Bulletin

NEXT MEETING

Marriott West
600 Maryville Center

March 10, 2020

Clayton Scanlon, M.D.

Historical Review and Current Concept of Stargardt's Disease

6:00 p.m. Buffet

RSVP no later than March 6, 2020
paula@stlouisoptometricsociety.org
Text--314 725-2020
Sponsored by Allergan

7:00 p.m. Business Meeting

7:30 p.m. ***OSD: Moving from Adequate to Expert***

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Thank You SunPharma and Optos for Sponsoring our February Meeting

OSD: Moving from Adequate to Expert

Presenters:

Gregg J. Berdy, M.D., F.A.C.S.,
Ranjan Malhotra, M.D, F.A.C.S.

Submitted by: Steven Brandstetter

Dry eye disease is a great practice builder. 344 million people worldwide have dry eye. Of those, 30 million are in the US, or 10% of the world's dry eye population. About 50% of dry eye patients are undiagnosed and only 1.5 million get a prescription for their dryness. If you compare these numbers to glaucoma patients, you could say we're doing a horrible job managing this condition.

Reasons dryness is more prevalent is increased screen time, reduced blink rate, more awareness as providers, better marketing by companies such as Restasis and Xiidra, and new generic treatments available.

Berdy and Malhotra were involved in the Phaco study which evaluated dryness in every patient coming in for cataract surgery. The study looked for any corneal staining. 77% of patients in the study had corneal staining, but only 22% had a diagnosis or dry eye prior to the cataract evaluation.

The global market for dry eye is expected to keep growing. In 2016, $3.4 billion was spent on dry eye and is estimated to reach $5.2 billion in 2021. The estimated cost to patients is between $300-$500/year and that's even when using only OTC tears. Needless to say, there's a market to treat dry eye patients. If you treat patients for dry eye you can make around $500/per patient versus $40 from a vision exam.

The underlying pathology is hyperosmolarity. You lose homeostasis of tears and the epithelium breaks down. All dry eye is inflammation, not just in autoimmune patients. Eyelid changes, keratinization, stem cell dysfunction, and epithelial cell dysfunction all contribute to the dry eye complex. Mucin is really important for the ocular surface. It helps tears stick to the ocular surface.

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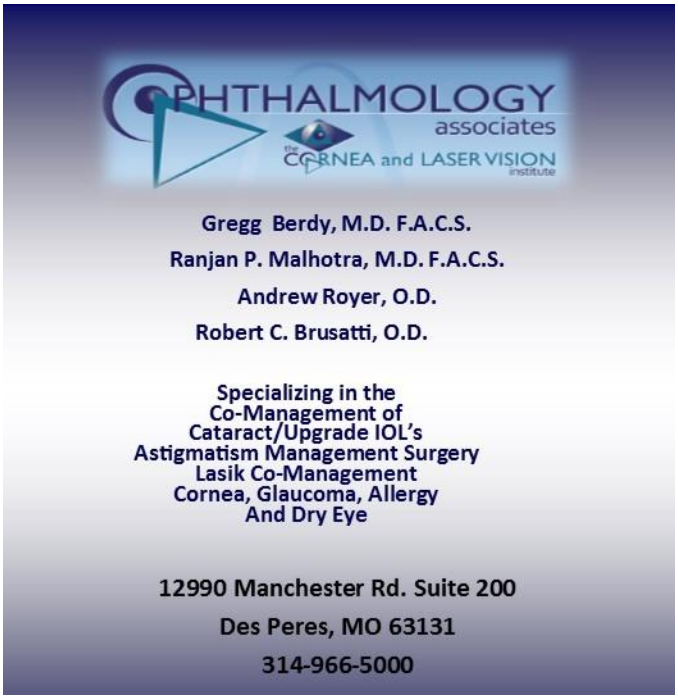

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Discomfort in dry eye is caused by hyperosmolarity, exposed corneal nerves, inflammatory cytokines,and poor corneal neural feedback. Dry eye disease is not necessarily progressive. The sooner you treat, the easier it will be for patients. Risk factors in patients for dry eye include aging population, ocular surgery, reduced androgens, autoimmunity, medications, and menopause.

You can explain dry eye to patients in stages. In the early stage you have abnormal tears, later you have reduced tear production, and last you have damaged surface. This is why we call it ocular surface disease. It's important to have a dry eye questionnaire. The results will change as the patient gets better.

Dr. Berdy has a mnemonic he uses for dry eye called XFIRM FLOSS.

