Subspecialty Day Meetings
An Insider’s Guide
Talk to your astigmatic patients about toric IOL options earlier, and help them see cataract surgery as an opportunity to correct two eye conditions at once.

mycataracts.com: online patient resources
1-844-MYCATARACT (1-844-692-2827): cataract counselors
4-8 What’s Hot at Subspecialty Day
The program directors preview some of the highlights.

10 Dr. Hoskins on Data
The Orbital Gala honoree discusses the importance of mining for big-data gold.

12-14 Meet Drs. McLeod and Schachat
The editors-in-chief of the Academy’s journals are quizzed by Drs. Blomquist, Corrêa, Miller, and Rapuano.

16 New Glaucoma Education Center
Surgical simulations, interactive data, clinical tools, and more.

18-19 Award-Winning Photos
First Place winners from the 2016 OPS exhibit.

20-22 Why Hire a Low Vision Employee?
A win-win for the ophthalmologist and the new staff person.

27-28 Honorary Lectures, Part 1
Preview 9 of this year’s named lectures.

30 Hidden New Orleans Gems
Discover spots that are off the beaten path.

### From the Editor
Welcome to Subspecialty Day 2017!

This year’s Subspecialty Day presentations will cover the latest developments in diagnosis, treatments, and procedures by world-renowned ophthalmologists in disciplines ranging from cornea to retina. On Saturday, there will be Subspecialty Day meetings in cornea, glaucoma, neuro-ophthalmology, oculofacial plastic surgery, and pediatric ophthalmology and strabismus. Refractive surgery is covered Friday, and retina is both Friday and Saturday. I urge you to take time to explore disciplines other than your own. Often, pearls from 1 subspecialty can be applied to a completely different arena in surprising and useful ways. Please see this issue’s “Program Directors Share Insights on Subspecialty Day” (page 4) to find topics that might be of interest to you. Look for the second edition of AAO 2017 News on Sunday, and check your email each evening for AAO 2017 Daily, a roundup of news from Subspecialty Day and AAO 2017. The content can also be found at aao.org/eyenet/daily.

### EyeNet® Magazine helps you make the most of your time at AAO 2017 by bringing you free corporate educational program events* onsite at the Ernest N. Morial Convention Center.

**2 BREAKFASTS**  
Saturday, Nov. 11  
Sunday, Nov. 12  
Check-in and Meal Pickup: 6:45-7:00 a.m.  
Program: 7:00-8:00 a.m.

**3 LUNCHES**  
Saturday, Nov. 11  
Sunday, Nov. 12  
Monday, Nov. 13  
Check-in and Meal Pickup: 12:15-12:30 p.m.  
Program: 12:30-1:30 p.m.

Ernest N. Morial Convention Center  
Room R02-04, 2nd Floor

aao.org/eyenet/corporate-events

* These programs are non-CME and are developed independently by industry. They are not affiliated with the official program of AAO 2017 or Subspecialty Day. By attending an event, you may be subject to reporting under the Physician Payment Sunshine Act.

### NOTICE:
This publication was printed in advance of Subspecialty Day and AAO 2017. For the most up-to-date information, check the Program Search (aao.org/programsearch) or the Mobile Meeting Guide (aao.org/mobile). American Academy of Ophthalmic Executives®, EyeNet®, EyeSmart®, IRIS® Registry, ONE®, and Preferred Practice Patterns® are trademarks of the American Academy of Ophthalmology®. All other trademarks are the property of their respective owners. © 2017 American Academy of Ophthalmology.

### On the Cover
**Traumatic Cataract**

Photo by Robert Prusak, CRA  
University of Michigan  
Kellogg Eye Center

NEW ORLEANS
T o provide an inside look at Subspecialty Day, AAO 2017 News contacted the program directors from each meeting and asked the follow ing questions: 1) Which presentations will have broad appeal across subspecialties? 2) Which presentations might cause subspecialists to reconsider an area of their clinical practice? 3) Which presentations address particularly novel or exciting developments within the field? Here are those answers, with descriptions provided by the program directors.

Most Subspecialty Day meetings take place on Saturday. However, Refractive Surgery Subspecialty Day takes place on Friday only, allowing refractive surgeons the opportunity to register for the Saturday Cornea Subspecialty Day—or any other Saturday program. As always, Retina Subspecialty Day takes place on Friday and Saturday.

Note: All summaries were written in advance of Subspecialty Day. Be sure to check the Subspecialty Day schedule at aao.org/2017 (click “Education,” and check the Subspecialty Day schedule at advance of Subspecialty Day. Be sure to Friday and Saturday.

Here are those answers, with descriptions of their clinical practice? 3) Which presentations? 2) Which presentations might cause subspecialists to reconsider an area of specialties to present diagnostic protocols and therapeutic options. Ask them to present diagnostic protocols and therapeutic options. Ask them when to obtain a consult (rheumatology/uveitis), how to manage iris bombe, and how to achieve adequate reduction of intraocular pressure. Peter Netland, MD, PhD, will discuss “The Good, The Bad, and The Ugly of Treatment Options: What Works? The Evidence.”

For the pediatric case, the advantages and downsides of using steroids will be discussed, and surgical treatments will be covered. Alan Beck, MD, will be on hand to speak on “Goniotomy in Uveitic Glaucoma: What is the Evidence?”

—Shan Lin, MD, Glaucoma program director

Dry eye patients can present a challenge for any ophthalmologist, as they frequently have chronic symptoms that may significantly affect their visual function and quality of life. Unfortunately, the perceived lack of subjective symptomatic improvement can be a source of long-term frustration for both patient and provider.

During Cornea Subspecialty Day, Anat Galor, MD, will address the issue of dry eye management and the use of new testing modalities for patients with dry eyes during the presentation entitled “Point-of-Care Testing for Dry Eyes: Tears of Joy, or Tears From the Expense?” presented by Anat Galor, MD (Saturday, 4:03-4:12 p.m.).

At some point, all ophthalmologists may present with a patient who has double vision, and the differential diagnosis for this symptom includes not only common conditions such as dry eye and monocular diplopia from cataracts but also potentially life-threatening disorders like aneurysmal cranial nerve palsy. Patients describe their visual symptoms in a variety of ways, and the concept and perception of “double vision” varies across ages and even regions of the country and world.

The session will engage the audience with several cases in which the initial symptoms alone can lead the clinician down several diagnostic and therapeutic pathways. New this year is a discussion of diplopia in the setting of concussion, which can be confusing when patients have additional neurological symptoms. Our speakers and expert panelists will help the ophthalmologist identify these problems and direct diagnosis and management in the most efficient and effective way. Come to this session and learn more!

—Prem S. Subramanian, MD, PhD, Neuro-Ophthalmology program director

We will have an entire session dedicated to nonsurgical aesthetics, including facial and eyelid shaping with neurotoxins and fillers. These presentations will be given by experts in the field of nonsurgical facial rejuvenation and will cover everything from the basics to advanced techniques. We will also discuss devices and topical treatments. This session will be useful to all ophthalmologists who are looking to add aesthetics to their practices.

—Wendy W. Lee, MD, Oculofacial Plastic Surgery program director

Glaucoma secondary to uveitis and/or steroid use for uveitic inflammation is one of the most challenging forms of the disease to manage. The comprehensive ophthalmologist, uveitis specialist, retina specialist, anterior segment specialist, and pediatric ophthalmologist will appreciate and learn from presentations and discussion of real-life cases (both adult and pediatric). Experts in glaucoma therapeutics, pediatric glaucoma, and uveitis will be on hand to present diagnostic protocols and therapeutic options. Ask them when to obtain a consult (rheumatology/uveitis), how to manage iris bombe, and how to achieve adequate reduction of intraocular pressure. Peter Netland, MD, PhD, will discuss “The Good, The Bad, and The Ugly of Treatment Options: What Works? The Evidence.”

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—Wendy W. Lee, MD, Oculofacial Plastic Surgery program director

OcuLOFACIAL PLASTIC SURGERY
Room 243
Aesthetics I, moderated by Ivan M. Vrcek, MD (Saturday, 8:05-9:35 a.m.)

We will have an entire session dedicated to nonsurgical aesthetics, including facial and eyelid shaping with neurotoxins and fillers. These presentations will be given by experts in the field of nonsurgical facial rejuvenation and will cover everything from the basics to advanced techniques. We will also discuss devices and topical treatments. This session will be useful to all ophthalmologists who are looking to add aesthetics to their practices.

—Wendy W. Lee, MD, Oculofacial Plastic Surgery program director

REFRACTIVE SURGERY
La Nouvelle Ballroom AB
The Role of Personalized Medicine in Refractive Surgery, presented by John Marshall, PhD (Friday, 8:05-8:15 a.m.)

Personalized medicine is coming to all subspecialties within ophthalmology, and it’s already affecting refractive surgery. The Refractive Surgery keynote lecture, delivered by John Marshall, PhD, covers how the knowledge of the human genome coupled with rapid advances...
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in the molecular biology of diagnostic techniques promise a new era of surgery undertaken by personal molecular screening. In fact, the 3 corneal granular dystrophies can now be identified with 100% accuracy using a simple buccal swab. This is just the first group of diseases to be explored by this technology, which is very useful in Asia, where these dystrophies are especially prevalent.

Ectasia and keratoconus also have been studied so that risk genes were identified. While this is not as accurate as traditional diagnostic imaging, such advantages may represent huge progress for screening ectasia risk among refractive candidates. This talk provides a prospective overview in relation to refractive surgery, including cross-linking, and the present situation and future expectations.

