Learning Method and Medium
This educational activity consists of a supplement and ten (10) study questions. The participant should, in order, read the learning objectives contained at the beginning of this supplement, read the supplement, answer all questions in the post test, and complete the Activity Evaluation/Credit Request form. To receive credit for this activity, please follow the instructions provided on the post test and Activity Evaluation/Credit Request form. This educational activity should take a maximum of 1 hour to complete.

Content Source
This continuing medical education (CME) activity captures content from a CME symposium held on November 10, 2012, in Chicago, Illinois.

Activity Description
The management of patients with ocular hypertension or glaucoma increases in complexity as comorbid conditions such as ocular surface disease and cataract present. The goal of this program is to improve the knowledge and clinical performance of glaucoma specialists and comprehensive ophthalmologists by disseminating new information on ocular surface health in patients on glaucoma therapy, and providing expert clinical insight on the management of challenging cases.

Target Audience
This educational activity is intended for glaucoma specialists and comprehensive ophthalmologists.

Learning Objectives
Upon completion of this activity, participants should be better able to:
• Identify ocular surface disease in their patients with glaucoma or ocular hypertension
• Describe the effects of preservatives in glaucoma medications on ocular health
• Plan effective medical regimens for patients with glaucoma or ocular hypertension and complex presentations including ocular surface disease

Accreditation Statement
This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of The New York Eye and Ear Infirmary and MedEdicus LLC. The New York Eye and Ear Infirmary is accredited by the ACCME to provide continuing medical education for physicians.

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Grantor Statement
This continuing medical education activity is supported through an unrestricted educational grant from Merck & Co, Inc.

Disclosure Policy Statement
It is the policy of The New York Eye and Ear Infirmary that the faculty and anyone in a position to control activity content disclose any real or apparent conflicts of interest relating to the topics of this educational activity, and also disclose discussions of unlabeled/unapproved uses of drugs or devices during their presentation(s). The New York Eye and Ear Infirmary has established policies in place that will identify and resolve all conflicts of interest prior to this educational activity. Full disclosure of faculty/planners and their commercial relationships, if any, follows.
Introduction

For patients with glaucoma or ocular hypertension, the end goal is preserving vision by medically and/or surgically lowering intraocular pressure (IOP). An underappreciated factor than can affect treatment outcomes is preexisting or concurrent ocular surface disease (OSD).

Recently, 5 leading ophthalmologists convened at a continuing medical education (CME) symposium to present complex clinical cases focusing on the intersection of IOP management and ocular surface health. This CME activity summarizes highlights from the case presentations and includes panel discussion in 2 of the cases, to share with you the particular debate and varied perspectives those cases engendered. We hope the evidence presented and the panel’s insight on this topic will be helpful to you in managing patients with glaucoma or ocular hypertension.

—Richard K. Parrish II, MD

EVALUATING THE OCULAR SURFACE IN PATIENTS WITH GLAUCOMA OR OCULAR HYPERTENSION

—Stephen C. Pflugfelder, MD

Case 1: The patient is a 64-year-old female with a several-year history of eye irritation and intermittent tearing that worsens upon awakening. Glaucoma was diagnosed a year ago and she is currently being treated with generic latanoprost preserved with benzalkonium chloride (BAK). Over the past 3 months, redness and burning have been noted throughout the day, with worsening after evening latanoprost instillation.

The patient’s tear break-up time (TBUT), as measured by standard fluorescein testing, is 3 seconds. She has inferior corneal fluorescein staining and poorly expressible meibomian glands with ducal keratinization and posterior lid margin neovascularization. External examination with lissamine green dye finds lid parallel conjunctival folds, which is indicative of conjunctivochalasis. (Figure 1A) Anterior segment optical coherence tomography (OCT) shows her tear meniscus height centrally to be 378 µm, approximately 50% higher than the normal height of 250 µm. (Figure 1B)

What are the factors contributing to this patient’s presentation of ocular surface signs and symptoms?