X = exposure	F= Foam
F = Face	L= Lashes
I = Induration	O= Oriffices
R = Redness	S= Secretions
M = Margins	S= Stains (fluorescein, lissamine green)

Tests to diagnose dryness including tear osmolarity, Inflamma-dry and oculus keratograph. Tear osmolarity is a great test. It is a valid metric and it correlates well with disease but has poor reimbursement. Inflamma-dry tests for MMP9 released by dead/dying cells. It is a positive/negative test. The Oculus Keratograph can measure TBUT, meibography, lipid layer thickness and tear meniscus size.

Treatments for dry eye include artificial tears, autologous serum, plugs, amniotic membranes, Omega 3 fish oils, prescription drops and treating the eyelids. Not all artificial tears are created equal. Preservative free, higher viscosity and lower osmolarity tears are preferred. Good examples include Oasis, Retaine, Refresh Omega-3.

Autologous serum can be prescribed using Vital Tears. The cost is about $110/month and is not covered under insurance. Amniotic membranes break down the inflammatory cascade and have great healing properties, but they are not a cure for dry eye. They really help when the epithelium is broken down.

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Restasis and Xiidra help dry eye patients, but they still need to use an artificial tear along with it. Cequa is 2x more concentrated versus Restasis. It is a great drop with better absorption.

The eye lid margin (blepharitis and MGD) must be addressed. Express the meibomian glands at exams to evaluate for MGD. If no expression occurs that is bad. If it's turbid, these patients really need treatment. MGD treatment includes Bruder masks with compression,Blephex, Artificial tears, Omega 3, tetracyclines,sprays like Avenova, Azasite, and IPL (Intense Pulse Light). Z-paks can be used instead of doxycycline for better tolerance and less GI trouble.

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TAYE website,
http://thinkaboutyoureyes.com/aoa
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https://www.moeyecare.org/resources/job-opportunities/

MOA Report January 2020

Submitted by: Jason Riley, O.D.
Jenna Osseck, O.D.

The Special Olympics Vision Screening will be held in St. Charles at the Lindenwood campus on Saturday, March 21st. Volunteers are needed - doctors, paras, or others who'd like to help out! The UMSL vision van will be on site for refractions and the MOA is looking for an autorefractor to also use the day of the screening. Please let your trustees or Dr. Barrett know if you are interested in participating in this event.

As a reminder, the MOA Leadership Retreat will be June 5-6th in Kansas City. The team building event will be axe throwing as the MOA competes against the KOA. On August 22nd, the MOA and IOA will be teaming up for the Cards-Cubs game at Wrigley Field. More information to come.

The 2020 MOA Convention will be in Branson this fall, October 15-18th at the Chateau on the Lake. So mark your calendars!

On the legislative front, SB 942 and HB 2382 were recently introduced which define "surgery" and would greatly affect optometry's scope. The bill was not introduced against optometry, but will have significant ramifications if passed. The MOA and keypersons are currently speaking to the bill sponsors. Our keypersons system will be very important this legislative session, so you may be contacted to speak with your legislator. Please be ready to help in any way possible.

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The Physicians of THE RETINA INSTITUTE

are excited and pleased to announce the 6th Annual

Spring Retina Update

Saturday, April 18, 2020
St. Luke's Institute for Health Education Emerson Auditorium.

This year's symposium will feature talks on Drug Toxicity, New Observations on Injection Complications, How OCTA Can Be Used in Non-exudative AMD, Results of the PRO Study and CSRS.

This educational opportunity is free of charge. Continuing medical credits will be available through IMED for AMA category 1, the information is below**. Credit will also be available through COPE and IJCAHPO. Registration is required.

To register for this event, click here. https://docs.google.com/forms/d/1JCTpxNYDM4WN8L1AUrb6tYmeF0CqWmtfcEAEyyEzNqo/edit

The symposium begins at 7:00 am and ends at 12:30 pm.

The Emerson Auditorium is located at
222 S. Woods Mill Road
Chesterfield, Missouri 63017

We hope that you will be able to join us for this very informative program.

Warmest regards,

The Physicians of THE RETINA INSTITUTE

UPCOMING EVENTS

NEXT MEETING
SLOS Meeting Marriott West
March 11, 2020
Clayton Scanlon, M.D.
Historical Review and Current Concept of Stargardt's Disease

April 18, 2020 - 7:00 am-12:30 pm
6th Annual Spring Retina Update
St. Luke's Institute for Health Education Emerson Auditorium
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See Previous Page for more information and Registration details

Part-time O.D. Needed – Mondays and/or 2 Saturdays/month

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