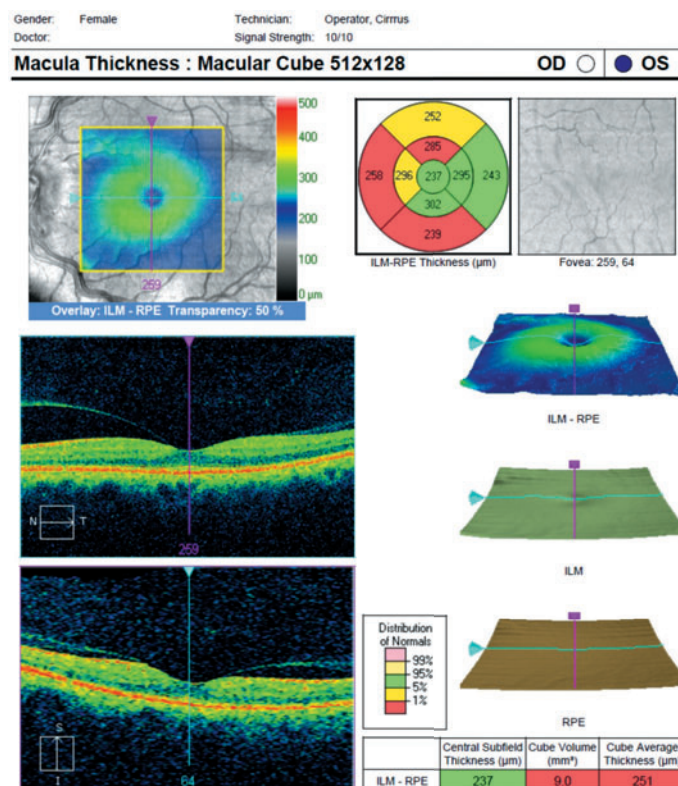
A word about the mechanism of MH formation is in order. Following posterior vitreous detachment, when there is residual adherence by the vitreous at the macula, macular hole is a risk. The pathophysiology is anterior-posterior force. The anterior anchor of the vitreous is the anatomical attachment at the vitreous base. The posterior attachment is the remaining traction at the macula.

With each ocular excursion, the mass of the detached vitreous exerts traction in that anterior-posterior direction. This mechanism is distinct from that of lamellar MH formation where widespread VMT causes concentric enlargement that generally spares the outer retina and allows the patient to maintain relatively good visual acuity.

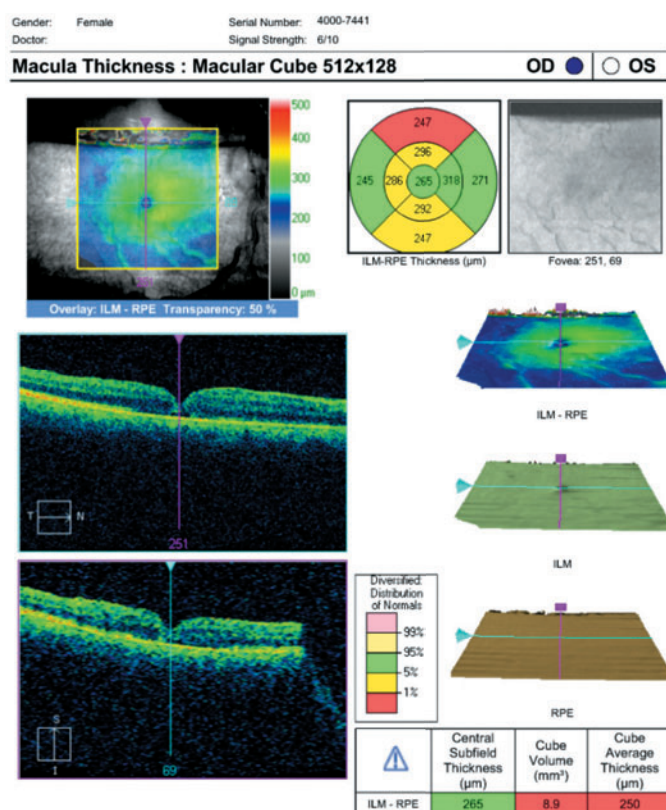
In early-stage macular hole formation, there is only VMT. Later stages involve inner and outer layer tissue damage. Ultimately, full-thickness retinal defect can result, such as occurred in the OD of this case.

The frequency of examination in patients with residual macular traction should be at 6- to 12-week intervals. Some cases will resolve spontaneously, others will maintain VMT without consequences and the small remaining percentage will progress to macular hole.

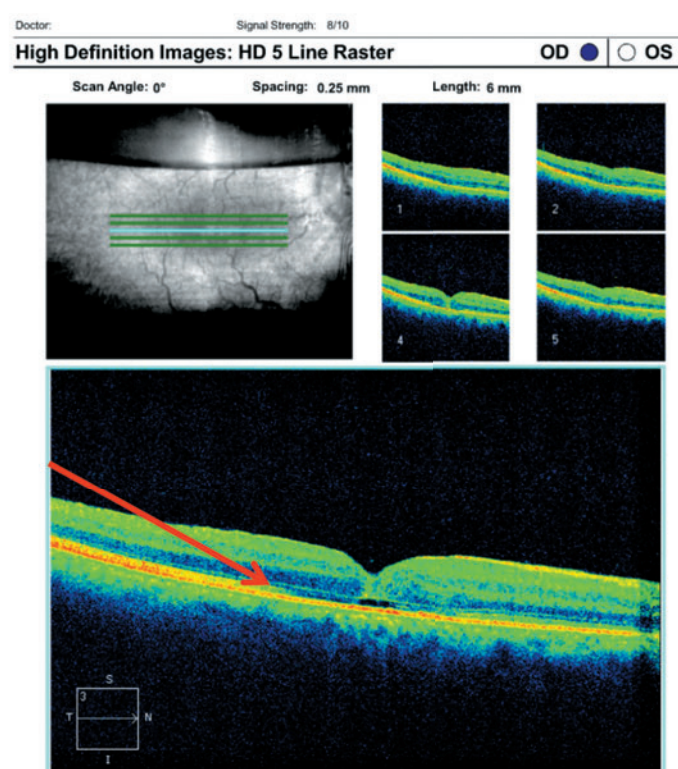
Ocriplasmin (Jetrea, ThromboGenics Inc.) was recently FDA approved for the relief of symptomatic VMT. When tincture of time does not produce spontaneous resolution and the patient shows persistent traction with tissue changes and declining visual acuity, usually worse than 20/40, ocriplasmin may represent an alternative to vitrectomy. **ODT**



**Figure 3.** The OCT cross-sectional images of the OS show normal retinal thickness and minimal vitreoretinal adherence. This is consistent with the fundus image seen in Figure 1. (Photo courtesy Leo Semes, OD, FAAO)



**Figure 4.** The OCT shows relatively normal foveal contour and thickness. (Photo courtesy Leo Semes, OD, FAAO)



**Figure 5.** The high-resolution scans show absence of photoreceptors in the center of the macula. In the bottom image, the red arrow indicates that the obscuration of the superior portion of the reflectance image is due to the gas buckle placed during surgery for closure of the macular hole. The retinal pigment epithelium is intact. (Photo courtesy Leo Semes, OD, FAAO)



# The Benefits and Dangers OF BLUE LIGHT

By Christian Sotty

**T**he blue light region in the visible light spectrum has captured the interest of scientists due its role of in non-visual biological mechanisms such as regulation of the circadian cycle. This part of blue light can have a positive impact on health, and it ranges from 465 to 495 nanometers (nm) (Blue-Turquoise light).<sup>1</sup> However, in the range of 415 to 455 nm (Blue-Violet light), it has been established that light induces a high level of mortality in the retinal pigment epithelium (RPE) cells.<sup>2</sup> Blue light (also known as high energy visible light) ranges from 380 nm to 500 nm. It is emitted by both natural (sun) and artificial light sources, such as LED lighting.

## Synchronizing our biological clock

Light, and in particular “good” blue light, also known as “chronobiological light,” regulates our individual circadian rhythm. We need to reset our biological clocks daily in order to synchronize our biological rhythm. Our clock transmits to a number of parts of the body, such as the liver, muscles, heart, kidneys and other organs. All biological functions need to work at the right moment, and because our biological clock drives this particular rhythm, it ensures particular functions are active at the right time.

“Light acts on the retina through the action of specific cells—melanopsin-containing ganglion cells—which are different from the cones and rods that are the photoreceptors used in vision,” said Claude Gronfier, INSERM (French Institute of Health and Medical Research) chronobiology researcher. “When these ganglion cells are activated by blue light, they transmit a nerve signal that runs along the optic nerve and, rather than activating the visual structures in the brain, activates non-visual structures such as our internal circadian clock. So it’s exposure to light that resets the time on the biological clock.”

## Blue light and AMD

Recently, it has been shown that exposure to light contributes to the early occurrence of age-related macular degeneration (AMD).<sup>3</sup> *In-vitro* experiments on porcine cell cultures point specifically to blue light, which is more energy intensive. Macular pigments are natural filters for these wavelengths. Unfortunately, pigments don’t accumulate well in the retina as we age or when disease starts.

“It’s essential to combine several approaches to help explain the pathophysiological impact of light on the retina and the part played by these effects on retinal conditions,” said Serge Picaud, INSERM director of research at the Paris Vision Institute. “This multidisciplinary aspect was one of the challenges of a recent project in which we tried to determine toxic wavelengths in the visible spectrum. Our main aim was to calculate the relative quantity of light reaching the retina in each wavelength. We measured the toxicity of these relative irradiances using an AMD porcine cell model.

“The work enabled us to define the most phototoxic spectral bands against this cellular model,” he said. “Optics specialists from Essilor took part in the project to help us design optical devices to calculate retinal light irradiances and to manipulate concepts involving light, while researchers from the Paris Vision Institute brought their knowledge of vision and their know-how in experimental biology as applied to the retina. It was important to be able to draw on the results to establish preventive strategies designed to limit the initial development or further progress of visual pathologies.”

## 10-nm illumination bands

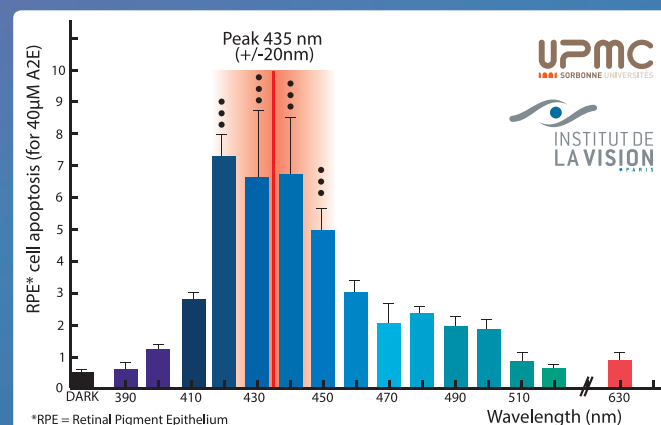
The blue light spectrum is very wide, ranging in broad terms from 380 to 500 nm. It was

important to target the blue wavelengths that were most harmful and control the illumination values used to expose the cells to light.

“We produced an illumination device that allowed us to convey light on very restricted, narrow wavelengths—and we split the visible light spectrum into 10-nanometer bands,” said Emilie Arnault, photobiology project manager in the Translational Systemic and Therapeutic Biology of Vision department at the Paris Vision Institute. “Each band was guided by an optic fiber toward a cell incubator. This allowed us to split the visible light spectrum and precisely control the degree of illumination for each wavelength. We were able to produce intensities of illumination in proportion to those of the solar spectrum for each 10 nm band.”

All of these elements confirm the importance of the research currently conducted to accurately describe the wavelengths of blue light: we need to be able to distinguish good from bad clearly so that we can then develop a sophisticated filtering system to address the harmful effects of one while retaining the positive effects of the other.

## RPE Cell Death per Wavelength<sup>2</sup>



## References

1. Hattar S, Liao HW, Takao M, Berson DM, Yau KW. Melanopsin-containing retinal ganglion cells: architecture, projections, and intrinsic photosensitivity. *Science*. 2002 Feb 8;295(5557):1065-70.
2. Arnault E, Barrau C, Nanteau C, et al. Characterization of the blue light toxicity spectrum on A2E-loaded RPE cells in sunlight normalized conditions. Poster presented at: Association for Research and Vision in Ophthalmology Annual Meeting; 2013 May 5-9; Seattle, WA.
3. Sui GY, Liu GC, Liu GY, Deng Y, et al. Is sunlight exposure a risk factor for age-related macular degeneration? A systemic review and meta-analysis. *Br J Ophthalmol*. 2013 Apr;97(4):389-94.