—Renate Ambrósio Jr., MD, Retina program director

RETINA
Great-Hall
Diabetes, moderated by Jennifer K. Sun, MD, and Lloyd P. Aiello, MD, PhD (Saturday, 11:14-11:56 a.m.)

A plethora of clinical trial information has come from the Diabetic Retinopathy Clinical Research Network (DRCR.net), including the Protocol T and S studies. The results of these trials are reshaping how we manage various aspects of diabetic retinopathy, such as diabetic macular edema (DME) and proliferative diabetic retinopathy (PDR). With each passing year, we are moving away from lasers to treat DME and PDR and toward pharmacotherapy with anti-VEGF agents, and the FDA has recently expanded the clinical indications of these drugs in this setting. The section on diabetes consists of a series of updates from the DRCR.net trials to help us fully understand how to best manage various aspects of diabetic retinopathy with the available treatment modalities, both old and new. Perhaps consider holding off on that new laser!

—Carl D. Regillo, MD, and Richard F. Spaide, MD, Retina program directors

Clinical Practices to Reconsider

CORNEA
La Nouvelle Orleans Ballroom AB
Should We Still Be Doing DSAEK?
presented by Winston D. Chamberlain, MD, PhD (Saturday, 9:14-9:24 a.m.)

Endothelial keratoplasty (EK) has evolved in recent years, and traditional Descemet stripping automated EK (DSAEK) may not provide the best outcomes for our patients, now that ultra-thin (UT) DSAEK and Descemet membrane EK (DMEK) are available. Winston D. Chamberlain, MD, PhD, will present data on both visual outcomes and graft rejection rates of the various types of EK. He will also discuss other advantages and disadvantages of each procedure and outline the clinical indications for employing UT-DSAEK versus DMEK. In addition, surgical challenges of transitioning from traditional DSAEK to UT-DSAEK and DMEK will be discussed. Understanding the best surgical procedure for each patient will allow the cornea surgeons to provide the very best patient care possible using current data.

—Benjie H. Jeng, MD, Cornea program director

GLAUCOMA
New Orleans Theatre AB
Cataract Controversies—What Now?!?
moderated by Anna K. Junk, MD, and Anup K. Khatana, MD (Saturday, 4:24-5:26 p.m.)

Cataract surgery in patients with glaucoma has numerous controversial aspects. Should you use a toric or multifocal intraocular lens (IOL) in the patient who has a previous filtering surgery or who has a good chance of such a surgery in the future? Is clear lens extraction a surgical procedure for each patient will allow the cornea surgeons to provide the very best patient care possible using current data.

—Prem S. Subramanian, MD, PhD, Neuro-Ophthalmology program director

OCTUROFACIAL PLASTIC SURGERY
Room 243
Thyroid Eye Disease, moderated by Raymond S. Douglas, MD, PhD (Saturday, 4:10-5:15 p.m.)

Diagnosis and management of thyroid eye disease can be challenging. Decisions about how and when to proceed can be controversial. Raymond S. Douglas, MD, PhD, will lead a session on thyroid eye disease that will include case presentations and discussion of medical and surgical management. His research and his experience with management of patients in this field is vast. The knowledge that he will share should prove valuable to all.

—Wendy W. Lee, MD, Oculofacial Plastic Surgery program director

PEDIATRIC OPHTHALMOLOGY
New Orleans Theatre C
The Heart and Soul—Bourbon Street and Strabisimus, moderated by Jona-
than M. Holmes, MD (Saturday, 8:01-9:22 a.m.)

Strabisimus surgeons will enjoy an exciting back-and-forth discussion of challenging cases. Two experienced strabisimus surgeons will present their preferred surgical approach for each case, with clinical pearls and tips. This will be followed by a panel discussion. The audience members will vote on their preferred approach for each case, both before and after the presentations. Attendees will take home ideas for improving their own previously-preferred technique—and, perhaps, practical recommendations for an alternative technique that they are not using.

One clinical scenario to be discussed will be a hypotropia that is worse in aduction. This scenario indicates that the superior oblique needs to be weakened over another, with practical step-by-step illustrations of how to perform each specific type of procedure.

—Jonathan M. Holmes, MD, and Yasmin Bradfield, MD, Pediatric Ophthalmology program directors

REFRACTIVE SURGERY
La Nouvelle Ballroom AB
JRS: Hot, Hotter, Hottest: Late Breaking News, moderated by J. Bradley Randleman, MD (Friday, 4:03-5:28 p.m.)

The Refractive Surgery program ends with a Journal of Refractive Surgery session, moderated by J. Bradley Randleman, MD, in which the Troutman award goes to Ricardo Vinciguerra, MD, with a presentation on his paper “Detection of Keratoconus With A New Biomechanical Index.” In this study, a novel combined biomechanical index called the Corvis Biomechanical Index (CBI) is described. The CBI is based on corneal thickness profile and deformation parameters obtained by Corvis ST (Oculus) and was calculated to optimized accuracy to detect keratoconic corneas. In this multicenter retrospective study, 98.2% of the cases included in
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the training set were correctly classified with 100% specificity and 94.1% sensitivity. In the validation dataset, the same cutoff point correctly classified 98.8% of the cases with 98.4% specificity and 100% sensitivity. These novel data are integrated with tomography to further augment accuracy on cases with subclinical cataract.

—Renato Ambrósio Jr., MD, Refractive Surgery program director

RETINA

Great Hall

Imaging Section, moderated by Aman Fawzi, MD, and Giovanni Staurenghi, MD (Saturday, 8:05-8:53 a.m.)

Optical coherence tomography (OCT) technology and diagnostic capabilities continue to evolve rapidly. The imaging section of the Retina Subspecialty Day meeting will consist of a series of lectures to bring everyone up to date on exactly how and when the various OCT techniques such as OCT angiography, en face imaging, and widefield options are expected to be clinically useful. We are on the cusp of using these newer diagnostic approaches to supplant, at least in part, what we have traditionally been doing with retinal photography and fluorescence angiography. We will get the latest on precisely how the various imaging techniques compare as well as on how to get the most accurate information from a multimodal approach for common conditions such as age-related macular degeneration (AMD) and diabetic retinopathy.

—Carl D. Regillo, MD, and Richard F. Spande, MD, Retina program directors

Exciting Developments

CORNEA

La Nouvelle Orleans Ballroom AB

Corneal Imaging to Improve Surgical Outcomes, presented by Mohamed F. Abou Shousha, MD (Saturday, 1:42-1:51 p.m.)

Anterior segment optical coherence tomography (OCT) has revolutionized the field of corneal imaging. Real-time cross-sectional images of the anterior segment with few micrometers’ resolution are now possible to obtain not only in the office but also intraoperatively in the operating room. In his presentation, “Corneal Imaging to Improve Surgical Outcomes,” Mohamed F. Abou Shousha, MD, will demonstrate how the general ophthalmologist and the cornea specialist can take advantage of this new technology to improve clinical and surgical outcomes. Through clinical scenarios, he will show how advanced corneal imaging can be used preoperatively to plan and intraoperatively to guide surgery. The presentation will also highlight how corneal imaging became an indispensable tool to diagnose and manage surgical complications. In his presentation, Dr. Shousha will show the cornea specialist and the general ophthalmologist how to use OCT to manage commonly encountered problems.

—Carol L. Karp, MD, Cornea program director

GLAUCOMA

New Orleans Theatre AB

What’s Up Doc? New Therapeutics and Delivery Systems on the Horizon, moderated by Robert D. Fechtner, MD, FACS, and Malik Y. Kahook, MD (Saturday, 8:09-9:07 a.m.)

The field of glaucoma is entering a new Golden Age, with the advent of sophisticated diagnostics and exciting medical and surgical therapies. In this session on new drugs and novel ways to deliver medications, you will hear the very latest on drugs that are pending approval and on those in clinical development (Gary Novack, PhD). Drugs that are in preclinical investigation will also be presented (Joo Schuman, MD). Lisa S. Gamell, MD, will speak on “Herbs and Supplements” for the potential treatment of glaucoma, as most of these are thought to act as possible neuroprotective agents. As we move away from the more than 100-year-old method of eyedrop delivery of glaucoma medications, new modalities may become available as “Intraocular Drug Delivery Systems” (Jonathan S. Myers, MD) and “Extraocular Drug Delivery Systems” (Janet B. Serle, MD). New and possibly more effective forms of “Punctal Plug Delivery Systems” (Marlene R. Moster, MD) will also be discussed. Don’t miss these talks on new ways to treat your patients with glaucoma.

—Shan Lin, MD, Glaucoma program director

NEURO-OPTHALMOLOGY

La Nouvelle Orleans Ballroom C

Help, My Patient Can’t See! moderated by Serita B. Dave, MD, and Julie Falabeau, MD (Saturday, 8:05-9:54 a.m.)

Patients with transient vision loss can frustrate the ophthalmologist because the eye examination is likely to be normal when the patient is not in the midst of an event. The major concern is that this symptom could herald permanent vision loss and/or stroke. In many cases, the patient may have cardiovascular risk factors that would seem to explain the episodes, but the need to act on related findings (such as carotid artery stenosis seen on vascular imaging) has not been clear based on the older literature. In this session, speakers and panelists will discuss cases of transient vision loss and consider new research that points to the predictive value of acute neuroimaging in the prediction of stroke risk. Come and learn when the workup of transient vision loss may be urgent and when it is likely not, and put those older studies and data behind you!

