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New deans at optometry schools

Flanagan, Zadnik to take new roles

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

Two schools of optometry recently announced changes in their leadership. The University of California at Berkeley School of Optometry appointed John Flanagan, MCOptom, PhD, FAAO, as its eighth dean, and The Ohio State University College of Optometry has named Karla Zadnik, OD, PhD, FAAO, as its first woman dean.

Currently, Dr. Flanagan is professor at the School of Optometry and Vision Science, University of Waterloo, and the Department of Ophthalmology and Vision Sciences, University of Toronto. In addition, he is director of the Glaucoma Research Unit at the Toronto Western Research Institute and a senior scientist at the Toronto Western Hospital, University Health Network. Dr. Flanagan will succeed Dennis M. Levi, OD, PhD, who has held the position since 2001.

Dr. Zadnik currently serves as the Glenn A. Fry, Professor of Optometry and Physiological Optics and associate dean at The Ohio State University College of Optometry. She will succeed Melvin D. Shipp, OD, MPH, who has been dean since 2004.

Drs. Flanagan and Zadnik will assume their new posts in June 2014.

In related news, Linda Casser, OD, FAAO, dean of Pennsylvania College of Optometry (PCO) at Salus University, will be stepping down effective December 31, 2013. She will remain as interim associate dean for the Practice of Optometric Medicine from January 1, 2014, through at least June 30, 2014. **ODT**

Defining Medicare payment rates

What you need to know, and why

By Scott Baltic
Special to *Optometry Times*

Physicians who treat Medicare patients know that there's a process behind setting payment rates for services and a committee that's responsible for the task. Lately, some industry observers have characterized the group—the American Medical Association (AMA)/Specialty Society Relative Value Scale Update Committee (RUC)—as either:

- An obscure committee that holds three boring meetings each year to do tedious evaluations that help the Centers for Medicare and Medicaid Services (CMS) set Medicare rates for physician reimbursements; or
- A secretive, highly politicized group that wields enormous influence over physician reimbursements—from both CMS and private insurers—that also has conflicting interests and little oversight.

TOPIC: Representation

CRITICS Primary care is poorly represented on the RUC.

RUC From 1991 to 2011, the portion of Medicare money paid to primary care rose from 37% to 43%, while the portion paid to surgical specialties dropped from 32% to 21%.

TOPIC: Rate accuracy

CRITICS The amount of time attributed to many procedures has remained high even as the procedures now require less time to perform.

RUC Some procedures do take less time to perform, but for certain ones, reimbursement per surgery has declined significantly.

The truth likely lies somewhere in the middle. According to the AMA, the RUC makes annual
See **RUC** on page 5

OPTOMETRIC COMMENTARY

By Ernie Bowling, OD, FAAO
Chief Optometric Editor

This issue of *Optometry Times* includes an article on the American Medical Association (AMA)/Specialty Society Relative Value Scale Update Committee (RUC). While the RUC story may seem a tad removed from optometry, this committee sets the relative value scale and therefore has a huge impact on what all medical professionals, including optometrists, are paid by Medicare. Because most insurers use the Medicare fee schedule as a reference point in establishing

their own individual fee schedules, this becomes even more important to our profession. The article makes the point that primary-care professions are underrepresented on the RUC committee and, perhaps not by coincidence, are underpaid in comparison to their specialist counterparts. As optometry is the primary eyecare profession, I feel certain all optometrists feel we are definitely underpaid.

While the RUC may well by headcount be heavier on specialists than primary-care providers, it does not go unnoticed that optometry does not have a seat at this table. Until we do, we are at the mercy of nameless, faceless individuals who may or may not have any idea about what we do or the value we bring. **ODT**

INSIDE

LOW VISION/VISION THERAPY

Treating patients with brain injuries

Although how injuries affect patients differ, most visual symptoms are similar. **SEE PAGE 18**



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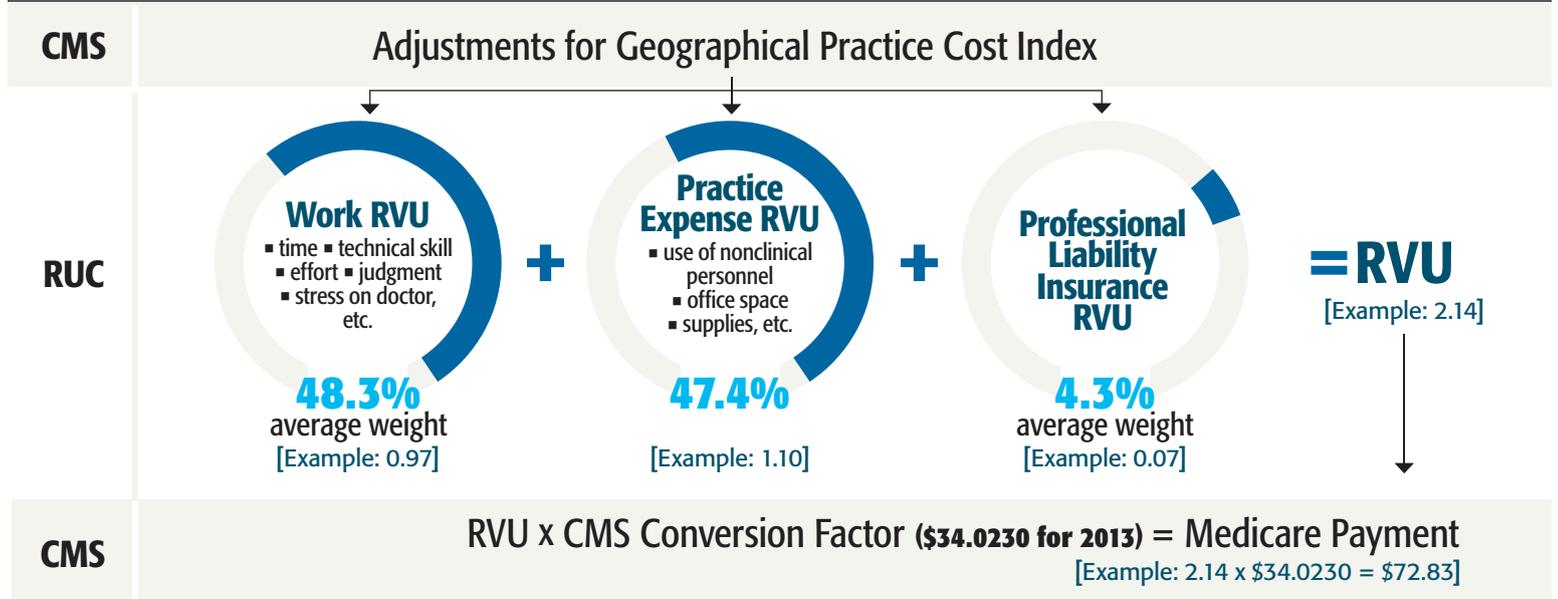
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How a CPT code's Medicare allowable is determined



Abbreviations: CMS=Centers for Medicare & Medicaid Services RUC=American Medical Association (AMA)/Specialty Society Relative Value Scale Update Committee
 RVU=Relative Value Unit
 Example based on CPT code 99213

Source: American Medical Association. Additional *Managed Healthcare Executive* analysis.

RUC

Continued from page 1

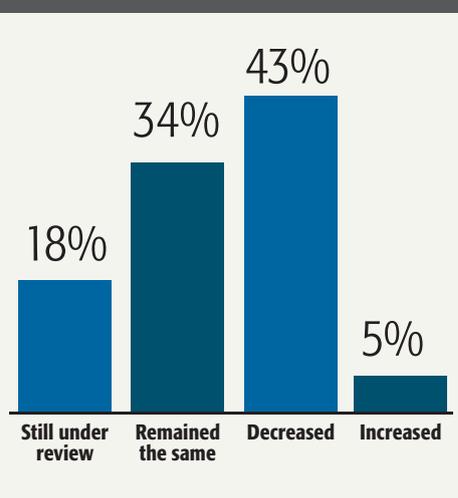
recommendations to CMS regarding new and revised physician services and performs broad reviews of the Resource-Based Relative Value Scale (RBRVS) every 5 years. The RBRVS is a function that weighs physicians' services relative to their value and time investment in order to arrive at a benchmark for compensation on behalf of CMS.

It's not actual dollar figures, but relative values that translate to dollar figures using a complex formula involving a conversion factor (See figure above).

What is most important to note is the broad influence the RUC has on how much physicians get paid—both by CMS directly and by private insurers who base their payments on a percent of Medicare payments. While the committee makes recommendations for relative value, those recommendations carry great weight as industrywide benchmarks for actual-dollar payment rates.

Those who participate in the RUC and those who criticize it have polarizing views. An article in the Feb. 20, 2007, *Annals of Internal Medicine* discussing the income gap between primary care and medical specialties took the committee to task for failing to do more to close that gap.¹ Specifically, the article blamed the over-representation of specialty physicians on the RUC for the lower incomes of primary-care providers (PCPs). The article did note other factors, however, such as private insurers "reimbursing specialists at

Since 2010, RUC has reviewed 1,553 codes



large percentages and primary care providers at small percentages over Medicare rates."

Perhaps the most vilifying headline appeared on a July/August 2013 article in *Washington Monthly*: "Special Deal: The shadowy cartel of doctors that controls Medicare."² It and other articles are clear on a number of criticisms.

Critics: There is weak representation of primary care on the RUC, therefore the RUC's recommendations are skewed in favor of specialists.

Much of the focus specifically falls on the committee's purported effects on reimbursements for PCPs. The committee is in fact

skewed toward medical specialists than PCPs by headcount, which may promote the ongoing tendency for procedural CPT codes to be reimbursed more generously than cognitive codes, such as those for patient Evaluation and Management (E/M). And because PCPs tend to engage in a higher proportion of activities that fall under E/M codes, a related criticism is that the updating process undervalues the work of PCPs.

RUC: Primary care compensation is increasing appropriately.

From 1991 to 2011, the portion of Medicare money paid to primary care increased from 37% to 43% while the portion going to surgical specialties dropped from 32% to 21%, according to William L. Rich III, MD, FACS, an ophthalmologist and former RUC chair. Similarly, reimbursement for routine office visits with established patients (E/M code 99213) has risen from \$32 to \$66 since 1995, he says.

"There has been a redistribution of valuation by the RUC," says Rich. "There has been an absolute shift of dollars to primary care, appropriately."

Glen Stream, MD, past president and former board chair of the American Academy of Family Physicians (AAFP), counters that though the tide is turning back toward primary care, it's only to a small and inadequate degree.