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# Primary-care optometry in the 21st century

By Michael W. Ohlson, OD, FAAO

**C**omprehensive care of the visual system is and will remain the foundation of our profession. However, as medical knowledge has advanced, so has understanding of the eye and related systemic disease. The definition of “primary care optometry” includes the components visual care, ocular health, and care associated with related systemic disorders.<sup>1</sup>

As primary care providers representing an entry point into the healthcare system, optometrists are responsible for more than the visual needs of their patients. While optometry has increased its scope of practice, ophthalmology has become increasingly sub-specialized.<sup>2</sup> Yet specialization does not relieve a doctor from the duty to ensure that the patient receives appropriate treatment, begging the question: Is optometry an eye profession with some interest in systemic disease, or will time and technology demonstrate optometry to be a primary-care profession with specialized interest in the visual system?

## Symptoms of greater concern

The components of a comprehensive ophthalmic exam demonstrate the systemic nature of modern optometry. Along with the chief complaint and the history of present illness, the review of systems helps the optometrist determine systemic concerns, particularly symptoms relating to eye care. Ocular-related constitutional symptoms may include fever, change in weight, and malaise. Diplopia, ocular pain and redness, subconjunctival hemorrhage, and transient or persistent loss of vision may indicate systemic disorders.

The ears/nose/mouth/throat review might reveal reduced hearing, nasal congestion, dry mouth, mouth sores, or sore throat. Chest pain or reduced exercise tolerance (cardiovascular system) and shortness of breath, cough, or wheezing (respiratory system) relate to optometric care. Snoring could indicate obstructive sleep apnea (OSA), linked to multiple ocular complications including floppy eyelid syndrome and glaucoma.<sup>3</sup>

Gastrointestinal symptoms such as abdominal pain, polyphagia, nausea, vomiting, or bleeding may be important to patient management with oral nonsteroidal anti-inflammatory drugs, oral corticosteroids, or anterior uveitis cases. Relevant genitourinary system conditions include pregnancy, kidney stones, and polyuria. Musculoskeletal complaints



**Scleral show in thyroid eye disease.** (Photo courtesy Ernest L. Bowling, OD)

may include joint pain, back, or neck pain, weakness, and jaw claudication. Important integumentary symptoms include scalp tenderness, lumps/bumps, and rash.

Depression, anxiety, and short-term memory loss (psychiatric) may affect ongoing care or be related to diagnosed glaucoma or vision loss.<sup>4</sup> Seizure, numbness, tingling, headache, hallucination, aura, syncope (neurological), easy bruising, swollen glands or nodes (hematological/lymphatic), polydipsia, heat/cold intolerance (endocrine), hives/itching (allergic) may all prove useful in relating ocular care to systemic care.

Crucial for comprehensive care of optometric patients:<sup>5</sup>

- General observation
- Prescription and herbal medications
- Supplements
- Past history (eye diseases, injuries, surgeries, asthma, chronic obstructive pulmonary disease, hypertension, stroke, migraine, autoimmune disorders, OSA, herpes simplex virus [HSV])
- Family history (eye and related systemic diseases, migraine)
- Social history (driving status, living arrangements, occupation, activities, pets, alcohol, tobacco, and illicit drugs)

Related systemic diseases seen in optometric practices are large in number. Conditions may include diabetes mellitus (DM) and other endocrine disorders such as hyperthyroidism, hypothyroidism, pituitary tumor, hyperparathyroidism, hypoparathyroidism, Cushing's disease, and Addison's disease. Optometrists are specifically cited as important members of teams caring for patients with diabetes.<sup>6</sup> Vascular diseases, such as hypertension, carotid artery disease, coronary artery disease, and vertebral-basilar disease, and blood disorders, such as anemia or sickle cell disease, have ocular manifestations. Immune system disorders, such as Sjögren's syndrome, rheumatoid arthritis (RA), systemic lupus erythematosus

(SLE), giant cell arteritis (GCA) and sarcoidosis, frequently have ocular manifestations.

Further examples of systemic conditions with ocular relevance include cancer—melanoma, basal cell carcinoma, breast or lung cancer metastasis—infectious diseases, such as presumed ocular histoplasmosis syndrome (POHS), Lyme disease, toxoplasmosis, HSV, herpes zoster virus (HZV), epidemic keratoconjunctivitis (EKC), sexually transmitted diseases (STDs), and dermatological conditions such as rosacea, and dermatitis.

Kidney disease may produce ophthalmic findings including band-shaped keratopathy, posterior subcapsular cataract, renal retinopathy, Elschnig's spots, nonrhegmatogenous retinal detachment, and Seigert's streaks.<sup>7</sup> Gastrointestinal disorders such as Crohn's disease and psychiatric disorders are also significant systemic conditions with multiple associations to primary eye care. Neurological conditions such as cardiovascular accident (CVA), traumatic brain injury (TBI), multiple sclerosis (MS), pseudotumor cerebri, tumor, Horner's syndrome, and cranial nerve palsies are familiar to optometrists. Obesity is linked to ocular complications.<sup>8</sup> Sudden illnesses can occur in any optometric office, including fainting, choking (particularly infants), seizure, CVA, diabetic emergencies, anaphylaxis, and acute myocardial infarction.<sup>9</sup>

## Diagnostics and testing

Optometrists routinely order laboratory testing for systemic disease with ocular manifestations (sickle cell disease, GCA, DM, thyroid disorders, etc.). In-office testing for EKC is readily available.<sup>10</sup> Improved technology should allow easy in-office testing for other etiologies of systemic/ocular disease.<sup>11</sup> Genetic testing will increasingly provide optometrists the ability to diagnose and educate patients regarding risks of multiple conditions.<sup>12</sup> Imaging studies ordered by ODs allow for the diagnosis of diseases such as Grave's disease, CVA, and tumor.

See **Systemic Disease** on page 16



Brien Holden Vision Institute is one of the largest and most successful social enterprises in the history of eye care. By applying commercial strategies to vision research and product development the Institute has generated income for research and public health programs that provide quality eye care solutions and sustainable services for the most disadvantaged people in our world.

The concern for the devastating shortfall in eye care education in developing communities, especially for correction of refractive error, became action in 1998 for those at the Institute. The lack of training institutes and educational opportunities was creating a human resource gap and a critical eye care shortage for hundreds of millions of people in need of services. The concern and willingness to address the issue gave rise to the International Centre for Eyecare Education (ICEE).

Almost 15 years later, and acknowledging that 640 million people are still without access to permanent eye care, concern has galvanised

into action again. To advance the process of addressing the challenge, both ICEE and Brien Holden Vision Institute will more closely align, share one common purpose and one name.

Together, we believe if we harness our efforts and broaden our scope we can achieve much more.

Together, we aim to drive, innovate, educate, collaborate, advocate and negotiate what is needed so that hundreds of millions of people worldwide can enjoy the right to sight.

Whether it's research to develop the technology to slow the progress of myopia, investment in new systems for diagnosis of disease, delivery of sustainable access to services or provision of eye care education in the most marginalised and remote communities in the world, the Institute will focus on the quality of vision people experience and equity in eye care access worldwide.

We believe in vision for everyone...everywhere.

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*The Durban community in South Africa arrives in hundreds to support the Brien Holden Vision Institutes initiative Drive for Sight, part of the World Sight Day celebrations in October 2012. All attendees were offered free eye examinations, access to free or affordable low cost spectacles and referrals for further eye care where necessary. Photo by Graeme Wyllie.*



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## Systemic Disease

Continued from page 14

Oral pharmaceuticals used for systemic treatment often produce adverse ocular effects. Tamoxifen, hydroxychloroquine, amiodarone, bisphosphonates, cetirizine, retinoids, and topiramate are well known to eyecare providers (ECPs). Oral fluoroquinolones have recently been considered to increase the risk of retinal detachment.<sup>13</sup> In addition, ODs write prescriptions for oral pharmaceuticals, including antibiotics, antivirals, steroids, and opiate analgesics in multiple jurisdictions. This privilege necessitates a thorough and ongoing understanding of pharmacology and organ systems.

Nutrition research is an ongoing concern for ECPs. While generally safe, adverse effects from the supplements used in the Age-Related Eye Disease Study include urinary tract problems. There are additional concerns regarding possible risks of prostate cancer and lung cancer.<sup>14</sup> Illicit drug use is also responsible for multiple adverse ocular events.<sup>15</sup>

As experts in care of the visual system, optometrists frequently encounter and manage disorders of the central nervous system (CNS) or their manifestations, including MS, cranial nerve palsies, TBI, pupil anomalies, CVA, Parkinson's disease, Alzheimer's disease, and more.

### Anterior, posterior segments

The examination of the posterior segment often reveals conditions relevant to systemic care. Congenital hypertrophy of the retinal pigment epithelium is associated with familial colorectal cancer.<sup>16</sup> Age-related macular degeneration (AMD) may be associated with increased risk of CVA as well as depression.<sup>17</sup> Infectious diseases, including toxoplasmosis, toxocariasis, and POHS, are posterior segment diagnoses of systemic relevance.<sup>18</sup> Retinopathy may indicate diminished cognitive ability and vascular changes in the brain.<sup>19</sup>

The anterior segment also provides opportunities for the OD to diagnose, suspect, or manage related systemic disease. The tear film, lids, and lacrimal system are frequently

affected by dermatological, endocrine, infectious, or autoimmune disorders.<sup>20</sup> Corneal disorders may be associated with collagen vascular disease, Wilson's disease, Fabry disease, obvious infection (HSV, HZV), and many others.<sup>21,22</sup> Uveitis is a relatively common condition with multiple systemic etiologies.<sup>23</sup> Crystalline lens abnormalities may be associated with effects of medications, DM, tobacco, or ultraviolet radiation (UVR).<sup>24</sup>

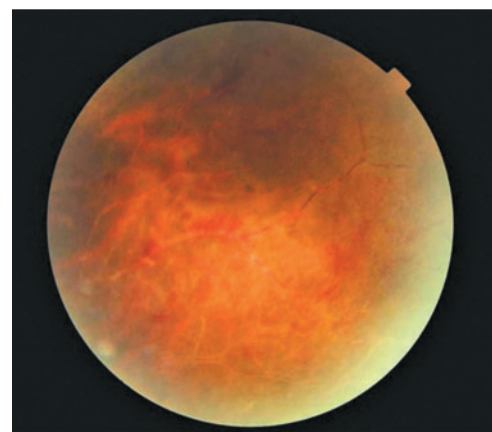
Because optometrists co-manage or perform surgical procedures, expertise of related systemic diseases is required. Knowledge of pharmacology, adverse effects of medications, and potential operative and post-operative complications can be crucial to outcomes. Immunodeficient, autoimmune disease, and pregnant patients may be poor refractive surgery candidates.<sup>25</sup> Alpha-1 blockers used for treatment of benign prostatic hyperplasia are linked to intraoperative floppy iris syndrome.<sup>26</sup> Intravitreal injections of vascular endothelial growth factor inhibitors for the treatment of AMD have been linked to non-fatal myocardial infarction, CVA, and vascular death.<sup>27</sup>

Optometrists manage glaucoma at some level in 49 United States jurisdictions. Interestingly, primary open-angle glaucoma may represent a neurological disease rather than an ocular disease.<sup>28</sup> In addition, pseudoexfoliation and pseudoexfoliation glaucoma are ocular manifestations of a systemic condition.<sup>29</sup> The medications used to manage glaucoma have significant systemic adverse effects.<sup>30</sup> Examination of the patient's fingers may reveal ulnar deviation and joint swelling, limiting the ability to instill drops, or nail bed hemorrhages linked to disc hemorrhage and glaucoma.<sup>31</sup> The diagnosis of glaucoma has been linked to a broad range of patient comorbidities, emotions, and concerns.<sup>32</sup>

### Specialized patient populations

As primary care providers, optometrists often deliver care to specific patient populations—nursing homes, residential care facilities, assisted living facilities, prisons, Veterans Administration, the Indian Health Service, vision care missions, and many more communities. In addition, public health aspects may include environmental optometry, occupational vision, and infection control, all with systemic ramifications. Ultraviolet radiation has been linked to skin and eye cancers.<sup>33</sup> Computer vision syndrome includes associated symptoms such as headache, pain in the back, neck, shoulders, arms, or wrists, tension, fatigue, irritability, nervousness, and drowsiness.<sup>34</sup>

ODs involved primarily with refractive or visual system care are responsible for significant related systemic care. Sports vision, in-



**Retinal vasculitis secondary to systemic lupus.**

(Photo courtesy Ernest L. Bowling, OD)

cluding specialty contact lenses to enhance athletic performance and concussion testing, is essentially systemic in nature.<sup>35</sup> Contact lenses have also been shown to have a positive effect of vision-related quality of life in pediatric patients.<sup>36</sup> Keratoconus has been associated with atopy, connective tissue disorders, and genetics.<sup>37</sup> Pediatric care offers many challenges, including an understanding of human development and congenital disease.<sup>38</sup> While relatively uncommon in pediatric care, the ocular/systemic conditions associated with childhood may be very serious, including retinoblastoma and juvenile rheumatoid arthritis. Early signs of adverse changes to the retinal microvascular structure have been documented in sedentary 6-year-olds.<sup>39</sup> ECPs are mandatory reporters and have been urged to be vigilant for signs of abuse.<sup>40</sup> InfantSEE, a volunteer optometric program, brings infants to the primary care office setting, allowing for early diagnosis of potentially serious disorders.<sup>41</sup>

Vision rehabilitation and neuro-optometric rehabilitation involve multiple systemic aspects including orientation, mobility, and perception.<sup>42</sup> While currently lacking a large amount of supporting literature, behavioral optometry also appears to positively affect optometric patients in complex situations beyond refractive or ocular care.<sup>43</sup> In addition, many low vision patients have diseases with multiple systemic complications requiring understanding. Unusual refractive changes may signal diabetes<sup>44</sup> (hyperopic or myopic) or be related to autoimmune disease (often myopic).<sup>45</sup> Special populations (Down's syndrome, cerebral palsy, autism spectrum disorder, TBI, attention deficit hyperactivity disorder, etc.) often have complicated ocular and systemic histories and needs.