—Prem S. Subramanian, MD, PhD, Neuro-Ophthalmology program director

OCULOFACIAL PLASTIC SURGERY

Orbit, moderated by Brett W. Davies, MD, and Eric M. Hink, MD (Saturday, 1:30-3:35 p.m.)

The lacrimal gland and lacrimal system will be areas of focus during the Orbit section at this year’s Oculofacial Plastic Surgery Subspecialty Day. Dave Tie, MD, will give a talk on tumors of the lacrimal gland and will include a case presentation and expert discussion (1:50-2:20 p.m.). Regarding lacrimal surgery, traditional procedures are often followed, but new developments have recently arisen. Andrew R. Harrison, MD, will speak about minimally invasive conjunctivodacryocystorhinostomy (2:20-2:55 p.m.), and Stephen J. Laquis, MD, will speak about nonsurgical transnasal dacryocystorhinostomy (2:55-3:10 p.m.).

—Wendy W. Lee, MD, Oculofacial Plastic Surgery program director

PEDIATRIC OPHTHALMOLOGY

New Orleans Theatre C

Architectural Details—Corneal Structure and Disease, moderated by Serena X. Wang, MD (Saturday, 11:01 a.m.-12:06 p.m.)

Pediatric and comprehensive ophthalmologists will be excited to hear the latest developments in pediatric cornea. There will be a lively exchange between 2 cornea specialists on the pros and cons of using the KPro (Boston Keraatopros thesis) in the most challenging pediatric cases. Are the benefits worth the risk? Are the results long-lasting enough to warrant putting a baby through this? Kathryn A. Colby, MD, PhD, will discuss the alternatives to the KPro and present her view of their risks and benefits (11:06-11:16 a.m.). In a counterpart, Sarah M. Nehls, MD, will share the latest developments in this technology, and she will present her opinions on the current indications (11:16-11:26 a.m.). Additional presentations in this section will include discussions on conjunctival stem cell transplantation and corneal cross-linking in the pediatric population. This will be an exciting session of “what’s new” for kids with corneal problems!

—Jonathan M. Holmes, MD, and Yasmin Bradfield, MD, Pediatric Ophthalmology program directors

REFRACTIVE SURGERY

La Nouvelle Ballroom AB

Advances in the War on Presbyopia, moderated by Simonetta Morselli, MD, and Gerd U. Auffarth, MD (Friday, 2:28-3:13 p.m.)

A joint session with ESCRS is focused on presbyopia and covers the most innovative options we have in this groundbreaking field. Luca Guaidi, MD, discusses his experience with “Ciliary Muscle Electrostimulation to Restore Accommodation” (CMERA, 2:28-2:34 p.m.). CMERA is a novel noninvasive procedure that enables some restoration of the accommodation by the natural crystalline lens. The treatment rationale is covered along with an insightful understanding on how to customize the best strategy for each patient.

—Renato Ambrósio Jr., MD, Refractive Surgery program director

RETINA

Great Hall

Late Breaking Development—Part II, moderated by Joan W. Miller, MD (Saturday, 8:53-9:25 a.m.)

The field of retina continues to move forward at a rapid pace. Numerous drugs and devices are in various stages of clinical trials. These therapies include small molecules, biologics, sustained-release medications, and gene therapies. All are targeting various unmet needs in wet AMD, dry AMD, diabetic retinopathy, uveitis, retinal degeneration, and other conditions. The Late-Breaking Developments section promises the very latest on the status of the various emerging treatments. We anticipate results from several phase 2 studies that will help to provide perspective on new treatments that are expected to arrive within 3 to 5 years. Surgical advances in the use of smaller diameter instruments, ultrasonic vitrectors, intraoperative OCT, and heads-up 3D viewing are revolutionizing vitreous surgery. Stay tuned!

—Carl D. Regillo, MD, and Richard F. Spande, MD, Retina program directors

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H. Dunbar Hoskins Jr., MD
Orbital Gala Special Honoree

H. Dunbar Hoskins Jr., MD, is the guest of honor at the Orbital Gala on Sunday night. An internationally recognized glaucoma specialist, Dr. Hoskins inspires many as a champion for ophthalmic education, physician and patient advocacy, and technological innovation. He also spent 16 years (1993-2009) leading the Academy as its Executive Vice President. Below, Dr. Hoskins discusses his legacy of physician data collection and his hopes for the future of the information collected by the IRIS Registry (Intelligent Research in Sight).

The Academy was kind enough to honor my retirement in 2009 by establishing the H. Dunbar Hoskins Jr., MD Center for Quality Eye Care (aao.org/about-hoskins-center). Since it was created, the Center has continued to improve our knowledge of high-quality, evidence-based eye care within a tightening economic environment that demands increased value for any services provided. When David W. Parke II, MD, took the helm of the Academy in 2009, he saw an opportunity to take advantage of the advent of electronic health records (EHRs) by creating a comprehensive eye disease and condition repository housed within the Hoskins Center. After several years of careful planning, testing, and tweaking, the repository was dubbed the IRIS Registry (Intelligent Research in Sight), and it went live in 2014.

The IRIS Registry is a centralized data mine and reporting tool (covering all aspects of ophthalmology) that can analyze patient information to produce national and interpractice benchmark reports. Ophthalmologists can compare their patient outcomes, professional performance, and care processes against other ophthalmologists across the country. It now contains more than 100 terabytes of data, making it the largest specialty-based clinical data registry in the world. In only 3 years, the IRIS Registry has collected data from 37 million individual patients and 148 million patient visits.

This collection of data is a treasure trove of information, and it is imperative that we put it to work to advance clinical knowledge and improve patients’ lives. But to convert data into knowledge requires difficult and time-consuming efforts. We have all heard of “data mining,” but few of us understand what it truly means. A collection of data is like a gold mine. We know that there is definitely treasure there, but to produce it requires separating the gold from the dirt, iron, rocks, and even fool’s gold, and bringing it together in a coherent mass to ultimately process it into pure gold.

The same is true with data. Information comes in many forms, with many names and metadata. These must be sorted, tabulated, and constructed into a meaningful presentation that we as physicians can understand and interpret in order to incorporate it into our knowledge. It is much like creating a beautiful mosaic from hundreds of tiny stone chips of varying sizes. The process requires using digital techniques to dis-till the data into similar batches and then bringing humans in to analyze and further subdivide the batches into accurate and meaningful groups. It involves some sophistication to ask the right question the right way, curate the data, analyze it using the right tools, and write it up so that it can be shared with peers. It is an extremely time-consuming and arduous process.

Nevertheless, mining and creating deep knowledge from bits of data will become an essential part of our future, and the Academy hopes to accelerate this process. Training future investigators to use data-mining techniques on the IRIS Registry database will establish better standards for managing our patients. This requires implementing a scholarship program to bring young investigators to the Academy headquarters in San Francisco for a short stay to learn the techniques needed to extract knowledge from the data; they can then develop their own data batches from the IRIS Registry to work on. Through this effort, a cadre of investigators who understand the processes and the problems will be established, and we will all reap the benefits. These investigators will improve our data collection and interpretation, accelerate the development of knowledge in ophthalmology, and help us help our patients more effectively and efficiently. I can’t overstate the importance of training these young investigators how to analyze big data in this way. It’s a vital skill to have not just for ophthalmology in the current moment but also for the future.

To get this off the ground, the Research and Analytics IRIS Registry Task Force has developed an application, a review process, and a policy for approval, data review, and publication, but cost is a large issue. Toward this end, the Academy has established the Hoskins Center IRIS Registry Research Fund to support these efforts. My wife, Ann, and I have made a significant pledge to start the campaign and hope you will consider helping us reach our initial goal of $3 million. In addition, all proceeds from the Orbital Gala will go to support the IRIS Registry and this new research fund. We need to train ophthalmologists to extract pearls from the data to reach the full potential of the IRIS Registry and ultimately improve patient care.

—H. Dunbar Hoskins Jr., MD

About the Orbital Gala

Now in its 14th year, the Orbital Gala is an annual fundraising and social event that takes place on Sunday during the annual meeting. Hosted by the Academy Foundation, the evening includes a buffet dinner, dancing, silent auction, and celebration of its special honoree—this year, Dr. Hoskins—that includes presentation of a tribute book with personal messages from those who donate $250 or more. Proceeds benefit the Academy’s educational, quality of care, and service programs.

Event: Ticket sales ended Nov. 6. Tickets for this year’s gala are no longer available. Keep an eye on aao.org/foundation next May to secure tickets for the 2018 Orbital Gala in Chicago.

Tribute: It’s not too late. Although the tribute book has already been printed, you can still make a gift in honor of Dr. Hoskins at aao.org/foundation or at the Foundation booth in the Resource Center (Booth #3140), and the Foundation will notify him of the gift.
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Start with ME.

TECNIS Sy\(\text{ym\text{fony}}\)\(^*\) and TECNIS Sy\(\text{ym\text{fony}}\)\(^*\) Toric IOLs deliver state-of-the-art presbyopia mitigation and astigmatism correction\(^*\) while providing a full range of high-quality, continuous vision. I've never let anything keep me from seeing the big picture. Why would you?

Don't wait to leave a legacy of seamless brilliance. Start now with TECNIS Sy\(\text{ym\text{fony}}\)\(^*\) and TECNIS Sy\(\text{ym\text{fony}}\)\(^*\) Toric Extended Depth of Focus IOLs.