AAFP has recommended that CMS create primary-care-specific E/M codes. The acad-

See RUC on page 6

RUC

Continued from page 5

emy's position is that E/M work in primary care is more demanding and complex than in specialties, especially with an aging population that often presents with multiple or chronic conditions.

But the whole idea behind the RUC and its value determinations is to arrive at relatively fair compensation for time and skill. Each CPT code—created exclusively by the AMA to document healthcare services for the purpose of reimbursement—has a relative value unit (RVU) assigned to it. When the RVU is multiplied by a conversion factor and a geographical adjustment, it creates the compensation for a particular service.

Although it's not the only formula, private insurers often use Medicare rates as a baseline for their separately negotiated rates with providers. Market forces, quality programs, pay for performance and other factors figure in as well.

Critics: Service time metrics can become out-of-date with medical advances.

The amount of time attributed to many procedures has remained high even as the procedures have advanced to become more routine, requiring less of the physician's time than previously documented.

A *Washington Post* article noted that 78 physicians in Florida had—on paper—performed at least 24 hours worth of procedures in a single work day based on RVU figures, which would clearly be impossible in the real world.³ And reportedly, certain ophthalmologists performed 30 to 40 procedures in a single day, which would have been more than 30 hours worth of work based on RVU figures.

RUC: The numbers must be examined in context.

In a press release shortly after the article appeared, the AMA stated that it had asked to see the magazine's cited data for the Florida physicians, but that the documentation was not provided.⁴ Regarding the ophthalmologists, the association noted that the procedures cited appeared to have included LASIK, for which RVU values have never been determined because the procedure is not covered by Medicare.

As to the system not addressing procedures that have become more efficient, Rich says that over a 10-year period, he went from performing three cataract surgeries in about 7 hours

to performing 10, but his reimbursement per surgery declined significantly. The Medicare reimbursement for cataract surgery was \$941 in 1995 and is \$578 currently (figures not adjusted for inflation), Rich says.

Critics: RVU numbers assigned to procedures always go up.

Reimbursement just keeps growing over time, say the critics. A *Washington Post* analysis of records for 5,700 procedures reportedly showed that work RVUs are 7 times likelier to increase than to fall.

RUC: The values are relative.

The AMA and the RUC have repeatedly emphasized that the RBRVS and its updates are based on relative values. In other words, if everything is inflated by a similar factor, the RVU figures are still valid, compared to each other.

It's a common misperception that RUC is somehow jacking up physicians' fees in absolute terms, according to AMA. With the various steps between an RVU allocation by the RUC and a final dollar figure in the following year's Physician Fee Schedule, accusations of "price-fixing" are off the mark.

"The RUC does not control revenue," Rich says, "it just determines valuation." Further, he says, since 2010, the RUC has reviewed 1,553 codes. Of those, only 5% increased, 43% decreased, 34% stayed the same, and 18% are still under review. Most of the redistribution

of value was to primary care, he says.

Critics: There is overvaluation of certain procedures.

Overvaluation encourages overuse, not only under Medicare, but under private insurance, too. Many insurers use the RBRVS as a baseline for their own payment scales, with some using a percentage of Medicare payment—such as 125%—as a final rate. This "Medicare spillover" effect does exist, Muhlestein says. Medicare is the payer with the most clout, and its rates do influence private insurers.

RUC: The RBRVS as administered by the CMS is budget-neutral, as reflected by annual adjustments in the conversion factor.

The amount that Medicare spends on physician fees, even fees per patient, continues to rise drastically, of course, but that's being driven by other factors, such as utilization increasing overall. As for private insurers, the RUC has no control over whether they use the RBRVS values or whether or how they modify them.

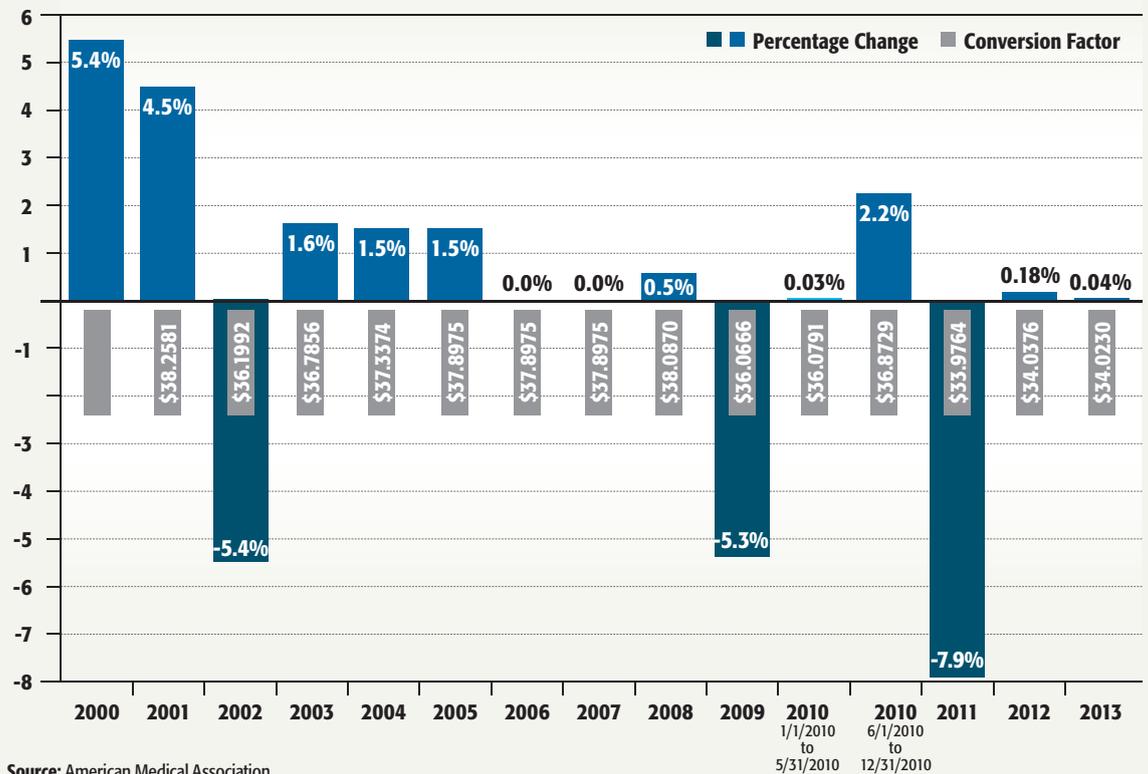
Critics: The RUC is "secretive."

In not publishing the results of RVU votes and in requiring a broad nondisclosure agreement from any non-members allowed to attend a meeting, the RUC appears to be less than transparent in its decision-making process.

Medicare is becoming somewhat more open

See RUC on page 8

CMS Conversion Factor year-over-year change



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What do you like best about



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What did you wish you knew back then?

I wish I knew back then that we would make the strides we have in material advances and have the ability to manufacture lenses in a

consistent and affordable way to allow people to wear lenses on a disposable basis.

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JOSEPH P. SHOWLIN, OD, FAAO, HAS PRACTICED IN SCRANTON, PA, FOR 32 YEARS.

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References: 1. Brobst A, Wang C, Rappon J. Clinical comparison of the visual performance of silicone hydrogel toric lenses with different stabilization systems. *Cont Lens Anterior Eye*. 2009;32(5):243. 2. In a randomized, subject-masked clinical study with 154 patients at 14 sites; significance demonstrated at the 0.05 level; Alcon data on file, 2008.

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RUC

Continued from page 6

about what it pays providers since a federal judge lifted a 1979 injunction that prohibited CMS from disclosing Medicare payments. In May, CMS released hospital charge data for 100 common procedures, but physicians remain divided on the issue of making the information public.⁵

RUC: Some information is better kept within the committee.

RUC meetings are closed for good reasons, principally that new CPT codes requiring an RVU recommendation often involve new medical devices, and the RUC doesn't want its deliberations to become fodder for the stock market.

"They [CMS] don't want Wall Street responding to the debates in that room," says Rich.

The AMA also notes that RUC meetings typically are attended by 300 people, so the attendees hardly comprise a small, clandestine "cartel."

Transforming the RUC from the inside

RUC leadership has been moving to address at least a couple of the concerns highlighted by recent media coverage. For example, one allegation has been that RUC members vote in blocs and that the surgeons or other specialties agree to vote in concert.

Around 1999 and 2000, Levy says, there were factions that would meet separately the night before a meeting to plan their votes, but both she and Rich worked hard to drive that attitude out.

In another change, Levy says, RUC votes will be published for the first time after CMS publishes its final rule—likely this month. The votes will be reported only as totals for and against a given RVU assignment, however, not as individual voting records.

The RBRVS update process is based entirely on effort, so it's lacking any elements connected with health outcomes or the value to a patient of a procedure or E/M.

Physician payments should be based to an extent on effort, as they currently are, says Roy Poses, MD, a clinical associate professor of medicine at Brown University, an internist and blogger who has followed the RUC for half a dozen years. But the most important thing to add to the RBRVS, he says, would be some measure of value for the patient.

Transforming the RUC from the outside

Section 3134 of the Affordable Care Act mandates that CMS establish a process to validate RVUs of Physician Fee Schedule services, and

the agency has contracted with the Urban Institute and the RAND Corp. to do so.

One of the issues underlying these efforts seems to be the question of who would be better qualified to determine physician work values than the physicians themselves? To put it another way: Could a body substantially different from the RUC do the same job, but better?

Levy is skeptical, noting that almost everyone on the RUC is a practicing physician. She questions how a non-physician could set RVUs, particularly those relating to aspects of a procedure's intensity and potential harm that might result.

On one hand, Muhlestein explains, the reported \$7 million that the AMA spends annually to operate the RUC is roughly one ten-thousandth of the approximately \$60 billion a year that Medicare pays for physicians' fees, so more effort in ensuring that RVU allocations are accurate wouldn't be a big hit to the federal budget. On the other hand, he points out, Congress has never given CMS the resources to replace or supplement the RUC.

Calling the RUC's procedures "complicated and opaque," Brown University's Poses says RBRVS should be updated by a formal federal advisory committee whose members are appointed by the federal government; which accepts open, public comments; and which includes "some representation by patients and taxpayers."

A potential step in the direction that Muhlestein and Poses suggest was taken in June, when U.S. Rep. Jim McDermott, MD (D-Wash.) introduced a bill that would create a new panel to oversee the RUC.

McDermott is a psychiatrist as well as the ranking member of the House Ways and Means Subcommittee on Health.