Geriatric care presents multiple conditions for optometrists including vision loss, associated depression, elder abuse, and systemic diseases

See **Systemic Disease** on page 19

## Instrumentation needs

Existing office instrumentation often aids in the diagnosis of related systemic conditions.

- Sphygmomanometry
- Perimetry
- Color vision testing
- Optical coherence tomography
- Visual evoked potential



For the reduction of IOP in patients with POAG or OHTN

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- Effective at lowering IOP throughout the day and over the long term<sup>1-3</sup>
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- Established ocular side effects profile: In clinical trials comparing RESCULA and timolol\*, both were generally well tolerated regarding ocular adverse events, with similar incidence of hyperemia and similar changes to eyelash length and density<sup>1,4,5</sup>
  - The only events seen significantly more often with RESCULA than with timolol were burning and stinging and burning/stinging upon instillation; these events were generally mild and transient<sup>2,4</sup>
- No labeled drug-drug interactions<sup>1,4</sup>

### **Indication**

RESCULA (unoprostone isopropyl ophthalmic solution) 0.15% is indicated for the lowering of intraocular pressure in patients with open-angle glaucoma or ocular hypertension.

### **Important Safety Information**

RESCULA is contraindicated in patients with hypersensitivity to unoprostone isopropyl or any other ingredient in this product.

RESCULA has been reported to increase pigmentation of the iris, periorbital tissues, and eyelashes. Patients should be advised about the potential for increased brown iris pigmentation which is likely to be permanent.

RESCULA should be used with caution in patients with active intraocular inflammation (e.g., uveitis) because the inflammation may be exacerbated.

Macular edema, including cystoid macular edema, has been reported. RESCULA should be used with caution in aphakic patients, in pseudophakic patients with a torn posterior lens capsule, or in patients with known risk factors for macular edema.

\*In pooled safety analyses of pivotal trials comparing RESCULA with timolol maleate 0.5%.<sup>4</sup>

**Please see Brief Summary on reverse and full Prescribing Information, available from your Sucampo representative.**



## **Brief Summary of Prescribing Information for RESCULA.**

### **INDICATIONS AND USAGE**

Rescula (unoprostone isopropyl ophthalmic solution) 0.15% is indicated for the lowering of intraocular pressure in patients with open-angle glaucoma or ocular hypertension.

### **DOSAGE AND ADMINISTRATION**

The recommended dosage is one drop in the affected eye(s) twice daily.

Rescula may be used concomitantly with other topical ophthalmic drug products to lower intraocular pressure. If two drugs are used, they should be administered at least five (5) minutes apart.

### **CONTRAINDICATIONS**

Rescula is contraindicated in patients with hypersensitivity to unoprostone isopropyl or any other ingredient in this product.

### **WARNINGS AND PRECAUTIONS**

#### **Iris Pigmentation**

Unoprostone isopropyl ophthalmic solution may gradually increase the pigmentation of the iris. The pigmentation change is believed to be due to increased melanin content in the melanocytes rather than to an increase in the number of melanocytes. The long term effects of increased pigmentation are not known. Iris color changes seen with administration of unoprostone isopropyl ophthalmic solution may not be noticeable for several months to years. Typically, the brown pigmentation around the pupil spreads concentrically towards the periphery of the iris and the entire iris or parts of the iris become more brownish. Neither nevi nor freckles of the iris appear to be affected by treatment. Treatment with Rescula solution can be continued in patients who develop noticeably increased iris pigmentation. Patients who receive treatment with Rescula should be informed of the possibility of increased pigmentation.

#### **Lid Pigmentation**

Unoprostone isopropyl has been reported to cause pigment changes (darkening) to periorbital pigmented tissues and eyelashes. The pigmentation is expected to increase as long as unoprostone isopropyl is administered, but has been reported to be reversible upon discontinuation of unoprostone isopropyl ophthalmic solution in most patients.

#### **Intraocular Inflammation**

Rescula should be used with caution in patients with active intraocular inflammation (e.g., uveitis) because the inflammation may be exacerbated.

#### **Macular Edema**

Macular edema, including cystoid macular edema, has been reported. Rescula should be used with caution in aphakic patients, in pseudophakic patients with a torn posterior lens capsule, or in patients with known risk factors for macular edema.

#### **Contamination of Tip and Solution**

To minimize contaminating the dropper tip and solution, care should be taken not to touch the eyelids or surrounding areas with the dropper tip of the bottle. Keep bottle tightly closed when not in use. There have been reports of bacterial keratitis associated with the use of multiple-dose containers of topical ophthalmic products.

#### **Use with Contact Lenses**

Rescula contains benzalkonium chloride, which may be absorbed by soft contact lenses. Contact lenses should be removed prior to application of solution and may be reinserted 15 minutes following its administration.

### **ADVERSE REACTIONS**

#### **Clinical Studies Experience**

Because clinical studies are conducted under widely varying conditions, adverse reaction rates observed in the clinical studies of a drug cannot be directly compared to rates in the clinical studies of another drug and may not reflect the rates observed in practice.

In clinical studies, the most common ocular adverse reactions with use of Rescula were burning/stinging, burning/stinging upon drug instillation, dry eyes, itching, increased length of eyelashes, and injection. These were reported in approximately 10–25% of patients. Approximately 10–14% of patients were observed to have an increase in the length of eyelashes ( $\geq 1$  mm) at 12 months, while 7% of patients were observed to have a decrease in the length of eyelashes.

Ocular adverse reactions occurring in approximately 5–10% of patients were abnormal vision, eyelid disorder, foreign body sensation, and lacrimation disorder.

Ocular adverse reactions occurring in approximately 1–5% of patients were blepharitis, cataract, conjunctivitis, corneal lesion, discharge from the eye, eye hemorrhage, eye pain, keratitis, irritation, photophobia, and vitreous disorder.

The most frequently reported nonocular adverse reaction associated with the use of Rescula in the clinical trials was flu-like syndrome that was observed in approximately 6% of patients. Nonocular adverse reactions reported in the 1–5% of patients were accidental injury, allergic reaction, back pain, bronchitis, increased cough, diabetes mellitus, dizziness, headache, hypertension, insomnia, pharyngitis, pain, rhinitis, and sinusitis.

#### **Postmarketing Experience**

The following adverse reactions have been identified during post-approval use of Rescula. Because these reactions are reported voluntarily from a population of uncertain size, it is not always possible to reliably estimate their frequency or establish causal relationship to drug exposure.

Voluntary reports of adverse reactions occurring with the use of Rescula include corneal erosion.

There have been rare spontaneous reports with a different formulation of unoprostone isopropyl (0.12%) of chemosis, dry mouth, nausea, vomiting and palpitations.

### **USE IN SPECIFIC POPULATIONS**

**Pregnancy Category C** - There are no adequate and well-controlled studies in pregnant women. Because animal studies are not always predictive of human response, RESCULA should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**Pediatric Use** - the safety and efficacy of RESCULA in pediatric patients have not been established.

It is not known whether RESCULA is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when RESCULA is administered to a nursing woman.

No overall differences in safety or effectiveness of RESCULA have been observed between elderly and other adult populations.

### **CLINICAL PHARMACOLOGY**

#### **Mechanism of Action**

Rescula is believed to reduce elevated intraocular pressure (IOP) by increasing the outflow of aqueous humor through the trabecular meshwork. Unoprostone isopropyl (UI) may have a local effect on BK (Big Potassium) channels and CIC-2 chloride channels, but the exact mechanism is unknown at this time.

#### **STORAGE AND HANDLING**

Store between 2°–25°C (36°–77°F).

**For more detailed information please read the Prescribing Information.**

#### **Marketed by:**

Sucampo Pharma Americas, LLC  
Bethesda, MD 20814

Revised 01/2013

**References:** 1. RESCULA [package insert]. Bethesda, MD: Sucampo Pharmaceuticals, Inc; 2012. 2. Data on file. CSR C97-UIOS-004. Sucampo Pharmaceuticals, Inc. 3. Data on file. CSR C97-UIOS-005. Sucampo Pharmaceuticals, Inc. 4. Data on file. Integrated summary of clinical safety. Sucampo Pharmaceuticals, Inc. 5. McCarey BE, Kapik BM, Kane FE; Unoprostone Monotherapy Study Group. Low incidence of iris pigmentation and eyelash changes in 2 randomized clinical trials with unoprostone isopropyl 0.15%. *Ophthalmology*. 2004;111(8):1480-1488.







## Systemic Disease

Continued from page 16

associated with aging.<sup>46</sup> Lee found significant numbers of geriatric patients with depression, functional disabilities, and possible dementia via screening techniques in an eye clinic.<sup>47</sup> One recent study demonstrated reduced falls in unfamiliar outdoor locations with single-vision lenses as compared to multifocal lenses.<sup>48</sup> Neurological conditions are linked to visual complaints. Parkinson's disease may result in ocular tremor or convergence insufficiency.<sup>49</sup> Alzheimer's disease may be associated with varied visual symptoms or the lack of proper eye care and visual correction.<sup>50</sup>

While the basis of optometry remains optimizing and maintaining patients' vision, the importance of viewing the profession as part of the realm of primary health care is increasingly clear. This evolution of optometry not only allows comprehensive eye care for our patients, but also requires our ongoing dedication and commitment to professional development. **ODT**