\(^*\)TECNIS Sy\(\text{ym\text{fony}}\)\(^*\) Toric IOLs only

INDICATIONS AND IMPORTANT SAFETY INFORMATION FOR THE TECNIS SYMFONY® AND TECNIS SYMFONY® TORIC EXTENDED RANGE OF VISION IOLs

Rx Only

INDICATIONS: The TECNIS Sy\(\text{ym\text{fony}}\)® Extended Range of Vision IOL, model ZXR00, is indicated for primary implantation for the visual correction of aphakia, in adult patients with less than 1 diopter of pre-existing corneal astigmatism, in whom a cataractous lens has been removed. The lens mitigates the effects of presbyopia by providing an extended depth of focus. Compared to an aspheric monofocal IOL, the lens provides improved intermediate and near visual acuity, while maintaining comparable distance visual acuity. The model ZXR00 IOL is intended for capsular bag placement only. The TECNIS Sy\(\text{ym\text{fony}}\)® Toric Extended Range of Vision IOLs, models ZXT150, ZXT225, ZXT300, and ZXT375, are indicated for primary implantation for the visual correction of aphakia and for reduction of residual refractive astigmatism in adult patients with greater than or equal to 1 diopter of preoperative corneal astigmatism, in whom a cataractous lens has been removed. The lens mitigates the effects of presbyopia by providing an extended depth of focus. Compared to an aspheric monofocal IOL, the lens provides improved intermediate and near visual acuity, while maintaining comparable distance visual acuity. The model series ZXT IOLs are intended for capsular bag placement only. WARNINGS: May cause a reduction in contrast sensitivity under certain conditions, compared to an aspheric monofocal IOL. Inform patients to exercise special caution when driving at night or in poor visibility conditions. Some visual effects may be expected due to the lens design, including: perception of halos, glare, or starbursts around lights under nighttime conditions. These will be bothersome or very bothersome in some people, particularly in low-illumination conditions, and on rare occasions, may be significant enough that the patient may request removal of the IOL. Rotation of the TECNIS Sy\(\text{ym\text{fony}}\)® Toric IOLs away from their intended axis can reduce their astigmatic correction, and misalignment greater than 30° may increase postoperative refractive cylinder. If necessary, lens repositioning should occur as early as possible prior to lens encapsulation. ATTENTION: Reference the Directions for Use for a complete listing of Indications and Important Safety Information.

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Two powerhouses have taken the helm at the Academy’s journals—and Drs. Blomquist, Corrêa, Miller, and Rapuano cross-examine them.

**Ask Me Anything: Meet The Editors-in-Chief**

From Preston H. Blomquist, MD

**Q.** While Ophthalmology is the preeminent clinical journal for the profession, is the journal planning any changes to make it more pertinent to the practicing comprehensive ophthalmologist?

**A.** As the number of high-quality submissions to Ophthalmology increases each year—we now receive 2,600 submissions annually—we can be much more discriminating about what we consider to be a good fit for the journal. One of those criteria is definitively “broad relevance.” In other words, the most important articles will change practice and scientific thought in the major sub-specialties within ophthalmology and are more likely to be pertinent to the practicing comprehensive ophthalmologist.

From Zélia M. Corrêa, MD, PhD

**Q.** What changes (if any) are you planning to make to the Ophthalmology journal to make it more friendly for manuscript submission?

**A.** There is a lot that can and should be done to improve the user-friendliness of the journal’s platform, both for authors and for our reviewers. We have been gun intense discussions with the journal’s publisher, Elsevier, and are confident that over the next few months we will see substantial improvements in the interface.

From Kevin M. Miller, MD

**Q.** With the proliferation of trade journals and informational websites, how do you see Ophthalmology maintaining interest among readers going forward?

**A.** I think that it is really important to recognize that these different publications all serve different purposes, and no one publication can—or should—be all things to all people. Some publications are meant to stimulate the readership by presenting the latest ideas and trends in the field but don’t intend to critically evaluate them. Others are meant to provide an up-to-date summary of current thought to help clinicians care for patients, even where hard evidence might be lacking. Others—like Ophthalmology—are meant to be the venue where the best scientific evidence is put out to the public so that clinicians and other researchers may critically evaluate and respond to it. The question then becomes, does that publication serve its readers well, and does it draw them back with each issue? Ophthalmology is first and foremost a scientific journal, but it is intended to be clinically relevant and to be read by a general audience that includes trainees, comprehensive ophthalmologists, and subspecialists.

Ophthalmology has been incredibly successful and continues to have the highest impact factor of all the major clinical ophthalmology journals. However, Ophthalmology is not created for researchers to write papers to each other (which is how impact factor is ultimately calculated). It is intended to be the place where the most important work is first published and where readers should have confidence that if a paper is published, it represents the most rigorous standards.

**Q.** How do you balance the selection process? Do you have pearls to share with editors and reviewers?

**A.** I actually don’t make a conscious effort to balance representatives across all of the subspecialties. To some extent, the balance is driven by what comes in, and it’s probably not surprising that there are far more retina and glaucoma submissions than there are plastics and pathology. What is a bit surprising to me is that relative to the level of clinical and publishing activity in the field, we only receive a small share of cataract studies. As a cornea, cataract, and anterior segment surgeon, I hope that authors will recognize the journal as being friendly to the field so that we can garner more submissions!

From Dr. McLeod and Schachat, MD

**Q.** How do you balance the selection of articles for an issue among the various subspecialties of ophthalmology?

**A.** I think that a good study is based on an interesting question for a general ophthalmology audience, even for a person outside of the subspecialty. The observation should also be novel, meaning that a credible answer hasn’t already been provided by a prior report. And make sure the methodology is sound. With that, it’s accepted (almost) every time!

From Dr. McLeod and Schachat, MD

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From Stephen D. McLeod, MD

**Q.** Do you have pearls to share with Academy members to increase their awareness and usage of EyeNet?

**A.** There is a lot that can and should be done to improve the user-friendliness of the journal’s platform, both for authors and for our reviewers. We have been gun intense discussions with the journal’s publisher, Elsevier, and are confident that over the next few months we will see substantial improvements in the interface.

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If that is the case, then when an Ophthalmology paper offers clinical guidance, the evidence to justify that guidance must be of the highest quality possible. And if that study is suggesting a fundamental change in the way we think about a clinical problem, this change in direction must serve our patients well and likely hold up going forward.

**Q.** How do you balance the selection of articles for an issue among the various subspecialties of ophthalmology?

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IMPORTANT SAFETY INFORMATION

OMIDRIA (phenylephrine and ketorolac injection) 1% / 0.3% must be added to irrigation solution prior to intraocular use.

OMIDRIA is contraindicated in patients with a known hypersensitivity to any of its ingredients.

Systemic exposure of phenylephrine may cause elevations in blood pressure.

Use OMIDRIA with caution in individuals who have previously exhibited sensitivities to acetylsalicylic acid, phenylacetic acid derivatives, and other nonsteroidal anti-inflammatory drugs (NSAIDs), or have a past medical history of asthma.

The most commonly reported adverse reactions at 2-24% are eye irritation, posterior capsule opacification, increased intraocular pressure, and anterior chamber inflammation.

Use of OMIDRIA in children has not been established.

INDICATIONS AND USAGE

OMIDRIA is added to ophthalmic irrigation solution used during cataract surgery or intraocular lens replacement and is indicated for maintaining pupil size by preventing intraoperative miosis and reducing postoperative ocular pain.


Please see the Full Prescribing Information at www.omidria.com/prescribinginformation.

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OMIDRIA® is the first and only FDA-approved drug that provides continuous intracameral delivery of NSAID and mydriatic/anti-miotic therapy during cataract surgery.
an outstanding faculty and staff in our department who perform at an extremely high level. So, while it’s a truly complex environment, it makes a huge difference working with smart, competent people. The same is true of the entire community that surrounds the journal. The Academy is a well-oiled machine, and the Ophthalmology editorial office staff under May Piotrowski are just outstanding, as is every single member of the editorial board. I simply don’t waste time prodding people, and the work that comes together to produce the journal is superb. The second is time management—every minute of the day seems to have purpose, and I clear my calendar of leftover activities by the end of the day every Friday so that the weekends belong to Marion and Elise.

From Christopher J. Rapuano, MD

Q. Given that the vast majority of Academy members are clinicians, and I suspect most of us are not strictly ophthalmologists, how do you balance the number of clinical versus basic science articles you accept for publication?

A. We really want to present articles that are very likely to change decision-making and patient care for ophthalmologists immediately or in the foreseeable future. There are some so-called “translational” articles that include presentation of the science behind these advances, but those are infrequent compared to clinical articles. As a rule, because of the distance between discovery and application, we rarely consider publishing experimental work at the level of molecules and cells or in animal models. As a journal of clinical science, Ophthalmology’s focus really is on presenting the best scientific evidence to guide clinical care.

Q. How did your vineyard in Napa survive the recent great California drought?

A. Yes, we have a small vineyard in Sonoma, where we grow Rhône varietals. Much of the growing season in that area tends to be extremely dry and so just about everyone relies on drip irrigation. Unfortunately, irrigation can only go so far; we think of stressed vines as creating more complex fruit, but without the normal seasonal cycle and winter rain, you end up with an unhealthy stressed vine. Because the irrigation source is ground water, you accumulate a lot of salts in the soil, which throws off the chemistry of water, you accumulate a lot of salts in the soil, which throws off the chemistry of water, you accumulate a lot of salts in the soil, which throws off the chemistry of water, you accumulate a lot of salts in the soil, which throws off the chemistry of water, you accumulate a lot of salts in the soil, which throws off the chemistry of water, you accumulate a lot of salts in the soil, which throws off the chemistry of water.