There are several factors that may be contributing to the patient’s presentation: preexisting and persistent OSD, deleterious effects of BAK, and abnormal tear dynamics and delayed tear clearance.

Preexisting and Persistent OSD

Prior to the initiation of ocular hypotensive therapy, the patient’s several-year history of eye irritation and tearing is consistent with OSD. Her current signs and symptoms—reduced TBUT, corneal...
fluorescein staining, meibomian gland dysfunction, redness and burning in the eyes—indicate persistent OSD.

**Deleterious Effects of BAK on the Ocular Surface**

BAK, the most commonly used preservative in ocular medications, is a quaternary ammonium chloride compound with surfactant and detergent properties.1 The toxicity of BAK has been studied extensively. BAK disrupts corneal epithelial tight junctions,2 leading to accelerated desquamation, or loss of the apical corneal and conjunctival epithelium.2 BAK can also be found to be proinflammatory, increasing expression of inflammatory markers on the ocular surface epithelial cells,4 promoting inflammatory cell infiltration4 and goblet cell loss.12 The disruption of both goblet cell mucin production and meibomian gland secretion of the lipid component of tears results in an unstable tear film and increased tear film evaporation, and thereby contributes to the dry eye often seen in patients with glaucoma.5 BAK has been detected in the corneal and conjunctival tissues for 7 days following instillation of a single 30-µL drop.4 Chronic use of BAK may lead to an increased risk of corneal complications such as punctate epitheliopathy,4 a decrease in functional vision, and may affect tasks that require extended concentration, such as reading.4 BAK-induced toxicity may lead to decreased productivity and overall quality of life.12

**Abnormal Tear Dynamics and Delayed Tear Clearance**

This patient has conjunctivochalasis, a condition that increases with age.3 Conjunctivochalasis can compartmentalize the tear film in the center of the eye, which results in pooling and stagnation of the central tear meniscus.13 Her abnormal tear dynamics is increasing BAK’s concentration in the precorneal tear layer, which is likely responsible for the finding of punctate epitheliopathy of the inferior cornea. The conjunctivochalasis also is causing delayed tear clearance, resulting in retention of the ocular hypertensive in the precorneal tear meniscus.

**Glaucoma and OSD**

This case is representative of the common problem of coexisting OSD in patients with glaucoma. Leung and colleagues found that 59% of patients with glaucoma or ocular hypertension complained of symptoms of OSD.9 In addition, they found that for each additional BAK-preserved ocular hypertensive used, there were approximately 2 times higher odds of showing abnormal results on corneal and conjunctival lissamine green staining.12

**Identifying patients at risk for ocular hypertensive toxicity**

It is prudent to perform an ocular surface assessment in patients with glaucoma in order to determine if the condition of their ocular surface places them at greater risk for ocular surface toxicity with the use of ocular hypertensives. (See Sidebar.)

**Managing patients with glaucoma and OSD**

First, I switch the patient to a BAK-free ocular hypertensive. If the patient’s OSD is not improved, I initiate an ocular hypertensive drop holiday, and treat the patient’s glaucoma with an oral carbonic anhydrase inhibitor. I consider instituting dry eye therapy with a preservative-free, low-dose ocular steroid, such as dexamethasone 0.01%, which can be compounded by a specialty pharmacy. Other dry eye therapies to consider include oral cyclopentolate A 0.05%; low-dose oral doxycycline (20 mg twice a day or 40 mg once daily), which inhibits desquamation in the corneal epithelium14; or punctal occlusion plugs (only after the patient has discontinued the BAK-preserved ocular hypertensive). For ocular hypertensive-naive patients, the decision to avoid ocular hypertensives containing BAK can mitigate the risk of developing ocular surface problems. Rossi and colleagues found that initiating IOP-lowering therapy with a preservative-free ocular hypertensive in ocular hypertensive-naive patients resulted in no new cases of OSD and maintained the quality of life of treated patients.19

Dr Pflugfelder’s Ocular Surface Assessment

1. Inquire about ocular irritation symptoms: Although there are many validated questionnaires available, their administration can be quite cumbersome and time consuming. I have found a single question to be just as valuable as a set of many questions. Identifying OSD can be as simple as asking your patients 1 question, “Are you experiencing eye irritation?”