### REFERENCES

- Hopkins D. Primary care optometry: are we all on the "same page"? *Optom Vis Sci* 2006;83:1-2.
- Lee PP, Relles DA, Jackson CA. Subspecialty distributions of ophthalmologists in the workforce. *Arch Ophthalmol* 1998;116:917-920.
- Waller EA, Bendel RE, Kaplan J. Sleep disorders and the eye. *Mayo Clin Proc* 2008;83:1251-1261.
- Popescu ML, Boisjoly H, et al. Explaining the relationship between three eye diseases and depressive symptoms in older adults. *Invest Ophthalmol Vis Sci* 2012;53:2308-13.
- Fraunfelder FW. Ocular side effects from herbal medicines and nutritional supplements. *Am J Ophthalmol* 2004;138:639-647.
- National Diabetes Education Program. Redesigning the Health Care Team: Diabetes Prevention and Lifelong Management. Available at: <http://www.ndep.nih.gov/media/TeamCare.pdf>. Accessed August 31, 2012.
- Muchnick B. *Clinical Medicine in Optometric Practice*. St. Louis, Mosby;2008:98-99,236.
- Bohlman H. Communicating the ocular and systemic complications of obesity to patients. *Optometry* 2005;76:701-712.
- Heinberger MH, Madonna RJ, Nehmad L. *Emergency Care in the Optometric Setting*. New York, McGraw-Hill;2004:27-49.
- Kaufman HE. Adenovirus advances: new diagnostic and therapeutic options. *Curr Opin Ophthalmol* 2011;22:290-293.
- Leyden MR, Messinger RJ, Schuman C, Sharf T, Remcho VT, Squires TM et al. Increasing the detection speed of an all-electronic real-time biosensor. *Lab Chip* 2012;12:954-959.
- Stone EM. Genetic testing for inherited eye disease. *Arch Ophthalmol* 2007;125:205-212.
- Etmann M, Forooghian F, Brophy JM, Bird ST, Maberly D. Oral fluoroquinolones and the risk of retinal detachment. *JAMA* 2012;307:1414-1419.
- The Alpha-Tocopherol, Beta Carotene Cancer Prevention Study Group. The effect of vitamin E and beta carotene on the incidence of lung cancer and other cancers in male smokers. *N Engl J Med* 1994;330:1029-1035.
- French DD, Margo CE, Harman LE. Substance use disorder and the risk of open-angle glaucoma. *J Glaucoma* 2011;20:452-457.
- Chen CS, Phillips KD, Grist S, et al. Congenital hypertrophy of the retinal pigment epithelium (CHRPE) in familial colorectal cancer. *Fam Cancer* 2006;5:397-404.
- Ikram MK, Mitchell P, Klein R, et al. Age-related macular degeneration and long-term risk of stroke subtypes. *Stroke* 2012 Jun;43(6):1681.
- McLeod R, Boyer KM, Lee D, Mui E, Wroblewski K, Karrison T et al. Prematurity and severity are associated with toxoplasma gondii alleles (NCCCTS, 1981-2009). *Clin Infect Dis* 2012 Jun;54(11):1595-605.
- Haan M, Espeland MA, Klein BE, Casanova R, Gaussoin SA, Jackson RD et al. Cognitive function and retinal ischemic brain changes: The Women's Health Initiative. *Neurology* 2012;78:942-949.
- Karns K, Herr AE. Human tear protein analysis enabled by an alkaline microfluidic homogeneous immunoassay. *Anal Chem* 2011;83:8115-8122.
- Garmizo G, Fraens BJ. Corneal copper deposition secondary to oral contraceptives. *Optom Vis Sci* 2008;85:E802-807.
- Samily N. Ocular features of Fabry disease: diagnosis of a treatable life-threatening disorder. *Surv Ophthalmol* 2008;53:416-423.
- American Optometric Association. Optometric Clinical Practice Guideline. Care of the Patient with Anterior Uveitis. Revised 2004.
- Roberts JE. Ultraviolet radiation as a risk factor for cataract and macular degeneration. *Eye Contact Lens* 2011;37:246-249.
- Barbazzetto IA, Pizzarello LD. Ocular changes during pregnancy. *Compr Ophthalmol Update* 2007;8:155-167.
- Chatziralli IP, Sergentanis TN. Risk factors for intraoperative floppy iris syndrome: a meta-analysis. *Ophthalmol* 2011;188:730-735.
- Stewart MW. The expanding role of vascular endothelial growth factor inhibitors in ophthalmology. *Mayo Clin Proc* 2012;87:77-88.
- Chang EE, Goldberg JL. Glaucoma 2.0: neuroprotection, neuroregeneration, neuroenhancement. *Ophthalmology* 2012;119:979-986.
- Praveen MR, Shah SK, Vasavada AR, et al. Pseudoexfoliation as a risk factor for peripheral vascular disease: a case-controlled study. *Eye (Lond.)* 2011;25:174-179.
- Detry-Morel M. Side effects of glaucoma medications. *Bull Soc belge Ophthalmol* 2006;299:27-40.
- Park HY, Park SH, Oh YS, Park CK. Nail bed hemorrhage: a clinical marker of optic disc hemorrhage in patients with glaucoma. *Arch Ophthalmol* 2011;129:1299-1304.
- Wu PX, Guo WY, Xia HO, Lu HJ, Xi SX. Patients' experience of living with glaucoma: a phenomenological study. *J Adv Nurs* 2011;67:800-810.
- Gallagher RP, Lee TK, Bajdik CD, Borugian M. Ultraviolet radiation. *Chronic Dis Can* 2010;29 Suppl 1:51-68.
- Sheedy JE, Shaw-McMinn PG. *Diagnosing and Treating Computer-Related Vision Problems*. Burlington, MA, Butterworth Heinemann;2003:40-43.
- Erickson GB, Horn FC, Barney T, Pexton B, Baird RY. Visual performance with sport-tinted contact lenses in natural sunlight. *Optom Vis Sci* 2009;86:509-516.
- Rah MJ, Walline JJ, Jones-Jordan LA, et al. Vision-specific quality of life of pediatric contact lens wearers. *Optom Vis Sci* 2010;87:560-566.
- Bennett ES, Barr JT, Szczotka Flynn L. Keratoconus. In: Bennett ES, Henry VA, ed. *Clinical Manual of Contact Lenses*. Philadelphia, Lippincott Williams & Wilkins;2009:468-470.
- Bremont-Gignac D, Copin H, Lapillonne A, Milazzo S. Visual development in infants: physiological and pathological mechanisms. *Curr Opin Ophthalmol* 2011;22:Suppl:S1-8.
- Gopinath B, Baur LA, Wang JJ, et al. Influence of physical activity and screen time on the retinal microvasculature in young children. *Arterioscler Thromb Vasc Biol* 2011;31:1233-1239.
- Moore DB, Herlihy EP, Weiss AH. Chronic keratoconjunctivitis with dermatitis as a presenting sign of child abuse. *J AAPOS* 2012;16:193-195.
- InfantSEE. Available at: <http://www.infantsee.org/>. Accessed September 1, 2012.
- Hayes A, Chen CS, Clarke G, Thompson A. Functional improvements following the use of the NVT Vision Rehabilitation program for patients with hemianopia following stroke. *NeuroRehabilitation* 2012;31:1-12.
- Barrett BT. A critical evaluation of the evidence supporting the practice of behavioural vision therapy. *Ophthalmol Physiol Opt* 2009;29:4-25.
- Giusti C. Transient hyperopic refractive changes in newly diagnosed juvenile diabetes. *Swiss Med Wkly* 2003;133:200-205.
- Arellanes-Garcia L, Preciado-Delgadillo M, Garza-Leon M. Refractive changes in patients with autoimmune scleritis. *J Ophthalmol Inflamm Infect* 2011;1:173-175.
- Schmitt EP, Castillo RE. Primary Vision Care in Geriatrics: An Overview. In: Rosenbloom AA, ed. *Rosenbloom & Morgan's Vision and Aging*. St. Louis, Butterworth Heinemann;2007:1-30.
- Lee AG, Beaver HA, Jogerst G, Daly JM. Screening elderly patients in an outpatient ophthalmology clinic for dementia, depression, and functional impairment. *Ophthalmology* 2003;110:651-657.
- Haran MJ, Cameron ID, Ivers RQ, et al. Effect on falls of providing single lens distance vision glasses to multifocal glasses wearers: VISIBLE randomized controlled trial. *BMJ* 2010 May 25;340:c2265.
- Almer Z, Klein KS, Marsh L, Gerstenhaber M, Repka MX. Ocular motor and sensory function in Parkinson's disease. *Ophthalmology* 2012;119:178-182.
- Pelak VS. Ocular motility of aging and dementia. *Curr Neurol Neurosci Rep* 2010;10:440-447.

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## POINT

# You need a practice Web site

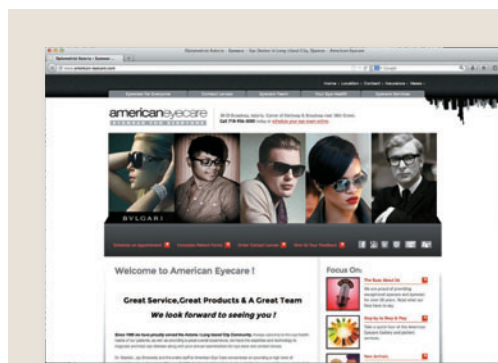
It's the first place a prospective or existing patient will go for information

By Jason Daniels

As Facebook continues to soar past one billion users and expand its geographic reach, practice owners might consider pulling the plug on their Web sites in favor of having Facebook as their sole representation in the digital space.

However, contrary to some other opinions and Facebook's volume of usage, pulling the plug on your Web site would be a grave marketing mistake. There are various facets to what exactly a Facebook page is and how it should function for a practice, but as we will see, a Facebook page cannot be the be-all and end-all—yet.

Take a gander at the Web sites of some of the largest companies in the world. Be sure to stop by the sites of top-tier brands such as Coca-Cola, Apple, and Nike. The first thing you'll notice is that they all have Web sites, and not just any Web site. These leading international businesses use the most advanced forms of programming which encompass the sharpest resolutions, most vibrant colors, and movement—all have created a pristine user experience. Meanwhile, all of these companies will make it as simple as can be to access the company's Facebook page directly from their Web sites—except for Apple, because Apple doesn't have a way to access its Facebook page from its Web site because it doesn't have a corporate Facebook page that is regularly updated. This reality showcases the Web site/Facebook duality. The world's most successful businesses, with the most recognizable brands which, by the way, employ the most innovative and effective marketing teams on Earth, clearly are subscribers to the dual Web site/Facebook presence (aside from Apple). The reason for this is because a Web site and a Facebook page seek to solve two different problems and accomplish entirely different goals.



**WEB SITE** Examples of practice Web sites Daniels has worked on at EyeCare Pro. Shutting down your Web site would be like hiding the identity and presence of your practice from the sight of thousands of pairs of eyes, he says.



## Take-Home Message

Have a social media presence, but be sure to keep your Web site updated. It's the first place an interested customer or searching patient will go for information about products and services.

A Web site is the first place an interested customer or a searching patient will go to experience the desired product or service. Very few Web sites look alike, or at least Web sites shouldn't look alike because a Web site is the most versatile way for a practice or business to express its look and feel into the virtual arena. You will not see Coca-Cola look like it does on its Web site anywhere else on the Internet, certainly not on Facebook. The way a Web site looks should be what a business or product looks in its essential form—the business's smiles, colors,

its people, its movement, its edges, and its lines. No other medium gives a business or product this degree of expressiveness. That's exactly why the Web site maintains a quintessential role in forming the customer's perception of you and what you provide—the Web site grants the visitor a broad view which allows for a business review that cannot be obtained from any other online source.

The Facebook page is a place where a customer or prospective customer can perceive inflections of the company's or product's personality but cannot perceive or define the business or product itself. The Facebook page is auxiliary to the Web site. Inflections are those traits that might help determine the quality of a business or the immediacy of action a customer may take. This is readily apparent as, outside of the content, all

See **Social media** on page 22



## COUNTERPOINT

# So long Web site, hello social media

Social media gives my business a true persona to interact with patients and other businesses

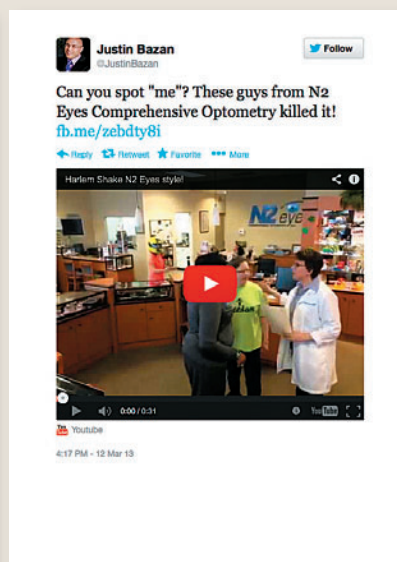
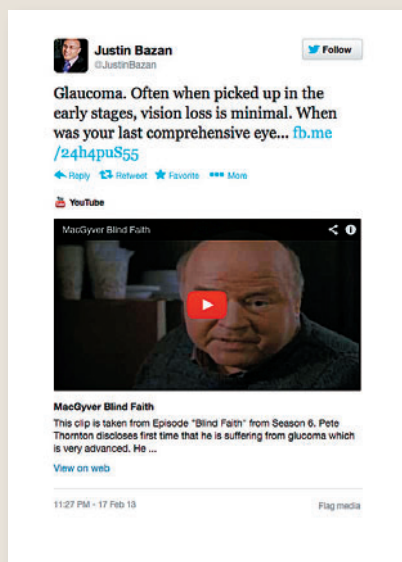
By Justin Bazan, OD

**B**ecause we do business in a digital age, it's clear that having a presence online is essential. More than 2 years ago, I eliminated my traditional Web site from this equation. Without having to address the inherent problems surrounding legacy Web site design, I was able to create a highly effective online presence using the free tools of social media (SM). For me to have an impactful Web site, I would have had to continue spending thousands of dollars on the design, hundreds more to keep it running, and even more money on search engine optimization (SEO). It just seemed unnecessary when there were so many new, free, easy-to-use online tools that did things better than my Web site.

Facebook (FB), YouTube (YT), blogs, and user review sites were doing things that even the best Web sites still struggle to do: attract and engage people. So long Web site, hello SM. Since focusing my efforts on SM, the results have been outstanding, and I have not had one inquiry about where my Web site went. (Keep in mind, it was a pretty cool Web site!) My Web site never changed the way I practiced, but social media has for sure.