Andrew P. Schachat, MD

Editor-in-Chief

Ophthalmology Retina

From Dr. Blomquist

Q. What was the driving force for the creation of Ophthalmology Retina?

A. The driving force was the exploration of new information in retina. We receive about twice as many good retina submissions as we have space to print in Ophthalmology. The “most read” and “most cited” papers in recent years have more retina topics than any other. For example, right now, the most read papers are on atrope for myopia, a diabetic retinopathy epidemiology paper, a high myopia epidemiology paper, a paper on the clinical importance of the diabetic retinopathy severity score, and a paper on factors predictive of progression of diabetic retinopathy—5 out of 5 are retina. We target mainly results-type papers on common retina diseases of interest to all ophthalmologists for the main journal, but we can cascade submissions relating to more highly specialized retina content to Ophthalmology Retina. As we free up space in the main journal, we make room for more content of interest to general ophthalmologists. I view this as a win-win for readers, authors, and our field.

Q. What sets the new journal apart from other retina journals?

A. There are not that many peer-reviewed retina journals. The most prominent, of course, is Retina. Its editor, Sandy Brucker, has done an amazing job—the journal is wonderful and plays an important role in our field. What differentiates Ophthalmology Retina is the association with Ophthalmology and with the Academy. Ophthalmology has the highest impact factor of any clinical eye journal. Currently, it has a 17-day time frame to initial decision, and authors appreciate that. With a click, we can move files from the main journal website to that of Ophthalmology Retina. Also, Ophthalmology Retina has access to the main journal reviewer pool. We have the same journal staff and the same Academy collaboration and support. There is nearly complete overlap of retina editorial board members.

From Dr. Corrêa

Q. Is there an overlap of authors and readers between Ophthalmology Retina, Retina, and the new Journal of Vitreo-Retinal Diseases from the American Society of Retina Specialists (ASRS)?

A. Of course, just as there is membership overlap within the retina organizations, there will be overlap of authors and readers for the retina-focused journals. As they say, “We is us and us is them.” The retina journals will evolve and take on slightly different characters, looks, and even emphases.

Q. What is your strategy to encourage retina and ocular oncology specialists to submit to Ophthalmology Retina instead of the Retina journal or the Ocular Oncology and Pathology journal?

A. For one, while authors are welcome to submit to Ophthalmology Retina directly, we offer “one-stop shopping” and encourage submission to Ophthalmology if the authors think the paper will be competitive and of interest to the broad spectrum of readers. Sometimes, the editors may suggest transfer of an article to Ophthalmology Retina if we think the topic is too esoteric, but often we will send the paper for review and learn as we digest the reviewer comments. While we do not want to print things that are incorrect, I believe that “the perfect is the enemy of the good enough,” and I have written that when it comes to journals, faster is better. We focus on that.

From Dr. Miller

Q. How does the journal maintain interest of reviewers? They receive no remuneration, what they do requires a lot of work, and a relatively small number of them do most of the reviewing.

A. You are correct that a small number do a lot of reviews, but we do have a large pool of reviewers and many do just a few reviews a year. There is broad participation. And why are reviewers interested and willing to do the work? Maybe again, it is the participation theme. Reviewers benefit in many ways. They see new information sooner. They have a chance to have an impact on the manuscript by offering advice to make it better. By participating, they help advance science and improve care. I am sure they enjoy that. There is an unspoken expectation that if you submit manuscripts to a peer-reviewed journal, you should participate as a reviewer. Being a reviewer expands your knowledge, helps you keep current, and plays a significant role in career advancement.

Q. What would you say is the most important article published by Ophthalmology during the last 10 years?

A. Maybe the most highly cited? A 1992 Beaver Dam Eye Study diabetic retinopathy prevalence paper has been cited 1,331 times. A 1991 Early Treatment Diabetic Retinopathy Study main result paper has 962 cites. But to get close to your 10-year parameter, in 2006, a paper by Bob Avery and colleagues on bevacizumab for wet AMD has been cited 895 times. As a retina specialist, it has been thrilling to see the improved outcomes for some of the most common eye diseases with the introduction of anti-VEGF therapy. While large clinical trial papers and meta-analyses are the most important, Bob’s wins in most cites over the last 10 years or so.

From Dr. Rapuano

Q. What is the process of getting an impact factor for a new journal such as Ophthalmology Retina, and do you think that affects the authors?

A. It is important and does affect author interest in the journal, especially for international authors, as their promotions committees pay more attention to the impact factor than do committees in the United States. Before you can apply to be included in PubMed, you need to have a certain number of issues to show the selection committee. The journal is judged on nuts-and-bolts types of measures, such as whether it came out on time or if there is evidence that conflict of interest issues are disclosed and resolved appropriately. There are many other measures, including how often papers are cited. So, it takes perhaps a year to have a sufficient track record to apply. While approval was routine 25 years ago, it definitely is not now. I am told that about 10% of journals are approved at the time of their first submission. Inclusion in PubMed was critical in the past, but now more papers are found via Googling than by searching in PubMed.

Q. I chuckle when I read case reports and small case series that have 4 or 5 times (and occasionally more) as many authors as subjects. Does the number of authors affect how you judge a paper?

A. I tend to judge papers based on the reviews and my sense of whether there is new information, whether it is valid, and whether it would be of interest to our readers. A large number of authors makes me raise an eyebrow sometimes—we may receive a complete manuscript with 50 authors or even more. I wonder if each one actually read it, no less met authorship criteria. To answer your question, it makes me chuckle as well, but I try to focus on the science.
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NEW ORLEANS

See the exciting tools available through the new David E.I. Pyott Glaucoma Center. View a demo at the Clinical Education kiosk in the Resource Center (Hall G, Booth 3140).

Launching at AAO 2017, the new online David E.I. Pyott Glaucoma Education Center makes publicly available most of the Ophthalmic News and Education (ONE) Network glaucoma content, and it is providing for new glaucoma features. When Mr. Pyott, former CEO of Allergan, pledged $2 million to the Academy Foundation for glaucoma education, he wanted to provide instruction to eye care providers globally and allow for easy sharing of information among them. “This is my way of giving back. I am delighted to continue a long and rewarding heritage of helping the physicians all over the world speed improvements in patient outcomes,” said Mr. Pyott.

The center also introduces many new features to complement the ONE Network’s existing educational materials. Among the novel tools that are rolling out at AAO 2017 are the following:

- **Surgical video and animation.** The center offers fresh perspectives on surgeries by showing videos of procedures accompanied by animation clearly illustrating each step. For example, a video shows Joseph Caprioli, MD, performing a trabeculectomy, while an integrated animation shows each stage, from the initial conjunctival incisions to tying surgical knots for wound closure (Fig. 1).

- **Interactive maps and data.** Epidemiologic and incidence data come alive through an interactive map that quickly conveys basic information for each U.S. state (Fig. 2).

- **Diagnosis and treatment algorithms.** Remember treatment flowcharts? Now the Glaucoma Education Center lets the clinician specify a disease (POAG, PACG, etc.) and navigate stepwise through each decision needed to arrive at a management algorithm—designed for use on a smartphone (Fig. 3).

- **Gonioscopy videos.** The Color Atlas of Gonioscopy, now available through the center, gives users access to clinical videos of procedures for the angle (Fig. 4).

“David Pyott is an extraordinary philanthropist,” said David W. Parke, II, MD, CEO of the American Academy of Ophthalmology. “He is knowledgeable and personally experienced and engaged in the problem of treatable global blindness. This endowment will serve as a legacy gift for decades to come—helping current and future physicians around the globe, as well as providing resources for their patients. We are deeply grateful for his steadfast generosity that enhances our capability to protect sight and empower lives.”

**AT THE RESOURCE CENTER**

**ONE Network: Celebrating Innovation in Education**

Join the visionaries of the Academy’s ONE Network for a special look at the evolution and impact of the world’s largest collection of ophthalmic education, inclusive of the launch of the new David E.I. Pyott Glaucoma Education Center. When: Saturday, 2:00-3:00 p.m. Where: Resource Center (Hall G, Booth 3140). Access: Open to all attendees.
Automated technology includes the OPD-Scan III Integrated Wavefront Aberrometer, the TRS5100/3100 Digital Refractors, Autorefractors/Keratometers and EPIC Refraction Workstation. **NEW PRODUCTS INCLUDE:** TS-310 Tabletop Refractive Workstation, LM-7 Series Lensmeters—all with EMR integration. Also introducing the NEW Ultra M Series Slit Lamps with the integrated anterior segment **ION IMAGING** System.

**The Difference is Marco.**
Winning Photography Is on Display

The photos shown here were selected from among the First Place winners—in both the print and stereo categories—at the 2016 Ophthalmic Photographers’ Society (OPS) Scientific Exhibit during AAO 2016 in Chicago. To see this year’s winners, stop by the 2017 OPS Scientific Exhibit (Hall H, Booth 3940), and enter the raffle. Prizes include: one mounted print, two 1-year OPS memberships, which includes 2 certification-oriented webinars (the CRA and OCT-C*), and three 2018 OPS calendars. Calendars will also be for sale for $15 at the booth.

Proceeds help fund the OPS scholarship program to assist photographers in getting started in the field by funding part of their travel to and registration for the OPS annual meeting, which takes place simultaneously with the Academy’s annual meeting.

Learn more about the OPS at opsweb.org.

2016 OPS Exhibit Winners.

From left to right, and top to bottom.

Gonio Photography, Print. Trauma Exposing Ciliary Body. David T. Miller, CRA. Wake Forest University Eye Center.


*Certified Retinal Angiographer and Optical Coherence Tomographer-Certified.