2. Examine the ocular surface:
   - Examine the puncta. Do they have edema or stenosis?
   - Examine the lid margins. Do they present with meibomian gland disease, ectropion, or conjunctival injection or chalasis? I have found chalasis to be prevalent in patients aged older than 45 years, and I have become much attuned to its presence.
   - Check tear stability with fluorescein. Instill fluorescein; wait a few seconds; ask the patient to blink, and then check the TBUT.
   - Consider examining the inferior tear meniscus. Instilling dye in the eye makes it fairly simple to examine the meniscus and will indicate if the tear meniscus is low, normal, elevated, or blocked by conjunctivochalasis.
   - Consider measuring tear production.
   - A more sophisticated approach is to measure tear osmolarity. There is now a commercially available osmometer to measure tear osmolarity. The clinical value of this test is still unknown; however, I believe that in the context of prescribing ocular hypertensive therapy, it may be quite valuable. If a patient consistently has a tear osmolarity in the range of 320 mOsm/L or higher, which is greater than the range of 308 to 316 mOsm/L that has been found to be a sensitive predictor of dry eye disease,12 then that patient should be prescribed an ocular hypertensive without BAK.

**Recognizing the Issue of Poor Adherence in Patients Treated With Ocular Hypotensives**

—Steven L. Mansberger, MD, MPH

Case 2: The patient is an 85-year-old female who reports that she is “doing fine.” IOP in both eyes is 10 mm Hg (her baseline IOP in both eyes before beginning IOP-lowering therapy was 18 mm Hg). Her medication regimen includes timolol twice daily, brimonidine 3 times daily, and dorzolamide 3 times daily. Fundoscopy finds evidence of disc hemorrhage inferiorly. (Figure 2)

**Disc hemorrhage in patients with glaucoma**

There should be concern when disc hemorrhage is observed in the setting of good IOP readings. Just as hemoglobin A1C may be used as an indicator of glucose control in patients with diabetes, the presence of disc hemorrhage in patients with glaucoma may indicate poor adherence with ocular hypertensives. Disc hemorrhages persist, on average, for 3 to 6 months, and can be a sign that either patients are poorly adherent to their medications or that their glaucoma is worsening. The finding of a disc hemorrhage should prompt opthalmologists to ask patients about adherence.

—Steven L. Mansberger, MD, MPH
How adherent are patients with their prescribed ocular hypotensives?

Examining Adherence Patterns and Persistence of Adherence

When analyzing adherence patterns of patients with their ocular hypotensives, researchers find that patients typically are most adherent immediately after their ophthalmologist appointment and then immediately before they return for another office visit. Therefore, the level of adherence to medications is lower in between visits. One way to combat this dip in adherence, especially in patients with suspected poor adherence, is to increase the frequency of office visits.

We also know that with time, we can expect a considerable decrease in our patients’ adherence to their ocular hypotensives. Reardon and colleagues examined the persistency of patients with glaucoma in adhering to their ocular hypotensive regimens over time. When they looked at latanoprost refill records, they found that only approximately 50% of patients were refilling their medications at 6 months.

Therapy adherence and visual function

Stewart and colleagues assessed factors associated with decreased or stable visual function in patients with glaucoma and end-stage cupping of the optic disc. Grading patients as either poorly adherent or adherent to glaucoma treatment, the researchers found that of those who were adherent, approximately 90% were graded as stable in their disease progression, whereas only approximately 50% of the poorly adherent group were stable. Consequences of poor adherence in these patients can be worsening of the visual field or the requirement of surgical intervention to manage IOP.