## Revelation, revolution

SM is the single biggest shift in the communications paradigm that we have seen in our lifetime. For the first time in the history of communications, we see a platform that allows many people to communicate with many other people all at the same time. Think about it. Your Web site was a one-to-many type of design. You put up info, many people saw it, and a dialogue was nearly impossible. Now think about your FB page. You put up info, many people see it, but now many people comment, like it, or share it. Right away, with just that one feature FB has evolved the Internet beyond where any Web site had previously taken it.



**SOCIAL MEDIA**  
Dr. Bazan comments frequently on his Facebook page and Twitter feed throughout the day. He also includes images, funny anecdotes, and personal comments.

## Take-Home Message

Social media is a communication paradigm shift. It allows dialogue where a traditional Web site does not. Social media tools have completely reinvented the way businesses are represented online.

There is no turning back. SM is a better way of online communication. Why? Because engagement allows you to attract new fans and retain current fans with unprecedented results. Seriously think about the following scenario. Let's say that your eye doctor has a top-notch Web site and an impressive FB page. How often do you really think you'll visit the practice Web site? Probably only when you need some info. Now, how about if you saw engaging posts from your eye doc pop up frequently in your FB newsfeed? Chances are you might engage a few, but even if you don't, your eye doc still got into your mind. SM clearly trumps a traditional Web site in this scenario.

One of the biggest advantages is how important and powerful SM is when it comes to getting found online. Before SM sites, you had to have a Web site to be found. It was your online shingle. It was your online spot as where you could advertise, much

like the way you had to do offline with traditional media, such as the Yellow Pages. You often times had to pay for SEO in order to rank high in the search results. When a Web site was all we had, it certainly was great. Now that we have better, we can do better. There is nothing a Web designer can do that you cannot find being done more effectively—and for free—via one of the many SM platforms. Search engines love content that is keyword rich, fresh, and of high value. SM is the king of this content, so it's no wonder why I have seen my social media sites rise to the top of the search heap. Sure, my Web site used to rank up there but it has not been missed because my SM sites occupy many of those top spots now. And I didn't have to continually pay anyone for SEO!

## Image is everything

We must also realize SM tools, such as FB, have completely reinvented the way our businesses are represented online. Web sites are simply limited in their ability to give our business a persona. Sure, you can create one to represent the look and feel of your brand, but it's merely cosmetic. A professional Web site is the glamour shot. It's you after

See **Social media** on page 23

## Web site

Continued from page 20

Facebook pages look identical in structure and presentation—in its form and layout, a given business page or personal page is largely identical to every other business and personal page out there. If Facebook were to allow users to customize the elements of their pages, such as layout, color scheme, or number of pages, it would essentially become Google. Instead of having a Web site on Google, we would have a Web site on Facebook. Facebook would become a place that people could go to see the differences in what companies have to offer; it would be a place where people would come to find and to see what businesses out there can meet their needs.

As we see, Facebook is not Google. What people look for on Google is the nature of a business, the soul of a business, while Facebook provides a different service, one where we come to know some of that company's nuance and flavor. This helps us understand why Apple doesn't have an active Facebook

*'A Web site maintains  
a quintessential role in  
forming an impression.'*

Jason Daniels

page. Apple's voice and Apple's soul come through so clearly on its Web site. When you couple this with the unprecedented brand allegiance Apple has inspired, there is absolutely nothing it needs to supplement, solve or create with a Facebook page. Everything Apple's brand stands for is known by its customer base and is readily apparent to a prospective customer by exploring its Web site. Until Facebook becomes Google, Apple has no need for Facebook.

For companies that don't have Apple's level of brand loyalty, Facebook is a way to level the playing field, tip the scales in your favor over your competitor. Maybe it's some type of community-based campaign, cute pictures of your youngest patients, or

your upcoming trunk show—whatever. Your presence on Facebook could be a powerful tool in influencing a prospective patient or customer to act now rather than later or with the practice down the street. The facts remain, although Facebook can be our ally, who we are and what we provide is in large part disclosed by what our Web site says about us. Until Facebook can become a medium that showcases the voice and soul of a business like a Web site can, shutting down your Web site would be like hiding the identity and presence of your practice from the sight of thousands of pairs of eyes. **ODT**

### Author Info



Jason Daniels has been director of sales at EyeCarePro for the past 5 years. His focus has been identifying how the Internet serves the optometry practice, then developing solutions so that practices can benefit most efficiently. E-mail him at [jason@eyecarepro.net](mailto:jason@eyecarepro.net).



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## Social media

Continued from page 21

plastic surgery, wearing designer clothes, standing next to a rented Lamborghini in a photo shoot. Sure, it's your "best you," but it's not the "real" you. The real you is who we would catch in jeans and a T-shirt on Wednesday afternoon on your way to pick up the kids. For a small independent practitioner in today's world, the real you is what counts. SM is the real you. For the first time in the history of business, we see FB give our business a true persona that can interact not only with people, but also with other businesses. That is epic.

We have enjoyed tremendous success using FB to build relationships with other businesses. This is simply impossible to do with a traditional Web site. Your FB page gives an up-to-date snapshot of your business life. People and other businesses learn about your company through its actions and engagement. All the traditional info found on an archaic Web site is there, but it is enriched and enhanced with the overlay

'Social media is a better way of online communication.'

Justin Bazan, OD

of a social media experience. For example, let's say your office had a great event last night featuring a local artist. Think about what you had to do to get this on a Web site. Hire a professional photographer to cover it. Pay your Web guy to put up the pics. That takes time and money. Think about how that would go down on FB. People come, take pics, and post them on FB, and tag your business. The content is instantly and automatically updated to your FB page. You may also choose to do the same. All of this content is instantly seen by many people and very often liked, commented on, and shared. You then store it on your FB page in your photo section for people to see at a later date.

That reminds me of how frustrating it is to visit a Web site for the first time. Nothing seems to be where I expect it to be. On a FB page, everything has a standard home, which makes finding what I'm looking for easy.

SM has made the traditional Web site obsolete. SM outshines these outmoded online communication platforms and adds features that Web sites could never incorporate as effectively.

Businesspeople, including independent optometrists, must focus on optimizing a social media presence. A Web site is not an essential part of that effort. Just remember that it's OK to let go of the past. **ODT**

### Author Info



**Justin Bazan, OD**, is a 2004 SUNY grad and the owner of Vision Source Park Slope Eye in Brooklyn. Reach him on his Facebook page.

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# Going locum

The best choice I ever made was selling my practice before I or it declined

I have a simple message to share with any ODs contemplating retirement: Sell your practice before either it dies or you do. I consider myself fortunate to have sold my practice sooner than I had anticipated; only much later did I realize it was at exactly the right time.

I started my practice in 1964 and built it into a state-of-the-art solo private practice before I sold it 36 years later in November 2000 to a new graduate of SCO. In retrospect, selling my practice before it was in decline or before I was in poor health was one of the best things that I ever did.

## Take-Home Message

If you're considering retirement, look into creating a locum tenens practice. Don't wait until your practice is declining, your patient load is down, and the practice income has dropped too much for you to sell it. A locum tenens practice allows you to keep practicing.

## My locum tenens practice

After selling my practice I made a decision to start my own *locum tenens* optometry practice. (*Locum* refers to someone who provides professional optometric or other services on an irregular basis to other optometrists or other professionals.) *Locum Life*, a magazine dedicated to locum tenens physicians, lists more than 70 healthcare providers and only optometrists and ophthalmologists are those listed in the ophthalmic arena. I decided to start my own locums practice independent of any agency. I call it "Your On-Call Georgia Optometrist—On call for you, always."

In the 10 years I have been doing this, I have worked in more than 100 optometric practices in Georgia, many a few dozen times. When I started this model a decade ago, I knew of only one other Georgia optometrist who "floated." Since then I have seen this mode of practice grow here in Georgia. Among those are private practice ODs looking to supplement their income. I work the entire state of Georgia, and my fees vary as I take

## Locum tenens practice hints

I learned early on to take a few things with me from office to office:

- **An ophthalmoscope.** I like my own. Plus there have been times when the only one in an office expired and there were no replacement batteries.
- **Sample meds.** I like to have my own available.
- **An Amsler grid.** A simple test that can be diagnostic.
- **A portable IOP device of your choice.**
- **A Tyler's Quarterly Contact Lens Guide for prescribing.**
- **A vertex conversion chart.**
- **Saline for irrigation.** I find that many offices have only sample disinfection solutions they use for irrigation.

■ **A pupillometer.** Some offices do not have one, and I am very picky about monocular PDs with my spectacle Rx's.

■ **A penlight.** Some offices do not have a transilluminator.



'In the 10 years I have been doing this, I have worked in more than 100 practices in Georgia, many of them a few dozen times.'

Bill Sharpton, OD, FAAO

into consideration travel time and expenses, such as gasoline and accommodations. The minimum per diem I charge is \$500 for an 8-hour workday with a 1-hour lunch break.

Don't wait until your practice is declining, your patient load is down, and the practice income has dropped too much for you to sell your practice. If you are independent, realize that you won't be getting a pension, so you must invest and save for retirement or you will find yourself in a jam at a bad time. And, if you are so inclined, consider a locum tenens arrangement if you wish to continue to practice the profession you love. **ODT**

## Author Info



**Bill Sharpton, OD, FAAO**, is a graduate of Southern College of Optometry (SCO). He practiced in Acworth, GA, for 36 years before launching a locum tenens practice in 2002. E-mail him at [sharpton@windstream.net](mailto:sharpton@windstream.net).



# The locum tenens process: How to get started and what to expect

These tips will help you create a locum practice

**T**he prospect of undertaking something new and different can be intimidating, even for the most confident among us. Think back to when you first considered the possibility of optometry school. You probably asked yourself questions like: How does the process work? Where do I begin? Who can help me figure this out?

## Do your research first

National Association of Locum Tenens Organizations (NALTO) board member Andrea Hernandez says the first step is to identify agencies you want to associate yourself with. "If you know someone who's been doing locums, talk to him about his experience," said Hernandez. Find out which companies he has worked with and what he liked and didn't like about each one. A list of more than 60 NALTO member firms is available on the organization's Web site, [www.nalto.org](http://www.nalto.org). This is also a good place to research agencies that have agreed, as NALTO members, to voluntarily adhere to a set of quality and ethical guidelines.

Hernandez recommended taking time to research and interview several agencies before making the decision about which ones to work with. "Be sure to talk directly to the person who would be representing you if you signed on with the company," she said. "Get to know the people, not just the company. You need to feel confident that they have a good grasp of your specialty so that they can partner with you and help you guide your locum tenens career," she said.

Affiliating with three to five agencies is a smart move, especially if you plan on locum tenens as your full-time career. "You'll have more opportunities with greater variety," said Hernandez. One critical factor to consider when choosing an agency is the quality of the liability insurance it provides. Make sure that it's from a highly rated company and that it includes tail coverage.

## Organizing the paperwork

Once you've chosen your companies, you'll be asked to submit all the standard documentation required for credentialing, including

a current CV, copies of licenses and certificates, and references. "Have people lined up who have agreed to be your references. The industry standard is to list three colleagues you've worked with within the past 2 years," said Hernandez.

*'You need to feel confident that the agency has a good grasp of your specialty.'*

**Andrea Hernandez**

Each agency will ask you to sign an independent contractor agreement. This outlines your working relationship and confirms that you are a free agent, not an employee. This means you will receive 1099 tax forms, as opposed to W-2s, and that you are responsible for paying your own income taxes. "The independent contractor agreement is a blanket contract and not attached to a specific assignment. For each assignment, you'll get a separate confirmation letter that outlines specific details. Some agencies require that letter to be signed each time, and some don't," said Hernandez. Assignment letters cover the location, length, hours, call duties, housing, travel details, and compensation associated with each assignment.

When you're ready to begin considering locum tenens assignments, be clear about what you want in terms of where you'd like to work, what type of services you will provide, and for how many weeks or months you're willing to be away from home during a given year. "This will help your agency representatives call you about assignments that match your criteria," said Hernandez. Plan ahead if you're going to work in a state where you don't currently hold a license. Licensure rules vary from state to state.

## Setting the ground rules

"Once you're contacted about assignments,

it's important to be organized by keeping a logbook that tracks specifically which agency called you and the details of the assignment, including the practice name and service dates," said Hernandez. "If company A calls you on Monday with an offer to work at ABC Practice for the month of June and company B calls you on Tuesday about that same assignment, you're obligated, if you accept, to go with company A," she said.

There isn't much negotiation when it comes to compensation. Factors that influence pay include specialty, geographic location, and the duties associated with the assignment.