Based on a recommendation from the Medicare Payment Advisory Committee, the Accuracy in Medicare Physician Payment Act of 2013 introduced by McDermott in June would establish a panel of independent experts within CMS "to identify distortions in the fee schedule and develop evidence to justify more accurate updates."⁶

The future of the RBRVS

It's clear that the RUC is, for better or worse, handcuffed to the RBRVS, which was built on a fee-for-service model. With or without major changes, what might the future hold for the RBRVS?

Even within group practices, accountable care organizations (ACOs) and other care models, rewards need to be divvied up somehow, says Rich, either by RVU or some equivalent, and the current RVU assignments are already very commonly used for such purposes.

Levy adds that in addition to being part of how ACOs apportion salaries, the RBRVS is likely to be part of any bundled-payment valuations.

The RVU is "the default standard" for such purposes, Muhlestein agrees. He notes that Leavitt Partners' Center for Accountable Care Intelligence has been tracking ACOs and their payment arrangements for about three years and concludes that most contracts are still fee-for-service based. In addition, the ACOs in the Medicare Shared Savings Program are all based on fee-for-service, he says.

Catalyst for Payment Reform (CPR), a national, not-for-profit collaborative of large employers, in March found that 10.9% of commercial healthcare payments today are tied to value rather than volume.⁷

The biggest take-away from the current controversy about the RBRVS and its updates, Muhlestein says, is simply that RUC is still very relevant and will be relevant for a long time. **ODT**

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In Brief

AOA wants input on diabetic guidelines

St. Louis—Healthcare reform comes with strict new government standards for evidence-based health care. Now, the first guideline developed to help optometrists meet those standards is available for review (<http://www.aoa.org/optometrists/tools-and-resources/evidenced-based-optometry/cpg-3--eye-care-of-the-patient-with-diabetes-mellitus>) and public input during a 30-day comment period.

Practicing optometrists, along with the general public and other stakeholders, can review the AOA Evidence-Based Guideline on Eye Care of the Patient with Diabetes Mellitus and submit comments for consideration, according to the AOA Evidence-Based Optometry Committee.

“The guideline was developed over the past 2 years by an internationally recognized, interdisciplinary panel of leading eyecare practitioners, health policy experts, and patient advocates,” says Diane T. Adamczyk, OD, chair of the Evidence-Based Optometry Committee. “It is designed to provide useful guidance for optometrists in day-to-day practice. It also offers definitive optometric norms and recommendations that will be recognized and respected by all segments of the health care community.”

Institute of Medicine (IOM) guideline development standards call for external review from relevant stakeholders, including scientific and clinical experts, organizations, agencies, patients, and representatives of the public. With that in mind, optometrists have a chance to review and submit comments through an e-form. Comments may then be incorporated in the document.

To participate in the review process, record all comments and suggestions on the Peer & Public Review Document. Save the document and send via e-mail to Quality-Improvement@aoa.org, or mail or fax the document to:

AOA Guideline Development Group,
American Optometric Association, 243 N. Lindbergh Blvd., Floor 1, St. Louis, MO 63141.
FAX: 314-991-4101

The guideline document will be accessible for review online for 30 days. Comments will be accepted until Nov. 30. The AOA Evidence-Based Optometry Committee plans to release a final version of the guideline in January 2014.

TFOS addresses contact lens discomfort

Boston—The Tear Film & Ocular Surface Society (TFOS) has organized the TFOS International Workshop on Contact Lens Discomfort (CLD) to address what may be the leading cause of patient dissatisfaction and contact lens dropout. The CLD Workshop reported its findings in a recent issue of *Investigative Ophthalmology & Visual Science* (<http://www.iovs.org/content/54/11/TFOS1.full.pdf+html>).

The TFOS International Workshop on Contact Lens Discomfort Report is freely available to scientists and clinicians worldwide. Complete or partial translations of the report will be offered in numerous languages.

The CLD Workshop took 18 months to complete and involved 79 experts from around the world.

“Workshop participants used an evidence-based approach and a process of open communication, dialogue, and transparency in order to achieve a global consensus concerning multiple aspects of CLD,” says Mark Willcox, PhD, FBCLA, FAAO, MASM, professor, School of Optometry & Vision Science, University of New South Wales, and vice-chair of the Workshop.

B+L launches PureVision 2 MF

Seattle—Bausch + Lomb introduced PureVision2 Multi-Focal (balafilcon A) monthly silicone hydrogel multifocal contact lenses at the recent annual American Academy of Optometry meeting. Featuring a next-generation 3-zone progressive design, these lenses are designed to improve near and intermediate vision while providing excellent distance clarity.

The lens design allows for a more predictable, quick fit for the eyecare professional. According to the company, PureVision2 Multi-Focal helped maintain clear near, intermediate, and distance vision in real-world conditions.

The lenses are approved for extended wear up to 30 days in powers ranging from +6.00 D to -10.00 D in 0.25 D steps. Low add power helps patients needing 0.75 D to 1.50 D of near power, while the high add power addresses needs of 1.75 D to 2.50 D. Base curve is 8.6 mm, and diameter is 14.0 mm.

“We know that consistent, crisp, clear vision at all distances can be a challenge for people with presbyopia. These new lenses will provide that consistency whether viewing a screen on your mobile phone or a screen at

the cinema,” said Joseph Barr, OD, MS, vice president, Medical Affairs, Pharmaceuticals, Vision Care, Bausch + Lomb. “We’re optimistic that the combination of a streamlined fit and a satisfied patient will make this lens a favorite for the eyecare professional.”

WCO curriculum support document available

London—The World Council of Optometry’s (WCO) published its first curriculum support document: “Curricular support elements for an optometry programme,” available for download on WCO’s Web site: www.worldoptometry.org/en/publications/curricular-support-elements-for-an-optometry-programme. It was produced by the WCO education committee to help schools, colleges, and universities starting or upgrading an optometry program and can be used as a basis for designing their curriculum.

Some 15 elements of practice are covered in the guide, including:

- Patient examination
- Patient management
- General health assessment
- Specialized care
- Professional responsibilities

The guide features a detailed outline of topics for the highest level of optometry education for institutions developing or upgrading optometric programs and for individual faculty members developing courses.

Cooper launches Biofinity XR, adds cylinder to Avaira

Pleasanton, CA—CooperVision, Inc. announced the launch of its Biofinity XR contact lens brand, an extension to its Biofinity (comfilcon A) silicone hydrogel technology. Biofinity XR lenses are now available in powers from +8.50 D to +15.00 D (in 0.50 D steps) and -12.50 D to -20.00 D (in 0.50 D steps). The current Biofinity line continues to be available in +8.00 D to -12.00 D.

In other news, CooperVision expands Avaira toric lens parameters with the addition of a -2.25 D cylinder power availability. With this extension, Avaira is available in sphere powers of -6.00 D to +6.00 D in 0.25 D steps; -6.50 D to -10.00 D in 0.50 D steps; cylinder powers of -0.75 D, -1.25 D, -1.75 D, and -2.25 D; and axes from 10 degrees to 180 degrees in 10 degree steps. **ODT**

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What about noncompliance?



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

I get to write a lot with this gig. While I take pride (and responsibility) for everything I've written, October's issue contained an article I'm especially proud of. "The High Cost of Non-Compliance" discussed patient non-compliance with contact lens wear. I am especially pleased with the paper firstly because it is the initial collaborative effort between myself and our editor-in-chief, Gretchyn Bailey. I hope to do more of these collaborative pieces with both Gretchyn and our Associate Optometric Editor Kathy Mastrotta. Two sharper people I have never met. I am satisfied with the piece because it also helped me to understand patient non-compliance in a larger perspective.

How many of you are more than mildly vexed with your patients' non-compliance with contact lens wear and care? For years I've watched in silent and sometimes not-so-silent frustration as my patients abused their eyes with contact lenses. It is little wonder contact lens patients are often called the junkies of eye care. It seemed that no matter of persuasion could alter the habits of these patients. Don't get me wrong—the majority of our contact lens-wearing patients are compliant with our recommendations. Yet that minority are

the ones who would cause me to pull out my hair (if I had any).

I used to take noncompliance personally. I was failing my patients. After all, it's my job to explain the risks of contact lens wear and care non-compliance, and if my patients weren't complying then I must be doing a poor job of communicating those risks.

One of the many points I learned preparing this piece: It's not my fault! Many patients aren't going to comply no matter what you say. Some even think they are complying with your instructions, but in reality they aren't.

The other point I learned is we aren't alone in our noncompliance conundrum. Patient non-compliance with systemic medications is a huge medical problem, causing over 100,000 deaths each year, up to 25% of all nursing home admissions, and costing our healthcare system over \$317 BILLION dollars annually.¹

The question still remains: How do we get our patients to comply? We make the point that patient education is the key and hit compliance hard with every contact lens patient at each and every visit. Changing to a daily disposable lens seems to help. I keep really gruesome pictures of corneal ulcers and other contact lens complications posted on my exam room walls so I can reference them for all my noncompliant patients. I give patients wear and care handouts. I probably sound like an optometric version of Chicken Little: "You're going to get an ulcer! You're going to get an ulcer!"

That concerns me because the great majority of noncompliers aren't going to have an adverse event, I'm sounding like a harbinger of doom when doom isn't coming, and I worry that my patients are going to tune me out.

Lately I've been thinking that perhaps the best way to get through to the hard-core contact lens abusers is to hit 'em where they'll understand—in their wallets. One study mentioned in the article discussed treatment costs of adverse events and found them to be pretty high. I prefer to point out to the patient in my chair presenting with the "positive washcloth test" that this corneal ulcer is going to cost you \$X in an office visit, \$Y in topical medications, and you may or may not lose \$Z in missed wages while you're treating the eye. All of which could've probably been prevented had you worn your contact lenses as recommended and cared for them as you should.

Harsh? Probably. Those patients seem to get it, though. My most compliant patients are those who have had an adverse event. They simply don't want to go through it again. Or maybe they're just going somewhere else where there is no hassle for their lenses—like the corner convenience store. Alas, that is another discussion. **ODT**

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The power of community



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

It's the time of year when people think about what they're thankful for. During the month of November, some people are posting each day on Facebook one thing that they're grateful for. I'll spare you 30 of them and stick with one.

I'm thankful for community.

In my use of the word, I'm going with dictionary.com's third definition: a social, religious, occupational, or other group sharing common characteristics or interests and perceived or perceiving itself as distinct in some respect from the larger society within which it exists.

Traditionally, community has meant the locale in which you live. But it can be so much more than that. Community can be virtual, such as the ODs on Facebook group or an online parenting messaging forum. It can be your small group of friends or a big group with which you feel affinity, such as Tea Party Republicans or fellow Burning Man attendees.

I'm grateful for many communities: my family, of course, both my husband and daughter, and the wider group of us, including my second cousin who is living in Rio de Janeiro. I also have experienced wonderful communities at both of my daughter's schools. The concept of community is front and center there, and it's amazing to see it in action. I'm definitely going to miss the Abington Friends School community once she goes to college in 2 short years.

Professionally, I'm grateful for the optometric community at large, including our readers. I really enjoy hanging out with you guys! Narrowing it down a bit, I feel community with the contact lens folks because I've spent so much time with them during my career. I also love the community of Women of Vision. I'm adding a new community in my professional life: that of the Public Health and Environmental Vision Section of the American Academy of Optometry. I qualified as a candidate for Diplomate a few weeks ago in Seattle.

Community can be a very powerful thing, and we may not appreciate it until we actually give some thought to the communities to which we belong. During this season of thankfulness and giving, be mindful of your community, and be grateful. **ODT**

Dry eye and contact lens wear

Follow these tips to keep your patients more comfortable

Over three-quarters of our patients will discontinue contact lens (CL) wear at one time or another due to discomfort.¹ Patients with CL-related dry eye (CLIDE) may complain of dryness, discomfort, grittiness, irritation, burning, or foreign body sensation.² There are about 35 million CL wearers in the United States, which suggests that as many as 17 million CL wearers experience significant dry eye symptoms.³

Be proactive

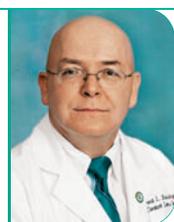
How do we keep our CL patients who suffer from dry eye comfortable in their CLs? First, be proactive. Diagnose and treat dry eye before attempting CL wear. Start by gathering the patient's medical history to understand general systemic health and medical therapies. Medications that cause ocular surface dryness (eg, oral antihistamines, anticholinergics, antihypertensives, cardiac antiarrhythmics, antidepressants, oral contraceptives) should be minimized. Advise your patient that alcohol and smoking will worsen dry eye symptoms.⁴ Perform a complete dry eye work-up. (See box.) Assess meibomian gland function—meibomian gland disease (MGD) is the most common cause of contact lens intolerance.⁵

Treating underlying dry eye

Once a diagnosis of dry eye has been made, treat the dry eye before attempting CLs. Absent a stable precorneal tear film, the patient attempting CL wear is doomed to failure. Concomitant lid disease needs to be addressed as well.

Inflammation is a critical component in dry eye, and short-term topical corticosteroids will provide immediate relief as well as address the underlying cause. The patient may need to begin lid scrubs and warm compresses to treat plugged meibomian glands and blepharitis.

The use of 0.5% cyclosporine A (Restasis, Allergan) in CL patients before applying CLs and after lens removal can also significantly increase comfortable wearing time.⁶ A study by Hom showed a significant reduction in CL intolerance with the use of Restasis when the med-



By Ernie Bowling, OD

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

ication was used before and after CL wear.⁷ Oral doxycycline may be of benefit in the treatment of dry eye. Doxycycline modifies the fatty acid metabolism within the meibomian glands and enhances the lipid layer of the tear film. Topical azithromycin is another option. Both drugs are commonly used in the treatment of MGD, although their use is off label.

Lenses and care solutions

All soft CLs dehydrate on the eye, most likely through evaporation. Use of artificial tears and rewetting drops are the mainstay of treatment. Instruct your patient remove her lenses about halfway through the day and place them in a case with fresh saline for half an hour while also rehydrating her eyes using non-preserved artificial tears. This step allows the lens to rehydrate and can extend the wearing time of patients with more severe dry eye.⁸

Consider refitting your patients into silicone hydrogel lens materials. Remember that an improper lens fit can cause symptoms that can be misdiagnosed as a dry eye.

An easy way to avoid lens care solution interaction in CLIDE is to eliminate care solutions. Changing the patient to a daily disposable lens may be your best alternative. For those patients for whom

In attempting to keep CL patients more comfortable during lens wear, perform a complete dry eye work up.

This should include the following:

- Sodium fluorescein staining of the cornea and conjunctiva
- Tear film break-up testing
- Lissamine green staining of the cornea and conjunctiva
- Schirmer's or phenol red thread testing
- Tear meniscus height evaluation
- Tear film osmolarity testing or lactoferrin microassay evaluation
- Meibomian gland function assessment
- Conjunctival parallel folds and lid wiper epitheliopathy appraisal

this isn't an option, changing the care regimen to a preservative-free hydrogen peroxide disinfection system is another choice. **ODT**

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Refer to your optometric colleagues

A comanaging relationship doesn't need to be with an MD

It fills me with a sense of pride when I think about working with another physician to either complement the care of my patient or obtain services I cannot perform. Let's face it, we are not capable of doing everything for our patients and thus we have to seek the guidance of those who are better at specific skills. We as a profession need to have our pulse on what other physicians are providing for our patients. This is the essence of comanaging our patient—it is not a financial agreement, it is a “what's in your patients best interest” agreement.

A great example is non-FDA approved procedures that are in clinical trials, such as dry eye studies, contact lens studies, and new IOLs, to name a few. However, currently one clinical study can have a tremendous effect on your patients: corneal collagen cross-linking (CXL). The application of riboflavin to the stromal collagen creates a bond that stabilizes the structure of the cornea. Yet, when you refer, recommend, or simply tell your patient to get involved with this procedure, you are creating a bond with your patient.

As a clinical investigator in the CX-LUSA clinical trial, I can speak firsthand to the symbiotic relationship between optometrist and investigator. When a clinic is using the epi-on CXL technique, the patient experience has limited to

their vision through LASIK or other refractive surgical procedures. However, patients with keratoconus or irregular corneas were not ideal candidates. The same was also noted with patients who had previously had radial keratometry (RK) and were attempting to relieve the time that they were glasses- or contact-lens-free. These are the patients who should not wait for FDA approval, haggle with insurance, or hear about this procedure from anyone but their optometrist that they trust.

Comanage with an OD

The influx of new technology allows our patients to buy an e-ticket into Tomorrowland and be provided today with the happiest of all treatments. Yet, we don't always think of this as a comanagement because the referring optometrist is not

able, in most cases, to assist in the care. Au contraire, my learned optometric colleague. As in the example of CXL, our corneal dystrophy, post-refractive, keratoconic, and high myopic patients

can have a life-altering change. These patients still will be wearing corrective lenses and require comprehensive eye care and evaluation of their ocular health. Similar to a patient who has a new toric IOL or partakes in a clinical trial for dry eye, the referring doctor is still involved. Frankly, referring doctors are often viewed as the true patient

champions for their initiative and forward thinking.

This comanagement agreement is also extended to optometrists who refer their patients to other optometrists who can provide a service they do not. I never had a great desire to treat low vision or perform vision therapy. However, I respect those doctors who have the patience and desire to work with these patients. As in any arrangement, you should talk with your colleagues about how to best cooperatively manage the patient. Personally, I prefer to keep the patient in my practice for all health exams, and refer to the specialist (in this case the optometrist) for the treatment. This extends to any area of treatment you do not feel you want or are capable of managing. Seek out a colleague, check out her practice, and have a game plan in mind on to how to handle the patient's care.

Referring doctors are often viewed as the true patient champions for their initiative and forward thinking.

Using a current example, I recently read Dr. Kathy Mastrotta's article on *Demodex* and have watched *Optometry Times's* video series on *Demodex* treatments and what we as optometrists can do to remove this nasty bug on our patients' lids. This may be something you want to do—or better yet, prefer to refer to a colleague to exterminate your patients' lids. Such a situation would be a comanaged relationship.

As optometrists, we pridefully hang the “primary care” moniker on ourselves. Nowhere can this be visible to the patient when you introduce her to a treatment, a new material, or a clinical trial that can benefit her or her family in the future. **ODT**



By Marc R. Bloomenstein, OD, FAAO

Dr. Bloomenstein is director of optometric services at Schwartz Laser Eye Center in Scottsdale, AZ.

E-mail him at mbloomenstein@gmail.com.

no symptoms, and follow-up is strictly evaluating the change in topography and other metrics. Specifically speaking, any patient in your practice who has the potential for corneal irregularity will be an ideal candidate for CXL. As a practitioner involved in the refractive surgical arena, I have watched patients attempt to stabilize or improve the quality of

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Why I recommend PRK

Help your patients understand why this procedure may be the best choice

One of the most common questions I hear from patients: Why am I not a good candidate for LASIK, and why are you recommending PRK? I answer by assuring the patient that *I am recommending PRK because it is the procedure that gives you the best chance of 20/20 vision safely.* Let's discuss the clinical findings that can lead to a recommendation of PRK.

Thin corneas. One of the most important factors when considering elective corneal surgery is safety. Patients who have thinner corneas (less than 500 μm) may be at greater risk for corneal destabilization or the development of ectasia.¹ We know that the more collagen fibers we alter, the greater the risk for biomechanical instability. Because surface ablation does not require a stromal corneal flap, we alter fewer of the collagen fibers most important for corneal stability.

Topographic irregularity. While keratoconus is reported to have an incidence of 1 in 2,000 in the general population, higher incidence is reported in certain populations. Up to 32% of corneal topography studies have some asymmetry or irregularity² (Figure 1). Many surgeons prefer to minimize tissue removal for these patients.³

Dry eye. Most patients who undergo surface ablation have subjective dry eye symptoms during the postop period, but studies show a return to baseline for most



William Tullo, OD

Dr. Tullo is the vice president of clinical services for TLC Vision and adjunct assistant clinical professor at SUNY College of Optometry.

patients after 12 months.⁴ Some studies suggest fewer dryness symptoms after PRK as compared to LASIK.⁵

Epithelial disease. Patients who suffer from certain types of epithelial disease such as recurrent corneal erosion or epithelial basement membrane dystrophy may increase their risks of symptomatology if a LASIK flap is created. Surface ablation may indeed offer a therapeutic treatment for patients with epithelial disease.⁶

Research supports that visual outcomes of surface ablation with experienced surgeons are similar to LASIK in low to moderate myopia with or without astigmatism.⁷ PRK also offers the following advantages as compared to LASIK:

- No risk of flap complications
- Surgery itself is faster, more comfortable, and less complex
- Room for enhancements
- Occupation/hobby with high risk of ocular trauma

It is important to remind patients who have surface ablation that visual recovery is slower than LASIK, and many patients can experience discomfort during the early postop period. I explain to patients that PRK is more comfortable than LASIK during the actual procedure but less comfortable for a few days afterward. I assure them that they will be provided medication to minimize

any discomfort and a bandage contact lens will maximize comfort and vision. Most patients can expect legal driving vision within the first week, which will gradually improve to their best acuity in several weeks.

Patient satisfaction with PRK is similar to that of LASIK, with greater than 95% reporting satisfied or extremely satisfied.⁸ When PRK is the best procedure for your patient, help him understand the benefits of surface ablation while alleviating his disappointment about not qualifying for LASIK. Setting proper patient expectations and educating patients with clinical information will allow your patient to make the choice best for his vision. **ODT**

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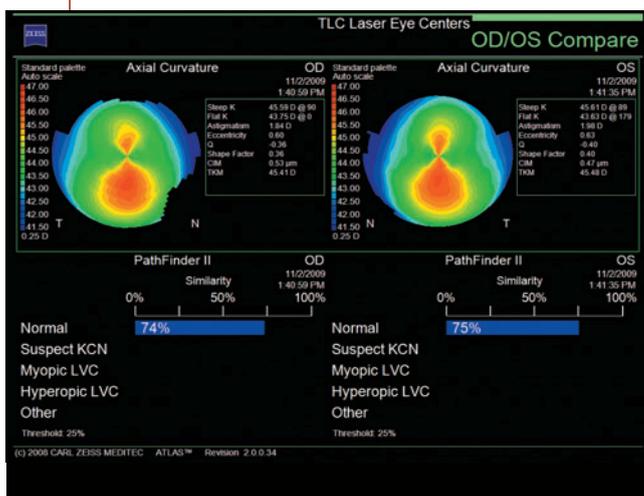


Figure 1. Irregular topography. (Photo courtesy William Tullo, OD)

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Treating patients with brain injuries

Although how injuries affect patients differ, most visual symptoms are similar.

Approximately 2.6 million people suffer a traumatic (TBI) or acquired brain injury (ABI) annually.¹ Optometrists, in many cases, are part of the treatment team, or they may be the first point of contact. These patients will inevitably walk into your office, and you must be ready to ensure your patient's visual and systemic well-being.

Acquired brain injury is an injury to the brain that is not congenital.² The most common cause, by far, is stroke/cerebrovascular accident (CVA), followed by tumor and aneurysm.¹ The incidence annually of ABI is about 917,000 individuals. A TBI is a sudden physical assault on the head that causes damage to the brain.² The trauma can be a closed (shaken baby syndrome, stroke) or penetrating head injury (gun shot, car accident). TBI is the leading cause of death and disability among children and young adults in the United States. Approximately 1.7 million Americans sustain a TBI each year,³ and 5.3 million live with a long-term disability as a result.¹ A greater risk has been documented in adolescents, young adults, and persons older than age 75. Men are twice as likely as women to sustain a TBI.¹

An understanding of the anatomy and physiology of the brain is necessary; the area of the brain injury will dictate the types of deficits with which patients present (Figure 1). The left hemisphere is responsible for language,

memory, and analysis. The right hemisphere is responsible for object location, body position, remembering, and forming percepts. Table 1 reviews the specific functions of the lobes of the brain.⁴

While there are certainly patterns that emerge when treating patients with brain injury, no two patients are identical. Each patient's injuries impact them differently—physically, socially, emotionally, and cognitively. Managing patient and family member expectations should be done cautiously, and promises should never be made. Patients who present for optometric care related to TBI and ABI range in age tremendously and often seek treatment anywhere from days to years after the initial incident. These patients typically are involved in several concurrent treatments, including physical, occupational, cognitive, and speech-language therapies, and are taking multiple medications. Working with the other professionals on the treatment team, including physical and occupational therapists, physiatrists, and a multitude of medical specialists, is vital. The optometrist will often need to coordinate care to ensure that visual care is incorporated into the greater treatment plan.

Brain injuries and vision

Regardless of the type of injury—TBI or ABI—the most common visual symptoms are similar. Patients often complain of loss of balance, dizziness, eyestrain and headaches with near work, loss of place while reading, and distance and near blur. Frequent concerns also relate to visual field defects, reduced or diminished stereopsis, reduced reaction time, reduced accommodative ability and flexibility, dry eye symptoms from a decreased blink rate, and reduced hand-eye coordination.⁵⁻⁷

The conditions encountered, including binocular vision, accommodative, ocular motor and visual information processing concerns, visual field defects/visual neglect, and nerve palsies, occur in greater amounts in relation

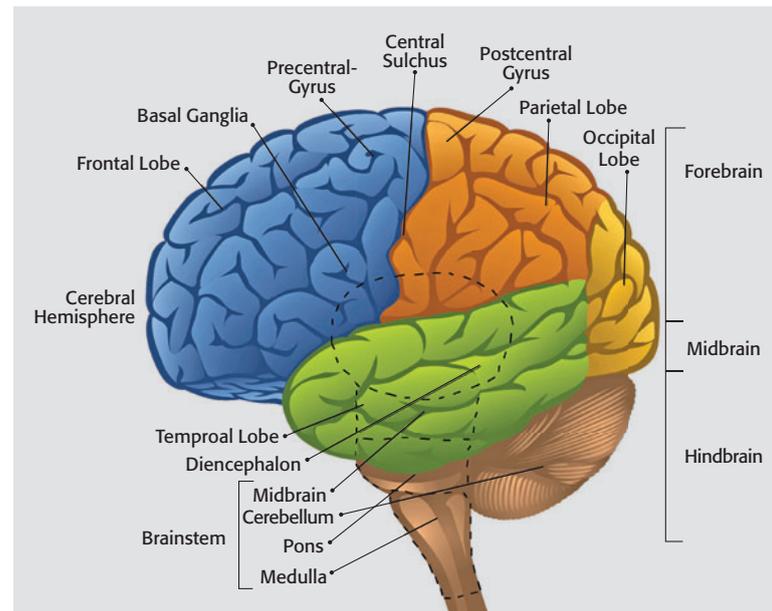


Figure 1. Anatomy of the brain. (Reprinted with permission from the Optometric Extension Program Foundation)

Functions of the Lobes of the Brain

Lobe of the Brain	Function(s)
Frontal lobes	Emotional control center Home to our personality
Parietal lobes	Sensory integration Sensation and perception
Temporal lobes	Memory skills Organizing sensory input
Brainstem	Attention Arousal Consciousness All information passes through brain stem
Cerebellum	Movement Balance equilibrium Muscle tone

Take-Home Message

The idea of working with patients with ABI can be intimidating at first. The results can be rewarding, making it worth the time and effort spent. The difference you can make is life-altering.

to the general population. Alvarez et al,⁸ in a study involving 557 civilians with TBI, found in the inpatient subgroup:

- Convergence insufficiency both with and without simultaneous diagnoses (23.3% [130])
- Convergence insufficiency without simultaneous diagnoses (9%)
- Cranial nerve palsies (26.9%)
- Accommodative dysfunction (24.4% [76 of 314])
- Visual field deficits or unilateral visual spatial inattention/neglect (29.6% [80 of 270])

Within the convergence insufficiency subgroup, photophobia (16.3%) and vestibular dysfunction (18.5%) were detected.

Treating patients with brain injuries

In serving this population, optometric care can be provided either within the rehabilitation center or hospital as an inpatient, or as an outpatient in a traditional office. Both

types of care can be challenging and require a different approach. In an acute care setting, you are tasked with ensuring both the quality of the visual system as well as the health of the eye. In slightly over 2 years of patient care at Memphis' premier rehabilitation facility, I estimate that 20% of referrals were ultimately related to structure, not function. These problems can run the gamut from retinal to corneal in etiology. Artificial tears and ointments become vital treatment modalities. Keep in mind that the patient's health history is not wiped clean and that findings may be related to previous conditions.

Visual complications should be approached in a stepwise manner, and you must address the patient's and treatment team's concerns. By far, the main problems that are found at the rehabilitation facility are related to visual field loss/neglect and diplopia. Both can impact the care the patient is receiving from occupational and physical therapists, so the goal is to eliminate diplopia and provide information to the care team to maximize success. If there is a field cut, therapists are educated and advised on how to best to work with that patient on their specific deficits. For example, if there is a right homonymous field defect, do not approach the patient from the right side. Seems simple, but a little bit of knowledge can go a long way.

Diplopia has a simple treatment—a black patch. Patch on, problem solved, right? Wrong! Full occlusion is in no way therapeutic and can inhibit the rehabilitation process in some cases. Occlusion should be aimed at preserving as much visual information as possible while eliminating the diplopia.⁹ For example, if the patient suffers from a 6th nerve palsy, there will be diplopia in a lateral view on the affected side. Patching of the temporal spectacle lens will help alleviate symptoms (Figure 2). Binasal occlusion could also be considered to reduce the amount of incoming visual information in patients with processing difficulties⁹ and has been shown to impact VEP amplitude in TBI patients.¹⁰ Another option for the relief of diplopia is Fresnel prism (Figure 3). This “stick on” prism can be applied to any spectacle lens, on either the front or back surface. Because the visual system is in a dynamic state, using this type of treatment allows for quick changes in the prism power as the healing process is taking place.

Activities aimed at preserving and improving visual function should be provided to the therapists because they are working with your patients on a daily basis. For example, for visual neglect, consider using yoked prism with varying orientations with hand-eye coordination activities to “show” the brain what it



Figure 2. Partial occlusion on glasses.



Figure 3. Fresnel prism on glasses. (Courtesy of Fresnel Prism and Lens Company)

is missing. This will set the stage for the optometric vision therapy that will come later once the patient has been released from the acute care facility.

One of the difficulties related to in-patient care is vision correction. Because the average patient stay can last anywhere from 3 to 8 days, updating the prescription should be delayed unless in an extreme emergency. It can be a challenge for the practitioner to make a return trip for dispensing with such a tight window.

In the office, the practitioner must be prepared to improvise. Cognitive problems may prevent subjective testing, or the patient may be limited physically, reducing the ability to rely on traditional testing techniques. Testing may need to be broken up into several visits as fatigue may be an impediment. Having a variety of evaluation methods on which you can rely is the key to a comprehensive evaluation.

Optometric vision therapy is a crucial part of the treatment plan for those with an ABI or TBI. In a retrospective analysis of TBI/ CVA patients with oculomotor dysfunction, 100% of patients had successful treatment which was stable 2 to 3 months later.¹¹ Convergence insufficiency, has been found to be best treated with in-office vision therapy, and it was successful in about 75% of patients (resulting in normal or significantly improved symptoms and signs).¹² If the office at which you work does not offer optometric vision therapy, seek out the nearest provider to manage the care. These optometrists can be located by using the doctor locator options at the Web sites for the Optometric Extension Program Foundation (www.oepf.org) and the College of Optometrists in Vision Development (www.covd.org). The Neuro Optometric Rehabilitation Association (www.nora.cc) should also be considered a great resource. **ODT**

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In Brief

Eyes of Faith adds to NOTW collection



Shield and Vine join the Not of This World collection from Eyes of Faith.

Shield is a big and bold acetate shape, available in Obsidian Stripe and Smoky Grey with sleek, beveled temples that showcase a NOTW shield and Psalm 28:7 scripture printed inside its temple. Available in size 56-17-145.

Vine is a softly-rounded, feminine front shape with just a hint of an uplifting cat-eye, keyhole bridge and layered acetates Golden Olive, Golden Brown, and Navy Sapphire. Each temple features a -swirled, metallic logo plaque on the outside and a signature heart logo on the inside of each temple tip. This style features the scripture John 15:1 printed inside every frame. Available in size 50-18-135.

Gucci launches its 'Web Ribbon' collection



Gucci is pleased to introduce a new eyewear collection featuring its web stripe detail on the temples.

Maui Jim allows you to switch it up



Coming next summer, Maui Jim brings a frame technology to allow sunglass wearers to switch out their lenses to address various light conditions during outdoor activities.

Switchbacks feature a proprietary quick-release lens mechanism and 5 options for lens colors. By pressing a button at the top of the frame, the one-piece lens is released from its hold and can be easily swapped for a lens of a different color. The replacement lens then snaps into the frame with the push of a button that securely locks the lens into place. MSRP is \$319.

This full-wrap frame has anti-corrosive pin hinges attached to wide temples with holes for straps. The oversized rubber temple grips offer the ultimate in hold and stability. A benefit of this frame is its adjustable Rabalon nose bridge for a custom-feel fit. These frames are available in Matte Black Rubber or Matte Rootbeer.

Each frame comes with two lightweight, flexible, scratch- and impact-resistant polycarbonate lenses. Matte Black Rubber comes with a PolarizedPlus2 Neutral Grey lens, plus an anti-

reflective clear lens. The Neutral Grey lens cuts 100 percent of UV rays and 99.9 percent of glare while enhancing color on bright sunny days. Matte Rootbeer comes with the clear lens plus an HCL Bronze lens for variable light conditions with patented PolarizedPlus2 lens technology.

Other available PolarizedPlus2 lenses can be purchased for \$100 MSRP and come in Maui Rose, a soft rosy tint that provides high contrast for fast-moving sports, and Maui HT, a palm-green tint that balances contrast and depth of field for crisper details during varying light conditions. Additional clear lenses are available at \$40 MSRP. Extra lenses come with a dual pouch cleaning cloth.

All Switchbacks lenses have waterproof and oleophobic coatings to shed water and repel smudges, as well as proprietary Clearshell scratch-resistant coating to reduce scratches. Each lens has an 8 base curvature. Switchbacks has an eye size of 68 mm, bridge size of 16 mm, and temple length of 115 mm. This style is not available in prescription.

The web stripe is one of Gucci's most iconic motifs. The sunglasses and optical frames, available in metal versions or in Optyl, are decorated with the web stripe detail on the temples, fixed externally by a gold-coloured metallic "GG Britt" logo and internally by a metal plaque bearing Gucci's engraved trademark.

The collection includes 4 sunglass and 3 optical frames, plus 3 Asian fit sunglass and 2 Asian fit optical frames. These models come in a variety of shapes—round, square, or rectangular—and in a variety of natural tones, such as Havana, white, red, blue, and black.

New hybrid styles join Costa's 2013 collection



Marrying its patented, nearly-indestructible, co-injected, molded nylon frame construction with quality corrosive-resistant Monel metal, Costa adds Conch and Tower frames to its 2013 collection.

Conch is a classic, large aviator sunglass shape and features sturdy integral hinges and adjustable silicone nose pads for optimal fit. It's available in palladium and gunmetal frame colors.

Tower's retro rectangle shape is a medium fit and includes no-slip temple tips to help keep the sunglasses comfortably in place all day. Like Conch, Tower features integral hinges and adjustable silicone nose pads. Frame colors include palladium, gunmetal and gold.

Both Conch and Tower are available with Costa Rx lenses. Combining its 580 lens technology with proprietary lens designs and in-house digital lens processing, Costa is able to offer sharp, clear Rx sunglasses.

Lens color options include gray,



X-IDE unveils Silmo 2013 collection

Silicon, contrast, and color are highlights of X-IDE's 2013 Silmo collection.

Silicon temples are on two new models, Shifters and Spokes, the first with a metal front and the other with painted acetate in a soft rubberised effect. The silicon is hypoallergenic and breathable and can easily be twisted to create fun colour combinations.

Contrast is featured in Rear, on which the application of acetate sheets over a steel frame produce an visual effect giv-

ing the impression of plastic on a light metal frame.

Chromatic colour gave life to Stem, originally a limited edition. An image is transferred to the frame, creating the Scottish Tartan Check, with transparent resin covering the frame.

Previous best sellers such as Factory and Urban join the collection with new mirrored lenses and tri-layer acetate.

X-IDE frames are produced by Imagine 98.

copper, amber, blue mirror, and green mirror in Costa's patented 580 lens technology. The 580 lenses block yellow light from entering the eye, eliminating

glare, and creating sharp color enhancement and polarization capability.

Pricing for Conch and Tower start at \$199.ODT

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Who Are Your Dry Eye Patients? Providing Optimal Management

Helene, a 62-year-old attorney, is referred for cataract surgery. She wears contact lenses and has recently noted decreased visual acuity. She is interested in presbyopia-correcting intraocular lens options so that she can eliminate her use of contact lenses altogether. Examination and medical history reveal signs and symptoms of undiagnosed dry eye disease, including 2+ blepharitis, Schirmer test <5 mm in each eye, punctate staining of the cornea with lissamine green, and elevated tear osmolarity. Further examination confirms the presence of a 2+ posterior subcapsular cataract in the right eye and a less advanced cataract in the left. What are the potential issues with cataract surgery in this patient with symptoms suggestive of dry eye disease?

The Cataract Surgery Patient

Eye care professionals are often aware of the importance of dry eye disease (DED) management in the perioperative care of refractive surgery patients. Ocular dryness symptoms occur in as many as 48% of patients after refractive surgery, and the presence of these symptoms has a significant impact on patient satisfaction.¹ Addressing DED preoperatively can also improve the results of refractive surgery.²

The prevalence of undiagnosed DED is high in patients presenting for cataract surgery. In the Prospective Health Assessment of Cataract Patients Ocular Surface (PHACO) study, investigators found that, of 136 patients (272 eyes), only 22% reported previously receiving a diagnosis of DED. However, when these patients were tested, 62.9% had a tear break-up time (TBUT) of less than 5 seconds, 76.8% had positive corneal staining, 50% had central corneal staining, and 21.5% had a Schirmer score of 5 mm or less. These are all classic signs of DED.³

For further details about Helene, including insight into her perioperative treatment and long-term management, check out our separate CME/CE activity at www.iche.edu/dryeyecase3

Cataract surgery itself also constitutes a risk factor for DED. With multiple topical medications prescribed preoperatively and postoperatively, as well as disruption of the ocular surface due to the incision, the cataract surgery episode can induce DED even in healthy eyes and exacerbate the condition in patients with existing DED. As a result, visual outcomes of cataract surgery can be diminished, especially in patients implanted with presbyopia-correcting intraocular lenses (IOLs).⁴

Dry Eye is a Chronic Condition

Effective management of DED during the perioperative period can help to make sure patients reap the optimum benefits of cataract surgery. Proper attention to the ocular surface can make the difference between a patient who reaches targeted visual acuity and one that is plagued with additional problems and reduced quality of life.

Diagnosing Dry Eye Disease

It is helpful to keep in mind the risk factors for DED: female gender, increasing age, use of a computer for work, concurrent use of topical medications containing benzalkonium chloride (BAK), postmenopausal use of estrogen-replacement therapy, comorbidities such as connective tissue disease, environmental factors, low dietary intake of omega-3 fatty acids, and numerous others.⁵ In assessing patients for DED before cataract surgery, it should be considered that the symptoms and signs of DED can fluctuate or progressively worsen over time.² Therefore, a careful ophthalmic history, eliciting comments about past as well as current complaints of DED symptoms, is vital. A longitudinal study found that commonly used biomarkers of dry eye, including tear osmolarity, corneal staining,

LEARNING OBJECTIVES

- Describe recent guideline protocols for diagnosing dry eye disease (DED), classifying DED severity, and differentiating underlying etiologies of DED
- Describe the complications of DED in the setting of delayed diagnosis
- List the current recommendations for the treatment and follow-up of DED by level of severity and underlying etiologies

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conjunctival staining, and meibomian gland grading, all varied at monthly examinations over a 3-month period (although tear osmolarity showed the least variability).⁶

Stabilizing the Dry Eye

Once DED is diagnosed in a cataract surgery candidate, a treatment plan should be formulated to bring the chronic condition of DED under control preoperatively and keep it that way postoperatively.

Inflammation plays an important role in the pathophysiology of DED.² In a healthy eye, the ocular surface and tear-secreting glands operate as an integrated unit to maintain the tear film. When this integrated functioning is disrupted, the inflammatory response initiated on the ocular surface leads to DED.^{4,7}

In many cases, blepharitis associated with meibomianitis is also a part of DED leading to excessive tear evaporation due to lipid deficiency in the tear film.⁵ Blepharitis can be addressed with lid hygiene and warm compresses.

When inflammation involves the ocular surface or there is a mixed etiology of DED, anti-inflammatory therapy is a key component of care. Anti-inflammatory therapies for moderate DED can include topical cyclosporine and corticosteroids; in severe cases, systemic anti-inflammatory treatment may be necessary.⁵

The Perils of Not Treating DED Perioperatively

Roberts and Elie performed a randomized, blinded study that demonstrated the development of dry eye symptoms after routine cataract surgery. In 30 female cataract surgery patients, half received treatment with topical cyclosporine for 1 month before and

1 month after surgery, while the other half received placebo. Symptoms were assessed with questionnaires preoperatively and at 1 week and 1 month postoperatively. In placebo-treated patients, 1 month following surgery, 87% reported needing artificial tear supplementation at least once daily, 80% experienced dry eyes at least occasionally, 73% reported foreign body sensation at least occasionally, 53% reported burning sensation at least occasionally, and 47% reported blurred vision at least once a day. The number of patients reporting these symptoms increased from the preoperative assessment. The cyclosporine-treated patients fared better; 1 month postoperatively, 53% reported no need for artificial tears, and greater numbers of treated patients reported “never” or “not usually” experiencing dryness, burning, and blurred vision compared with placebo-treated patients.⁸

DED can also negatively affect visual outcomes of cataract surgery with presbyopia-correcting IOLs. In a randomized, prospective study, patients undergoing bilateral cataract surgery with presbyopic IOL implantation who were treated with cyclosporine in one eye and an artificial tear in the other eye showed improvement in DED signs and better visual acuity outcomes in the cyclosporine-treated eye at 2 months postoperatively.⁴

Extending the DED treatment regimen to encompass the preoperative and postoperative periods helps to ensure that any exacerbation due to the trauma of surgery or toxicity from associated medications is kept to a minimum. Adequate lubrication can also help control postoperative symptoms. In fact, Bloomenstien reported that quality of vision was improved in patients who used artificial tears aggressively after cataract surgery and in the same dosing regimen as a postoperative refractive patient.⁹

Assessing Dry Eye

In order to recognize signs of DED and address the condition before cataract surgery is scheduled, conventional tests to assess the ocular surface, including TBUT with fluorescein, Schirmer test, lissamine green staining, tear meniscus height assessment, and meibomian gland grading, should be routinely performed. Corneal topography and tear osmolarity testing can also be valuable additions to the cataract DED diagnostic workup. Assessing corneal topography indices, Liu and

Pflugfelder found that patients with aqueous deficiency have irregular corneal surfaces that may contribute to visual difficulties. They suggested that surface regularity and asymmetry indices can serve as objective diagnostic measures for identifying DED and assessing its severity.¹⁰ Tear osmolarity is a relatively new objective diagnostic modality that has been shown to be more sensitive for diagnosing and grading the severity of DED than conventional measures.^{4,11}

Patient Education Pearls

Because patient education is an important component of DED management, it may also be helpful to have the cataract surgery candidate fill out the Ocular Surface Disease Index (OSDI) questionnaire at a baseline visit and periodically thereafter to assess the severity of DED.¹² Explaining to the patient how he or she has scored on the questionnaire may help to demonstrate the need to improve his or her ocular surface health before cataract surgery can be considered.

The Continuum of Care

Because DED is a chronic condition that can worsen over time, and because cataract surgery can be an exacerbating factor, it is important to understand the management of DED in the cataract patient as an ongoing process, i.e., a continuum of care. The ocular surface must be made healthy before surgery is scheduled, possibly with a regimen including a topical corticosteroid and cyclosporine, and follow-up must continue for a longer and more intense period than the standard 90-day period of postoperative care for uncomplicated cataract surgery.

Conclusions and Final Clarifications

DED is often underdiagnosed in presurgical patients. All necessary diagnostic tests and DED treatment should begin before surgery is considered. It is important to remember that DED is a chronic condition, and patients will need continued monitoring and management to achieve excellent postoperative quality of vision and optimal levels of overall satisfaction.

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Image showing cataract surgery

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E-mail: joleen@woa-eyes.org

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Contact: Jeanne Oliver

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E-mail: jeanne@pacificu.edu

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Contact: Ron Fiegel, OD

Tel: 316-729-8900

E-mail: registration@thehoacs.org

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Eye doctor uses magic to teach valuable business lessons

Magical presentations help corporate employees expand their perception to solve business problems



Dr. Sterling uses illusions to help expand people's perspectives to help them creatively solve problems.

Photos courtesy Jay Sterling, OD

'Incorporate anything that offers entertainment value. Doing something interactive is much more powerful in today's market.'

Jay Sterling, OD

As a practicing optometrist and illusionist in Lancaster, PA, Jay Sterling, OD—his stage name—knows all about the difference between clear vision and perception. For the past 15 years, his business presentations have taught employees the difference, which in turn, helps them think more creatively when solving daily business challenges.

"Most of us accept the way our vision functions on a day-to-day basis," Dr. Sterling said, adding that a firm that markets his speaking engagements prefers he doesn't release his real last name. "But so much of what we see is distorted. By helping people see how their eyes can deceive them, we can help them make better decisions in business or in their personal life, reach beyond their

comfort zones, and do things they normally wouldn't think of doing."

Dr. Sterling's speaking career began as a coincidence approximately 15 years ago. After he performed illusions for company banquets, businesses started asking him to incorporate their new product, service, or promotion into his presentation. So rather than simply entertain employees with magical illusions, he began using his magic skills a way to deliver a key business message: people's narrow perspectives often limit their abilities and opportunities to creatively solve problems, both at work and in their personal life.

Seeing differently

One common exercise in his hour-long presentations includes a 3 x 5 index card. He

'People become bored with PowerPoint. Incorporate anything that offers entertainment value. Doing something interactive is much more powerful.'

Jay Sterling, OD

asks participants to tear a small hole in the middle of the card so they can put their finger through it. He later asks them to enlarge the hole so they can stick their hand through it. Easy enough. But then he asks them to tear a hole large enough to put their head through it.

Most people laugh or look at him in disbelief, he said. Their perception is that it's an impossible task. It simply can't be done. Then he proves them wrong.



Your eyes can deceive you. Dr. Sterling helps you see more clearly.

"What happens is our eyes see the perimeter of the paper and see that tearing a hole that large is impossible," he said, adding that readers will have to attend his presentation to learn how this challenge is accomplished. "But there's actually a very easy way to do it just by changing your perspective, which makes the process easier to understand and do."

Since then, Dr. Sterling has performed several times each month for hundreds of companies, mostly in the United States, but some as

far away as Shanghai, China; Dubai, United Arab Emirates; and Cape Town, South Africa.

Throughout his presentation, he incorporates business props, such as money, laptops, or cell phones, into his illusions. For example, he'll make a cell phone vanish from one spot, then reappear later in another to illustrate how perception can cloud a person's creative ability and judgment when tackling business concerns.

Beyond PowerPoint

Over the years, employees weren't the only ones learning at his shows. Dr. Sterling also created his own bag of tricks on how to become a successful public speaker. His top five tips include:

- Develop a niche presentation with global appeal. The deeper the niche, the more universal the message, the better. His presentations address a common business challenge—encouraging employees to think outside the box when solving problems.
- Entertain, don't just inform. "People become bored with PowerPoint," he said. "Incorporate anything that offers entertainment value. Doing something interactive is much more powerful in today's market."
- Offer experiences that participants can relate to and immediately apply at work when they return to their offices.

- Hire a marketing company to represent you. It's typically easier for somebody else to promote you than to promote yourself. Dr. Sterling, who is represented by several different marketing firms, said a professional speaker typically earns upwards of \$3,000 per engagement.
- Publish a book on your presentation's topic. Dr. Sterling published his first book titled, *The Other Side of Vision* (Advantage Media, 2009). "Your book can be your quintessential business card," he said, adding that a book lends credibility and better positions you as an expert on that topic.

Then don't forget to follow your own advice. Dr. Sterling routinely expands his perspective or "gives himself new eyes." When traveling, he often mystery shops other optometry practices. His office encourages anonymous suggestions from staff about practice management ideas. Every now and then, he also acts like a patient by lingering in his own waiting area to observe patient-staff interactions.

"It seems like everyone is always looking for the newest, latest concept in improving themselves or their business," Dr. Sterling said. "But rather than searching for new landscapes, you may simply need new eyes." **ODT**

FYI



Jay Sterling, OD

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BAUSCH + LOMB

LOTEMAX[®]

loteprednol etabonate
ophthalmic gel 0.5%

Brief Summary: Based on full prescribing information.

To report SUSPECTED ADVERSE REACTIONS, contact Bausch & Lomb at 1-800-323-0000 or FDA at 1-800-FDA-1088 or www.fda.gov/medwatch

INDICATIONS AND USAGE

LOTEMAX is a corticosteroid indicated for the treatment of post-operative inflammation and pain following ocular surgery.

DOSAGE AND ADMINISTRATION

Invert closed bottle and shake once to fill tip before instilling drops.

Apply one to two drops of LOTEMAX into the conjunctival sac of the affected eye four times daily beginning the day after surgery and continuing throughout the first 2 weeks of the post-operative period.

CONTRAINDICATIONS

LOTEMAX, as with other ophthalmic corticosteroids, is contraindicated in most viral diseases of the cornea and conjunctiva including epithelial herpes simplex keratitis (dendritic keratitis), vaccinia, and varicella, and also in mycobacterial infection of the eye and fungal diseases of ocular structures.

WARNINGS AND PRECAUTIONS

Intraocular Pressure (IOP) Increase

Prolonged use of corticosteroids may result in glaucoma with damage to the optic nerve, defects in visual acuity and fields of vision. Steroids should be used with caution in the presence of glaucoma. If this product is used for 10 days or longer, intraocular pressure should be monitored.

Cataracts

Use of corticosteroids may result in posterior subcapsular cataract formation.

Delayed Healing

The use of steroids after cataract surgery may delay healing and increase the incidence of bleb formation. In those diseases causing thinning of the cornea or sclera, perforations have been known to occur with the use of topical steroids. The initial prescription and renewal of the medication order should be made by a physician only after examination of the patient with the aid of magnification such as slit lamp biomicroscopy and, where appropriate, fluorescein staining.

Bacterial Infections

Prolonged use of corticosteroids may suppress the host response and thus increase the hazard of secondary ocular infections. In acute purulent conditions of the eye, steroids may mask infection or enhance existing infection.

Viral Infections

Employment of a corticosteroid medication in the treatment of patients with a history of herpes simplex requires great caution. Use of ocular steroids may prolong the course and may exacerbate the severity of many viral infections of the eye (including herpes simplex).

Fungal Infections

Fungal infections of the cornea are particularly prone to develop coincidentally with long-term local steroid application. Fungus invasion must be considered in any persistent corneal ulceration where a steroid has been used or is in use. Fungal cultures should be taken when appropriate.

Contact Lens Wear

Patients should not wear contact lenses during their course of therapy with LOTEMAX.

ADVERSE REACTIONS

Adverse reactions associated with ophthalmic steroids include elevated intraocular pressure, which may be associated with infrequent optic nerve damage, visual acuity and field defects, posterior subcapsular cataract formation, delayed wound healing and secondary ocular infection from pathogens including herpes simplex, and perforation of the globe where there is thinning of the cornea or sclera.