Combining the control of a manual delivery system with the benefits of a pre-loaded injector, the UltraSert™ System provides:

- **Smooth Injection.** The TensionGlide™ plunger provides smooth, one-handed plunger advancement.\(^*\),\(^1\),\(^2\)
- **Preserved Incisions.** The depth guard nozzle is designed to minimize wound stretch.\(^2\),\(^3\)
- **Consistent Delivery.** The plunger tip is designed to ensure correct haptic configuration and precise IOL placement.\(^2\),\(^3\)

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Consider Hiring a Visually Impaired Employee

What started with one ophthalmologist’s passion resulted in a great experience for one low vision employee and his ophthalmologist-employer.

M arie D. Acierno, MD, a neuro-ophthalmologist in Scottsdale, Arizona, strongly believes in the Academy’s mission to protect patients’ sight and empower their lives. She is passionate about helping visually impaired patients find work—especially in ophthalmology offices. In fact, Dr. Acierno completed her Academy Leadership Development Program (LDP) 2016 project on this topic.

“By employing the visually impaired in your office, you are allowing them to participate in the Academy’s mission, generate an income, and develop a sense of independence. Then consider your own visually impaired patients who may fear for their future: Patients who are diagnosed with acute or devastating chronic visual loss are often concerned that their visual impairment will take away from their everyday lives. Seeing a visually impaired employee behind your front desk could help allay their fears,” she said.

LDP project: As the LDP participant representing the North American Neuro-Ophthalmology Society (NANOS), Dr. Acierno selected a project that would allow her to pursue her passion to 1) create awareness about vision in the community and 2) allow people with visual impairments to share their experiences and abilities as a way of dispelling myths about their limitations. She conducted a pilot study by sending a 7-question survey to 643 members of NANOS to identify physicians who would be interested in hiring a visually impaired person in their office or hospital practice. Upon completing the survey, she contacted physicians who expressed interest to further define needs in their practices, which allowed her to select the best offices for the pilot study. The physicians received disability employment consultations to learn about hiring the right candidate for the job, job needs, and tax incentives. A local Lighthouse and/or Vocational Rehabilitation office was contacted on the physicians’ behalf to select possible visually impaired job candidates for a potential hire. Please visit aao.org/about/leadership-development/project-abstracts and click “LDP XVIII, Class of 2016 Project Abstracts” for details on the survey responses.

Dr. O’Sullivan’s experience. Prior to her LDP involvement, in her role as a Lighthouse Louisiana board member, Dr. Acierno had adopted a personal goal of encouraging ophthalmologists to hire people with visual impairments. In September 2015, she attended a Lighthouse Louisiana Job Fair, where she met Randy Lewis, a Walgreens senior vice president who has a strong commitment to building relationships and creating equal opportunities for hiring persons with disabilities. That day, Mr. Lewis encouraged her to keep pursuing her goal—just one hire at a time. As it happened, Sean O’Sullivan, MD, also a Lighthouse board member and retina specialist in New Orleans, had been at the fair. So, she said, “I approached Dr. O’Sullivan as a trusted colleague and friend whom I have known to have a compassionate spirit and shared my idea. Just as I suspected, Dr. O’Sullivan embraced the idea and was willing to go the distance.” Dr. O’Sullivan hired a low vision employee for a project that lasted about a year. He talked with EyeNet below, about his experience.

The Decision to Hire a Low Vision Employee

EyeNet: Did you have a specific job that you wanted to fill?

Dr. O’Sullivan: At that time, I wanted someone for data mining of electronic medical records and setting up a program to keep track of our referring doctors and patients and track how many procedures we were doing every day. Lighthouse put me in touch with a young man who had a college degree and was really good with computers. He fit right into that job.

EyeNet: Did you need to make special accommodations for him?

Dr. O’Sullivan: He worked in the insurance industry for awhile so he had computer skills, but we trained him over time.

EyeNet: Did he have all the necessary skills in advance, or did you train him?

Dr. O’Sullivan: When I had just started my practice, Dr. Acierno and I were both on the board of directors for Lighthouse Louisiana.

After taking a tour of Lighthouse of Louisiana’s paper manufacturing plant, where people with impaired vision are employed, I was inspired and felt moved to provide someone with low vision an opportunity to work. Lighthouse has a job placement agency, and I knew that they helped people with low vision get jobs, make their own money, and get out there and show people that they can be independent. This, along with Dr. Acierno’s encouragement, inspired me to try and find someone through Lighthouse for our clinic.

EyeNet: How did you decide to hire a low vision employee?

Dr. O’Sullivan: When I had just started my practice, Dr. Acierno and I were both on the board of directors for Lighthouse Louisiana.

After taking a tour of Lighthouse of Louisiana’s paper manufacturing plant, where people with impaired vision are employed, I was inspired and felt moved to provide someone with low vision an opportunity to work. Lighthouse has a job placement agency, and I knew that they helped people with low vision get jobs, make their own money, and get out there and show people that they can be independent.

Dr. Acierno: I approached Dr. O’Sullivan as a trusted colleague and friend whom I have known to have a compassionate spirit and shared my idea. Just as I suspected, Dr. O’Sullivan embraced the idea and was willing to go the distance.” Dr. O’Sullivan hired a low vision employee for a project that lasted about a year. He talked with EyeNet below, about his experience.

Dr. O’Sullivan presents her project to LDP classmates and the incoming LDP class.

Lighthouse Louisiana helps people who are blind or visually impaired learn the skills they’ll need for employment.

Learn More

Lighthouse Louisiana offers services to individuals who are blind or visually impaired with the goal of allowing them independence, self-reliance, and success. These services include a low vision clinic, social services, orientation and mobility training, assistance with developing adaptive techniques, support groups, classes in using assistive technologies, Braille classes, employment services, and transportation services, and they even have a manufacturing plant (mostly paper products) that employs about 70+ visually impaired workers on a full-time basis.

Lighthouse Louisiana welcomes AAO 2017 attendees to see its facilities. Call in advance to arrange a tour. The number is 504-899-4501. Facility hours are from 8:00 a.m.-4:30 p.m.

The Academy Leadership Development Program identifies and develops future leaders of state, subspecialty, and specialized interest societies. During the 1-year program, class participants learn about leadership, advocacy, and association governance. Each class meets in person 4 times, twice in conjunction with the Academy annual meeting. Participants conclude their time in the program by completing a project in one of 10 key areas.

Learn more at aao.org/about/leadership-development/overview.
to come on board. Setup was a very positive experience and easy to implement.

**Advice: Fit and Honesty Are Important**

*EyeNet:* What advice would you give to a colleague who is contemplating hiring a low vision employee?  

*Dr. O'Sullivan:* First, I would say that if you find the right person for the right job, it will make you want to hire another low vision person! But there are some limitations that you can’t force. For instance, our employee was not going to be able to check in patients, check their vision, and do eye pressures. Of course, that’s not what he was hired to do.

When it comes to low vision, you need to know what the person’s visual function is and how that would affect his or her ability to do the job. Low vision covers a wide range. Some people have 20/400 or 20/200 in 1 eye or have depth perception difficulties, amblyopia, or trauma. But when you make a good hire, and they’re trained for the job, they’re just like everyone else.

*EyeNet:* What was the most difficult part of the process?  

*Dr. O’Sullivan:* The toughest thing is finding a job that they can do. As ophthalmologists and retina surgeons, we—of all people—should be able to accommodate them a little bit more than an average place of employment.

**Benefits to Practice**

*EyeNet:* What are the benefits to your practice of having a low vision employee?  

*Dr. O’Sullivan:* The patients loved it! Because of his desk-oriented job, he didn’t have a lot of direct interaction with patients, but he was up and down and walking around. He had a cane, so people noticed him. He was there for more than a year, and patients got to know him.

His presence was inspiring for everybody. When he was a child, he had a tumor that pressed on his optic nerve so that he couldn’t see. But he’d come far in life; he had graduated from one of the top high schools in New Orleans and gone on to college, and then he was out there doing what we all do every day.

I think the staff recognized how the patients felt too. We work with people all day who are going blind, and we’re trying to save their vision. Having patients come in and see him making his way as an independent individual gave everyone a positive perspective.

On a personal level, it gives me a good feeling that he was part of our team. I believe self-responsibility and hard work is the best thing for anyone’s psyche. It felt good to be giving him an opportunity.

**Benefits to Employee**

*EyeNet:* Do you think there’s anything about your practice—you said it’s a retina practice—that made it especially suitable?  

*Dr. O’Sullivan:* I think it’s less about being a retina or ophthalmology practice and more that it is small. I’m the only doctor, and we have 9 nurses and office staff. There is a family feel about being in the clinic with the patients, staff, and nurses.

It’s all personal preference, as well. A different employee might not want to feel like part of a family. They might have different objectives and values.

**Future Hires**

*EyeNet:* Will you hire another low vision employee?  

*Dr. O’Sullivan:* Yes, definitely. For this young man, I ran out of work for him to do. Next time, I will investigate other possible roles and keep in touch with the job placement director at Lighthouse.

She is always looking for jobs for her vision-impaired clients. She collects job descriptions from potential employers. Then she and her group have everything organized and computerized—resumes and references—and they find potential matches from their pool and interview the candidates extensively before making a recommendation to a potential employer. This way both the potential employee and employer know the expectations. When there is interest from an employer, Lighthouse tries to help custom fit the potential employee to the job.

The effort that Lighthouse puts into job placement makes it more feasible to hire employees who have low vision.