Part of the process of considering an assignment may include a phone interview with someone at the practice. "Practitioners may speak with an office manager or another practitioner," she said. This is your opportunity to ask about details such as patient volume, on-call expectations, and practice philosophy.

If an assignment involves inpatient care, the hospital will go through a credentialing process just as if you were applying for permanent staff privileges. "It's essential for doctors to get that paperwork turned around quickly," said Hernandez. "Agencies can help move the process along, but some things the doctor has to do him or herself."

The first few days on site are critical to the overall success of an assignment. Ask in advance what kind of orientation you should expect, and make sure you're comfortable using the electronic medical records system and that you understand the essential policies and procedures of practice before you begin.

You'll receive a timesheet to fill out and submit directly to your agency. "Find out what the payment schedule is," Hernandez said, adding that most companies offer direct deposit for their locum tenens practitioners.

Once you're established with locum tenens agencies and working assignments on a regular basis, keep your CV current and send updated credentials (e.g., renewed licenses) to each company. In addition, stay in touch with your agency representatives.

"Send a quick e-mail letting us know where you are, for how long, and what you'll be looking for next," said Hernandez. "This way we won't be calling you when you're not available, but we can be on the lookout for your next assignment based on when you will be ready." **ODT**

# Online payment helps drive efficiencies

By Carol Patton

Many organizations enable customers to pay their bills electronically. While online transactions are common across most industries, eye care has been among the exceptions.

After spending an average of \$7,000 monthly on postage and collections for its 250,000 patients, Thomas Eye Group in Atlanta implemented an online bill pay service. It now sends electronic statements to patients and enables them to pay online with a debit or credit card.

## Going paperless

The software, called PatientPay, was created by Clearwave Corp., a developer of patient information exchange software, and is powered by Zepherella Inc., which specializes in electronic payment processing. The system is among the few designed for eyecare practices.

According to Thomas Eye Group, many of its patients requested a paperless billing option. While it's premature to say how much money the practice will save, it projects a 30% savings on postage alone, which amounts to almost \$30,000 a year.

Patients who are eligible to use the system can either be self-pay or covered by a single insurance plan because patients with secondary insurance are rarely billed. The service was introduced via a message on kiosks at each of the practice's eight locations; patients use the kiosks to check in for their appointments.

## User-friendly process

When enrolling, a consent screen confirms that the patient agrees to receive electronic statements. Next, she enters personal information, such as her e-mail address and phone number, which are mandatory for enrollment.

Within minutes, the patient receives an e-mail from the practice, containing a link she must click on to continue the enrollment process. The patient creates a password, accepts the service's terms and conditions, enters additional information about herself, such as age and gender, adds additional family members, if appropriate, and enters the preferred method of payment.

Once an account is set up, the patient can access the portal to manage her payments with not only the practice but also other participating providers. The home page offers payment alerts, reminders, and recent payment history. Patients can edit their account information, view and pay invoices, and print receipts.

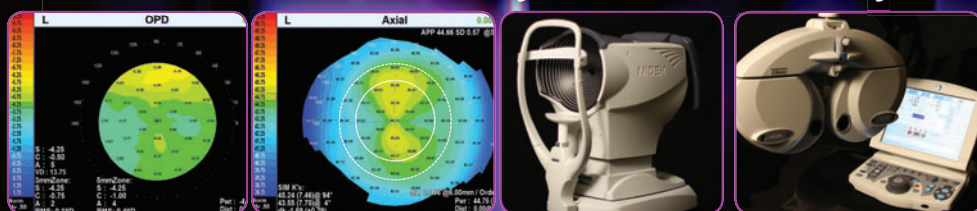
When the practice enters a bill in the system, the patient is automatically sent an e-mail notification containing a link so she can review the charges. Patients have 10 days to make a payment before the online service expires and, if needed, are sent two reminders. Patients also receive a confirmation e-mail that details the transaction and includes a link to view and print a detailed receipt.

However, if no online payment is made, a third and final e-mail is sent, notifying the patient that a traditional paper statement will be mailed.

During the week of the system's debut at Thomas Eye Group, nearly 40 patients signed up. However, the practice expects a 50% acceptance rate among its eligible patients. **ODT**

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# Multicultural markets offer wealth of opportunities

By Carol Patton

**H**alf of the U.S. population will be part of one racial or ethnic minority group or another by 2050,<sup>1</sup> presenting both challenges and opportunities to optometrists nationwide. It definitely won't be business as usual.

"There are tremendous opportunities for culturally sensitive care," said Kirk L. Smick, OD, FAAO, of Morrow, GA. "It's a changing world out there, and we need to get with it."

Dr. Smick invites optometrists to look at the math. The 46.7 million Hispanics in the U.S. today represent 15% of the population, and by 2050, this number will swell to 132.8 million, or 30% of the total population.<sup>1</sup> Other minority groups will follow suit. Asian-American buying power, which is \$509 billion today, will be \$752 billion by 2013.<sup>2</sup> African-Americans are expected to grow from 14% of the population today to 15% in 2050.<sup>1</sup>

Serving these discrete business segments will require an open mind, market research, and cultural sensitivity, said Dr. Smick. The greatest barrier to multicultural business is lack of awareness: do minority groups even know you exist? To answer the question he separated the business into five distinct parts: pre-visit outreach, reception, eye exam, dispensary, and post-visit outreach.

## First, size up your market

Start with a demographic analysis of the community and any competition, he said, and then buy advertising in media that is specific to each minority group and subsegment. A Laotian Web site will not necessarily be read by Cantonese people, even though both are Asian. Ads can take the form of education and can be as simple as postcards highlighting eye health needs.

Don't be shy about using the clinic's storefront to present images of diverse patients, including signage in non-English languages. This can be carried over to the Web site and to voicemail.

Don't hesitate to use social media, he said. Minority populations use social networking sites like Facebook more than the general population. LinkedIn and Twitter are very popular among Asian-Americans, and Hi5 is used by nearly 30% of the country's Spanish-speaking Hispanics.<sup>3</sup> Hispanics are 17% more likely than the average consumer to build or update a personal blog.<sup>4</sup> African

Americans have found their collective voice through Web sites such as BlackVoices.com and BlackPlanet.com.<sup>5</sup>

Racial and ethnic minority populations are also heavy users of mobile phones, which can be useful not only for appointment reminders but for eyewear promotions, Dr. Smick added.

## Stay ahead of the curve

ECPs should not assume that their staffs have cultural or linguistic competency. Dr. Smick recommends educating them in competency because diverse groups are very loyal to companies that make them feel comfortable.

It's not a bad idea to hire a staff that reflects the community's diversity. Multicultural hires can be a valuable investment, and incentive programs should be detailed to encourage the staff to bring in patients from their particular groups.

Once patients are in the door, the practitioner should remember that every ethnic group has its own cultural standards, which must be respected. Physical closeness, hand gestures, even eye contact can mean very different things to different populations. In the Hispanic community, a degree of formal politeness is often appreciated—for example, Mr. Gonzalez vs. Edward. Also, the Hispanic patient may prefer to sit beside the doctor rather than opposite.

Dr. Smick suggests hiring a consultant here, as well, to evaluate or monitor the practice and often to create a special staff manual or workshop.

"Incorporate diversity into mission statements and strategic planning," he said. "Make it a core objective."

Small physical touches around the practice can have large effects: ethnic décor on the walls and popular magazines in non-English languages in the waiting area will make members of minority groups feel more welcome. Point-of-sale materials in non-English languages are available from many suppliers or can be produced locally.

Every minority group has specific eye concerns. Hispanics have higher levels of diabetes and hypertension and suffer more diabetic and hypertensive retinopathy.<sup>6</sup> They also suffer from pterygia, cataracts, open-angle glaucoma, and macular degeneration.<sup>7</sup> African-Americans are five times more likely than Caucasians to have glaucoma<sup>8</sup> and also commonly develop cataracts, diabetes, and hypertension.<sup>8</sup> Sickle cell disease, which affects one in 12 African-Americans,<sup>9</sup> can lead to vision problems and

blindness. Asian-Americans often have myopia and angle-closure glaucoma.<sup>10</sup> They may develop Type 2 diabetes late in life,<sup>11</sup> and they develop tuberculosis more commonly than the Caucasian population,<sup>11</sup> leading to ocular tuberculosis. **ODT**

## REFERENCES

1. Minorities expected to be majority in 2050. CNN.com. Aug. 13, 2008. [www.cnn.com/2008/US/08/13/census.minorities/#cnnSTCText](http://www.cnn.com/2008/US/08/13/census.minorities/#cnnSTCText). Accessed April 8, 2013.
2. Asian Americans on the Road to Retirement. The Prudential Insurance Company of America. Newark, NJ. 2010. <http://research.prudential.com/documents/rp/AsianAmericansontheRoadtoRetirementFINAL.pdf>. Accessed April 8, 2013.
3. Internet and Social Media usage among U.S. Hispanic Moms: Executive Summary. Latinum Network. Bethesda, MD. October 2010. [www.latinumnetwork.com/attachments/Documents/Latinum-Moms\\_Cohort\\_Social%20Media\\_Executive\\_Summary.pdf](http://www.latinumnetwork.com/attachments/Documents/Latinum-Moms_Cohort_Social%20Media_Executive_Summary.pdf). Accessed April 8, 2013.
4. Nielsen Finds U.S. Hispanics Tops In Mobile, Social Activity. TechCrunch. April 20, 2012. <http://techcrunch.com/2012/04/20/nielsen-finds-u-s-hispanics-tops-in-mobile-social-activity>. Accessed April 8, 2013.
5. Fabris, M. Special Report on Multicultural Marketing: Market Power. Target Marketing. North American Publishing Co. Philadelphia, PA. May 2008. [www.targetmarketingmag.com/article/focusing-your-message-african-american-market-98162/1#](http://www.targetmarketingmag.com/article/focusing-your-message-african-american-market-98162/1#). Accessed April 8, 2013.
6. Tienda M, Mitchell F, editors. Hispanics and the Future of America. National Research Council Panel on Hispanics in the United States; Washington, DC: National Academies Press (U.S.); 2006. [www.ncbi.nlm.nih.gov/books/NBK19899](http://www.ncbi.nlm.nih.gov/books/NBK19899). Accessed April 8, 2013.
7. My Eyes & My Ethnicity: Health Issues For Hispanic Americans. Transitions Optical Inc. 2013. [www.eyeglassguide.com/my-eyes/ethnicity/hispanic.aspx](http://www.eyeglassguide.com/my-eyes/ethnicity/hispanic.aspx). Accessed April 8, 2013.
8. Glaucoma. Sight & Hearing Association. St. Paul, MN. 2013. [www.sightandhearing.org/sightcenter/glaucoma.asp](http://www.sightandhearing.org/sightcenter/glaucoma.asp). Accessed April 8, 2013.
9. Sickle Cell Disease. Centers for Disease Control and Prevention. Atlanta, GA. 2011. [www.cdc.gov/ncbddd/sicklecell/data.html](http://www.cdc.gov/ncbddd/sicklecell/data.html). Accessed April 8, 2013.
10. Reducing Risk of Glaucoma. Lighthouse International. New York, NY. 2013. [www.lighthouse.org/eye-health/prevention/reducing-risk-of-glaucoma](http://www.lighthouse.org/eye-health/prevention/reducing-risk-of-glaucoma). Accessed April 8, 2013.
11. Asian American Populations. Centers for Disease Control and Prevention, Office of Minority Health & Health Disparities. Atlanta, GA. [www.cdc.gov/omhd/populations/asianam/asianam.htm](http://www.cdc.gov/omhd/populations/asianam/asianam.htm). Accessed April 8, 2013.

# Bringing a practice up to speed

Investing in your practice means more than buying hardware—it's investing in your patients' futures

By G. Chad Green, OD

Capital investments can seem risky, especially when the economy has been anything but flourishing. And when you are one of few providers in a rural area, it is easy to assume that purchasing the latest computer systems and diagnostic equipment is unnecessary. However, my optometry practice in a small rural town has done just that, and the result has been improved patient care and excellent returns to the bottom line.

Located in western Alabama, my practice is a heavy medical optometry practice with a high percentage of geriatric patients. The patient population is comprised of many low-income individuals and a very high percentage of patients with diabetes. So, the majority of patient appointments are to address diseases such as glaucoma, diabetes, and macular degeneration. Revenue is generated 70% from professional fees and only 30% from optical fees.

## Finding the best fit

Over the past 3 years, we deliberately sought new technologies we felt would achieve two goals: improve patient care and increase practice profit.