Determining adherence to ocular hypotensive therapy

If patients admit they are poorly adherent, they probably are, and interventions should be employed to improve adherence. But what about patients who claim they never miss a drop? The finding of disc hemorrhage in this patient may suggest poor adherence to ocular hypotensive therapy despite a stable IOP reading at the office visit. To obtain a more accurate history, I have found it effective to help patients admit to poor adherence by suggesting an overestimate of nonadherence in a “safe” environment. For example, you might say, “It can be difficult to use eye drops every day. How often do you miss your drops? ...about half the time?” By suggesting this high rate of poor adherence, patients may be more comfortable discussing their difficulty with drop administration.

Improving adherence to ocular hypotensive therapy

A useful tool for determining the factors related to patient adherence to ocular hypotensives is the Health Belief Model. (Figure 3) The factors are broadly classified into 1 of 2 groups:

1) Factors that affect individual perception: the patient/doctor relationship, patient demographic features, social supports, patient personality, and patient knowledge of the disease.

2) Modifiable factors: perceived severity of disease, perceived benefits of adherence, perceived barriers to adherence, and perceived susceptibility to blindness. This category includes “Cues to Action” that refer to the external reminders some patients may need to help them remember to use their medication.

By identifying and addressing the following factors, patient adherence may be improved.

• **Patient Demographic Features**: Elderly patients often have poor corneal sensation. Refrigerating their ocular hypotensive may make the drop more obviously felt when hitting their eye, allowing them to know that they were successful in drop administration.

• **Social Supports**: Patients should consider inviting family members into the examination room. Having a family member in the room both reinforces the severity of the disease and provides an opportunity to enlist family members’ help with remembering the counseling relevant to medication adherence.

• **Perceived Barriers to Adherence**: Barriers to ocular hypotensives include medication adverse effects and inconvenience of drop administration. Medication adverse effects are a common reason for poor adherence; thus, switching to ocular hypotensives that are gentler to the eye, such as those without BAK, may improve adherence. Decreasing the frequency of drop administration, by using once-daily prostaglandin analogs, or by using fixed-combination drops, also could improve adherence.

• **Perceived Susceptibility to Blindness and Perceived Severity of Disease**: If patients neglect their ocular hypotensives because they perceive there is a low risk of vision loss, adherence may be improved through education. Also, patients may be poorly adherent when they do not have a measure for, and therefore cannot quantify, the degree of their susceptibility to blindness. These 2 scenarios may be addressed by keeping patients informed of the results of their glaucoma assessments.

• **Cues to Action**: Consider providing patients with cues to action; suggest they set their container of ocular hypotensive near their toothbrush to help them remember to instill their drops in much the same routine as brushing their teeth.

In summary, poor adherence to ocular hypotensives is common, recognizing and managing the issue may improve patient outcomes.

Recognizing Subtle Ocular Surface Disease Before Management of Intraocular Pressure

—Cindy M. L. Hutnik, MD, PhD

Case 3: A 68-year-old male without a significant medical history is referred by an optometrist who had been following him for elevated IOP and was concerned about his recent optic disc changes. The patient felt he was doing well, had no visual or ocular complaints, and was still phakic.

The ocular examination showed the following:

<table>
<thead>
<tr>
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<th>OD</th>
<th>OS</th>
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</thead>
<tbody>
<tr>
<td>IOP (mm Hg)</td>
<td>24</td>
<td>22</td>
</tr>
<tr>
<td>CCT (microns)</td>
<td>536</td>
<td>550</td>
</tr>
<tr>
<td>BCVA</td>
<td>20/25</td>
<td>20/25</td>
</tr>
<tr>
<td>Angle</td>
<td>III</td>
<td>III</td>
</tr>
</tbody>
</table>

BCVA=best corrected visual acuity; CCT=central corneal thickness; IOP=intracocular pressure.

The patient’s visual fields were noncontributory, but he was diagnosed with open-angle glaucoma based on IOP elevation, optic disc changes, and open angles on gonioscopy. Imaging revealed a thin retinal nerve fiber layer consistent with the diagnosis.