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**LOW VISION AT THE MEETING**

The meeting offers several opportunities to learn more about low vision. Four Saturday symposia take place in Room 242, which is close to the Cornea, Neuro-Ophthalmology, and Oculo-facial Plastic Surgery Subspecialty Days. Be sure to drop by!

Also, consider attending other low vision events—instruction courses, a Learning Lounge activity, and a Breakfast With the Experts. These take place from Sunday to Tuesday and are listed below.

**SATURDAY SYMPOSIA**  
*(Room 242, Free of charge)*

- **Let There Be Light** *(Sym01)*  
  When: 10:00-11:00 a.m.
- **The Psychological Impact of Irreversible Vision Loss** *(Sym02)*  
  When: 11:15 a.m.-12:15 p.m.
- **Current Research on Measuring Vision Rehabilitation Outcomes** *(Sym04)*  
  When: 1:00-2:00 p.m.
- **Technological Advancements in Vision Rehabilitation** *(Sym07)*  
  When: 2:15-3:15 p.m.

**SUNDAY AND BEYOND**

- **Identifying and Assisting the Patient with Low Vision** *(LL31)*  
  When: Monday, 2:00-3:00 p.m.
- **Advances in Vision Restoration Techniques and Devices** *(539)*  
  When: Monday, 4:30-5:30 p.m.
- **Smart Phones and Tablets for Low Vision** *(B175)*  
  When: Tuesday, 7:30-8:30 a.m.

Access: Free
Meeting the need. An increasing aging and diabetic population gives way to an increased number of patients diagnosed with retinal diseases. Regeneron is committed to delivering targeted therapies that can impact your patients' vision.

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Xiidra helped provide symptom relief from eye dryness in some patients at week 2—and a measurable reduction in signs of inferior corneal staining in just 12 weeks. Consider Xiidra to help your Dry Eye patients find the relief they've been waiting for.

**Take it all in at Xiidra-ECP.com**

Four randomized, double-masked, 12-week trials evaluated the efficacy and safety of Xiidra versus vehicle as assessed by improvement in the signs (measured by Inferior Corneal Staining Score) and symptoms (measured by Eye Dryness Score) of Dry Eye Disease (N=2133).
Xiidra helped provide symptom relief from eye dryness in some patients at week 2—and a measurable reduction in signs of inferior corneal staining in just 12 weeks. Consider Xiidra to help your Dry Eye patients find the relief they’ve been waiting for.

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**Indication**

Xiidra® (lifitegrast ophthalmic solution) 5% is indicated for the treatment of signs and symptoms of dry eye disease (DED).

**Important Safety Information**

In clinical trials, the most common adverse reactions reported in 5-25% of patients were instillation site irritation, dysgeusia and reduced visual acuity. Other adverse reactions reported in 1% to 5% of the patients were blurred vision, conjunctival hyperemia, eye irritation, headache, increased lacrimation, eye discharge, eye discomfort, eye pruritus and sinusitis.

To avoid the potential for eye injury or contamination of the solution, patients should not touch the tip of the single-use container to their eye or to any surface.

Contact lenses should be removed prior to the administration of Xiidra and may be reinserted 15 minutes following administration.

Safety and efficacy in pediatric patients below the age of 17 years have not been established.

For additional safety information, see accompanying Brief Summary of Safety Information and Full Prescribing Information on Xiidra-ECP.com.
BRIEF SUMMARY:
Consult the Full Prescribing Information for complete product information.

INDICATIONS AND USAGE
Xiidra® (lifitegrast ophthalmic solution) 5% is indicated for the treatment of the signs and symptoms of dry eye disease (DED).

DOSAGE AND ADMINISTRATION
Instill one drop of Xiidra twice daily (approximately 12 hours apart) into each eye using a single use container. Discard the single use container immediately after using in each eye. Contact lenses should be removed prior to the administration of Xiidra and may be reinserted 15 minutes following administration.

ADVERSE REACTIONS
Clinical Trials Experience
Because clinical studies are conducted under widely varying conditions, adverse reaction rates observed in clinical studies of a drug cannot be directly compared to rates in the clinical trials of another drug and may not reflect the rates observed in practice. In five clinical studies of dry eye disease conducted with lifitegrast ophthalmic solution, 1401 patients received at least 1 dose of lifitegrast (1287 of which received lifitegrast 5%). The majority of patients (84%) had ≤3 months of treatment exposure. 170 patients were exposed to lifitegrast for approximately 12 months. The majority of the treated patients were female (77%). The most common adverse reactions reported in 5-25% of patients were instillation site irritation, dysgeusia and reduced visual acuity. Other adverse reactions reported in 1% to 5% of the patients were blurred vision, conjunctival hyperemia, eye irritation, headache, increased lacrimation, eye discharge, eye discomfort, eye pruritus and sinusitis.

USE IN SPECIFIC POPULATIONS
Pregnancy
There are no available data on Xiidra use in pregnant women to inform any drug associated risks. Intravenous (IV) administration of lifitegrast to pregnant rats, from pre-mating through gestation day 17, did not produce teratogenicity at clinically relevant systemic exposures. Intravenous administration of lifitegrast to pregnant rabbits during organogenesis produced an increased incidence of omphalocoele at the lowest dose tested, 3 mg/kg/day (400-fold the human plasma exposure at the recommended human ophthalmic dose [RHOD], based on the area under the curve [AUC] level). Since human systemic exposure to lifitegrast following ocular administration of Xiidra at the RHOD is low, the applicability of animal findings to the risk of Xiidra use in humans during pregnancy is unclear.

Animal Data
Lifitegrast administered daily by intravenous (IV) injection to rats, from pre-mating through gestation day 17, caused an increase in mean preimplantation loss and an increased incidence of several minor skeletal anomalies at 30 mg/kg/day, representing 5,400-fold the human plasma exposure at the RHOD of Xiidra, based on AUC. No teratogenicity was observed in the rat at 10 mg/kg/day (460-fold the human plasma exposure at the RHOD, based on AUC). In the rabbit, an increased incidence of omphalocoele was observed at the lowest dose tested, 3 mg/kg/day (400-fold the human plasma exposure at the RHOD, based on AUC), when administered by IV injection daily from gestation days 7 through 19. A fetal No Observed Adverse Effect Level (NOAEL) was not identified in the rabbit.

Lactation
There are no data on the presence of lifitegrast in human milk, the effects on the breastfed infant, or the effects on milk production. However, systemic exposure to lifitegrast from ocular administration is low. The developmental and health benefits of breastfeeding should be considered, along with the mother's clinical need for Xiidra and any potential adverse effects on the breastfed child from Xiidra.

Pediatric Use
Safety and efficacy in pediatric patients below the age of 17 years have not been established.

Geriatric Use
No overall differences in safety or effectiveness have been observed between elderly and younger adult patients.

NONCLINICAL TOXICOLOGY
Carcinogenesis, Mutagenesis, Impairment of Fertility
Carcinogenesis: Animal studies have not been conducted to determine the carcinogenic potential of lifitegrast.
Mutagenesis: Lifitegrast was not mutagenic in the in vitro Ames assay. Lifitegrast was not clastogenic in the in vivo mouse micronucleus assay. In an in vitro chromosomal aberration assay using mammalian cells (Chinese hamster ovary cells), lifitegrast was positive at the highest concentration tested, without metabolic activation. Impairment of fertility: Lifitegrast administered at intravenous (IV) doses of up to 30 mg/kg/day (5400-fold the human plasma exposure at the recommended human ophthalmic dose (RHOD) of lifitegrast ophthalmic solution, 5%) had no effect on fertility and reproductive performance in male and female treated rats.
New Thinking in Ophthalmology
9 Honorary Lecturers Preview Their Presentations

The Opening Session and many Academy symposia are capped by an honorary lecture. These informative presentations by leaders in their fields are easy to fit into your schedule, as they are usually from 15 to 35 minutes long, and they are free. Preview the highlights of these lectures, below, and in the Sunday AAO 2017 News.

FRIDAY, Nov. 10

RETINA
The Charles L. Schepens, MD, Lecture: Clinical Trials in Ophthalmology: Past, Present, and Future, presented by Frederick L. Ferris, MD.

“Over the past 2 decades, we have seen an acceleration of advances in glaucoma diagnostics and therapeutics, which impact patient care. We are in the midst of a Glaucoma Renaissance. The best and brightest are being drawn to our subspecialty in this exciting era, with many more discoveries to come. This lecture will review recent glaucoma therapeutic advances and highlight the partnerships between practitioners, innovators, regulators, and others who have created a unique environment that will undoubtedly lead to better glaucoma care and continue to make ours the most dynamic and innovative subspecialty in ophthalmology.”

Sym26, the Opening Session. Where: Great Hall.

“Intravitreal therapy for retinal diseases has grown from a few hundred intravitreal injections a year in the early 1990s to over 5 million injections in 2015 in the United States. This dramatic change in how we treat retinal diseases began with cytomegalovirus (CMV) retinitis and moved rapidly into posterior uveitis, diabetic macular edema, choroidal neovascularization (CNV) associated with AMD, and many retinal dystrophies. I have had the privilege of serving in a leadership role or participating in many of the clinical trials that spurred these changes and will cover this 20-year evolution from CMV retinitis to CNV. This lecture was not welcomed in the beginning; the results from many of the most important clinical trials and, in particular, will cover the political challenges and important clinical findings from the Comparison of Treatment of AMD Trials (CATT).”

The Opening Session (8:30-10:00 a.m.)