The most common adverse drug reactions reported were anterior chamber inflammation (5%), eye pain (2%), and foreign body sensation (2%).

USE IN SPECIFIC POPULATIONS

Pregnancy

Teratogenic Effects: Pregnancy Category C.

Loteprednol etabonate has been shown to be embryotoxic (delayed ossification) and teratogenic (increased incidence of meningocele, abnormal left common carotid artery, and limb flexures) when administered orally to rabbits during organogenesis at a dose of 3 mg/kg/day (35 times the maximum daily clinical dose), a dose which caused no maternal toxicity. The no-observed-effect-level (NOEL) for these effects was 0.5 mg/kg/day (6 times the maximum daily clinical dose). Oral treatment of rats during organogenesis resulted in teratogenicity (absent innominate artery at 5 mg/kg/day doses, and cleft palate and umbilical hernia at 50 mg/kg/day) and embryotoxicity (increased post-implantation losses at 100 mg/kg/day and decreased fetal body weight and skeletal ossification with 50 mg/kg/day). Treatment of rats with 0.5 mg/kg/day (6 times the maximum clinical dose) during organogenesis did not result in any reproductive toxicity. Loteprednol etabonate was maternally toxic (significantly reduced body weight gain during treatment) when administered to pregnant rats during organogenesis at doses of 5 mg/kg/day.

Oral exposure of female rats to 50 mg/kg/day of loteprednol etabonate from the start of the fetal period through the end of lactation, a maternally toxic treatment regimen (significantly decreased body weight gain), gave rise to decreased growth and survival, and retarded development in the offspring during lactation; the NOEL for these effects was 5 mg/kg/day. Loteprednol etabonate had no effect on the duration of gestation or parturition when administered orally to pregnant rats at doses up to 50 mg/kg/day during the fetal period.

There are no adequate and well controlled studies in pregnant women. LOTEMAX should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers

It is not known whether topical ophthalmic administration of corticosteroids could result in sufficient systemic absorption to produce detectable quantities in human milk. Systemic steroids appear in human milk and could suppress growth, interfere with endogenous corticosteroid production, or cause other untoward effects. Caution should be exercised when LOTEMAX is administered to a nursing woman.

Pediatric Use

Safety and effectiveness in pediatric patients have not been established.

Geriatric Use

No overall differences in safety and effectiveness have been observed between elderly and younger patients.

NONCLINICAL TOXICOLOGY

Carcinogenesis, Mutagenesis, Impairment Of Fertility

Long-term animal studies have not been conducted to evaluate the carcinogenic potential of loteprednol etabonate. Loteprednol etabonate was not genotoxic *in vitro* in the Ames test, the mouse lymphoma tk assay, or in a chromosome aberration test in human lymphocytes, or *in vivo* in the single dose mouse micronucleus assay. Treatment of male and female rats with up to 50 mg/kg/day and 25 mg/kg/day of loteprednol etabonate, respectively, (600 and 300 times the maximum clinical dose, respectively) prior to and during mating did not impair fertility in either gender.

PATIENT COUNSELING INFORMATION

Administration

Invert closed bottle and shake once to fill tip before instilling drops.

Risk of Contamination

Patients should be advised not to allow the dropper tip to touch any surface, as this may contaminate the gel.

Contact Lens Wear

Patients should be advised not to wear contact lenses when using LOTEMAX.

Risk of Secondary Infection

If pain develops, redness, itching or inflammation becomes aggravated, the patient should be advised to consult a physician.

FOR MORE DETAILED INFORMATION, PLEASE READ THE PRESCRIBING INFORMATION.

Bausch & Lomb Incorporated

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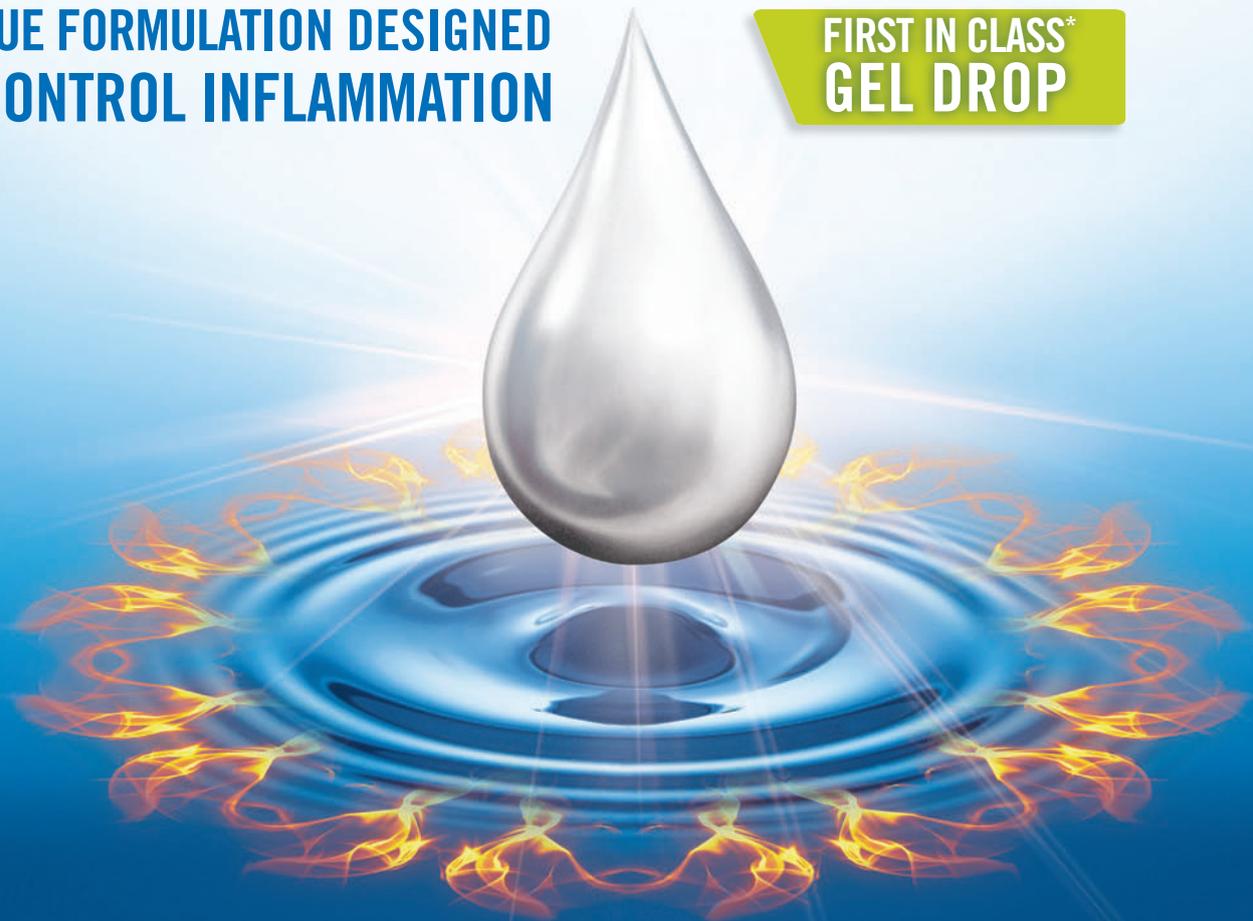
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Indications and Usage

- LOTEMAX® GEL is a corticosteroid indicated for the treatment of post-operative inflammation and pain following ocular surgery

Important Risk Information about LOTEMAX® GEL

- LOTEMAX® GEL is contraindicated in most viral diseases of the cornea and conjunctiva including epithelial herpes simplex keratitis (dendritic keratitis), vaccinia, and varicella, and also in mycobacterial infection of the eye and fungal diseases of ocular structures
- Intraocular pressure (IOP) increase—Prolonged use of corticosteroids may result in glaucoma with damage to the optic nerve, defects in visual acuity and fields of vision. If this product is used for 10 days or longer, IOP should be monitored
- Cataracts—Use of corticosteroids may result in posterior subcapsular cataract formation
- Delayed healing—Use of steroids after cataract surgery may delay healing and increase the incidence of bleb formation and occurrence of perforations in those with diseases causing corneal and scleral thinning. The initial prescription and renewal of the medication order should be made by a physician only after examination of the patient with the aid of magnification
- Bacterial infections—Prolonged use of corticosteroids may suppress the host response and thus increase the hazard of secondary ocular infection. In acute purulent conditions, steroids may mask infection or enhance existing infections
- Viral infections—Use of corticosteroid medication in the treatment of patients with a history of herpes simplex requires great caution. Use of ocular steroids may prolong the course and exacerbate the severity of many viral infections of the eye (including herpes simplex)
- Fungal infections—Fungal infections of the cornea are particularly prone to develop coincidentally with long-term local steroid application. Fungus invasion must be considered in any persistent corneal ulceration where a steroid has been used or is in use
- Contact lens wear—Patients should not wear contact lenses when using LOTEMAX® GEL
- The most common ocular adverse drug reactions were anterior chamber inflammation (5%), eye pain (2%) and foreign body sensation (2%)

Please see brief summary of full prescribing information on adjacent page.

*Ophthalmic corticosteroid.

References: 1. LOTEMAX GEL Prescribing Information, September 2012. 2. Fong R, Leitritz M, Siou-Mermet R, Erb T. Loteprednol etabonate gel 0.5% for postoperative pain and inflammation after cataract surgery: results of a multicenter trial. *Clin Ophthalmol.* 2012;6:1113-1124. 3. Data on file, Bausch & Lomb Incorporated.

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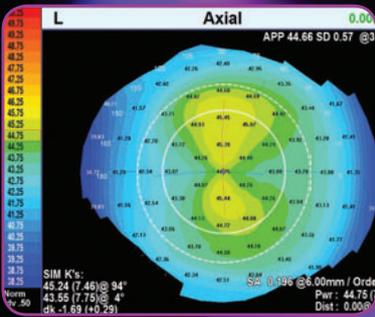
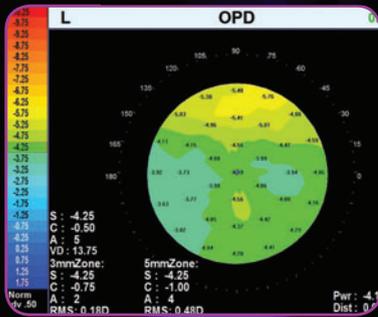
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- Validate Rx changes and increase patient satisfaction
- Optimize cataract and refractive outcomes to 20/happy
- Enjoy more patient loyalty

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