He was started on a BAK-preserved prostaglandin analog. Five days after initiation of therapy, the patient reported discontinuing the ocular hypotensive because of eye discomfort. He admitted that prior...
Dr Mansberger: I would ensure the patient is properly hydrated, drinking at least 8 to 12 cups of water per day, because dehydration may be contributing to dry eye. My tendency is to avoid using a steroid unless there are no options remaining. I also would suggest the patient take nutritional supplements, and switch him to a preservative-free ocular hypotensive.

What are the BAK-free ocular hypotensive options available in the United States?

In the United States, there are 2 commercially available non-BAK-preserved ocular hypotensives and 3 preservative-free ocular hypotensives. (Table 1)

Comparative ocular surface effects of ocular hypotensives without BAK vs BAK-preserved ocular hypotensives

Nakagawa and colleagues compared the effects of travoprost with sofZia™ to latanoprost with BAK and to phosphate-buffered saline controls on human corneal epithelial cells. The cell cultures exposed to travoprost with sofZia and those of the controls both exhibited 100% viability at 6 hours, whereas the BAK-exposed cells had 0% viability (P<0.05 vs control).29

Removing BAK from ocular hypotensives has also been found to be clinically beneficial. Horsley and Kahook evaluated patients’ ocular surface signs and symptoms during latanoprost with BAK therapy, and then reevaluated the patients 8 weeks after switching from latanoprost with BAK to travoprost with sofZia. The authors found improvements in TBUt, inferior corneal staining, and OSDI (OSDI index) scores after patients switched to travoprost with sofZia.30 (Table 2) Likewise, Janulević-Jenė and colleagues found that switching patients from latanoprost with BAK to preservative-free tafluprost led to normalization of tear osmolality, improved ocular comfort and TBUt, and decreased corneal staining.31 (Figure 5, Table 3)

Table 2. Mean TBUt, Inferior Corneal Staining Score, and OSDI Score on Latanoprost With BAK and at 8 Weeks After Switch to Travoprost With sofZia (P<0.001) in a Prospective, Open-label, Single-center Study Involving 20 Patients (40 Eyes)30

<table>
<thead>
<tr>
<th></th>
<th>Latanoprost With BAK</th>
<th>Travoprost With sofZia (8 weeks after switch)</th>
<th>P value (8 weeks after switch)</th>
</tr>
</thead>
<tbody>
<tr>
<td>TBUt (seconds)</td>
<td>2.02 ± 0.71</td>
<td>6.34 ± 1.31</td>
<td>&lt;0.001*</td>
</tr>
<tr>
<td>Inferior corneal staining</td>
<td>2.40 ± 0.87</td>
<td>1.38 ± 0.59</td>
<td>&lt;0.001*</td>
</tr>
<tr>
<td>OSDI score</td>
<td>26.31 ± 8.25</td>
<td>16.56 ± 6.19</td>
<td>&lt;0.001*</td>
</tr>
</tbody>
</table>

BAK=benzalkonium chloride; OSDI=ocular surface disease index; TBUt=tear breakup time.
*Student’s t-test

Dr Francis: I would treat the patient’s blepharitis with warm compresses and his dry eye with artificial tears, and also take the patient off BAK-preserved drops.

Table 1. Ocular Hypotensives Without BAK Available in the United States

<table>
<thead>
<tr>
<th>Generic Name</th>
<th>Brand Name</th>
<th>Medication Class</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brimonidine tartrate ophthalmic solution with Purite 0.1% or 0.15%</td>
<td>Alphagan® P</td>
<td>Alpha-adrenergic receptor agonist</td>
</tr>
<tr>
<td>Travoprost ophthalmic solution with sofZia™ (boric acid, propylene glycol, sorbitol, zinc chloride) 0.004%</td>
<td>Travatan Z®</td>
<td>Prostaglandin analog</td>
</tr>
<tr>
<td>Dorzolamide hydrochloride/timolol maleate ophthalmic solution 2%/0.5%</td>
<td>Cosopt® PF</td>
<td>Carbonic anhydrase inhibitor/Beta-adrenergic receptor antagonist</td>
</tr>
<tr>
<td>Tafluprost ophthalmic solution 0.0015%</td>
<td>Zioptan™</td>
<td>Prostaglandin analog</td>
</tr>
<tr>
<td>Timolol maleate ophthalmic solution 0.25% or 0.5%</td>
<td>Timoptic® in OcuDose®</td>
<td>Beta-adrenergic receptor antagonist</td>
</tr>
</tbody>
</table>