The first technology that fit the two criteria was a new practice management system with electronic medical records (EMR). This provided a way to streamline practice management as well as get the practice on board with new government requirements. Without proper record keeping and tracking, it is impossible to know if investments in technology are creating a return. In addition, disease patients need to be closely followed, and updates need to be sent to their other healthcare providers. A good EMR system will send out reminders when the patient needs a follow-up appointment, will assimilate diagnostic results over time so that patient progress is easily evaluated, and will automatically generate reports for the necessary co-managing providers.

Once the practice was organized electronically, we made several investments in diagnostic technology. We added improved optical coherence tomography, visual field testing units, corneal topographers, and specular microscopes. These tools not only

## Take-Home Message

Investing in technology allows you to provide patients with the best possible care while building your practice.

allow us to diagnose and manage nearly any eye condition, but they also aid against downturns in the economy. Diagnosis and management of ocular disease are typically medical insurance-covered services and can provide a more steady revenue stream as opposed to elective purchases, such as specialized lenses for eyeglasses.

This equipment also allows us to have a very active co-management role with retina and glaucoma specialists. We are fully capable of diagnosing and monitoring disease states as well as providing follow-up care after surgery. The combination of specialized imaging devices and our EMR system allows us to easily share information with surgeons and other medical providers.

## Dynamic education

Another area we deemed worthy of investment was high-tech patient education. We subscribe to the Echo patient education program (Eyemaginations Inc.), which provides us with 3D animated videos on a variety of disease states and other eye health topics. We also purchased tablet devices for each of our exam lanes. A tablet is attached to an articulating arm mounted on the instrument stand next to the exam chair. While the patient is waiting for the doctor, he or she can browse the videos available. After I finish the examination, I can select videos specific to the patient's diagnosis for him or her to watch while I update the patient's record. The videos generally last a couple of minutes, after which the clinician can discuss any conditions with the patient and answer any questions.

The educational videos cover topics such as glaucoma and age-related macular degeneration, treatment options such as intraocular lenses for cataract surgery, as well as information for traditional refractive patients. There are videos that demonstrate different lens options available for contacts and glasses. Cataract patients who are awaiting surgery come in for a short consultation visit where they are primarily seen by the technician. The technician uses the tablet device to review lens im-

plant options, the patient consent form, and the procedure for follow-up care.

Similar to practice management software, there is no direct fee associated with patient education that allows one to measure a direct return on investment. However, we have seen a number of benefits in our practice. First, it ensures that the patient understands his or her condition and the options for treatment much more effectively than if the doctor used static flipcharts or used only verbal communication. The dynamic education method increases patient compliance and satisfaction, all while saving the physician a significant amount of time.

*'We sought technologies to improve patient care and increase profit.'*

G. Chad Green, OD

There are approximately 8,000 inhabitants of the town where our practice is located, and about 25,000 people in the county. Needless to say, we aren't fighting a lot of competition. Regardless, we received a lot of positive feedback when we started making these changes. Throughout health care, patients are more educated, want more information, and want the best treatment possible. Increased patient satisfaction has corresponded with an increase in referrals.

As an optometrist, managing the diseases that I have been trained to manage is very rewarding, both professionally and financially. Making investments in optometric technology is part of practicing optometry; avoiding those expenditures would cause me to shortchange my patients, as well as my practice. So, despite the capital outlay, investing in technology has allowed me to provide my patients with the best possible care while building my practice. **ODT**

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# Clinical answers for improving a patient's 3D viewing experience

Common visual problems are discomfort, dizziness, and lack of depth

By Nancy Groves

**A**re 3D movies not only box-office blockbusters but also an emerging public health opportunity for optometry? As 3D and stereoscopic 3D (S3D) become more common in movies and television, video games, mobile devices, and in the classroom and the workplace, many people will discover that they can't appreciate this new technology because of vision problems.

An estimated 3 million to 9 million people in the United States have binocular vision problems; viewing 3D television and movies may make them aware of these problems and encourage them to seek treatment, according to Leonard J. Press, OD, FCOVD, FAAO, a developmental optometrist in Fair Lawn, NJ.

"Not only are we seeing changes in terms of media, but more and more jobs are requiring 3D," said Gary Etting, OD, FCOVD, of Los Angeles. Drs. Press and Etting discussed the clinical implications of viewing 3D media.

## 'More careful' evaluation

They urge their colleagues to brush up on their skills to prepare for more patients coming in with 3D-vision problems. "You don't have to become a developmental optometrist or provide vision therapy in your office," Dr. Etting said. "But you need to be more careful in your evaluation to make sure that you're looking for these potential problems."

The most common visual problems associated with S3D technology are discomfort, dizziness, and lack of depth. Testing phoria, vergence ranges, amplitude, lag, facility, AC/A ratios, and visual stress are key to evaluating accommodative-vergence interaction.

"The more testing you do, the better insight you'll get into how well equipped your patient's binocular and accommodative system is to handle this visual event," Dr. Press said. "Dust off your old optometry notes from school, buy a book, take a course."

## Using clinical guidelines

The American Optometric Association (AOA) has published clinical guidelines on accommodative-vergence interaction. In addition, the

## 5 questions to ask about 3D viewing

Here's what to ask your patients about their 3D viewing habits, according to AOA clinical guidelines:

- 1 Do you experience eyestrain or headaches during or after viewing?
- 2 Do you feel nauseated or dizzy during or after viewing?
- 3 Are you more comfortable viewing 2D TV or movies instead of 3D TV/movies?
- 4 Is it difficult for your eyes to adjust back to normal after watching 3D TV/movies?
- 5 Do other people seem to be enjoying the 3D viewing experience more than you?

AOA recently co-sponsored a 3D vision and eye-health symposium and helped prepare a public health report on 3D in the classroom.

The guidelines include a list of questions for evaluating the impact 3D viewing can have on vision and eye health:

- Do you experience eyestrain or headaches during or after viewing?
- Do you feel nauseated or dizzy during or after viewing?
- Are you more comfortable viewing 2D TV or movies instead of 3D TV/movies?
- Is it difficult for your eyes to adjust back to normal after watching 3D TV/movies?
- Do other people seem to be enjoying the 3D viewing experience more than you?

## Treatment options and goals

Many treatment options are available to patients who have vision problems that may affect 3D viewing, according to Dr. Etting. If an updated prescription doesn't alleviate the problems, a prescription specific for the task of sustained 3D viewing is an option. For example, Marchon offers 3D eyewear with circular polarization.

Other equipment used to tailor treatment or vision therapy to the patient's needs may

include therapeutic lenses, prisms, filters, occluders or patches, electronic targets with timing mechanisms, and balance boards.

Treatment goals include getting patients comfortable moving their eyes from far to near spaces and building degrees of freedom in a binocular system by stretching the relationship between the focus and the point of the eyes, Dr. Etting said. "In short, we're trying to arrange the conditions for them to learn to use their equipment in a more efficient way," he said.

## Fine-tuning the 3D experience

The doctors also offer a few tips for fine-tuning the 3D viewing experience. For example, pick a viewing angle within 30 degrees of center. This applies to television, movies, and handheld devices. If you're in a theater, choose a seat toward the center rear. The screen should occupy about half of your visual field.

*'The more testing you do, the better insight you'll get into how well equipped your patient's binocular and accommodative system is.'*

Leonard J. Press, OD, FCOVD, FAAO

While some people believe 3D is a passing fad, Dr. Press is convinced otherwise. He pointed out that the first 3D eye clinic opened in Beaverton, OR. The clinic is operated by Pacific University College of Optometry, Forest Grove, OR, and has significant industry support, Dr. Press said. This suggests that the clinic's corporate backers believe 3D will be a major force not just in the entertainment industry but also in other aspects of everyday life. **ODT**



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# Go green (without spending a lot of green)

Going eco friendly can help make your practice healthier, more energy efficient, less wasteful

By Brian P. Dunleavy

For Eric White, OD, “going green” started as a family affair.

Dr. White’s son Tyler, a recent college graduate with a degree in environmental studies from the University of California, Santa Barbara, came to him with the idea of making his practice more environmentally friendly. Given that some of Dr. White’s patients had expressed an interest in supporting green-conscious businesses, it seemed worth exploring.

## Take-Home Message

Going green can benefit not only the environment, but your practice, your staff, and your patients as well. Sit back and watch how your office operates daily to determine which eco-friendly steps—from going paperless to promoting eco-friendly acts—are the best fit for you.

“It was Tyler’s idea, and he’s taken the lead on it,” said Dr. White.

Like many college graduates in today’s volatile economy, Tyler is currently working multiple jobs to make ends meet. To begin the process of “greening” his father’s optometry practice, one of those jobs has been in effect working as the office cleaning person.

“It’s a lot of work,” Tyler said, “but it’s enabled me to get an idea of how the practice disposes of waste and what can be recycled. Cleaning the office has given me a good idea of how the practice works and what changes can be made. However, it’s been a step-by-step process.”

It’s inaccurate to say that Dr. White’s practice is part of a growing movement to make optometry green. Frankly, given the current economic woes, ODs are far more concerned with another kind of green: money. More and more practices have inquired about making their facilities more energy efficient and less wasteful, according to several design firms that specialize in eyecare offices.

So what can optometrists do to make their practices—particularly their optical departments—more eco-friendly? Here are a few suggestions:



**Go paperless.** New practice management software systems offer paperless billing and medical records filing capabilities. Going paperless saves trees, of course; it also reduces paper use and, therefore, costs. It’s not easy, as any OD who has done it knows, but this is the most obvious step. Dr. White’s practice is planning to be paperless soon.



**Clean green.** Not all “green” cleaning products are appropriate for all areas of a healthcare practice, noted Tyler. They just don’t clean well enough. Cleansers from companies such as Seventh Generation, however, are more than effective enough to clean areas such as the reception desk, waiting room, and optical shop.

Most of these products are comprised of organic mixtures rather than chemicals, which means they not only produce less air and water pollution when they are poured down the drain, but they are also healthier for staff and patients as well.



**Lighting the way.** According to Alan Winig, owner of Eye Designs LLC in Collegeville, PA, which specializes in designing optical facilities for optometry and ophthalmology practices, installing LED lighting is one of the easiest and most cost-effective ways for practices to make themselves more eco-friendly.

Even in a temperate climate like San Diego, energy-efficient windows have reduced the practice’s energy use—and costs.

LED lighting uses less energy than, say, standard halogen lighting, which is better for both the environment and the practice bud-

## Take a Stand

Keep your practice healthier for staff, patients, and the environment without breaking the bank. Try these suggestions:

- Go paperless—use electronic billing
- Clean your practice using eco-friendly products
- Use energy-efficient lighting
- Choose flooring and furnishings made from recycled materials
- Install energy-efficient windows
- Dispense eyeglass frames made from recycled materials
- Send a message—lead by example

get, thanks to reduced electric bills. Blanca Rivera, Eye Designs senior interior designer, added that LED lights also give off less heat than standard lighting, which in the optical means that frames on display will be exposed to less color- and material-damaging heat on the frame boards.



**Flooring and furnishings.** Practices willing to spend a bit more for the sake of the environment can also choose to use furniture made from recycled materials, according to Rivera. “Today, even ceiling tiles are made from recycled materials,” she said.

Several companies specialize in office furnishings made from recycled materials—including, from an optometry practice perspective, chairs and dispensing tables—but many of these products may be too pricey for cost-conscious practices.

Spending a bit more for quality furnishing that won’t break down or go out of style in a few years is one of the most overlooked ways a practice can go green—it means that less discarded furniture ends up on landfills, said Barbara L. Wright, CID, owner of Barbara Wright Designs in Nashville, TN.

“Remodeling a dispensary usually requires buying new display fixtures and dispensing tables, but if you have a sense of style and don’t mind shopping around you can recycle used yet stylish furniture by mixing it



in with new displays to give your dispensary a unique look,” added Wright. She has had several clients who mined local antique stores to furnish their offices, in effect, recycling furniture.

In terms of flooring, more and more manufacturers are offering carpeting, including area rugs, and flooring tiles made from recycled materials at little or no additional cost over traditional flooring options, according to Eye Designs’ Rivera.



**Window views.** One of the best green investments Dr. White’s practice made was installing energy-efficient, dual-pane windows throughout the office, said Tyler. Even in a temperate climate like San Diego, the windows have reduced the practice’s energy use—and costs—by keeping the cool air generated by air conditioning inside during the summer months and warm air produced by the heating system inside during the winter months.



**Frame up.** If your practice is really committed to going green, you can even look into dispensing spectacle frames made from recycled materials. In recent

years, a handful of manufacturers have made such products available. Keep in mind, though, that if these recycled frames don’t match the styles—or price points—of your patient base, they won’t sell, and that won’t help the practice or its eco-friendly ambitions.