NEURO-OPHTHALMOLOGY
William F. Hoyt Lecture: More Than Meets the Eye: What an Ophthalmologist Needs to Know About Migraine and the Eye, presented by Kathleen B. Digre, MD.

“Migraine is an extremely common disease: It affects almost 20% of all women and 10% of all men and is estimated to affect more than 36 million people in the United States alone. So, patients with migraine will show up in every ophthalmologist’s office every day! Migraine is more than a headache, too, as it also affects the eye and vision. Patients regularly visit the ophthalmologist with eye complaints, thinking the problem is related solely to their eyes. Ophthalmologists need to recognize when these visual complaints are related to migraine. Common symptoms include eye pain, photophobia, aura, and visual phenomena like visual snow. While the ophthalmologist may not want to treat migraine, all of us need to be able to recognize migraine, explain the ocular symptoms, address comorbidities (such as dry eyes), and direct the patient to find help for their migraine.

“In this lecture, we will explore how the anatomy and physiology of migraine cause many vexing visual phenomena, such as photophobia, eye pain, and visual snow. We will also explore facets of migraine that affect the visual quality of life. We will discuss how dry eye symptoms are frequently reported in patients with chronic migraine. Finally, we will give some practical tips that will simplify recognizing migraine and its related phenomena.”

From Ground Zero to the Moon: How Intracranial and Intraocular Pressure Disparities Relate to Vision (10:30-10:50 a.m.)

PATHOLOGY/ONCOLOGY
Zimmerman Lecture: Electron Microscopy: An Invaluable Diagnostic Adjunct in an Ophthalmic Pathology

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New Orleans Gems
Discover New Favorites

Because New Orleans is a recurring annual meeting destination, you might have already enjoyed some of its most famous activities: Bourbon Street, the Mardi Gras Museum, a scenic steamboat cruise, and eating your fill of beignets, among many others. If you’re looking for activities and dining off the beaten path this time around, here are a few suggestions, courtesy of a local.

Neighborhood Strolls
French Quarter without the commotion.
Avoid the crowds of the French Quarter but still enjoy its architecture by walking Royal, Dauphine, and Burgundy streets from end to end (Canal to Esplanade Ave.). The quiet walk through this enchanting neighborhood keeps you (almost) clear of rowdy tourists. Unique spots on this stroll include Bourbon French Parfums, a boutique perfume shop, and Papier Plume, a purveyor of luxury paper and writing implements.

The Bywater. Near the French Quarter, the Bywater is another great area to walk. It’s full of shotgun houses tucked next to each other. (The floorplan of these houses has a straight sight line between front and back doors; theoretically a shooter on the sidewalk could hit a person in the back yard. The design also allows for good airflow.) The neighborhood has a nice collection of bars, corner markets, and a few interesting churches. Be sure to visit Crescent Park, which is on the Mississippi River and offers a fantastic view downtown New Orleans. There are 3 park entrances (2 in the Bywater and 1 in the Marigny neighborhood).

Culture
Arts District (Warehouse District). Walking distance from the convention center, the National WWI Museum is a can’t-miss. A popular exhibit is “Final Mission: The U.S. Tang Experience,” which re-creates the submarine’s last battle. Allow 3 to 4 hours to see this museum, and a bit longer if you plan to watch the 4-D movie across the street, “Beyond All Boundaries.” Other museums in the area include the Ogden Museum of Southern Art and the Contemporary Arts Center.

Music. New Orleans is well-known for its many music venues, but a grittier local favorite that may not be easily discoverable is Chickie Wah Wah. They have a happy hour Monday-Friday, which includes free live music. This spot has fantastic drinks and the best of New Orleans local musicians. Tip: Be sure to arrive 30 minutes before the set begins so you can get a good seat. Where: 2828 Canal St. (at S. Dupre St.), Mid-City.

For more information, visit www.chickiewahwah.com.

Bars
Wine. Visit Oak Wine Bar for wines by the glass and some cool jazz. Their cellars house a notable collection of varietals broken into categories like “herbs and smoke,” “stones and acid,” and “flirting with oak.” The kitchen puts out a variety of snacks including charcuterie, cheese, scallops, bruschetta, and poutine. Check the website for their music lineup, which ranges from jazz to acoustic folk to R&B.
Where: 8118 Oak St. (at S. Carrollton Ave.), Leonidas.

For more information, visit www.oaknola.com.

Craft beers. Swing by Black Penny for North American craft beers, properly chilled and served in cans (because cans don’t let light in). Even though this spot is known for its more than 50 kinds of craft beer, they do have a full bar. Black Penny is in the French Quarter but is geared more toward locals than tourists and has a famously pleasant bar staff.
Where: 700 N Rampart St. (at St. Peter St.), French Quarter.

For more information, visit www.oaknola.com.

Food
Local flavor. Atchafalaya Restaurant was formerly a grocery, then a bar, and is now an art-filled eatery best known for brunch (often with a live music accompaniment). The inventive Louisiana fare and rustic yet elegant ambiance makes this spot a favorite among locals and tourists. Menu highlights include the eggs Atchafalaya (poached eggs, fried green tomatoes, jumbo lump crab, hollandaise), alligator sausage, and blue cheese flan.
Where: 901 Louisiana Ave. (at Laurel St.), East Riverside.

For more information, visit www.atchafalayarestaurant.com.

Refined local flavor. Take it up a notch at Patois, a small, tucked-away neighborhood restaurant. The chef is known for locally accented French cuisine focusing on farm-to-table ingredients. The ever-changing menu features the likes of sweetbreads, crawfish rameen, and brown butter almond tea cake.
Where: 6078 Laurel St. (at Webster St.), West Riverside.

For more information, visit www.patoisnola.com.

More upscale eating. For upscale dining at its best without having to wear a coat and tie, Herbsaint is a fantastic option. The dining room is perfectly lit and has an expert staff. The chef, Rebecca Wilkomb, won the 2017 James Beard Award for best chef in the South. The menu features items like beef short rib with potato rosti, salsu verde, and horseradish cream; baked asparagus with oregano and lemon; and coconut custard pie with buttermilk chantilly and orange caramel. The street cars passing by add to the atmosphere.
Where: 701 St. Charles Ave. (at Girard St.), Warehouse District.

For more information, visit www.herbaint.com.

Po’boys. Where are the best po’boys in New Orleans? The verdict is Bear’s Poboys at Genaro’s. Get the roast beef, get the onion rings, get the jalapenos, and don’t think twice! The cooks marinade the roast beef in their homemade gravy, roast it to perfection, and serve it on freshly baked Leidenheimer French bread. The menu includes a variety of other po’boys, as well as burgers, salads, and appetizers.
Where: 3206 Metairie Rd. (at N. Causeway Blvd.), Metairie.

For more information, visit www.bears poboy.com.

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Uniquely New Orleans experience. For a totally “N’awlins” experience, walk into Jack Dempsey’s Restaurant. This hole in the wall has boiled and fried seafood, large portions, and a welcoming staff, and the decor is straight out of the 1940s. It was named for a local police reporter—a colorful character known almost as much for his dogged reporting as for his signature straw hat and cigar.
Where: 738 Polanad Ave. (at Dauphine St.), Bywater.

For more information, visit www.jackdempseys.net.

Thanks to Scott McCrossen for these insider recommendations. An acquaintance of EyeNet senior editor Jean Shaw, Mr. McCrossen was born and raised in New Orleans and knows the city inside and out.
Saturday, November 11, 2017

9:30 AM
Understanding the Signs and Symptoms Disconnect
Richard Adler, MD, FACS

10:00 AM
Multifactorial Approaches to DME and RVO
Brian Chan-Kai, MD

10:30 AM
A Minimally Invasive Approach to IOP Control
Nathan Radcliffe, MD

11:00 AM
IOL Exchange From Mundane to Insane
Brandon Ayres, MD

11:30 AM
Multifactorial Approaches to DME and RVO
Adam Gerstenblith, MD

12:00 PM
Strategies for the Rock-Hard Nucleus
David Chang, MD

12:30 PM
Nasty Cataracts: Prevention and Management of Complications
Robert Osher, MD

1:00 PM
A Minimally Invasive Approach to IOP Control
Arsham Sheybani, MD

1:30 PM
A Minimally Invasive Approach to IOP Control
John Berdahl, MD

2:00 PM
The Key Elements of Effective Intravitreal Injection Reimbursement
William Koch, COA, COE, CPC

2:30 PM
A Minimally Invasive Approach to IOP Control
Jonathan Myers, MD

3:00 PM
Multifactorial Approaches to DME and RVO
Rajiv Shah, MD

3:30 PM
Complicated Case Management
Bonnie Henderson, MD

Sunday, November 12, 2017

9:30 AM
The Key Elements of Effective Intravitreal Injection Reimbursement
William Koch, COA, COE, CPC

10:00 AM
A Minimally Invasive Approach to IOP Control
Davinder Grover, MD

10:30 AM
The Science Behind Neurostimulation and Ophthalmology
Laura Periman, MD

11:00 AM
Multifactorial Approaches to DME and RVO
John Huang, MD, MBA, CPE

11:30 AM
Lowering IOP in the Real World
Ronald Gross, MD

12:00 PM
Breaking Bad—A Cataract Surgeon’s Guide to Unconventional Techniques
Gary Wortz, MD

12:30 PM
Multifactorial Approaches to DME and RVO
Robert Kwun, MD

Monday, November 13, 2017

9:30 AM
Approaches to Tough Cataracts
Eric Mann, MD

10:30 AM
The Science Behind Neurostimulation and Ophthalmology
Preeya Gupta, MD

Booth 1324

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