BAK=benzalkonium chloride.
Table 3. Patients’ Dry Eye Complaints, Mean TBUT, and Abnormal Corneal Fluorescein Staining at Baseline (latanoprost With BAK), and at 2, 6, and 12 Weeks After Changing to Preservative-free Tafluprost in a Prospective, Observer-masked Study Involving 30 Patients (60 Eyes)31

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Week 2</th>
<th>Week 6</th>
<th>Week 12</th>
<th>P value (12 weeks vs baseline)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dry eye complaints</td>
<td>30 (100%)</td>
<td>19 (63.3%)</td>
<td>11 (36.7%)</td>
<td>11 (36.7%)</td>
<td>&lt;.05*</td>
</tr>
<tr>
<td>(n= 30, patients)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>TBUT (seconds)</td>
<td>3.7 ± 1.1</td>
<td>4.1 ± 1.0</td>
<td>5.2 ± 1.5</td>
<td>6.5 ± 1.5</td>
<td>&lt;.005*</td>
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<tr>
<td>(n= 60, eyes)</td>
<td></td>
<td></td>
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<tr>
<td>Abnormal fluorescein</td>
<td>45 (75.0%)</td>
<td>35 (58.3%)</td>
<td>21 (35%)</td>
<td>7 (12%)</td>
<td>&lt;.005*</td>
</tr>
<tr>
<td>staining of the cornea</td>
<td>(n= 60, eyes)</td>
<td></td>
<td></td>
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</tbody>
</table>

TBUT=tear break-up time.

*p<.05, +p<.005, McNemar test, Paired t-test


The results of the study by Janulieviciené and colleagues emphasize the importance of setting realistic expectations for patients about when they should expect to see improvements in OSD symptoms after switching from a BAK-preserved to a preservative-free ocular hypotensive. Improvements in all OSD measures began to appear at week 2, although significant improvements were not seen until week 12. (Table 3) Indeed, in this patient, after the recognition and treatment of his subtle OSD, he was started on a preservative-free ocular hypotensive, which he has tolerated well.

Managing Advanced Glaucoma and Severe Ocular Surface Disease

—Brian A. Francis, MD, MS

Case 4: The patient is a 79-year-old female with a chief complaint of decreasing vision. She has a history of primary open-angle glaucoma, OSD, non-neovascular age-related macular degeneration, and cataract extraction with intraocular lens implantation in each eye. Her visual fields have progressively worsened over the last 3 years. Her medications, the only 2 ocular hypotensives she can tolerate, include branded latanoprost with BAK at bedtime and dorzolamide twice daily in each eye. She is also using artificial tears during the day. She has exposure keratopathy and pannus inferiorly in the cornea. (Figure 6) External examination finds advanced OSD and eyelid disease: considerable lagophthalmos, which prevents complete closure of the eyes. She also has exposure keratopathy and pannus inferiorly in the cornea. (Figure 6)

How should this patient with advanced glaucoma and severe OSD be managed?

Dr Hutnik: Certainly, this patient must become less dependent on ocular antihypertensives, particularly agents with BAK. A surgical option may need to be considered. Before undergoing a surgical procedure, her ocular surface and eyelids need time to heal, and her IOP could be managed with ocular antihypertensives without BAK or with an oral carbonic anhydrase inhibitor while awaiting the procedure.

Dr Mansberger: This patient has a high chance of going blind, based on her presentation of uncontrolled IOP and visual decline. I have not found trabeculoplasty to be effective in patients with implanted anterior chamber lenses. Trabeculectomy also may not be a good option, given the patient’s poor lid closure and conjunctival inflammation. Switching ocular hypotensives may be effective, but I would not choose this option because the patient’s visual field has been declining despite various attempts at maximal medical therapy. Minimally invasive glaucoma surgery (MIGS) also may not reduce pressures sufficiently. Most of these procedures will lower IOP to the high teens, which is not that different from the patient’s current IOP. I would likely consider implanting a tube, a Baerveldt tube or an Ahmed valve implant.