**Send a message.** Finally, sometimes going green isn’t about changing what your practice does but accounting for it, Tyler added. Several organizations sell “carbon credits”—in effect, allowances for the carbon footprint (the energy use or waste produced) of an individual or business—in exchange for a donation to an environment-related charity. According to Tyler, his father’s practice is currently investigating its options in this area, including a program offered by the San Diego Zoo.

“Ultimately, we want to put up a poster in the waiting room that shows the waste produced by the practice and the energy used by the practice, and what we’re doing to reduce or offset this energy,” said Tyler, whose green efforts are already being touted on the home page of the practice Web site, [www.dre-ricwhite.com](http://www.dre-ricwhite.com).

“As more and more people—including a lot

LED lighting uses less energy than standard halogen lighting, which is better for both the environment and the practice budget.

of my father’s patients—are becoming more concerned about the environment, this shows that we’re doing our best to be responsible. And that can only be a good thing for our reputation in the community,” Tyler said. **ODT**

FYI

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Dr. White did not indicate a financial interest in the subject.

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# In Brief

## VisoLux+ LED stand magnifier offers wide field

**Danbury, CT**—The VisoLux+ is an illuminated stand magnifier with a large, distortion-free viewing area illuminated with bright LEDs. It has a double lens system featuring a proprietary coating that not only minimizes scratches, but also allows text and images to appear crisp and clear, and extends the useful life of the product.



The field of view is 100 x 75 mm or 4 by 3 inches. The VisoLux+ contains two bright SMD LEDs that provide uniform illumination over the entire field of view. There are two color options—standard bright, white light and a softer orange light.

Because ergonomics were factored in the production of the VisoLux+, the lens is tilted toward the user, minimizing neck strain. The VisoLux+ also includes a sturdy zippered case.

For more information, contact Eschenbach at 800/487-5389 or visit [www.eschenbach.com](http://www.eschenbach.com).

## Transitions PRO site enhances online sources

**Pinellas Park, FL**—Transitions Optical Inc. has launched its updated Web site, Transitions PRO (Professional Resource Online), <http://TransitionsPRO.com>.

Transitions PRO gives anyone with a professional interest in vision care and eyewear, from eyecare professionals and students, to labs and managed vision care brokers, instant access to information and materials that aid in patient satisfaction and practice growth.



"We offer an array of free online resources that not only help our partners succeed with the Transitions family of products, but also assist them with growing their practices and reaching new patients," said Dana Reid, marketing manager, digital communications—trade, Transitions Optical.

The PRO site will help re-introduce a suite of tools aimed at helping eyecare professionals to market their practices—Transitions Marketing WIZ, Transitions MAP, and Transitions Online Marketing (TOM) tool.

## Tailored luxury marks Rye&Lye collection

**Calalzo di Cadore, Italy**—Wood and leather accentuate the Italian craftsmanship of the new eyewear by Rye&Lye.

The Amleto frame for men, shown below, has a boxy, elegant shape. Luxuriously detailed wood inserts on the acetate sidepieces give this frame a modern touch with a classic edge.



All Rye&Lye eyewear has a 5-jointed hinge, which makes for a smoother sidepiece and adds sturdiness to the design.

For more information, visit [www.rye-lye.com](http://www.rye-lye.com).

## Raen debuts first Rx-able frames

**Encinitas, CA**—Raen Optics has launched its first optical line, a full offering of Rx-able eyewear. The new line of handmade Rx frames boasts zyl acetate and features lux-

ury finishes throughout. The lightweight acetate frames also include rivet-hinge hardware for comfort and durability.



The Squire style, shown above, is inspired by classic shapes worn by James Dean in the 1950s. With metal screw temple detailing and a notched bridge, these hand crafted, horn-rimmed frames are designed for Rx or sunwear use.

For more information, visit [www.rae-noptics.com](http://www.rae-noptics.com).

## Distinctive titanium sunglasses from Blackfin

The Blackfin line of distinctive titanium eyewear has introduced two new sunwear styles—White Rock for women and Dynamite for men.



White Rock style BF680, shown above, has a large, soft-shaped frame that contrasts with the taut Blackfin lenses. The front is made from a single sheet of pure titanium. The large ciliaries, personalized by the Blackfin logo, protect the eyes from sunlight. Available in brown/midnight blue with shaded brown lenses, opaque black with smoke colored lenses, and matte military green with shaded green lenses.



Dynamite model BF681, shown above, is edgy with its larger dimensions, sculptured profile, and large ciliaries. Available in natural sandblasted titanium/opaque navy blue, matte black with smoke colored lenses, and matte military green with green shaded lenses.

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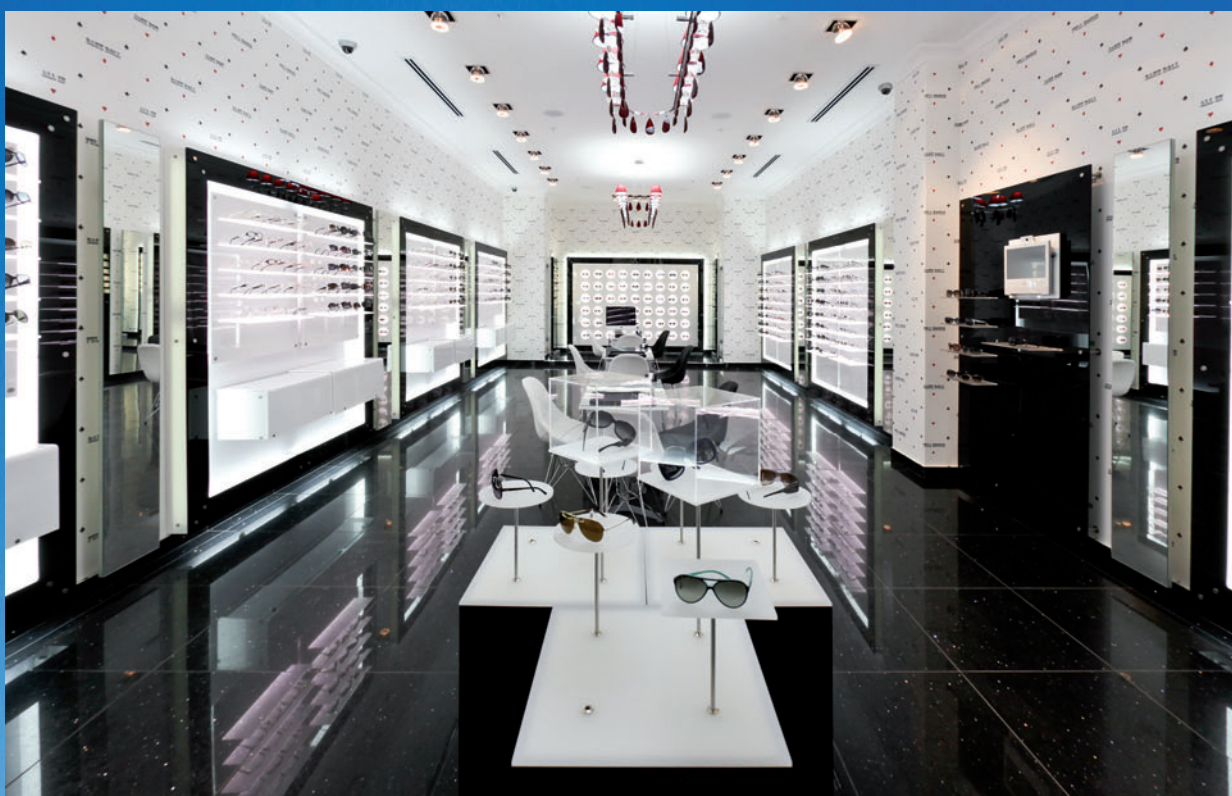
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Dr. Sutton documents a collection of "old iron" lining the sides of a canyon in the Ruby Hill Mining District in Eureka County, NV.

## Photojournalist

Continued from page 42

ute program dedicated to community events and interests.

"Stories are easy to tell, no matter how long or short they are," he said, adding that the segments mostly focused on local athletes and offered health tips. "Everything is in three-act plays. I introduce the character in a situation, develop the situation, then in the third act, come to some sort of resolution or explain why there is no resolution."

### Gaining traction

Dr. Sutton was very busy in 1982. While

practicing as an optometrist, he enrolled in several graduate courses in journalism at the University of Missouri, produced 2-minute segments for the local evening news, and then later expanded his niche to human-interest stories. His series called "The Invisible Society, A Study in Homelessness" won an Emmy along with a national award from the National Association of Christians and Jews in 1982. Dr. Sutton said he actually lived on and off with homeless people for a week so he could better understand their challenges, circumstances and, in some cases, lifestyle choice.

Likewise, Dr. Sutton and two associates formed a production company called Trails West Productions. For more than 20 years,

Trails West produced a series of documentaries for PBS and The Discovery Channel that included *The Ranch Hand*; *Grandpa's Tractor: The History of Farming in the Midwest*; *The Wild Horse in the American West*; *Collecting the Old West*; and *The American Biker*.

"When you look at the flavor of my stories, they describe a person and how that person fits into the scheme of preserving what's good and what's right in America—family values, love of country, and preserving the heritage of an area," Dr. Sutton said. "Kids can know where, as Nevadans, we've come from and how that knowledge can help us get to where we want to go."

### National recognition

His reputation as a journalist flourished, not only in Reno, but also in Northern California and Idaho where his programs were also broadcast. You can log on to [www.ktvn.com](http://www.ktvn.com) to see dozens of his recent stories.

"Over the years I've taught broadcast story telling, videography, writing, and editing to affiliate markets, but these days I teach only to local teams here on the West Coast," he said.

While Dr. Sutton enjoys being both an optometrist and journalist, he keeps those worlds separate. His face is rarely shown in his programs. You also won't find any kudos at his practice highlighting his journalistic accomplishments.

"I've seen other reporters whose work is similar to mine," Dr. Sutton said. "They say, 'Hi, I'm so and so. Look at how much fun I'm having. Don't you wish you were me?' That's never been my approach. I'll produce several stories without a stand-up or presence other than voice, until news directors order me to be seen. Then I'll do a couple that way and get back to giving those seven or eight seconds back to the real stars."

Although it's always an honor to be recognized by peers, Dr. Sutton said his job satisfaction doesn't come from accolades. It comes from being genuinely connected to people and their lives.

"I want viewers to appreciate the people or subjects in my stories," he said. "When someone says they really liked one of my stories or can somehow connect, that's all the reward in the world I need."

**ODT**

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FYI

Jack Sutton, OD

Phone: 775/323-1680

E-mail: [drjh@sbcglobal.net](mailto:drjh@sbcglobal.net)





Photojournalist Jack Sutton, OD, covers a story about a family that has been ranching in Eureka, NV, for five generations. Seven-year-old Kayla Cloninger (inset) belongs to the fifth generation.

# Citizen journalist

OD is respected journalist, videographer who preserves 'people stories'

Jack Sutton, OD, never had any intention of becoming a journalist. During college, he never stepped foot in a writing class. He never wrote for the school's newspaper. He never even applied for journalism jobs.

But Dr. Sutton has a natural talent for storytelling. For nearly 30 years he has scripted, shot, edited, narrated, and produced hundreds of TV shows or segments that have been broadcast on PBS, The Discovery Channel, and KTVN, the CBS-affiliate TV station in Reno, NV. In 2010, he was inducted into the Nevada Broadcasters Association Hall of Fame.

"I've always produced my stories between Fridays and Sundays," explained Dr. Sutton, a private practitioner in Reno. "It never interfered with my clinic hours. I still work 4 days a week."

## Telling people stories

"My work has always been a celebration of the people in my stories, not about me," he said. Dr. Sutton's people stories have included ranchers, marathon runners, and the homeless. One of his favorite stories told of a 103-year-old schoolteacher who was born and raised on her family's ranch in Washoe Valley, NV. Dr. Sutton said the ranch was in the same location as the Ponderosa, the Cartwright family ranch featured in the TV Western series, "Bonanza."

*Coincidence? Maybe.*

"It was just priceless to have met her and talk about her experiences meeting some of those early Nevada characters," he said, pointing to William James, a famous cowboy artist she had befriended.

Dr. Sutton's own story began in the late 1970s when a college buddy who was the news director at KTVN approached him with a tempting offer: produce brief segments on health and fitness for the local TV station. Dr. Sutton's background was in exercise physiology. While in the Army, he also taught exercise courses and afterward became very involved in running and training people for marathons.

While flattered, Dr. Sutton was more interested in establishing his optometry practice and gracefully declined. But his college friend was persistent. Three months later, Dr. Sutton became a TV reporter, producing health and fitness segments twice a week for nearly 1 year, which appeared on "Live at 5," a 30-min-

See **Photojournalist** on page 41



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