Dr Francis: This patient has reached the end of the line in terms of glaucoma medical treatment. I would avoid trabeculectomy in this case because there is a high risk that the procedure would be associated with poor outcomes because of her considerable OSD. Baudouin and colleagues found that long-term use of ocular hypotensives, particularly BAK-preserved ocular hypotensives, induces considerable histopathologic and inflammatory changes in the ocular surface and also in the trabecular meshwork. In addition, the researchers found that as the number of ocular hypotensives increased, so did the inflammatory markers and disruption of the normal conjunctival architecture. I would avoid MIGS-based procedures because of potentially insufficient IOP lowering.

Instead of these surgical options, it was decided to manage this patient with an aqueous tube shunt (Baerveldt implant) because of its efficacy in lowering IOP and the minimal need for postoperative ocular hypertensive use or additional surgical interventions following its implantation.

Conclusion

It is important to be mindful of the deleterious effects of BAK on ocular tissues and its potential to limit medical and surgical interventions in patients with glaucoma or ocular hypertension. Identifying preexisting or coexisting OSD in patients with glaucoma can assist clinicians in determining the therapeutic options that can effectively and safely manage IOP, without compromising ocular surface health. Today, the ophthalmologist’s toolbox has expanded to include non–BAK-preserved and preservative-free IOP-lowering therapies that effectively treat patients with or at risk for glaucoma.
Activity Evaluation/Credit Request

Expert Consultations in Diseases of the Aging Eye—Glaucoma, Ocular Surface Disease, and Beyond

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q Yes  q No  I and/or my family member have a financial relationship with The New York Eye and Ear Infirmary and/or refer Medicare/Medicaid patients to it.

I certify that I have participated in the entire activity and claim 1.0 AMA PRA Category 1 Credit™.

Signature Required ____________________________  Date Completed ____________________________

OUTCOMES MEASUREMENT

q Yes  q No  Did you perceive any commercial bias in any part of this activity? IMPORTANT! If you answered “Yes,” we urge you to be specific about where the bias occurred so we can address the perceived bias with the contributor and/or in the subject matter in future activities.

Circle the number that best reflects your opinion on the degree to which the following learning objectives were met:

5 = Strongly Agree  4 = Agree  3 = Neutral  2 = Disagree  1 = Strongly Disagree

Upon completion of this activity, I am better able to:

• Identify ocular surface disease in my patients with glaucoma or ocular hypertension

• Describe the effects of preservatives in glaucoma medications on ocular health

• Plan effective medical regimens for patients with glaucoma or ocular hypertension and complex presentations including ocular surface disease

1. Please list one or more things, if any, you learned from participating in this educational activity that you did not already know.

__________________________________________________________________________________________

2. As a result of the knowledge gained in this educational activity, how likely are you to implement changes in your practice?

4 = definitely will implement changes  3 = likely will implement changes  2 = likely will not implement any changes  1 = definitely will not make any changes

Please describe the change(s) you plan to make:

__________________________________________________________________________________________

3. Related to what you learned in this activity, what barriers to implementing these changes or achieving better patient outcomes do you face?

__________________________________________________________________________________________

4. Please check the Core Competencies (as defined by the Accreditation Council for Graduate Medical Education) that were enhanced for you through participation in this activity.

q Patient Care  q Practice-Based Learning and Improvement  q Professionalism

q Medical Knowledge  q Interpersonal and Communication Skills  q Systems-Based Practice

5. What other topics would you like to see covered in future CME programs?

__________________________________________________________________________________________

ADDITIONAL COMMENTS

__________________________________________________________________________________________

__________________________________________________________________________________________

POST TEST ANSWER BOX

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| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |