



AMERICAN ACADEMY
OF OPHTHALMOLOGY®

AAO 2022 News

CHICAGO

Meet Susan H. Day, MD
This Year's Orbital Gala Honoree

AAO 2022
gather





We're willing to bet most eye care professionals don't realize just how prevalent *Demodex* blepharitis is.¹

In fact, ~**25 million eye care patients** are affected by *Demodex* blepharitis (DB).^{2,3}

References: 1. Data on file, Tarsus Pharmaceuticals Inc. June 2022. 2. Trattler W, Karpecki P, Rapoport Y, et al. The prevalence of *Demodex* blepharitis in US eye care clinic patients as determined by collarettes: a pathognomonic sign. *Clin Ophthalmol.* 2022;16:1153-1164. 3. Saydah SH, Gerzoff, RB, Saaddine JB, Zhang X, Cotch MF. Eye care among US adults at high risk for vision loss in the United States in 2022 and 2017. *JAMA Ophthalmol.* 2020;138(5):479-489.

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A close-up photograph of a person's eye. The eye is closed, and the text "WHEN YOU GET YOUR PATIENTS LOOKING DOWN" is written in black marker on the upper eyelid. The skin around the eye is wrinkled, and the eyelashes are visible.

WHEN YOU GET
YOUR PATIENTS
LOOKING DOWN

JEANETTE, real DB patient

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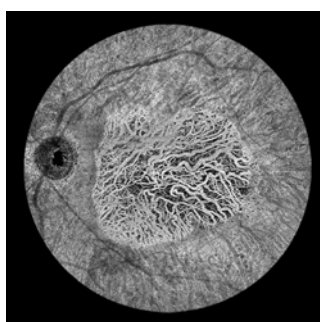
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From the Editor Welcome to AAO 2022!



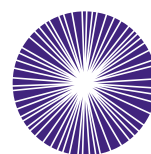
The Academy is proud to present its 126th annual meeting, AAO 2022. This year, the meeting offers more than 50 symposia. Between sessions, you can explore the Expo, where hundreds of companies are displaying their products. And don't miss the opportunity to socialize—Sunday's Orbital Gala at the Adler Planetarium is the perfect place to reconnect with colleagues while supporting the Academy's vital education programs. And last, the Closing Session features a keynote speech by Pulitzer Prize-winning author and presidential historian Doris Kearns Goodwin about her seventh book, *Leadership: In Turbulent Times*.

Ruth D. Williams, MD
Chief Medical Editor, *EyeNet Magazine*



On the Cover A Study of Stargardt's

Photo by Jody Troyer, CRA
University of Iowa Hospitals
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for updated program
information.

McCormick Place Convention Center

E353c Lakeside

Check-in and Lunch Pickup

12:30-12:45 p.m.

Lunches are provided
on a first-come basis.

Program

12:45-1:45 p.m.

These programs are non-CME and are developed independently by industry. They are not affiliated with the official program of AAO 2022 or Subspecialty Day. By attending a lunch, you may be subject to reporting under the Open Payments Program (Sunshine Act). Also, by attending a lunch, you consent to share your contact data, inclusive of National Provider ID, with the corporate partner.

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A Look at Leadership Insights From Doris Kearns Goodwin

This year's Closing Session is scheduled to feature Doris Kearns Goodwin, the world-renowned presidential historian and Pulitzer Prize-winning author of seven critically acclaimed *New York Times* best-selling books.

As American history buffs know, Ms. Goodwin brings history alive with an uncanny sense for detail and a master storyteller's grasp of drama and depth as she examines the leadership triumphs, trials, and tribulations of the men and women who have shaped this nation.

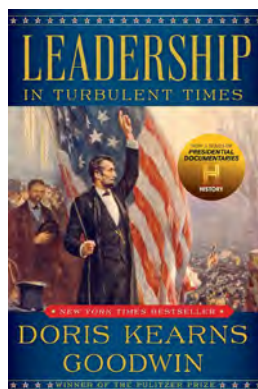
Four Presidents, Many Lessons

Ms. Goodwin's speech during the Closing Session will reflect insights from her most recent book, *Leadership: In Turbulent Times*. The book, which was published in September 2018 to critical acclaim and became an instant *New York Times* bestseller, is a culmination of Ms. Goodwin's five-decade career of studying the American presidents. It focuses on Presidents Abraham Lincoln, Theodore Roosevelt, Franklin Roosevelt, and Lyndon Baines Johnson, providing an accessible and essential road map for aspiring and established leaders in every field—and for all of us in our everyday lives.

Early Inspiration: LBJ

Ms. Goodwin's career as a presidential historian and author was inspired when—as a 24-year-old graduate student at Harvard—she was selected to join the White House Fellows, one of America's most prestigious programs for leadership and public service. Ms. Goodwin worked with President Johnson in the White House and later assisted him in the writing of his memoirs.

She then wrote *Lyndon Johnson and the American Dream*, which became a national bestseller and achieved critical acclaim. It was re-released in 2019 with a new foreword highlighting President Johnson's accomplishments in domestic affairs that have stood the test of time.



Education and Selected Awards

Ms. Goodwin graduated magna cum laude from Colby College in Waterville, Maine. She earned a doctorate degree in government from Harvard University, where she taught government, including a course on the American Presidency.

In 1995, Ms. Goodwin was awarded the Pulitzer Prize in history for *No Ordinary Time: Franklin and Eleanor Roosevelt: The Home Front in World War II*.

Her many other honors and awards



SPEAKER. Doris Kearns Goodwin will speak at the Closing Session (event code Sym58). When: Monday, 3:45-5:00 p.m. Where: Room E354.

include the Charles Frankel Prize, the Sarah Josepha Hale Medal, the New England Book Award, and the Carl Sandburg Literary Award.

Noted Commentator

Well-known for her television appearances and commentary, Ms. Goodwin is frequently seen in documentaries,

including Ken Burns' "The History of Baseball" and "The Roosevelts: An Intimate History." In addition, she often appears on news and cable networks as well as on shows such as "Meet The Press" and "The Late Show with Stephen Colbert." She played herself as a teacher on "The Simpsons" and as a historian on "American Horror Story."

In 2020, she served as the executive producer for History Channel's six-hour, three-night miniseries event, "Washington," which delves into the lesser-known details of America's first president and shows the arc of his developments as a leader.

Ms. Goodwin recently founded Pastimes Productions with Beth Laski

to develop and produce film, television, and digital projects. She lives in Boston and is a devoted fan of the World Series-winning Boston Red Sox (in 1979, she was the first woman to enter the Red Sox's locker room). Indeed, *Wait Till Next Year – A Memoir* is her personal story of growing up loving her family and baseball.

Book Notes

Ms. Goodwin has published widely, including numerous articles in such publications as the *Harvard Business Review* and *The Atlantic*. The following is a list of her seven best-selling books.

- *The Fitzgeralds and the Kennedys: An American Saga*. (Simon & Schuster, 1987). This book was adapted into an award-winning five-part television miniseries.

- *No Ordinary Time: Franklin and Eleanor Roosevelt: The Home Front in World War II* (Simon & Schuster, 1995). Winner of the Pulitzer Prize in history in 1995.

- *Wait Till Next Year – A Memoir* (Simon & Schuster, 1998). Personal reflections on Ms. Goodwin's childhood in New York.

- *Team of Rivals: The Political Genius of Abraham Lincoln* (Simon & Schuster, 2006). This book

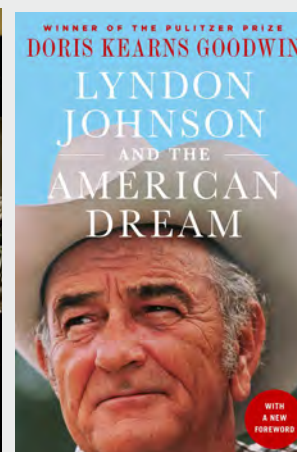
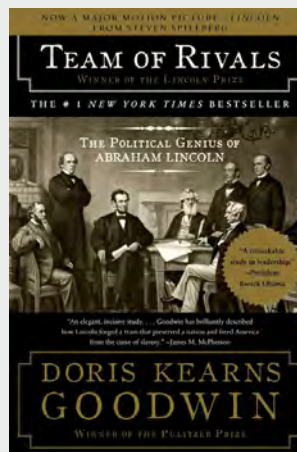
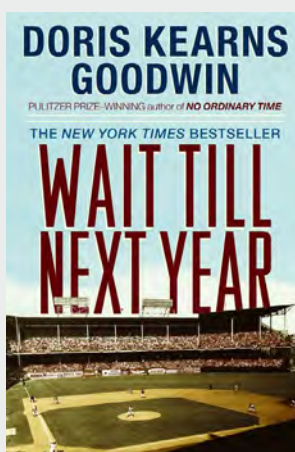
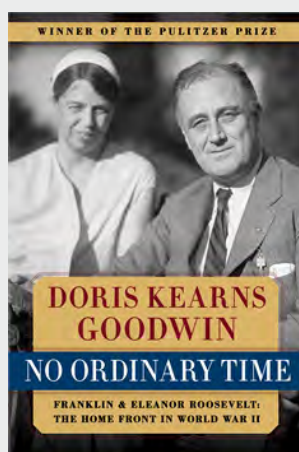
served as the basis for Steven Spielberg's hit film "Lincoln" and was awarded the prestigious Lincoln Prize, the inaugural Book Prize for American History, and the Lincoln Leadership Prize.

- *The Bully Pulpit: Theodore Roosevelt, William Howard Taft, and the Golden Age of Journalism*.

(Simon & Schuster, 2013). This book won the Carnegie Medal and is being developed into a film.

- *Leadership: In Turbulent Times* (Simon & Schuster, 2018). An assessment of presidential leadership in times of great challenge. The book served as the basis for two documentary miniseries, "Abraham Lincoln" and "Theodore Roosevelt," both of which premiered on the History Channel earlier this year.

- *Lyndon Johnson and the American Dream* (St. Martin's Griffin, 2019). Originally published in 1976 by Harper & Row. The 2019 edition includes a new foreword.



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Be Aware of Major Code of Ethics Revisions Effective Last January . . . and Review the Proposed Change for 2023

Significant revisions to the Code of Ethics were approved by the Academy membership in fall of 2021 and went into effect Jan. 1, 2022. Because all members are obligated to abide by the Code of Ethics as a condition of continued Academy membership, it's wise to familiarize yourself with the changes.

In addition, voting is now open on the bylaws changes that may be implemented in January 2023. Before you vote, review the proposed change to the Code of Ethics (see "Proposed Change for 2023").

Two New Principles of Ethics

In January the following went into effect.

Principle 10. Healthcare Inequities.

Ophthalmologists should be aware of disparities in ophthalmic care within the communities they serve in the United States and internationally. Ophthalmologists should assist patients in need to secure access to appropriate ophthalmic care.

Principle 11. Professional Civility.

Ophthalmologists should demonstrate courtesy, civility, inclusion, and respect to persons, groups, and organizations in professional communications of all types especially when discourse involves disagreement of opinion or disparate points of view.

Rationale. These two new Principles of Ethics were added to respond to recent social awareness of healthcare inequities and noncollegial public discourse.

Revisions to Rules

Rules 2 (Informed Consent), 4 (Other Opinions), 5 (The Impaired Ophthalmologist), 6 (Pretreatment Assessment), and 10 (Procedures and Materials) were revised to reinforce the focus of the rules toward patient care and the responsibility of the ophthalmologist to place patient care above other interests or concerns. Underlined text = additions. ~~Strike-through~~ = deletions.

Rule 2. Informed Consent. Informed consent is the process of shared decision-making between the ophthalmologist and the patient and must precede the The performance of medical or surgical procedures shall be preceded by appropriate procedures. During the informed consent process, pertinent medical and surgical facts, and recommendations consistent with good standard of care in medical/surgical practice must be presented in understandable terms to the patient or to the person responsible for the patient surrogate. Such information should include ~~alternative modes~~

~~of treatment, the indications, benefits, objectives, risks, and possible complications of such a treatment the procedure, alternatives to the procedure, and the potential consequences of no treatment.~~ The operating ophthalmologist must personally confirm comprehension of this information with the patient or patient surrogate ~~their (his or her) comprehension of this information.~~

Rationale. Rule 2 revisions reinforce the focus of the informed consent process being on dialogue and shared decision-making rather than merely on "obtaining" informed consent.

Rule 4. Other Opinions. Ophthalmologists should be cognizant of the limitations of his/her knowledge and skills and be willing to seek consultations in clinical situations where appropriate. The patient's request for additional opinion(s) ~~should~~ be respected. ~~Consultation(s) shall be obtained if required by the condition.~~

Rationale. The revision of Rule 4 adds the ophthalmologist's own perceived limitations as a valid reason to seek consultations with others.

Rule 5. The Impaired Ophthalmologist. An ophthalmologist who becomes temporarily or permanently impaired by illness, injury, chemical dependence, fatigue, or other conditions that affect medical judgment or performance ~~A physically, mentally or emotionally impaired ophthalmologist~~ should withdraw from those aspects of practice affected by the impairment and arrange for a qualified colleague to assume the responsibilities of ophthalmic care until the impairment has been resolved. If an impaired ophthalmologist does not appropriately withdraw, cease inappropriate behavior, it is the duty of other ophthalmologists who know of the impairment to take action to attempt to assure correction of the situation. ~~This may involve a wide range of remedial actions.~~

Rationale. These revisions are intended to improve the currency of Rule 5. The previous text did not reflect recent social discourse about these conditions.

Rule 6. Pretreatment Assessment. Treatment (including but not limited to surgery) ~~should~~ be recommended only after a careful consideration of the patient's physical, social, emotional and occupational needs. The ophthalmologist must evaluate and determine the need for treatment for each patient. If the pretreatment evaluation is performed by another health care provider, the ophthalmologist must ensure ~~assure~~ that the evaluation accurately documents



the ophthalmic findings and the indications for treatment. Recommendation of unnecessary treatment or withholding of necessary treatment is unethical.

Rationale. The revision of Rule 6 is designed to address a grammatical error. The noted word should be "ensure" (to guarantee) rather than "assure" (to promise).

Rule 10. Procedures and Materials. Ophthalmologists should order and/or utilize only those laboratory and surgical procedures, optical devices or pharmaco-

logical agents that are in the best interest of the patient. ~~It is unethical to prescribe or provide unnecessary services and procedures or seek compensation for those services. It is equally unethical to Order-ing unnecessary procedures or materials or withholding necessary services or procedures or materials is unethical.~~

Rationale. These revisions of Rule 10 are based on Ethics Committee case reviews and include "surgery" as well as procedures and materials used in patient care. Additionally, the "and/or utilize" edit is intended to address not only the recommendation of, but also the utilization of, necessary or unnecessary procedures, materials, or surgery.

Administrative Procedures

The Administrative Procedures of the Code of Ethics underwent a few revisions, the most significant of these was in **Section 4.e. Sanctions.** Text was added to strengthen the impact of a sanction on a member found to be in violation of the Code. Members must now petition the Board of Trustees for reentry into full membership.

PROPOSED CHANGE FOR 2023

The proposed revision to Code of Ethics Rule 13 is in bold:

13. Communications to the Public. Communications to the public must be accurate. They must not convey false, untrue, deceptive, or misleading information through statements, testimonials, photographs, graphics, or other means. They must not omit material information without which the communications would be deceptive. Communications must not appeal to an individual's anxiety in an excessive or unfair way; and they must not create unjustified expectations of results. **Communications must not promote health-related misinformation or claims that are false, deceptive, or misleading; statements based on opinion must be identified as such and must not contain material claims of safety and/or efficacy that cannot be substantiated.** If communications refer to benefits or other attributes of ophthalmic procedures that involve significant risks, realistic assessments of their safety and efficacy must also be included, as well as the availability of alternatives and, where necessary to avoid deception, descriptions and/or assessments of the benefits or other attributes of those alternatives. Communications must not misrepresent an ophthalmologist's credentials, training, experience, or ability, and must not contain material claims of superiority that cannot be substantiated. If a communication results from payment by an ophthalmologist, this must be disclosed unless the nature, format, or medium makes it apparent.

THE ETHICS COMMITTEE

Members of the committee (from left to right): Carla J. Siegfried, MD, Chair; Jessica B. Ciralsky, MD, Vice Chair; Zélia M. Corrêa, MD, PhD; Hardeep Dhindsa, MD; John A. Irvine, MD; Russell N. Van Gelder, MD, PhD; Brian A. Welcome, MD.



Of Music and Medicine: Susan H. Day, MD

Orbital Gala Special Honoree

Any serious flutist knows Mozart's flute concertos, as they are a rite of passage for those who seek to master the instrument. And if you were in Davies Hall in San Francisco in 1982, you would have heard Susan H. Day, MD, perform Mozart's Concerto No. 2 in D Major for Flute (K. 314) with the San Francisco Symphony. The concert was a special feature of the Academy's combined annual meeting with the International Council of Ophthalmology that year.

For Dr. Day, who is the guest of honor at the 2022 Orbital Gala, that night was one of many highlights in a remarkable—and multifaceted—career.

From Music to Medicine

Dr. Day was born in Shreveport, Louisiana. Both of her parents played the piano and taught music, and Dr. Day followed their lead, learning both flute and piano.

Initially, she continued her musical studies in college. But as she grew increasingly interested in science, she realized that she wanted to focus on medicine, and she earned her degree at Louisiana State University's School of Medicine in 1975.

She then moved to San Francisco, where she completed an internship at the Letterman Army Medical Center and her ophthalmology residency at California Pacific Medical Center (CPMC). This was

ophthalmology colleagues at the noon-time concerts that were a regular feature of the Academy's annual meeting for many years.

Stepping Into Leadership Roles

During her time in private practice, Dr. Day became increasingly interested in how residents are trained and how their educational standards are set.^{1,2} She joined the faculty at CPMC as service chief for pediatric ophthalmology and strabismus, then became director of the residency program in 1997 and chair of the department in 2000.

Dr. Day also became president of the Academy in 2005—in fact, she was the first woman to hold the position. She also served as president of the Association of University Professors of Ophthalmology, the American Association for Pediatric Ophthalmology and Strabismus (AAPOS), and the American Ophthalmological Society (AOS). In addition, she was chair of the Accreditation Council for Graduate Medical Education's (ACGME) Board of Directors and Board Director of the American Board of Ophthalmology, among other leadership positions.

She received multiple awards and honors throughout her career, including the Howe Medal, which is named for Lucien Howe, MD, and is the highest honor awarded annually by the AOS and denotes distinguished service to

ophthalmology. She also was awarded the AAPOS Parks Bronze and Silver Medals, both of which pay honor to the legendary pediatric ophthalmologist Marshall M. Parks, MD. As AAPOS notes, the Parks Silver Medal is "pediatric ophthalmology's equivalent of the Nobel Prize, recognizing monumental contributions. Such contributions may involve basic research, clinical research, clinical care, educational activities, organizational

activities, public health, or resource contributions." In addition, she received the Academy's EnergEYES Award and lifetime achievement awards from both the Academy and the AAPOS.

And when she considers her career, she notes the guidance she received from such leading pediatric ophthalmologists as Drs. Creig Hoyt, Arthur Jampolsky, Marilyn Miller, Alan Scott,



LEADER. Dr. Day's many accomplishments include her tenure as president of several ophthalmic organizations, including the Academy.

and David Taylor—as well as that from mentors Bill Spencer, Bruce Spivey, and Bob Stamper.

Not Your Average Retirement

In 2014, Dr. Day retired from active practice and relocated to Chicago to become senior vice president of medical affairs for ACGME International. As the organization grew, she became the organization's first president and CEO. Her goal: to help improve health care throughout the world by advancing the quality of residency education in all specialties. In this position, she worked to help other countries create their own accreditation programs.

In 2021, Dr. Day stepped down from

her position at ACGME. And once again, she took on a significant learning challenge.

This time, she is revisiting her musical roots as well as weaving in her love of science: she's focusing on the flute and studying the science of music at McGill University's Schulich School of Music in Montreal, Canada. She hopes to combine her lifelong fascination with music and medicine, perhaps culminating in a research project incorporating both disciplines.

1 Gedde SJ et al. *Ophthalmology*. 2013;120(12):2364-2365.

2 Day SH. *Ophthalmology*. 2016;123(9 Suppl):S50-S54.

About the Orbital Gala

This year's Orbital Gala—the 19th annual—is taking place at Chicago's iconic Adler Planetarium on Sunday from 6:00-8:00 p.m. The event, which is hosted by the Academy Foundation, will include a cocktail party and both silent and live auctions, all with the stunning backdrop of views of Chicago's skyline and Lake Michigan. As in past years, the proceeds benefit the Academy's programs. This year's beneficiary is EyeCare America, which is one of the country's leading public service programs and provides eye care through a pool of volunteer ophthalmologists.

Tickets sold out. There are no tickets left for this year's Orbital Gala. It's not too late to make a donation in honor of Dr. Susan Day or to support EyeCare America and be acknowledged: go to aao.org/foundation.



MULTITALENTED. Music continues to be a significant part of Dr. Day's life.

followed by two fellowships—one at The Hospital for Sick Children in London, the other at the University of Iowa—and a return to San Francisco, where she practiced pediatric ophthalmology and strabismus for 34 years.

Despite her growing responsibilities, she didn't let go of music altogether: in addition to that performance at Davies Hall, she regularly joined her musical

The History of Ophthalmic Innovations in Militaries

At AAO 2022, the Truhlsen-Marmor Museum of the Eye presents an exhibit exploring the relationship between ophthalmology and the armed forces, uncovering the people and stories that intersect medicine and the military.

Military medicine keeps armed forces healthy during peace and heals soldiers after conflict. While military medicine is often associated with battlefield surgery, it also encompasses sanitation, transportation, and rehabilitation. At AAO 2022, discover how armed forces across the globe have had an impact on ophthalmology. Visit the Truhlsen-Marmor Museum of the Eye's exhibit (Booth 1603) to explore more.

The Emergence of Specialty Hospitals

The Napoleonic Wars in the early 1800s exposed soldiers from around Europe to an eye disease then known as "military ophthalmia." It was, in fact, caused by several different types of bacterial infection. Physicians studied the diseases—including trachoma—that returning soldiers brought home. To facilitate this work, specialized hospitals for eye and ear medicine emerged. In 19th-century Britain, 52 specialty hospitals were built. One of these was the London Dispensary for Curing Diseases of the Eye and Ear, founded in 1805. Today, it is the world-famous Moorfields Eye Hospital.

Ocular Pathology

In 1862, during the American Civil War (1861-1865), the U.S. military founded the Army Medical Museum in Washington, D.C., to house medical specimens recovered from the battlefield. They would then catalog and analyze the specimens to improve the effectiveness of military medicine.

The collection continued to grow after the war with an emphasis on pathological specimens and medical photography. In 1918, ophthalmologist Harry Gradle, MD, (1883-1950) agreed to send eye pathological specimens to the Army Medical Museum in exchange for their help with analysis. This led to the founding of the Registry of Ophthalmic Pathology, the first of several specialty divisions. Eventually, Helenor Campbell Wilder Foerster (1895-1998) was hired

to develop and manage the ophthalmic registry. In 1946, the Army Medical Museum became a division of the new Army Institute of Pathology, and in 1949, it was renamed the Armed Forces Institute of Pathology (AFIP).

Until its disestablishment in 2011, the AFIP collaborated openly with non-military pathologists, who were recruited to help review and diagnose specimens. These partnerships, which produced several books on ophthalmic pathology, lasted more than six decades thanks to the mutual interest that military and civilian clinicians shared in advancing technical processes and interpreting pathological specimens.

Today the historical specimens in the former Army Medical Museum have been moved to the National Museum of Health and Medicine in Silver Spring, Maryland.

Oculofacial Plastic Surgery

Over the centuries and around the world, soldiers and civilians have sustained trauma to the eye and periorbital area during military conflict. Although tragic, these incidents have provided ophthalmologists the opportunity to improve oculoplastic surgery.

The study of injuries and postsurgical outcomes started with the Napoleonic Wars and ramped up during the American Civil War when the United States used photography to officially catalog soldiers' injuries. The more destructive weapons used during World War I only increased the number and severity of facial injuries. As a result, Harold Gillies, MD, (1882-1960) opened The Queen's Hospital in England in 1917. It was the first-ever hospital dedicated to the treatment of facial injuries.

In World War II, Byron Smith, MD, (1908-1990) performed similar work as the senior consultant in ophthalmology for the U.S. Military in Europe. Dr. Smith met with Gen. George Patton and led the Allied center for surgical reconstruction and rehabilitation.



WORLD WARS. During World War II, Dr. Smith (top right and bottom right) met with Gen. Patton (top left) and oversaw oculofacial plastic surgery efforts for injured Allied soldiers. Dr. Ishihara (bottom left) created color vision tests for the Imperial Japanese Army's efforts in World War I.

Identifying Color Deficiency

Another ophthalmologist influenced by his time in the military, Shinobu Ishihara, MD, (1879-1963) attended the University of Tokyo under a full scholarship from the Imperial Japanese Army. After training in ophthalmology, he began teaching at the Military Medical School in Tokyo. At the outbreak of World War I in 1914, he was assigned the task of creating a color vision test for army recruits. The first Ishihara plates were printed by the Japanese army in 1916. Dr. Ishihara created his tests so that everyone could see something on the page, making it extremely difficult to cheat or intentionally fail. The color vision plates have had a long life outside of the military. They

were published and distributed all over the world and became Dr. Ishihara's life's work. He personally edited each edition of the book to ensure that the color variations printed were exact.

More at AAO 2022

Attend the museum's annual history symposium: "Ophthalmologists During Wartime." Cosponsored by the Society of Military Ophthalmologists, the symposium explores the relationship between ophthalmology and the armed forces over the last 110 years and includes recollections from ophthalmologists. **Ophthalmologists During Wartime (Sym09).** When: Saturday, 11:30 a.m.-12:45 p.m. Where: Grand Ballroom S100c.

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Listen to These Podcasts on Your Flight Home

Both the ONE Network and the *Ophthalmology* family of journals unveiled topical, biweekly podcasts in the last year. Whether you haven't yet found them or are already a fan, read on.

And before you head home, find the Academy shows wherever you prefer to access podcasts and be sure to subscribe to each and download a few episodes. The shows are also streamable at aao.org/podcasts.

EXPERTS INSIGHT

The Academy's ONE Network launched a podcast in October 2021. *Experts InSight* (Fig. 1) provides a conversational digest of essential updates from subspecialists across ophthalmology.

Join host Jay Sridhar, MD, every other Thursday afternoon when each episode drops (Fig. 2). Listen to topical conversations with experts who focus on practical pearls that will improve your practice and patient care. Each 30-minute episode covers major research from the ophthalmic literature, surgical and medical updates, diagnostic pearls and pitfalls, and issues impacting the practice of medicine. The show has covered corneal transplantation, medical management of glaucoma, prevention of myopia progression, and more.

"*Experts InSight* is such a pleasure to host," said Dr. Sridhar, a retina specialist at Bascom Palmer in Miami. "With each episode, I learn so much about how our colleagues throughout ophthalmology manage subspecialty-specific diseases with cutting-edge therapies. Ophthalmology keeps evolving so quickly, and this podcast has allowed me the chance to try to keep up with all the wonderful advances and share them with the global ophthalmology community."

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Launched in February, the Academy's *Ophthalmology Journal* podcast (Fig. 3) dives deep into research articles, editorials, and more from the Academy's journal family: *Ophthalmology*, *Ophthalmology Retina*, *Ophthalmology Glaucoma*, and *Ophthalmology Science*. Subscribe to receive a new episode every other Thursday as *Ophthalmology's* social media editors interview authors and editors about their groundbreaking work (Fig. 4). So far, topics have included gene therapy, IOL power formulas, and representa-

tion of women in subspecialty societies, among others.

The social media editors represent various subspecialties and take turns hosting episodes. They are:

- Lorraine Provencher, MD, glaucoma specialist at the Cincinnati Eye Institute, @DrLorraineEyeMD.
- Andrew R. Carey, MD, neuro-ophthalmologist at the Wilmer Eye Institute in Baltimore, @DrewCareyMD.
- Matt Feng, MD, cornea, cataract, and anterior segment surgeon in private practice in Indianapolis, @iDrFeng.
- Rajesh C. Rao, MD, retina specialist at the University of Michigan, Ann Arbor, @SurgeonRetina.
- Edmund Tsui, MD, uveitis specialist at the Stein Eye Institute in Los Angeles, @EdmundTsuiMD.

Find episodes. Visit aao.org/podcasts to learn more and subscribe to *Ophthalmology Journal* and *Experts InSight*. Or find the show wherever you prefer to access your podcasts.

STRAIGHT FROM THE CUTTER'S MOUTH

Since 2018, the Academy has also been publishing *Straight From the Cutter's Mouth* on the ONE Network. This retina-focused podcast, hosted by Dr. Sridhar, covers topics from heads-up surgery and OCT angiography to gender equality in medicine, physician wellness, residency match, and more.

Unlike *Experts InSight* and *Ophthalmology Journal*, this podcast is not hosted by the Academy. However, the Academy is the exclusive provider of CME credit (usually 0.5 CME credits) for selected episodes posted to the ONE Network.

Find episodes. Check out past episodes at aao.org/clinical-education. Find Multimedia, then Browse the Podcast Archive (Fig. 5). All past podcasts from *Straight From the Cutter's Mouth*, as well as *Experts InSight* and *Ophthalmology Journal*, can be found there (Fig. 6).

SPECIAL EVENT. Don't miss "*Ophthalmology Journal* Podcast Live." The *Ophthalmology* social media editors record a podcast in front of a live audience. **When:** Sunday, 1:30-2:30 p.m. **Where:** Tech Pavilion, Booth 1044.

Experts InSight

Experts InSight provides an essential digest of practical updates from subspecialists across ophthalmology. Join Jay Sridhar, MD, every other Thursday afternoon for topical conversations with experts who focus on practical pearls that will improve your practice and patient care. Each episode covers major research from the ophthalmic literature, surgical and medical updates, diagnostic pearls and pitfalls, and issues impacting the practice of medicine.

Ophthalmology Journal

Ophthalmology Journal dives deep into research articles, editorials, and more from the American Academy of Ophthalmology's journal family: *Ophthalmology*, *Ophthalmology Retina*, *Ophthalmology Glaucoma*, and *Ophthalmology Science*. Join our rotating hosts of social media editors every other Thursday as they interview authors and editors about their groundbreaking work.

Experts InSight

Diagnosis and Treatment of Radiation Retinopathy

May 05, 2022

31:18

Approaches to Strabismus Surgery

Apr 21, 2022

36:36

Treatment Options for Neurotrophic Keratitis

Apr 07, 2022

29:01

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Experts InSight is in the Academy's media library, where you'll find all the episodes that carry CME credit. Each selected episode is eligible for up to 0.5 hours of credit.

About Dr. Jay Sridhar

Jay Sridhar, MD, is the creator and host of *Experts InSight*. He is an associate professor of clinical ophthalmology and vitreoretinal surgery, as well as the associate resident program director at the Bascom Palmer Eye Institute in Miami, Florida. Jay's other podcast series, *Straight from the Cutter's Mouth*, is also available online from the Academy.

Suggestions or questions about the show?

We want to hear from you. Our editorial team welcomes feedback—especially your ideas for new episodes, speaker recommendations, or how we could improve the show. Send all your thoughts to podcasts@aao.org.

Ophthalmology Journal

Representation of Women in Ophthalmology Subspecialty Soc

May 12, 2022

29:39

Topical Treatment of Secondary Macular Holes

Apr 04, 2022

19:23

Incidence of Herpes Zoster Ophthalmicus

Apr 14, 2022

32:15

About the hosts

Senior Social Media Editor

Lorraine Provencher, MD, is a glaucoma specialist at the Cincinnati Eye Institute and an assistant professor of clinical ophthalmology at the University of Cincinnati. Follow her on Twitter @DrLorraineEyeMD.

Social Media Editors

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Edmund Tsui, MD, is an assistant professor of ophthalmology in the uveitis service at the UCLA Stein Eye Institute, David Geffen School of Medicine. Follow him on Twitter @EdmundTsuiMD.

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Episodes 337: Journal Club - Retinal Detachment Trends During COVID-19, Racial Disparities in DME Trials, and more

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Local Therapy Options for Uveitis

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Episodes 336: Ophthalmology Residency Match 2021-2022 Discussion Part Two (Matched Applicants)

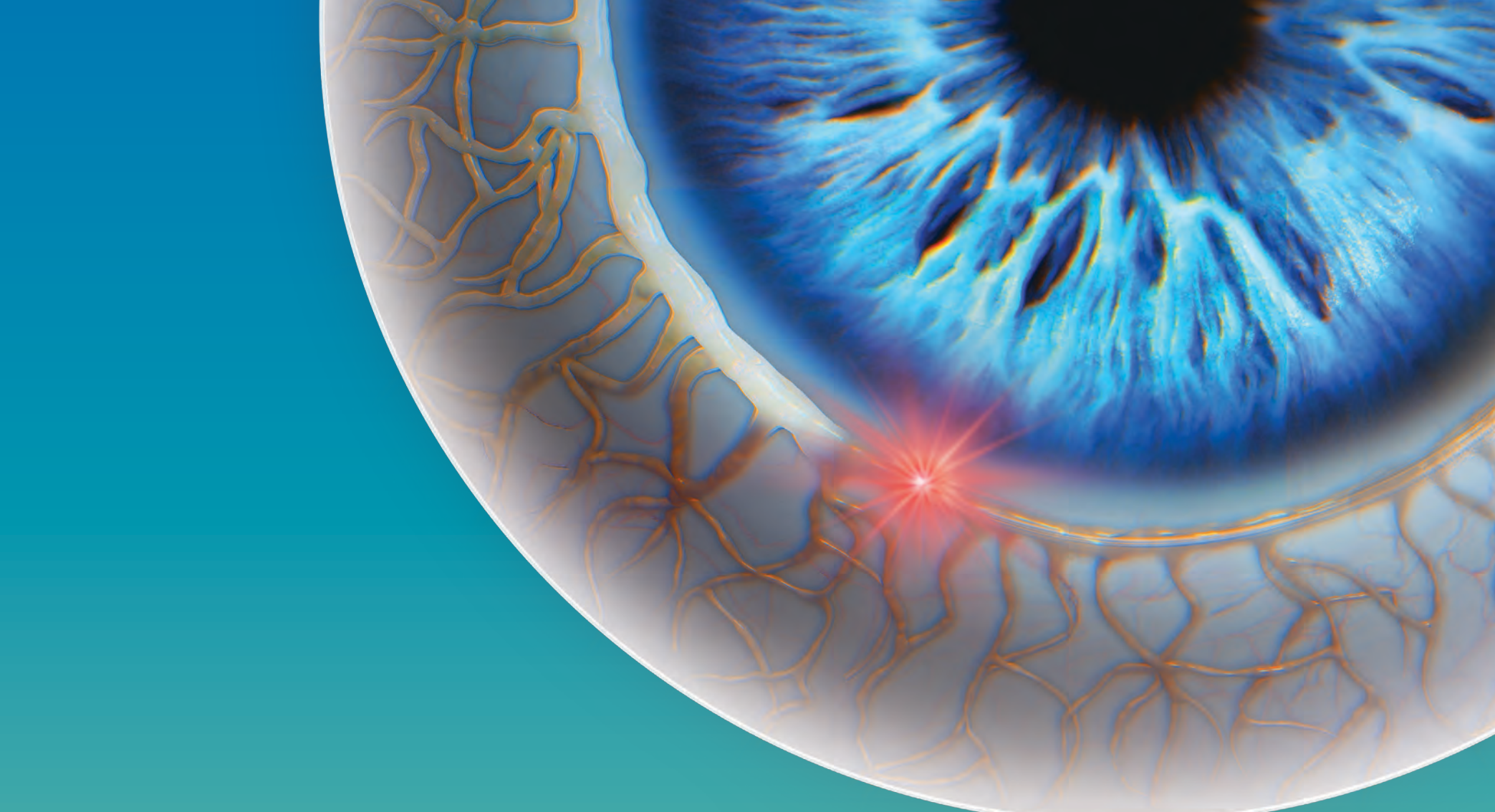
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Ergonomics to Prolong Your Career: The Earlier You Start, the Better

What can ophthalmologists do today to serve the future eye care needs of an aging population? They can start by dropping their traditional stoicism and becoming proactive about ergonomics.

Three physicians—each at a different career stage—share personal stories of pain, discuss why ergonomics gets overlooked in residency, and offer tips to prolong your career.

Dr. Early—Overcoming the Tradition of Toughing It Out

Allison D. Early, MD, is a cataract surgeon and comprehensive ophthalmologist at the Cincinnati Eye Institute. She is in her fourth year of practice.

When did you realize that the job you love might harm your health? Very early in residency, I began to notice that at the end of the day, my neck, shoulders, and trapezius muscle were really tight, but it wasn't until my first year of practice that I really focused on how to deal with these issues in a practical way.

Why is ergonomics underappreciated by residents? There's still a sense that you can earn a badge of honor by toughing it out, so you don't mention that you're overextended at the slit lamp or that the teaching scope is awkwardly positioned. You don't want to be the high maintenance resident, and you don't want to slow things down in the OR, so you slog through.

What advice would you give to young ophthalmologists? My No. 1 tip is getting the footrest of the patient exam chair out of the way. If the patient's legs are long enough to touch the floor, flip the footrest out of the way. Otherwise, elevate the chair by an inch or so—just enough so the casters of your exam chair will fit underneath. You can then scoot all the way forward to give yourself an upright spinal posture. Once I started making that change,

my upper spine and neck pain almost completely disappeared.

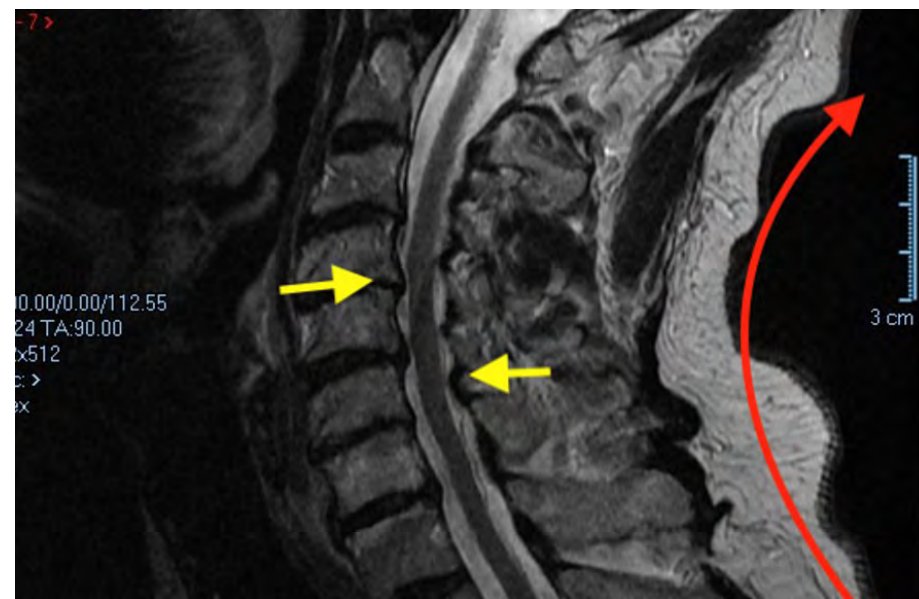
Dr. Garg—Feeling Sore? So Are Your Colleagues!

Sunir J. Garg, MD, is a partner at Mid Atlantic Retina and is professor of ophthalmology at the retina service of Wills Eye Hospital in Philadelphia. He has been in practice for 18 years.

When did you realize that the job you love was harming your health? I began having back pain when I first started going into the OR as a second-year resident. I learned ways to make certain things better, but as I've gotten older other issues have cropped up. So it's been an ongoing issue for my entire professional career.

Why is ergonomics underappreciated by residents? When you're in residency, the learning curve is really steep. When you go in the OR, you are focused on not messing the case up and on doing the rhexis properly. Your mind is going through the surgical checklist. You're young and resilient, your body doesn't really hurt, and you can't even imagine what arthritis feels like—so you power through. And as a profession, we haven't done a good job in teaching ourselves and our trainees about ergonomics. If we don't teach trainees that this is important for their professional longevity, then they won't know to focus on it. This is an opportunity for improvement that we could institute tomorrow at pretty much no cost.

What advice would you give to young ophthalmologists? Don't feel that you're the only one who is suffering. A lot of other ophthalmologists are experiencing back pain, neck pain, and wrist pain—we just don't talk about it very much! We need to encourage a louder and more expansive conversation about ergonomics and physician wellness.



CERVICAL SPINAL STENOSIS. Magnetic resonance imaging of Dr. Masket's neck at age 74. "The lordotic curve [red arrow] has been hyperextended and there is impingement [yellow arrows] of the spinal cord," he said. "I think this most likely comes from hyperextension over a long time—looking through the slit lamp and through the surgical microscope." Bring your questions to Dr. Masket at the Learning Lounge session: "Feel the Burn? Let's Focus on Wellness." For details, see aao.org/mobile or the list of wellness-related events at aao.org/wellness.

Dr. Masket—Do Your Future Self a Favor. Start Today. Sam Masket, MD, completed his training 49 years ago and founded an anterior segment practice in Los Angeles in 1977. At the outset of the COVID-19 public health emergency, he stopped seeing patients.

When did you realize that the job you love might harm your health? In mid-career, I had some back issues that I managed with Pilates and other exercises. Then, a few years ago, I experienced significant neck-related problems [see MRI, above].

Why is ergonomics underappreciated by residents? I trained in an earlier era when machismo was all pervasive, and we measured our self-worth by how busy we were. We were taught to "man up" and only be concerned about the patient's issues—you would never think about complaining about your own issues. I remember my first few visits to the OR: the nurses would have us scrub with what was basically steel wool until

we were about to bleed. You never paid attention to the wellness of the physician, and that's what has to change—we have to teach doctors to look after themselves at an earlier stage. Why? Because the literature tells us that about 15% of ophthalmologists stop practice because of musculoskeletal disorders.

What advice would you give to young ophthalmologists? When you start operating in any facility or in your training period, it's important that you make sure that you are in a neutral position and are physically comfortable. Even so, by the end of a surgical day, you can feel rather fatigued. At that point, it is worth stretching or doing yoga or some other exercise. Understanding your own comfort—whether in the examining room or the operating room—is extremely important. I'd really like us to pay attention to this in our training programs.

MORE ONLINE. This article is excerpted from a webinar that was moderated by Anna Luisa Di Lorenzo, MD. To view the full webinar, as well as other wellness resources, visit aao.org/wellness.



DR. EARLY: "By making small changes now, you can avoid having really serious long-term problems in the future."



DR. GARG: "At medical school, we are taught about *primum non nocere*, but that's not just for the patients—it applies to us, too."



DR. MASKET: "The important thing is to prevent problems from occurring, and that goes back to starting with the trainees."

WHAT COULD THEY SEE THIS YEAR?



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Inspired by real patients with Wet AMD, ME/RVO, and DME.

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IMPORTANT SAFETY INFORMATION CONTRAINDICATIONS

- EYLEA is contraindicated in patients with ocular or periocular infections, active intraocular inflammation, or known hypersensitivity to aflibercept or to any of the excipients in EYLEA.

WARNINGS AND PRECAUTIONS

- Intravitreal injections, including those with EYLEA, have been associated with endophthalmitis and retinal detachments. Proper aseptic injection technique must always be used when administering EYLEA. Patients should be instructed to report any symptoms suggestive of endophthalmitis or retinal detachment without delay and should be managed appropriately. Intraocular inflammation has been reported with the use of EYLEA.
- Acute increases in intraocular pressure have been seen within 60 minutes of intravitreal injection, including with EYLEA. Sustained increases in intraocular pressure have also been reported after repeated intravitreal dosing with VEGF inhibitors. Intraocular pressure and the perfusion of the optic nerve head should be monitored and managed appropriately.
- There is a potential risk of arterial thromboembolic events (ATEs) following intravitreal use of VEGF inhibitors, including EYLEA. ATEs are defined as nonfatal stroke, nonfatal myocardial infarction, or vascular death (including deaths of unknown cause). The incidence of reported thromboembolic events in wet AMD studies during the first year was 1.8% (32 out of 1824) in the combined group of patients treated with EYLEA compared with 1.5% (9 out of 595) in patients treated with ranibizumab; through 96 weeks, the incidence was 3.3% (60 out of 1824) in the EYLEA group compared with 3.2% (19 out of 595) in the ranibizumab group. The incidence in the DME studies from baseline to week 52 was 3.3% (19 out of 578) in the combined group of patients treated with EYLEA compared with 2.8% (8 out of 287) in the control group; from baseline to week 100, the incidence was 6.4% (37 out of 578) in the combined group of patients treated with EYLEA compared with 4.2% (12 out of 287) in the control group. There were no reported thromboembolic events in the patients treated with EYLEA in the first six months of the RVO studies.

ADVERSE REACTIONS

- Serious adverse reactions related to the injection procedure have occurred in <0.1% of intravitreal injections with EYLEA including endophthalmitis and retinal detachment.
- The most common adverse reactions (≥5%) reported in patients receiving EYLEA were conjunctival hemorrhage, eye pain, cataract, vitreous detachment, vitreous floaters, and intraocular pressure increased.
- Patients may experience temporary visual disturbances after an intravitreal injection with EYLEA and the associated eye examinations. Advise patients not to drive or use machinery until visual function has recovered sufficiently.

INDICATIONS

EYLEA[®] (aflibercept) Injection 2 mg (0.05 mL) is indicated for the treatment of patients with Neovascular (Wet) Age-related Macular Degeneration (AMD), Macular Edema following Retinal Vein Occlusion (RVO), Diabetic Macular Edema (DME), and Diabetic Retinopathy (DR).

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

References: 1. EYLEA[®] (aflibercept) Injection full U.S. Prescribing Information. Regeneron Pharmaceuticals, Inc. June 2021. 2. Data on file. Regeneron Pharmaceuticals, Inc.

REGENERON[®]

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777 Old Saw Mill River Road, Tarrytown, NY 10591

06/2022

EYL.22.05.0005



BRIEF SUMMARY—Please see the EYLEA full Prescribing Information available on HCP.EYLEA.US for additional product information.

1 INDICATIONS AND USAGE

EYLEA is a vascular endothelial growth factor (VEGF) inhibitor indicated for the treatment of patients with:

Neovascular (Wet) Age-Related Macular Degeneration (AMD), Macular Edema Following Retinal Vein Occlusion (RVO), Diabetic Macular Edema (DME), Diabetic Retinopathy (DR).

4 CONTRAINDICATIONS

4.1 Ocular or Periocular Infections

EYLEA is contraindicated in patients with ocular or periocular infections.

4.2 Active Intraocular Inflammation

EYLEA is contraindicated in patients with active intraocular inflammation.

4.3 Hypersensitivity

EYLEA is contraindicated in patients with known hypersensitivity to aflibercept or any of the excipients in EYLEA. Hypersensitivity reactions may manifest as rash, pruritus, urticaria, severe anaphylactic/anaphylactoid reactions, or severe intraocular inflammation.

5 WARNINGS AND PRECAUTIONS

5.1 Endophthalmitis and Retinal Detachments

Intravitreal injections, including those with EYLEA, have been associated with endophthalmitis and retinal detachments [see Adverse Reactions (6.1)]. Proper aseptic injection technique must always be used when administering EYLEA. Patients should be instructed to report any symptoms suggestive of endophthalmitis or retinal detachment without delay and should be managed appropriately [see Patient Counseling Information (17)].

5.2 Increase in Intraocular Pressure

Acute increases in intraocular pressure have been seen within 60 minutes of intravitreal injection, including with EYLEA [see Adverse Reactions (6.1)]. Sustained increases in intraocular pressure have also been reported after repeated intravitreal dosing with vascular endothelial growth factor (VEGF) inhibitors. Intraocular pressure and the perfusion of the optic nerve head should be monitored and managed appropriately.

5.3 Thromboembolic Events

There is a potential risk of arterial thromboembolic events (ATEs) following intravitreal use of VEGF inhibitors, including EYLEA. ATEs are defined as nonfatal stroke, nonfatal myocardial infarction, or vascular death (including deaths of unknown cause). The incidence of reported thromboembolic events in wet AMD studies during the first year was 1.8% (32 out of 1824) in the combined group of patients treated with EYLEA compared with 1.5% (9 out of 595) in patients treated with ranibizumab; through 96 weeks, the incidence was 3.3% (60 out of 1824) in the EYLEA group compared with 3.2% (19 out of 595) in the ranibizumab group. The incidence in the DME studies from baseline to week 52 was 3.3% (19 out of 578) in the combined group of patients treated with EYLEA compared with 2.8% (8 out of 287) in the control group; from baseline to week 100, the incidence was 6.4% (37 out of 578) in the combined group of patients treated with EYLEA compared with 4.2% (12 out of 287) in the control group. There were no reported thromboembolic events in the patients treated with EYLEA in the first six months of the RVO studies.

6 ADVERSE REACTIONS

The following potentially serious adverse reactions are described elsewhere in the labeling:

- Hypersensitivity [see Contraindications (4.3)]
- Endophthalmitis and retinal detachments [see Warnings and Precautions (5.1)]
- Increase in intraocular pressure [see Warnings and Precautions (5.2)]
- Thromboembolic events [see Warnings and Precautions (5.3)]

6.1 Clinical Trials Experience

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

A total of 2980 patients treated with EYLEA constituted the safety population in eight phase 3 studies. Among those, 2379 patients were treated with the recommended dose of 2 mg. Serious adverse reactions related to the injection procedure have occurred in <0.1% of intravitreal injections with EYLEA including endophthalmitis and retinal detachment. The most common adverse reactions (≥5%) reported in patients receiving EYLEA were conjunctival hemorrhage, eye pain, cataract, vitreous detachment, vitreous floaters, and intraocular pressure increased.

Neovascular (Wet) Age-Related Macular Degeneration (AMD). The data described below reflect exposure to EYLEA in 1824 patients with wet AMD, including 1223 patients treated with the 2-mg dose, in 2 double-masked, controlled clinical studies (VIEW1 and VIEW2) for 24 months (with active control in year 1). Safety data observed in the EYLEA group in a 52-week, double-masked, Phase 2 study were consistent with these results.

Table 1: Most Common Adverse Reactions (≥1%) in Wet AMD Studies

Adverse Reactions	Baseline to Week 52		Baseline to Week 96	
	EYLEA (N=1824)	Active Control (ranibizumab) (N=595)	EYLEA (N=1824)	Control (ranibizumab) (N=595)
Conjunctival hemorrhage	25%	28%	27%	30%
Eye pain	9%	9%	10%	10%
Cataract	7%	7%	13%	10%
Vitreous detachment	6%	6%	8%	8%
Vitreous floaters	6%	7%	8%	10%
Intraocular pressure increased	5%	7%	7%	11%
Ocular hyperemia	4%	8%	5%	10%
Corneal epithelium defect	4%	5%	5%	6%
Detachment of the retinal pigment epithelium	3%	3%	5%	5%
Injection site pain	3%	3%	3%	4%
Foreign body sensation in eyes	3%	4%	4%	4%
Lacrimation increased	3%	1%	4%	2%
Vision blurred	2%	2%	4%	3%
Intraocular inflammation	2%	3%	3%	4%
Retinal pigment epithelium tear	2%	1%	2%	2%
Injection site hemorrhage	1%	2%	2%	2%
Eyelid edema	1%	2%	2%	3%
Corneal edema	1%	1%	1%	1%
Retinal detachment	<1%	<1%	1%	1%

Less common serious adverse reactions reported in <1% of the patients treated with EYLEA were hypersensitivity, retinal tear, and endophthalmitis.

Macular Edema Following Retinal Vein Occlusion (RVO). The data described below reflect 6 months exposure to EYLEA with a monthly 2 mg dose in 218 patients following central retinal vein occlusion (CRVO) in 2 clinical studies (COPERNICUS and GALILEO) and 91 patients following branch retinal vein occlusion (BRVO) in one clinical study (VIBRANT).

REGENERON

Manufactured by:
Regeneron Pharmaceuticals, Inc.
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Tarrytown, NY 10591

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Issue Date: 08/2019
Initial U.S. Approval: 2011

Based on the August 2019
EYLEA® (aflibercept) Injection full
Prescribing Information.

EYL.20.09.0052

Table 2: Most Common Adverse Reactions (≥1%) in RVO Studies

Adverse Reactions	CRVO		BRVO	
	EYLEA (N=218)	Control (N=142)	EYLEA (N=91)	Control (N=92)
Eye pain	13%	5%	4%	5%
Conjunctival hemorrhage	12%	11%	20%	4%
Intraocular pressure increased	8%	6%	2%	0%
Corneal epithelium defect	5%	4%	2%	0%
Vitreous floaters	5%	1%	1%	0%
Ocular hyperemia	5%	3%	2%	2%
Foreign body sensation in eyes	3%	5%	3%	0%
Vitreous detachment	3%	4%	2%	0%
Lacrimation increased	3%	4%	3%	0%
Injection site pain	3%	1%	1%	0%
Vision blurred	1%	<1%	1%	1%
Intraocular inflammation	1%	1%	0%	0%
Cataract	<1%	1%	5%	0%
Eyelid edema	<1%	1%	1%	0%

Less common adverse reactions reported in <1% of the patients treated with EYLEA in the CRVO studies were corneal edema, retinal tear, hypersensitivity, and endophthalmitis.

Diabetic Macular Edema (DME) and Diabetic Retinopathy (DR). The data described below reflect exposure to EYLEA in 578 patients with DME treated with the 2-mg dose in 2 double-masked, controlled clinical studies (VIVID and VISTA) from baseline to week 52 and from baseline to week 100.

Table 3: Most Common Adverse Reactions (≥1%) in DME Studies

Adverse Reactions	Baseline to Week 52		Baseline to Week 100	
	EYLEA (N=578)	Control (N=287)	EYLEA (N=578)	Control (N=287)
Conjunctival hemorrhage	28%	17%	31%	21%
Eye pain	9%	6%	11%	9%
Cataract	8%	9%	19%	17%
Vitreous floaters	6%	3%	8%	6%
Corneal epithelium defect	5%	3%	7%	5%
Intraocular pressure increased	5%	3%	9%	5%
Ocular hyperemia	5%	6%	5%	6%
Vitreous detachment	3%	3%	8%	6%
Foreign body sensation in eyes	3%	3%	3%	3%
Lacrimation increased	3%	2%	4%	2%
Vision blurred	2%	2%	3%	4%
Intraocular inflammation	2%	<1%	3%	1%
Injection site pain	2%	<1%	2%	<1%
Eyelid edema	<1%	1%	2%	1%

Less common adverse reactions reported in <1% of the patients treated with EYLEA were hypersensitivity, retinal detachment, retinal tear, corneal edema, and injection site hemorrhage.

Safety data observed in 269 patients with nonproliferative diabetic retinopathy (NPDR) through week 52 in the PANORAMA trial were consistent with those seen in the phase 3 VIVID and VISTA trials (see Table 3 above).

6.2 Immunogenicity

As with all therapeutic proteins, there is a potential for an immune response in patients treated with EYLEA. The immunogenicity of EYLEA was evaluated in serum samples. The immunogenicity data reflect the percentage of patients whose test results were considered positive for antibodies to EYLEA in immunoassays. The detection of an immune response is highly dependent on the sensitivity and specificity of the assays used, sample handling, timing of sample collection, concomitant medications, and underlying disease. For these reasons, comparison of the incidence of antibodies to EYLEA with the incidence of antibodies to other products may be misleading.

In the wet AMD, RVO, and DME studies, the pre-treatment incidence of immunoreactivity to EYLEA was approximately 1% to 3% across treatment groups. After dosing with EYLEA for 24-100 weeks, antibodies to EYLEA were detected in a similar percentage range of patients. There were no differences in efficacy or safety between patients with or without immunoreactivity.

8 USE IN SPECIFIC POPULATIONS

8.1 Pregnancy

Risk Summary

Adequate and well-controlled studies with EYLEA have not been conducted in pregnant women. Aflibercept produced adverse embryofetal effects in rabbits, including external, visceral, and skeletal malformations. A fetal No Observed Adverse Effect Level (NOAEL) was not identified. At the lowest dose shown to produce adverse embryofetal effects, systemic exposures (based on AUC for free aflibercept) were approximately 6 times higher than AUC values observed in humans after a single intravitreal treatment at the recommended clinical dose [see Animal Data].

Animal reproduction studies are not always predictive of human response, and it is not known whether EYLEA can cause fetal harm when administered to a pregnant woman. Based on the anti-VEGF mechanism of action for aflibercept, treatment with EYLEA may pose a risk to human embryofetal development. EYLEA should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

All pregnancies have a background risk of birth defect, loss, or other adverse outcomes. The background risk of major birth defects and miscarriage for the indicated population is unknown. In the U.S. general population, the estimated background risk of major birth defects and miscarriage in clinically recognized pregnancies is 2-4% and 15-20%, respectively.

Data

Animal Data

In two embryofetal development studies, aflibercept produced adverse embryofetal effects when administered every three days during organogenesis to pregnant rabbits at intravenous doses ≥3 mg per kg, or every six days during organogenesis at subcutaneous doses ≥0.1 mg per kg.

Adverse embryofetal effects included increased incidences of postimplantation loss and fetal malformations, including anasarca, umbilical hernia, diaphragmatic hernia, gastroschisis, cleft palate, ectrodactyly, intestinal atresia, spina bifida, encephalomeningocele, heart and major vessel defects, and skeletal malformations (fused vertebrae, sternbrae, and ribs; supernumerary vertebral arches and ribs; and incomplete ossification). The maternal No Observed Adverse Effect Level (NOAEL) in these studies was 3 mg per kg. Aflibercept produced fetal malformations at all doses assessed in rabbits and the fetal NOAEL was not identified. At the lowest dose shown to produce adverse embryofetal effects in rabbits (0.1 mg per kg), systemic exposure (AUC) of free aflibercept was approximately 6 times higher than systemic exposure (AUC) observed in humans after a single intravitreal dose of 2 mg.

8.2 Lactation

Risk Summary

There is no information regarding the presence of aflibercept in human milk, the effects of the drug on the breastfed infant, or the effects of the drug on milk production/excretion. Because many drugs are excreted in human milk, and because the potential for absorption and harm to infant growth and development exists, EYLEA is not recommended during breastfeeding. The developmental and health benefits of breastfeeding should be considered along with the mother’s clinical need for EYLEA and any potential adverse effects on the breastfed child from EYLEA.

8.3 Females and Males of Reproductive Potential

Contraception

Females of reproductive potential are advised to use effective contraception prior to the initial dose, during treatment, and for at least 3 months after the last intravitreal injection of EYLEA.

Infertility

There are no data regarding the effects of EYLEA on human fertility. Aflibercept adversely affected female and male reproductive systems in cynomolgus monkeys when administered by intravenous injection at a dose approximately 1500 times higher than the systemic level observed humans with an intravitreal dose of 2 mg. A No Observed Adverse Effect Level (NOAEL) was not identified. These findings were reversible within 20 weeks after cessation of treatment.

8.4 Pediatric Use

The safety and effectiveness of EYLEA in pediatric patients have not been established.

8.5 Geriatric Use

In the clinical studies, approximately 76% (2049/2701) of patients randomized to treatment with EYLEA were ≥65 years of age and approximately 46% (1250/2701) were ≥75 years of age. No significant differences in efficacy or safety were seen with increasing age in these studies.

17 PATIENT COUNSELING INFORMATION

In the days following EYLEA administration, patients are at risk of developing endophthalmitis or retinal detachment. If the eye becomes red, sensitive to light, painful, or develops a change in vision, advise patients to seek immediate care from an ophthalmologist [see Warnings and Precautions (5.1)]. Patients may experience temporary visual disturbances after an intravitreal injection with EYLEA and the associated eye examinations [see Adverse Reactions (6)]. Advise patients not to drive or use machinery until visual function has recovered sufficiently.

Find Innovative Solutions at the Academy Resource Center

During AAO 2022, visit the Resource Center at Booth 1408 to explore helpful resources and products developed by the Academy and the American Academy of Ophthalmic Executives (AAOE). And don't miss out on the 10% discount.

Where to find the Academy Resource Center. Booth 1408 at McCormick Place.

When will staff be on hand? Academy and AAOE staff are available to answer your questions from Saturday through Monday, 9:00 a.m.-5:00 p.m.

SERVICES

Academy Information

Get all your Resource Center and annual meeting questions answered at the information desk.

Advocacy

Visit the Advocacy desk to get a summary of legislative issues, send a letter to Congress, and learn about OphthPAC and the Surgical Scope Fund.

Chat With the ABO

A representative from the American Board of Ophthalmology (ABO) will be available to answer questions at the Clinical Education product desk.

Coding Questions

Stop by the Coding desk to speak with experts about reimbursement, get critical coding updates, and obtain answers to your coding conundrums.

Conversations With the Experts

Schedule a free 20-minute consultation with a practice management expert.

EyeSmart

See a demonstration of aao.org/eyesmart and the Spanish version, aao.org/ojos. Learn how these resources for patients can benefit your practice.

Foundation

Learn how to support the Academy's educational, quality-of-care, and service programs. In addition, you can enroll as a volunteer for EyeCare America, an award-winning public service program; current volunteers can order a recognition certificate and pick up a gift.

IRIS Registry

Visit the IRIS Registry (Intelligent Research in Sight) kiosk to speak with experts about the world's largest eye disease and clinical condition registry.

Member Services

Pick up your awards at the Member Services booth, including pins for 2022 Achievement Award recipients and certificates (by request only) for the Achievement Award, International Education Award, and International Scholar Award recipients. Receive \$50 off all 2023 AAOE membership applications and \$100 off 2023 Academy membership applications (first-time applicants only).

PRODUCTS

New From the Academy

You can learn about all new products in one place at the New From the Academy kiosk.

New in Clinical Education

What's new in the 2022-2023 Basic and Clinical Science Course (BCSC). Each year, the 13-volume BCSC is reviewed by more than 100 ophthalmologists to ensure that it is as concise and current as possible. Each volume features videos, tables, self-assessment questions (with answers), photos and illustrations, and opportunities for earning AMA PRA Category 1 Credit.

While all 13 volumes have been updated, three of them have undergone major revisions:

- *Section 3: Clinical Optics and Vision Rehabilitation*
- *Section 6: Pediatric Ophthalmology and Strabismus*
- *Section 12: Retina and Vitreous*

In addition, a new chapter, Social Determinants of Health (Chapter 17), is part of the minor revision of Section 1 (General Medicine). This initial chapter, which addresses disparities in eye care, serves as a preview to the full-length version that will be included in the 2023-2024 BCSC major revision.

Guidelines. Stop by the Clinical Education product desk to see the newly updated *Ophthalmic Technology Assessments*, including Femtosecond Laser-Assisted Cataract Surgery, Orbital Radiation for Thyroid Eye Disease, Adjustable Sutures in the Treatment of Strabismus, and Intravitreal Pharmacotherapies for Diabetic Macular Edema.

While you are visiting the Resource Center. Over the years, the Academy has



COMPLIMENTARY HEADSHOTS. Drop in at the Headshot Lounge for a free professional photograph to use on your website or social media profile.

developed a rich repository of educational resources. In addition to learning about this year's new products, you can ask Academy staff about the AAO Ophthalmic Education App; the AAO e-book app, which allows you to search across all the Academy's clinical education e-book titles; and the BCSC Self-Assessment Program, which now features more than 4,275 high-yield questions. And look at print products, including *Basic Principles of Ophthalmic Surgery*; *Basic Techniques of Ophthalmic Surgery*; and the *Dictionary of Eye Terminology, Seventh Edition*, which uses plain-language definitions and full-color illustrations to make ophthalmic terminology accessible to everyone in your office.

See Patient Education Resources

Print-on-demand handout subscription.

This 12-month subscription provides access to the most comprehensive library of patient education handouts in ophthalmology. It features more than 160 topics in both English and Spanish. These handouts are easy to customize with your practice information. You can then print them in your office, as needed, in unlimited quantities.

Videos. Enhance your reach by showing treatment-specific informed consent videos on your website or patient portal. Use the Academy's subspecialty-specific

video collections to reinforce your diagnosis and treatment messaging when patients are best able to focus—at home, with family, or any time it's convenient for them. Documenting use of these OMIC-approved videos helps to mitigate malpractice risk. Videos are closed-captioned for the hearing impaired.

Other resources. Explore the Academy's other popular patient education resources, including more than 40 pre-printed brochures (with the seven most popular also in Spanish) and a collection of video animations for use on your website or patient portal, depicting eye anatomy, common eye conditions, and treatment options.

New in Practice Management

Ultimate Documentation Compliance Training for Scribes and Technicians

online course. Understand how to meet payer documentation requirements for every patient visit.

New edition! Ophthalmic Medical Assisting: An Independent Study Course. This course is an essential training for ophthalmic technicians. It includes detailed step-by-step instructions for 45 procedures, interactive activities, videos, and 300+ images.

2023 editions for preorder. Each year, there are changes to reimbursement codes, so the AAOE updates its arsenal of coding references:

- *ICD-10-CM for Ophthalmology: The Complete Reference*
- *Coding Coach: Complete Ophthalmic Coding Reference*
- *Retina Coding: Complete Reference Guide*
- *Fundamentals of Ophthalmic Coding*
- *CPT: Complete Pocket Ophthalmic Reference*
- *Coding Assistant for Subspecialties.*

Save 10% and get free shipping within the United States and Canada.

The Academy will ship free via FedEx Ground to the 50 U.S. states, Washington, D.C., and Canadian provinces only. Does not include U.S. territories. Applies only to product purchases at the Academy Resource Center, Saturday-Monday. The 10% discount does not apply to dues, annual meeting, courses, or other miscellaneous fees.

Best of Show at AAO 2022: 4 Must-See Videos

Out of the 169 scientific videos submitted, 60 were accepted and will be viewable during AAO 2022. Of those, just these four were selected as Best of Show. They cover cataract; refractive surgery; and retina, vitreous.

The 2022 Best of Show winners have provided descriptions, below, of what you can learn from watching their videos. All of this year's videos are accessible, on demand, through the AAO 2022 Virtual Meeting platform and through the Mobile Meeting Guide, aao.org/mobile.

CATARACT

The Dead Bag Syndrome (V03)

The exact etiology of dead bag syndrome is as of yet unknown, but we hypothesize that late postoperative zonular failure is related to capsule splitting/delamination occurring at the level of zonular attachments.

A "dead bag syndrome" has been recently described. In this scenario, the capsular bag appears to be clear many years after surgery, becoming diaphanous and floppy, and unable to support the IOL within it. The findings of cases suspected to be dead bag syndrome are described in this video and illustrated through surgical videoclips, clinical photographs, and histopathological evaluation.

Author: Liliana Werner, MD, PhD.

REFRACTIVE SURGERY

Pain Management Protocol in PRK and CXL: Cold to the Rescue (V37)

Despite being effective and beneficial procedures, acceptance of photorefractive keratectomy (PRK) and corneal collagen cross-linking (CXL) among patients and surgeons alike is limited considerably due to significant postoperative pain. We provide a practical and economical approach in controlling this pain.

A prospective study was conducted to compare pain after PRK and CXL with cold versus room temperature bandage contact lenses, and to identify associated molecular factors. Results indicate that cold temperature may be effective in controlling postoperative pain with no delay in epithelial healing and no risk of postoperative infection. Significant increase in the expression of transient receptor potential channel TRPM8 was also observed, indicating plausible impact at the molecular level.

Author: Sailie Shirodkar, MBBS, MS.

RETINA, VITREOUS

Urology Kidney Stone Basket for Intraocular Foreign Body Removal or Cataract Fragment Removal in Highly Myopic Eyes (V50)

A tipless urology stone basket allows for a stable platform with an internal diameter of up to 12 mm to allow for removal of foreign bodies of various surfaces and sizes. Guidewire length allows for utility in long axial length eyes.

The use of traditional vitreoretinal surgical instrumentation to remove foreign bodies or a dislocated native lens may prove difficult in certain cases due to the composition, shape, or size of the objects or to the axial length of eyes. Traditional forceps can fail at grasping and removing certain objects post trauma due to coefficient of friction or lack of an easily grasped edge. A tipless urology stone basket (Zero Tip Nitinol Urology Stone Retrieval Basket, Boston Scientific) can be successfully utilized to retrieve posterior segment intraocular foreign bodies or dislocated cataract fragments in eyes with a long axial length. The stone basket can be deployed in the midvitreous cavity to a desired diameter based on the size of the object, then slowly advanced to the location of the object to be removed, which is then guided into the basket. The basket is then retracted.

Author: Alia K. Durrani, MD.

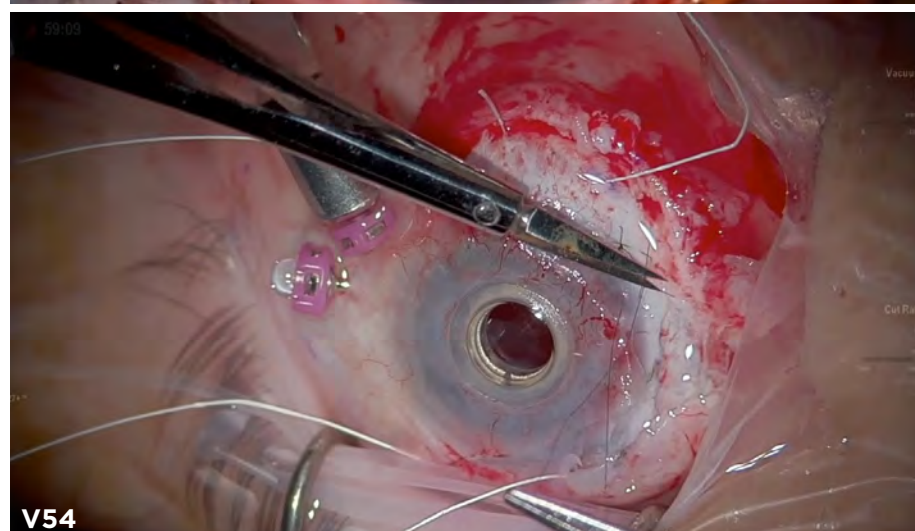
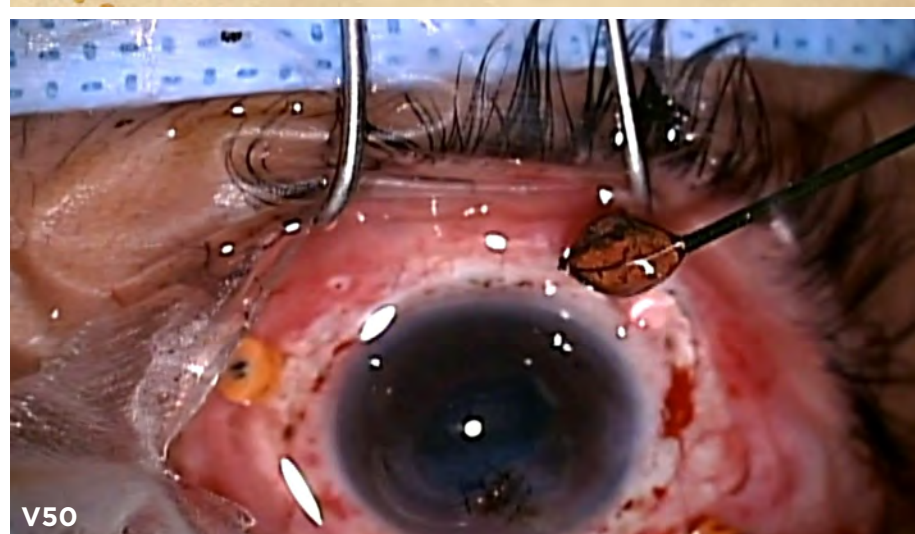
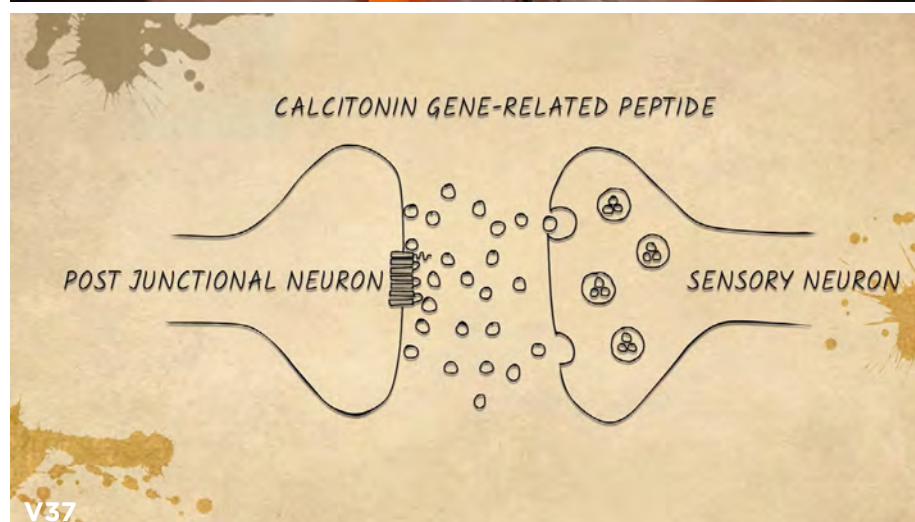
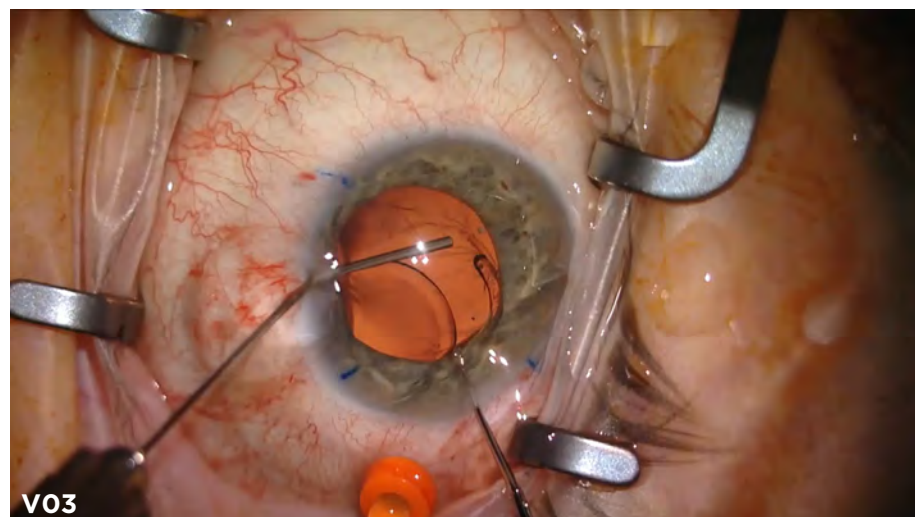
RETINA, VITREOUS

Expanding Your Surgical Armamentarium (V54)

A scleral tunnel is created to remove a dislocated Morcher implant (iris prosthesis and IOL implant).

A 39-year-old man presents with several months of fluctuating vision (20/70 to count fingers) and significant glare in the left eye. He has a history of aniridia, corneal prosthesis, tube shunt, and a Morcher implant. A large scleral tunnel is created to remove the dislocated implant. Endoscopy is used to remove a haptic arm embedded in the ciliary body. A new iris prosthesis and IOL are then surgically implanted. At one year, he had a final VA of 20/70 and no glare.

Author: Daniel A. Brill, MD.



Want to Be a Better Leader? Attend Sunday's AAOE Leadership Summit

As any physician-leader or practice manager knows, sound leadership skills are more important than ever in the current environment, which demands that leaders align their practice's business operations, patient experience, and personnel amid a shifting and uncertain health care market, marked by reimbursement decreases, staffing shortages, and cyberthreats—to name a few challenges.

AAOE launches Practice Management Leadership Summit. To address the need for ever-sharper leadership skills, the American Academy of Ophthalmic Executives (AAOE) debuts its brand-new Practice Management Leadership Summit at AAO 2022.

Free in Room S106b. The summit events take place all day Sunday, with a 75-minute break for lunch, and 30-minute intervals between sessions so attendees can network. The events are free for AAO 2022 registrants. For the latest program information, visit aao.org/mobile.

Bring your questions. The full-day educational event features five sessions, some with panel-led, townhall-style courses developed specifically for practice administrators, practice staff, and physician leaders. Each event will include an opportunity to ask questions. Courses include the following:

How to Communicate Better With Your Physician (event code 401). **Moderator:** Robert F. Melendez, MD, MBA. **When:** 8:00-9:15 a.m. **Where:** Room S106b.

In this presentation, the attendee will learn how to be a better manager and leader from a panel of physicians with different leadership styles, talking about communication and providing leadership tips.

Objectives: The panelists will discuss the good, the bad, and the ugly of interactions between physicians and administrators and how to be a better communicator. The attendee will learn about their own strengths and weakness and will develop strategies for becoming an excellent communicator in the workplace. The panel is comprised of physicians with different leadership styles, and the audience will learn how to communicate more effectively with these types of physicians.

Building Your Bench: DIY Leadership Training to Promote From Within (418). **Moderator:** Mike Lyons, MHRIR. **When:** 9:45-11:00 a.m. **Where:** Room S106b.

What is the business case for doing leadership development at the front-line level? How do you prepare nonmanagerial staff for future promotion into management? In this course, you'll learn how one medical practice built a leadership development program for staff to improve its pipeline of internal management candidates.

The course reviews the content areas to cover with your front-line staff to build their emotional intelligence as leaders. It also reviews specific topics like feedback, building trust, creating a culture of fun, and customizing communi-

cation for personality. Participants will learn how to translate these topics into engaging exercises that will reinforce knowledge. Session attendees will get slides and content they can implement immediately in their own organizations.

Objectives: Attendees will be able to 1) establish the business case for creating engaging do-it-yourself training, 2) design and carry out engaging training for emerging and first-time leaders, and 3) list the foundational skills needed for leadership.

Becoming an Effective Leader as a New Practice Administrator (432). **Moderator:** Alexandra Acaba, MSW. **When:** 11:30 a.m.-12:45 p.m. **Where:** Room S106b.

As a new practice administrator, it is often difficult to make impactful decisions and establish oneself as a leader in the role. This course, specifically designed for young and beginner practice administrators who have recently accepted the position, will tackle how to balance establishing oneself as a leader and building rapport with the staff. It will explore how to make difficult decisions that might not always be popular among staff members, how to communicate effectively to become a dependable administrator, and how a new administrator can lead the way to long-lasting change.

Objectives. By the completion of this course, attendees will have learned how to 1) build rapport with the staff they manage, 2) balance creating relationships with staff while establishing oneself as a leader, and 3) become a dependable manager who can effectively manage change in the organization.

How We Built This: Pearls From Leaders Who Turned Around Their Practice Culture (453). **Moderator:** Alan E. Kimura, MD, MPH. **When:** 2:00-3:15 p.m. **Where:** Room S106b.

The adage, "It starts at the top," applies to anyone who is responsible for managing and leading others. Today's practice, with its high stress and staff turnover, calls for emotionally intelligent leaders who engage with staff to address practice operations issues, increase the bottom line, improve communications, enhance patient care, and manage risk.



PRACTICE PEARLS. Dr. Melendez and others moderate sessions as part of the first-ever Practice Management Leadership Summit, which takes place on Sunday in Room S106b and is free to AAO 2022 registrants.

Objectives: Attendees will 1) learn the actual dollar costs of staff turnover, 2) understand how leadership style directly impacts the practice's bottom line, patient experience, risk management, and team, 3) learn which practice culture traits enable practices and their staff members to thrive, and 4) hear how three practice leaders turned around their practice culture and built winning teams.

Leadership Pearls for Young Ophthalmologists (470). **Moderator:** Robert F. Melendez, MD, MBA. **When:** 3:45-5:00 p.m. **Where:** Room S106b.

Effective leadership skills are necessary for young ophthalmologists who want to start their own practice, advance into partnership, and hold a leadership role or advance in their academic career. Often, young leaders focus too much on the position or title rather than the passion.

Objectives: Audience members will determine their leadership style and gain insight into how to be an effective leader. The panelists will share their own leadership style and pearls to help attendees become better leaders and serve in leadership positions, from committee membership, to chairs, business owners, and beyond. The audience will hear different perspectives on how to be a more effective communicator and leader. Numerous examples of leadership positions will be shared by the panelists, and the audience will learn how each panelist obtained and was successful in their position. The panelists have held state and national leadership positions.

Find Practice Management Solutions at AAOE

AAOE connects physicians and practice managers with a community of supportive, experienced professionals and the essential resources needed to manage a complex modern practice. Empower your entire team with business expertise, coding education, and comprehensive solutions to position your practice for success.

AAOE membership unlocks valuable benefits, including:

- **Actionable business intelligence:** Strategies from ophthalmic leaders and Academy experts for overcoming complex practice management challenges.
- **The most up-to-date coding and compliance advice:** Timely resources for HIPAA, MIPS reporting, and appropriately maximizing your reimbursements.
- **AAOE-Talk:** A dedicated online community network that allows members to connect directly throughout the day for support and to share information. Members rate this service as among AAOE's most valuable benefits.
- **An expanding video education library:** Hundreds of coding courses and expert-led webinars on demand.

Invest in your team to promote expertise and retention. Academy member physicians and their staff are eligible for AAOE membership. **Save \$50 on each physician and staff membership application submitted at AAO 2022.** View a complete list of benefits and see how AAOE membership can work for you at aao.org/membership/join-aaoe. Or visit the Academy Resource Center in Booth 1408.

From Academia to the Clinic 12 Eminent Speakers Talk About Current Issues

Whether you want a window into developments in colleagues' subspecialties or quick updates on your own field, consider attending an honorary lecture. These informative presentations by leaders in their fields are easy to fit into your schedule, as they are usually between 15 and 35 minutes long. Preview the highlights of these lectures below. Additional coverage can be found in the Friday AAO 2022 News.

Note: All summaries were written in advance of AAO 2022. At time of press, not all lectures and/or lecture times had been finalized. Be sure to check aao.org/mobile for the most up-to-date information.

SUNDAY, Oct. 2

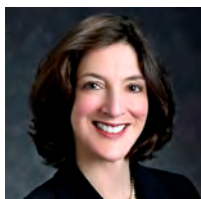
CORNEA

Castroviejo Lecture: My Superpower! How High-Resolution Imaging Has Changed My Practice of Ocular Surface Oncology, presented by Carol L. Karp, MD.

When: Sunday, 8:47-9:15 a.m., during Sym21, *I Can See: The Role of Anterior Segment Imaging*.

Where: Grand Ballroom S100ab.

"High-resolution anterior segment optical coherence tomography (HR-OCT) has emerged as a powerful and reliable



tool for the diagnosis of various anterior segment pathologies. Images of high axial resolution have allowed physicians to better visual-

ize with increasing detail the tear film, corneal layers, corneal/scleral junction, anterior chamber angle, and various layer interfaces.

"In particular, HR-OCT has revolutionized our ability to diagnose and differentiate between various ocular surface lesions, providing morphological information about the lesion of interest to help guide diagnosis and management. Ocular surface tumors, such as ocular surface squamous neoplasia, conjunctival melanoma, conjunctival lymphoma, conjunctival amyloidosis, and benign lesions such as pingueculae and pterygia have classic HR-OCT findings, providing an 'optical biopsy' of various ocular surface lesions. I like to joke that the HR-OCT gives me 'superpowers' to evaluate what is happening on the ocular surface in a way that compliments and supersedes the clinical examination.

"I plan to share my step-by-step ap-

proach to acquiring and interpreting HR-OCT images in my 2022 Castroviejo lecture. I hope this will allow you to best help your patients with ocular surface lesions."

I Can See: The Role of Anterior Segment Imaging (8:00-9:15 a.m.) is cosponsored by the Cornea Society.

PEDIATRIC OPHTHALMOLOGY

Marshall M. Parks Lecture: ROP: From "Plus" Disease to "Plus" Contributions! presented by Susan H. Day, MD.

When: Sunday, 8:50-9:15 a.m., during Sym20, *Retinopathy of Prematurity*.

Where: Room E450.

"In half a century, retinopathy of prematurity (ROP) is clearly one example of how scientific

advances occur: the ability to ask the right question; interdisciplinary research; enhanced technology; standardization of clinical features and language; QALY scales connoting value; NICU regulations requiring skilled eye examiners; and international awareness and education. The physicians' roles have been essential along every step of this journey. What remaining challenges deserve our attention as our careers mature?

"Retinopathy of prematurity is a perfect model for another 'ROP': responsibility, opportunity, and progress. The horizons of how we might help our patients are limitless, as are all ophthalmologists' potential, regardless of expertise, avocational interests, and demographic identities. As retirement ensues, what new chapters might unfold for us to continue to make a positive difference? How might we collectively apply our unique experience in the science and art of medicine to enrich the lives of others and of self?"

Retinopathy of Prematurity (8:00-9:15 a.m.) is cosponsored by the American Association of Pediatric Ophthalmology and Strabismus.

NEURO-OPHTHALMOLOGY

William F. Hoyt Lecture: The Superior Colliculus: A Path to Neuro-Ophthalmology, presented by Steven E. Feldon, MD.

When: Sunday, 12:25-12:45 p.m., during Sym31, *Vision- and Life-Threatening Signs and Symptoms: Pearls From Neuro-Ophthalmology*.

Where: Grand Ballroom S100ab.

"As an undergraduate student at the University of California, Los Angeles,



I had the unique opportunity to do vision research in the lab of Lawrence Kruger, PhD, professor of anatomy. My assignment was to

ascertain the topographic projection of the visual field on the superior colliculus of the cat. These studies resulted in my first scientific publication in 1970 and led to my fascination with the neurology of the visual system and to my career as a neuro-ophthalmologist. In this lecture honoring my mentor, William F. Hoyt, I return to that formative stage in my career path to introduce this audience to the extensively studied, but clinically underappreciated, role of the superior colliculus (SC) in health and disease.

"The SC is a laminated dorsal mid-brain structure with multiple layers. The superficial layer is dominated by sensory inputs from the retina, and there are projections from the SC to the lateral geniculate, pulvinar, and visual cortex. The deeper layers are primarily associated with the initiation of saccadic eye movements to visual targets. Sensorimotor integration occurs in the intermediate layers.

"The decision to look at or ignore any specific target in the contralateral hemifield may be, at least in part, based upon valences computed by the SC. The computation uses not only visual inputs but also multiple sensory and even emotional inputs. The SC is also involved in basic visual motor interactions, such as maintaining visual fixation with microsaccades, suppressing images during saccadic eye movements, and generating express saccades that are initiated more quickly than volitional saccades. Perhaps unexpectedly, the SC is implicated in esoteric and complex conditions such as 'blindsight' and autism."

Vision- and Life-Threatening Signs and Symptoms: Pearls From Neuro-Ophthalmology (11:30 a.m.-12:45 p.m.) is cosponsored by the North American Neuro-Ophthalmology Society.

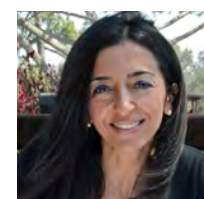
OCULOPLASTICS

Wendell L. Hughes Lecture: Multi-Disciplinary Management of Eyelid and Orbital Cancers in the Era of Biologics and Immunotherapy, presented by Bitá Esmaeli, MD.

When: Sunday, during Sym30, *I've Been Waiting for Someone to Ask: Tips to Improving Your Oculofacial Plastic Clinic Exam & Surgical Outcomes*.

Where: Room E450.

"What an honor to give the lecture that is named after a legend in ophthalmic plastic surgery, Dr. Wendell Hughes. In more than 25 years of practice as an oncologic ophthalmic plastic surgeon at a tertiary cancer hospital in the United States, I have witnessed firsthand the very positive impact the Hughes procedure has had on my patients' well-being and quality of life.



"I have also seen the revolutionary discovery of biologics and immunotherapy-based cancer drugs and how they have enhanced the

surgical care that I can deliver to cancer patients with challenging locally advanced disease. In my talk, I will show a potpourri of interesting periocular and orbital cancer cases, both common and rare, that have benefited from a multidisciplinary individualized treatment approach. I will highlight practical information such as patient selection, expected outcomes, and surgical pearls for achieving the best functional and aesthetic results."

I've Been Waiting for Someone to Ask: Tips to Improving Your Oculofacial Plastic Clinic Exam & Surgical Outcomes (11:30 a.m.-12:45 p.m.) is cosponsored by the American Society of Ophthalmic Plastic and Reconstructive Surgery.

UVEITIS AND IMMUNOLOGY

C. Stephen and Frances Foster Lecture on Uveitis and Immunology, presented by Debra A. Goldstein, MD.

When: Sunday, 11:30 a.m.-12:30 p.m., during Sym34, *C. Stephen and Frances Foster Lecture on Uveitis and Immunology*.

Where: Room S406a.

The C. Stephen and Frances Foster Lecture in Ocular Immunology recognizes the groundbreaking work of C. Stephen Foster, MD, FACS, FRCR, founder and president of Massachusetts Eye and Research Institution.

Each year, the Foster Lecture is presented by an eminent authority on a clinical, research, or therapeutic subject related to ocular inflammatory disease.

This year's speaker is Debra A. Goldstein, MD, director of uveitis in the department of ophthalmology and Magerstadt Professor of Ophthalmology



at the Northwestern University Feinberg School of Medicine in Chicago.

C. Stephen and Frances Foster Lecture on Uveitis and Immunology (11:30 a.m.-12:30 p.m.).

REFRACTIVE SURGERY

Barraquer Lecture, presented by Graham Barrett, MD.

When: Sunday, during Sym33, *Treatment of Presbyopia*.

Where: Grand Ballroom S100c.

The José I. Barraquer Lecture and Award honors a physician who has made significant contributions in the field of refractive surgery during his or her career. This individual exemplifies the character and scientific dedication of José I. Barraquer, MD—one of the founding fathers of refractive surgery,



who innovated both in techniques and instrumentation.

This year's lecturer, Dr. Barrett, is consultant ophthalmic surgeon at Sir Charles Gairdner Hospital and clinical professor in the University of Western Australia's Centre for Ophthalmology and Visual Science. Dr. Barrett's interests include lens prediction formulas, new techniques in cataract and refractive surgery, and IOL design.

Treatment of Presbyopia (11:30 a.m.-12:45 p.m.) is cosponsored by the International Society of Refractive Surgery.

ORGANIZED MEDICINE

Parker Heath Lecture

When: Sunday, during Sym32, *Innovations in Ophthalmology From Around the World*.

Where: Room E354.

At time of press, the 2022 lecture had not been finalized. The Parker Heath lecture honors Parker Heath, MD, who was the 54th president of the American Ophthalmic Society and was known as a pioneer in ophthalmic pathology. The Parker Heath lecturer is always a prominent ophthalmologist or other physician who can speak to topics that broadly apply to all of medicine.

Innovations in Ophthalmology From Around the World (11:30 a.m.-12:45 p.m.) is cosponsored by the American Medical Association Ophthalmology Section Council.

MICROBIOLOGY

Jones-Smolín Lecture: Acanthamoeba Keratitis Treatment; ODAK Phase 3 Trial Outcomes, presented by John K. Dart, MD.

When: Sunday, 2:47-3:10 p.m., during Sym39, *Ocular COVID-19: Questions and Answers*.

Where: Grand Ballroom S100c.

"Acanthamoeba keratitis (AK), fittingly for this lecture, was first described in 1975 by Dan Jones, a mentor with whom

I studied in 1983-1984. Infectious and inflammatory anterior segment disease has been the focus of my research since then, a time during which AK has become a frequent cause of severe keratitis and one of the most intractable.

"Although an orphan disease, AK is important because in many major economies contact lens use is the principal cause of microbial keratitis, of which AK accounts for about 50% of cases that develop sight loss. This problem led to the introduction, at Moorfields Eye Hospital, in 1992 of the disinfectant PHMB (polyhexanide) as a novel and effective topical antimicrobial.

"I will present the results of a pragmatic and widely applicable phase 3 trial, the last work package of a series that has included formulation, safety, and tolerability studies, supported by an EU grant and sponsored by SiFi pharmaceuticals and designed



to provide a licensed AK treatment. I will present not only the results of the trial, which has provided impressive medical cure rates, but also an evaluation of the protocol that was used—and the evidence that a treatment delivery protocol can be as important as drug efficacy."

Ocular COVID-19: Questions and Answers (2:00-3:15 p.m.) is cosponsored by the Ocular Microbiology and Immunology Group.

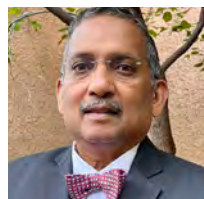
PATHOLOGY/ONCOLOGY

Zimmerman Lecture: Glaucoma Insights: An Ophthalmic Pathologist's Perspective, presented by Deepak P. Edward, MD, FACS, FARVO.

When: Sunday, 2:53-3:15 p.m., during Sym40, *An Update on Efforts to Improve Mortality in Ocular Cancers*.

Where: Room E450.

"The pathophysiology of the different forms of glaucoma is complex and so are the effects of treatment for the disorder. This lecture will include an ophthalmic



pathologist/glaucoma specialist's journey studying the pathology of congenital glaucoma and other glaucomas, and it will also review immunohisto-

pathologic changes in the optic nerve head in glaucoma. The presentation will discuss clinical-pathologic correlations of the trabeculectomy bleb and molecular pathology of the capsules from glaucoma shunt surgery, and how pathologic studies can provide insight in modifying surgery to improve surgical outcomes."

An Update on Efforts to Improve Mortality in Ocular Cancers (2:00-3:15 p.m.) is cosponsored by the American Association of Ocular Oncology and Pathology.

OCULOPLASTICS/PROSTHETICS

Ruedemann Lecture: Protecting the Inferior Cul-de-Sac, presented by Kenneth V. Cahill, MD, FACS.

When: Sunday, during Sym44, *Prosthetic and Surgical Management of Congenital Anophthalmia and Microphthalmia*.

Where: Room E350.

"Old ideas, new ideas, and forgotten ideas can be used to help maintain a healthy, functional, and cosmetically pleasing socket. Achieving this goal requires the collaboration of patients, surgeons, and ophthalmologists throughout the process, starting at the time of surgery, continuing with the fitting and maintenance of the prosthesis, and as changes occur. We will analyze this process with attention to the inferior conjunctival cul-de-sac to see if there are improvements we can make for the betterment of our patients."

Prosthetic and Surgical Management of Congenital Anophthalmia and Microphthalmia (3:45-5:00 p.m.) is cosponsored by the American Society of Ocularists.



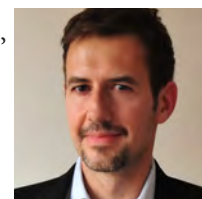
CORNEA

Whitney G. Sampson Lecture, presented by Damien Gatinel, MD.

When: Sunday, 4:35-4:50 p.m., during Sym43, *New Options for Near Vision: Emerging Treatments for Presbyopia Correction*.

Where: Grand Ballroom S100c.

This lecture is named for Whitney G. Sampson, MD (Oct. 2, 1932-July 18, 2000), who distinguished himself during a time of scientific progress and socioeconomic change. The lecture takes place during the symposium that is cosponsored by the Eye and Contact Lens Association.



This year's lecturer, Damien Gatinel, MD, is head of the anterior and refractive surgery department of the Rothschild Foundation, Paris, France.

New Options for Near Vision: Emerging Treatments for Presbyopia Correction (3:45-5:00 p.m.) is cosponsored by the Eye and Contact Lens Association.

MONDAY, Oct. 3

CATARACT

Charles D. Kelman Lecture: 25 Years Evaluating New IOL Technology and Complications, presented by Liliana Werner, MD, PhD.

When: Monday, during Sym45, *Spotlight on Cataract: M&M Rounds—Learning From My Mistakes*.

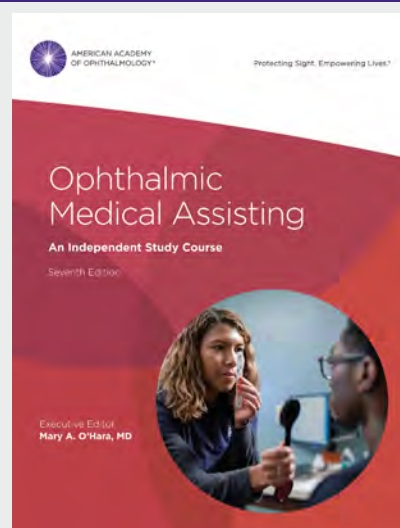
Where: Room E354.

"An increasing number of intraocular lens (IOL) designs, materials, and technology is introduced into markets every year. The focus of my career has been on the evaluation of IOLs since my PhD project on a new IOL coating. In this lecture, I will provide an overview of 25 years of work navigating between evaluating new IOL technology and describing the pathogenesis of IOL complications. It is very important to keep an open mind in approaching new ideas, as they have the potential to become the disruptive innovations of the future. However, it is only through a rigorous scientific process that we can ensure that new ideas are safely adopted and incorporated into clinical and surgical practice. Furthermore, exercising constant vigilance through promptly identifying and describing IOL-related complications provides valuable feedback to surgeons and industry alike, ultimately benefiting all patients."

Spotlight on Cataract: M&M Rounds—Learning From My Mistakes (8:00 a.m.-12:30 p.m.).



Conquer the Challenges of Tech Training



New edition: Increase the skill and confidence of your techs with the Academy's **Ophthalmic Medical Assisting: An Independent Study Course, 7th edition**. Your new techs can shorten the learning curve and gain fundamental ophthalmic knowledge with 45 step-by-step procedures, 26 training videos, 300+ photographs and illustrations, and 12 interactive models of the eye.

Available in print and eBook format.

Buy it in the Resource Center, Booth 1408. Or order it online through the Academy at aao.org/techs.

Meeting Veterans' Top Tips, Part 2: Schedules, Swag, and Serendipity

Make the most of AAO 2022's remaining two days. Four meeting veterans share their top tips and warn you about some of the biggest mistakes that attendees commonly make.

Rick Palmon, MD, Purnima S. Patel, MD, Julian D. Perry, MD, and Jennifer I. Lim, MD, share their meeting experiences.

Dr. Palmon—Learn New Skills, Meet Old Friends, and Volunteer

Rick Palmon, MD, is an anterior segment surgeon performing cornea, cataract, glaucoma, and refractive surgery. He practices in Fort Myers at Southwest Florida Eye Center, a two-physician practice that merged earlier this year with US Eye, which has centers throughout the Southeast.

My first annual meeting—1992. I was a third-year resident during my first annual meeting, which was in Dallas. I was overwhelmed by the sheer number of symposia, paper talks and course offerings, and by the grandeur of the exhibit hall.

My tip for scheduling—use the Mobile Meeting Guide. The Mobile Meeting Guide allows you to plan your schedule and get reminders. You also can see what's happening at the current moment [aao.org/mobile; for full functionality, you will need to log in].

The best clinical practice lessons I learned at the annual meeting—how to transition to new forms of surgery. Skills Transfer labs and other programming were hugely helpful when I made the transition from PKP [penetrating keratoplasty] to DSEK [Descemet stripping endothelial keratoplasty] and DALK [deep anterior lamellar keratoplasty], and later to DMEK [Descemet membrane endothelial keratoplasty]. I learned the pearls for surgical success, which made the transition much easier for me and for my patients.

My most rewarding experience—volunteering at the labs. There's nothing better than the joy of helping colleagues learn new skills, and I have been volunteering at the Skills Transfer sessions every year since I finished training in

cataract and corneal transplant.

How the annual meeting has changed—it is more condensed. My first annual meeting, 30 years ago, started on Sunday and finished on Thursday. Since then, the meeting has become more focused, providing the most helpful sessions over a long weekend. This makes it more practice friendly, in that you don't have to take a whole week off from work to get needed CME and the latest updates.

Format change that simplifies your scheduling—standardized session lengths. At my first annual meeting, I was like a kid in a candy store! I wanted to go to everything but found some of the events were going on simultaneously or overlapped. This year, the standardized session length [75 minutes] should help.

My guilty pleasure at the annual meeting—spending evenings with old friends. Since the annual meeting revisits locations, I've learned

about the best dining and music options to catch up with friends. This can keep you busy to the wee hours of the morning—getting up for an 8 o'clock session can be painful at times!

Dr. Patel—Thrive on the Energy, But Mind Your Feet

This year, after 11 years in academics, Purnima S. Patel, MD, founded Ophthalmology and Retina Associates of Georgia, a comprehensive ophthalmology practice that provides medical retina care. It is just outside Atlanta.

My first annual meeting—2006. At my first meeting, I was struck by how much energy there was and by the breadth and depth of learning. It



DR. PALMON: "The annual meeting gives me a chance to catch up with friends and colleagues from all around the United States and across the world."



DR. PATEL: "Don't underestimate the power of networking. This is where all of ophthalmology meets—so show up and speak up!"



NETWORK. Senior ophthalmologists (SOs; Academy members aged 60 or over), YOs (members-in-training or in the first five years of practice), members visiting the United States, and AAOE members can mingle in their own lounge areas, as shown in the above snapshot from AAO 2019. (SO Lounge: Room N426a; YO Lounge: Room N426b; International Lounge: Room N427d; and AAOE Lounge: Room S104b.)

was in New Orleans, and I was enthralled by how many people had traveled from so far.

The biggest beginner's mistake—uncomfortable shoes. You walk way more than you would expect, so wear shoes that are kind to your feet.

My best tip for making the most of the AAO meeting—plan in advance. Use the Mobile Meeting Guide and prioritize the courses, but also schedule networking sessions, plan your itinerary for the exhibit floor, and make restaurant reservations in advance. And don't miss the Global YO [Young Ophthalmologist] Reception!



DR. PERRY: "There's a huge breadth and depth of opportunities to learn, share, and connect—but you need a plan."

Dr. Perry—Arrive With a Plan, Leave With Some Swag

Julian D. Perry, MD, is the Service Director for Oculofacial Plastic Surgery at the Cole Eye Institute of the Cleveland Clinic.

My first annual meeting—1997. When I entered the exhibit hall in San Francisco, my first thought was, "Wow!" I was blown away by its sheer size, the number of booths, and all the learning and networking

going on.

The biggest beginner's mistake—not having a plan. There is so much going on, you'll be a deer in the headlights sifting through the program in the registration hall if you don't seize the opportunities the Academy provides to preplan your meeting. I recommend plotting out "can't miss" events well ahead of time.

My most rewarding experience at the annual meeting—serving as a program chair. The most

gratifying experience was serving as Oculoplastics/Oncology Annual Meeting Program Chair. The responsibility to coordinate the meeting content was the professional privilege of a lifetime, and it was a real joy to work with such a collegial and fun group of surgeons and Academy staff. I looked forward to every committee call and meeting, where we hammered out the papers, posters, courses, and other content. The best part is that the Academy offers so many opportunities for members to participate.

What role does serendipity play at the annual meeting—a constant one! At every single one of my 23 meetings, even separate from alumni and other social events, I inevitably bump into an old friend. These brief chances to reconnect are always special.

Continued on page 27

Did You Attend Subspecialty Day? Extend Your Learning!

If you attended a Subspecialty Day meeting and especially enjoyed a particular session and want to learn more, the Academy can help.

Go deep on keratoplasty. Let's say, for example, you enjoyed the Cornea Subspecialty Day session about endothelial keratoplasty. You can take advantage of related courses and Resource Center information in Chicago and/or continue your education at home.

AAO 2022

While you are in Chicago, check out these keratoplasty courses.

Endothelial Keratoplasty Techniques (event code Lab120A). Course director: Mark A. Terry, MD. When: Sunday, 8:00-10:00 a.m. Where: Room N227b. Note: The corresponding lecture took place on Saturday. Attendance at lectures are recommended but not required. Skills Transfer labs require a separate ticket.

DMEK: A Simplified Technique to Shorten the Learning Curve and Avoid Complications (460). Senior instructor: Mark A. Terry, MD. When: Sunday, 2:00-3:15 p.m. Where: Room E451a.

Anterior Lamellar Keratoplasty: Principles and Practice (Lec140 and Lab140A). Course director: Sheraz M. Daya, MD. When: Sunday, 2:00-3:15 p.m. (lecture) and Monday, 10:30 a.m.-12:30 p.m. (lab). Where: Room S101ab (lecture) and Room N227b (lab). Note: Skills Transfer labs require a separate ticket.

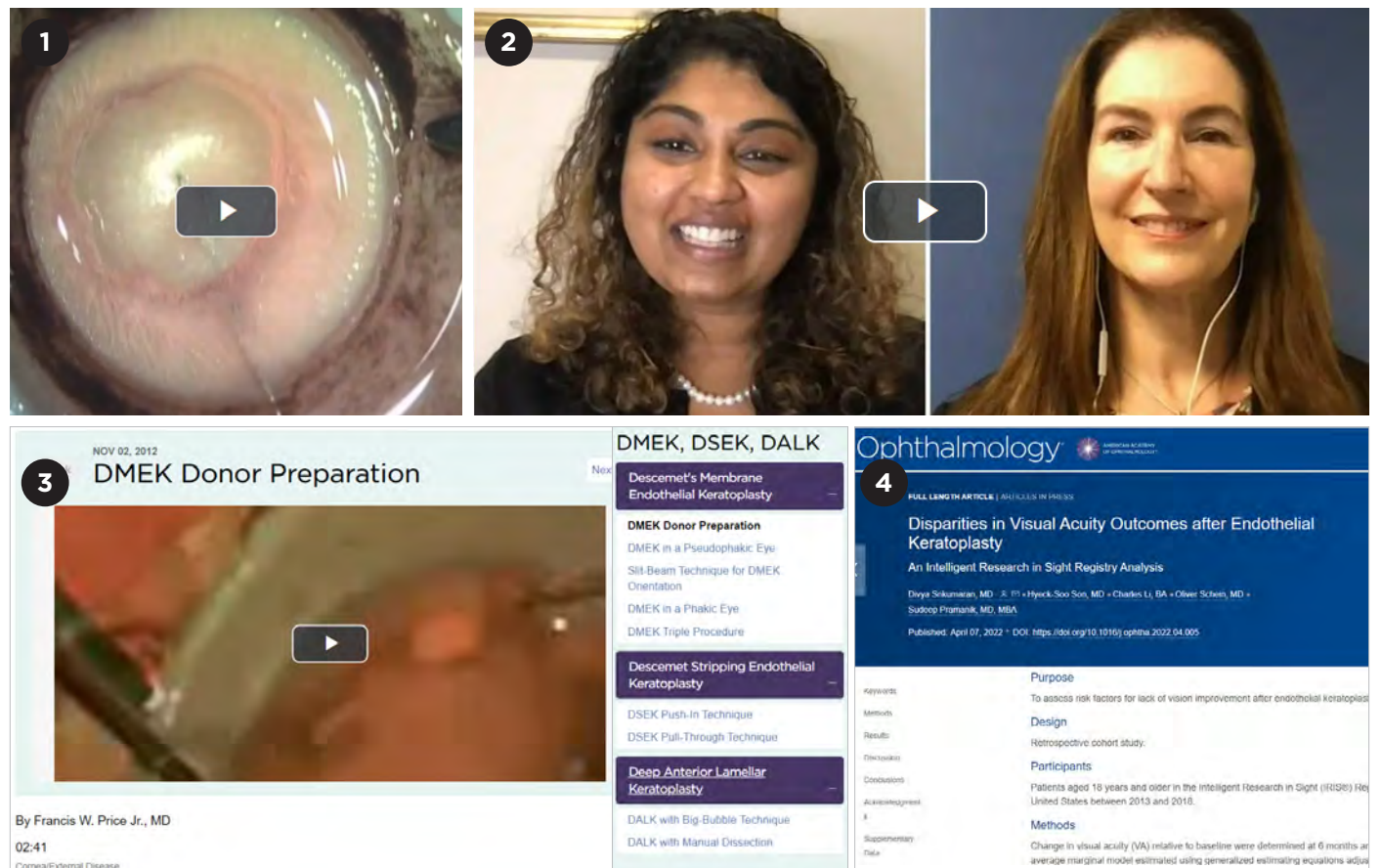
Innovative Techniques of Corneal Transplantation (637). Senior instructor: Rasik B. Vajpayee, MD. When: Monday, 9:45-11:00 a.m. Where: Room S102d.

ONE Network

The ONE Network (aao.org/clinical-education) offers educational webinars, videos, quizzes, and more. Visit aao.org/cornea-external-disease to find a web page that's curated specifically for those interested in cornea topics. There you will find resources including:

Videos. A multitude of keratoplasty videos is discoverable with a Search on "keratoplasty" and filtering by Multimedia/Video. Video types include:

- **One-minute videos.** For example, "Graft Preparation for Pre-Descemet's Endothelial Keratoplasty" (Fig. 1, aao.org/1-minute-video/graft-preparation-pre-descemet-s-endothelial-kerat).
- **Clinical and surgical videos.** Among many videos in this category, you will find "Large-Diameter Therapeutic Penetrating Keratoplasty" (aao.org/clinical-video/large-diameter-therapeutic-penetrating-keratoplasty).



- **Short interviews from recent meetings.** There's a three-minute interview from AAO 2021 about custom keratoplasty with a femtosecond laser (Fig. 2, aao.org/interview/custom-keratoplasty-with-femtosecond-laser).
- **Presentation and lecture videos from recent meetings.** You'll find "Therapeutic Keratoplasty: Expect the Unexpected" from AAO 2019 (aao.org/annual-meeting-video/therapeutic-keratoplasty-expect-unexpected).
- **Master Class videos.** "Master Class in Corneal Transplant Surgery" is a series of nine videos in which Francis W. Price Jr., MD, details surgical specifics in 10-minute videos on procedures from DALK to DMEK Triple Procedure. After you finish watching one video, hit the Next button to see the next in the series (Fig. 3, aao.org/master-class-video/dmek-donor-preparation).

Podcasts. The Academy's *Experts InSight* podcast with host Jayanth S. Sridhar, MD, covers topics across all subspecialties within ophthalmology. In the very first episode, Fasika A. Woreta, MD, and Brenton D. Finklea, MD, review corneal transplantation options (aao.org/audio/corneal-transplantation-in-2021, log in to claim 0.5 CME credits). Also, check out the *Ophthalmology Journal* podcast, at aao.org/podcasts.

Webinars. In a recorded webinar, "The 2021 Update on Cornea for Non-

Specialists," Katherine A. Colby, MD, PhD, discusses Fuchs endothelial dystrophy and several treatment approaches for it, including—briefly—endothelial keratoplasty procedures (aao.org/annual-meeting-video/2021-update-on-cornea-non-specialists).

Cases. "Persistent Post-DSAEK Complications" takes you through the case of a 61-year-old woman who underwent DSAEK surgery six months ago (aao.org/case/persistent-postdsaek-complications-copy). Initially she healed well, but several weeks later an infiltrate developed. Look at her presentation and history, perform a clinical exam, review the differential diagnosis, order and review lab tests and imaging, make the diagnosis, and treat the patient. (Log in to claim 1 CME credit.)

Diagnose This! Quick quizzes in myriad topics include one on keratoplasty, titled "Diagnose This: A Corneal Ulcer After Penetrating Keratoplasty" (aao.org/diagnose-this/diagnose-this-corneal-ulcer-after-penetrating-keratoplasty).

Clinical Guidelines

Keep current with the Academy's *Preferred Practice Patterns*. For those interested in cornea, check out aao.org/preferred-practice-pattern/corneal-edema-and-opacification-ppp-2018 and aao.org/preferred-practice-pattern/corneal-ectasia-ppp-2018.

EyeWiki

The wiki for all conditions ophthalmic, EyeWiki has entries for DALK (eyewiki.org/DALK), Descemet Membrane Endothelial Keratoplasty (eyewiki.org/Descemet_Membrane_Endothelial_Keratoplasty), Descemet Stripping Endothelial Keratoplasty (eyewiki.org/Descemet_Stripping_Endothelial_Keratoplasty), Descemetorhexis Without Endothelial Keratoplasty (eyewiki.org/Descemetorhexis_Without_Endothelial_Keratoplasty), Pediatric Penetrating Keratoplasty (eyewiki.org/Pediatric_Penetrating_Keratoplasty), Penetrating Keratoplasty (eyewiki.org/Penetrating_Keratoplasty), and more.

Publications

And don't forget to check *Ophthalmology* (aaojournal.org) and *EyeNet* (aao.org/eyenet) for the latest articles on keratoplasty and other topics—cornea and otherwise.

Check out *Ophthalmology*'s 2022 article titled "Disparities in Visual Acuity Outcomes After Endothelial Keratoplasty: An Intelligent Research in Sight Registry Analysis" by Srikumaran et al. (Fig. 4, [aaojournal.org/article/S0161-6420\(22\)00260-3/fulltext](http://aaojournal.org/article/S0161-6420(22)00260-3/fulltext)).

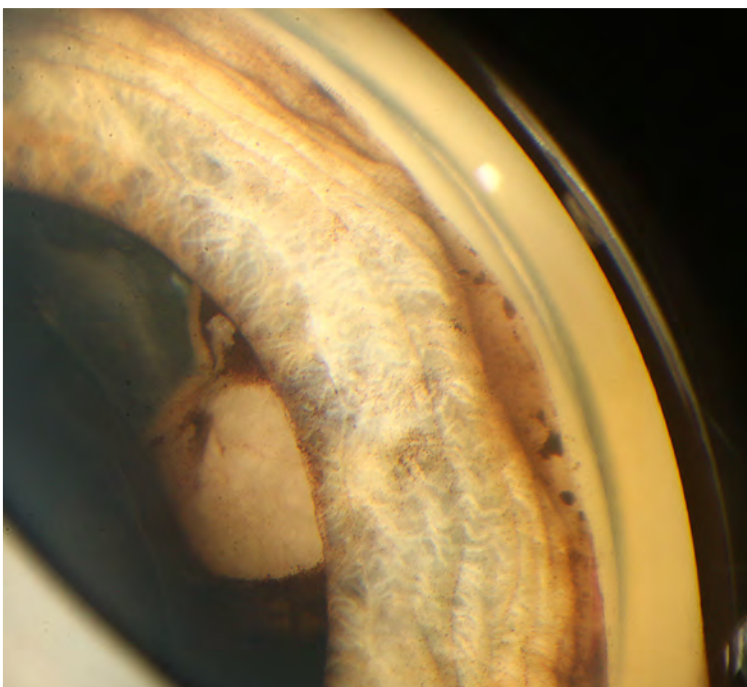
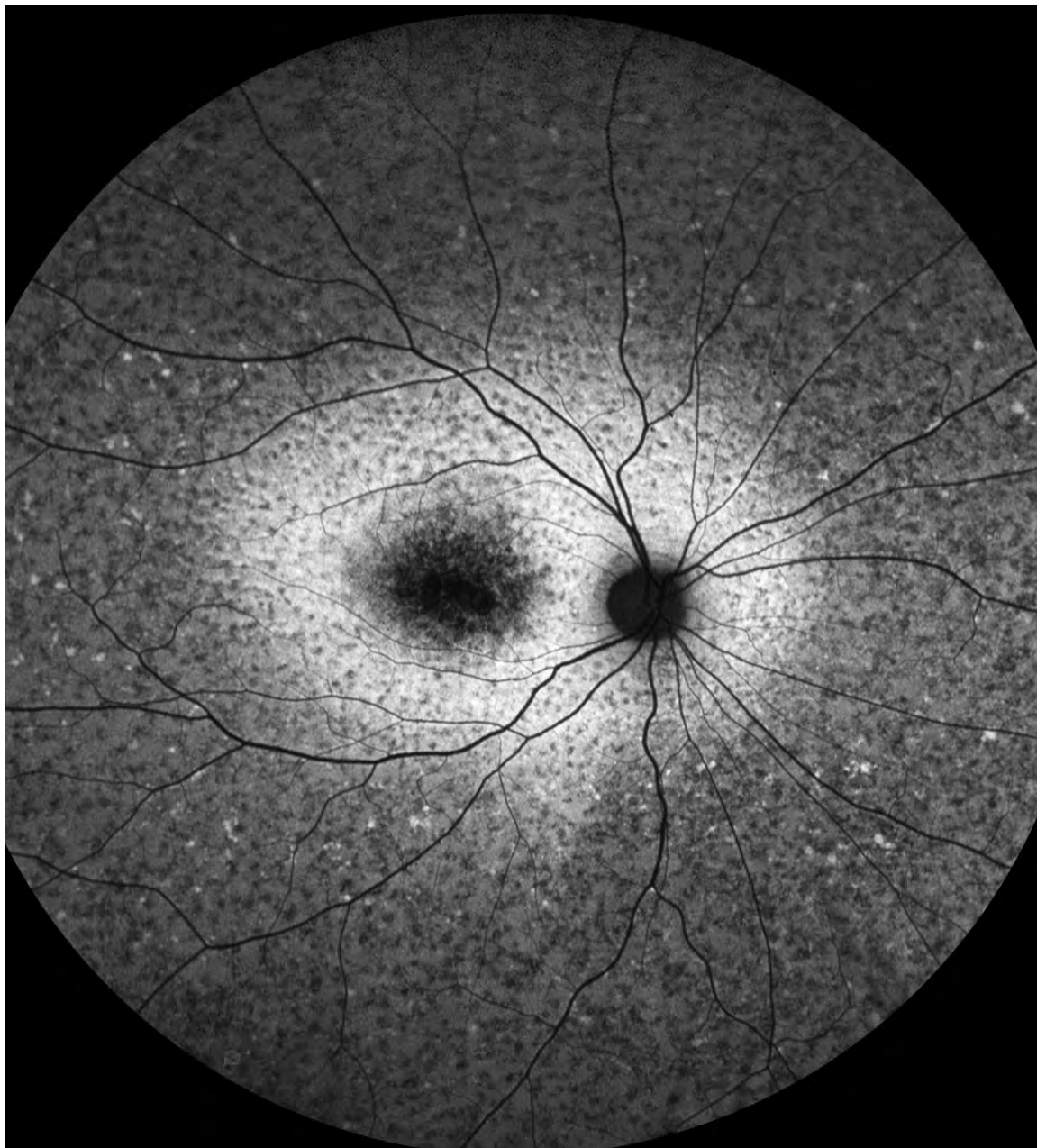
Learn more about these and other Academy offerings at the Resource Center (Booth 1408).

Winning Photography Is on Display

The photos shown here were selected from among the winners at the Ophthalmic Photographers' Society (OPS) Scientific Exhibit held in New Orleans last fall. This year, OPS will kick off a virtual program with a live session Saturday, Oct. 1. Two more will follow on Oct. 8 and Oct. 15. Other OPS programs will be available on demand throughout the month.

For more information, visit OPS at www.opsweb.org.

To see this year's winners, stop by the 2022 OPS Scientific Exhibit (Booth 1321).



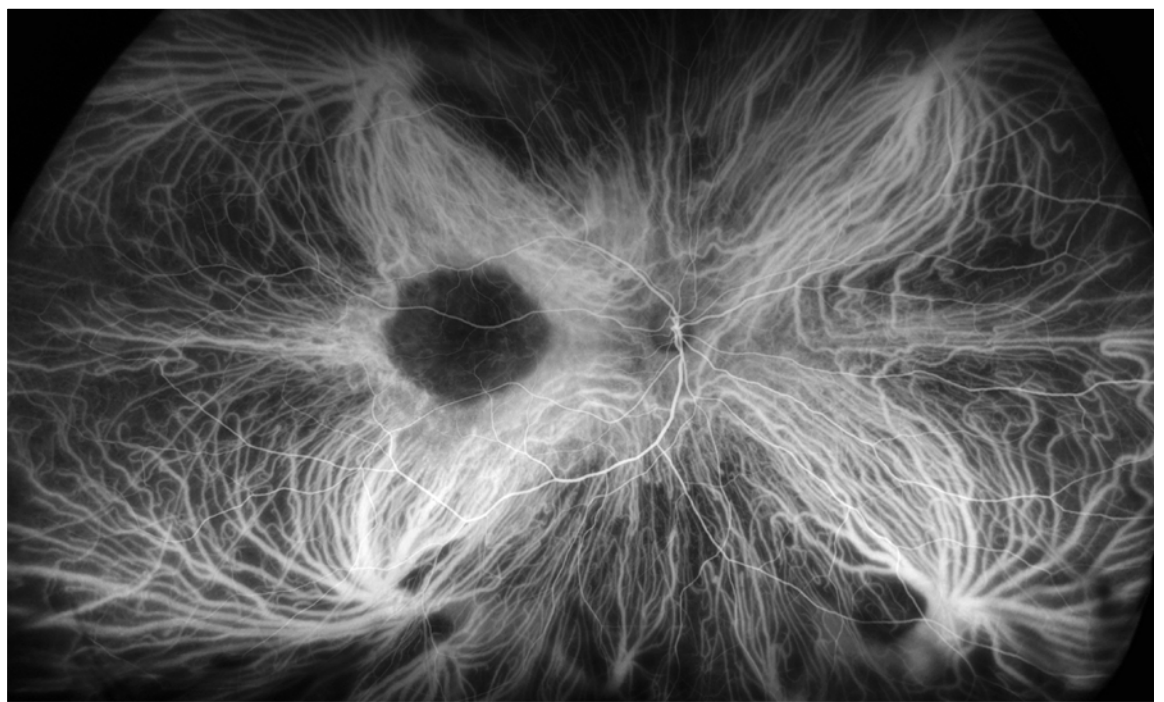
2021 OPS Exhibit Winners

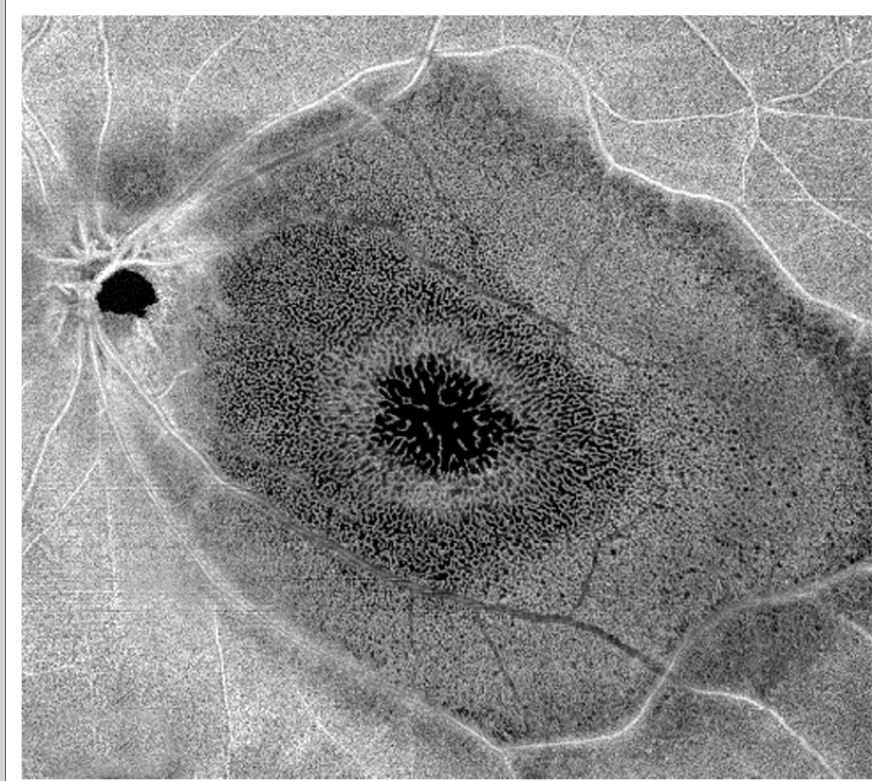
From left to right, and top to bottom.

Gonio Photography, Honorable Mention. *Malignant Melanoma of Ciliary Body.* Matthew Maas. University of Michigan, Kellogg Eye Center, Ann Arbor, Michigan.

Fundus Autofluorescence, First Place. *Stargardt's.* Dena Harris, CRA. University of Michigan, Kellogg Eye Center, Ann Arbor, Michigan.

Indocyanine Green Angiography, First Place. *Choroidal Melanoma.* Bryan Carmichael, CST, OSA. Mid-South Retina, Memphis, Tennessee.





Gonio Photography, Second Place. *Iris Lesion*. Matthew Maas. University of Michigan, Kellogg Eye Center, Ann Arbor, Michigan.

Optical Coherence Tomography Angiography, First Place. *X-Linked Retinoschisis*. Jody Troyer, CRA. University of Iowa Hospital and Clinics, Iowa City, Iowa.

Ultra-Widefield Imaging, Second Place. *Juvenile Retinal Dystrophy*. Becky Weeks, CRA, OCT-C. University of Utah, John Moran Eye Center, Salt Lake City.

Fundus Photography—Wide Angle, Second Place. *Gliotic Epiretinal Membrane Contiguous With Disc Neovascularization*. Jody Troyer, CRA. University of Iowa Hospital and Clinics, Iowa City, Iowa.

Have a Concern or an Idea? Take It to Your Council Representative

You know about the Academy Board of Trustees, but have you heard of the Council? This advisory body brings concerns, ideas, and recommendations from the membership to the Board. Most ophthalmologists have more than one avenue for airing their views because they can contact Council members representing their state society, their subspecialty society, and their specialized interest society. See the list of Academy councilors below and learn who your councilors are.

The Council: A Channel for Communication

Purpose. The Council was created in 1979 after the American Association of Ophthalmology merged with the Academy. Originally named “The Advisory Council,” its purpose was to aid and promote communication, cooperation, and coordination between members and the Academy Board of Trustees. Today, the Council is composed of ophthalmologists who represent various ophthalmic membership organizations that are incorporated as nonprofit corporations and who serve in a policy advisory capacity to the Academy Board of Trustees.

Composition. Currently, 52 ophthalmic state/regional societies (including the Puerto Rico and District of Columbia societies) and 30 ophthalmic subspecialty societies and specialized interest groups are represented on the Council. All told, 104 ophthalmologists serve as Academy councilors in either the state section or the subspecialty/specialized interest society section. The number of councilors representing a state ophthalmology society (between one and four) is based on the number of ophthalmologists in that state. For subspecialty/specialized interest societies, the number of representatives is based on the number of

Academy members within its membership. Councilors are elected or appointed by their society and can serve up to two three-year terms.

Leadership. The elected Council chair and vice chair are members of the Academy Board of Trustees and represent the concerns of the Council. A Council vice chair is elected every two years, after which he or she may be elected to serve as Council chair for two years.

The two Council sections—state and subspecialty/specialized interest—have their own Nominating Committees. The councilors elected to this committee each year work to determine the slate of candidates for the following year for the roles of Deputy Section Leader, Section Nominating Committee, and the Representative to the Academy’s Nominating Committee, which helps select nominees for the Academy Board of Trustees.

Council meetings. The Council holds two annual meetings, the Spring Council Meeting, held in conjunction with the Mid-Year Forum in Washington, D.C., and the Fall Council Meeting, held in conjunction with the Academy’s annual meeting. (This year’s Fall Council Meeting took place on Thursday, Sept. 29, at the Hilton Downtown.) Meetings are traditionally attended by councilors, society leadership, Academy committee members, and members of the Academy Board of Trustees and Committee of Secretaries. Meetings are open to all Academy members and are advertised on the Academy’s website at aao.org/council.

CARs. The Council brings concerns, ideas, and recommendations from the membership to the Board as Council Advisory Recommendations (CARs.) The CAR process provides a formal procedure for represented organizations to bring issues to the attention of the rest of the Council and, ultimately, to the Board.



COUNCIL MEETING. From left to right: John Mandeville, MD, PhD, councilor for the Massachusetts Society of Eye Physicians and Surgeons; Renee C. Bovel, MD, councilor for the Maryland Society of Eye Physicians and Surgeons; and Sara Bozorg, MD, councilor for the Maine Society of Eye Physicians and Surgeons, at the 2022 Spring Council Meeting. During AAO 2022, if you bump into your representatives (see list below), be sure to introduce yourself and bring up issues that are important to you.

A CAR hearing is held annually during the Spring Council Meeting to facilitate the deliberations of CARs and to formulate a report from the Council to the Board with specific recommendations. Members may bring issues forward to their society’s councilor for consideration as a CAR.

A few CARs recently discussed by the Council and taken action on include “Improving Ophthalmic Trauma Care and Education,” submitted on behalf of the American Society of Ophthalmic Trauma; “Corneal Donations by Gay Men,” submitted by the Colorado Society of Eye Physicians and Surgeons; and “Vision Therapy for Post-TBI Visual Symptoms,” which was from the Arizona Ophthalmological Society. You can read CAR status reports at aao.org/council.

Councilor advocacy. Many council-

ors are also actively involved in patient advocacy, working closely with their legislators to address struggles such as step therapy and prior authorization. They testify before state House and Senate committees, and they work to educate policymakers. Councilors also are expected to financially support advocacy efforts by contributing annually to the Surgical Scope Fund and OphthPAC.

An evolving deliberative body. The Council has been in existence for more than 40 years. Its structure has evolved and changed over the years, but it has always retained its broad-based representative structure as an advisory body.

Get involved. Interested in becoming a member of the Council? Contact your state or subspecialty/specialized interest society directly. Learn more about the Council at aao.org/council.

CONTACT YOUR COUNCILORS

Below is a list of councilors. Find their contact information on the Academy’s website at <https://secure.aao.org/aao/Rosters/Council-representatives>.

Council Leadership: Council Chair: Thomas A. Graul, MD

Council Vice Chair: Prem S. Subramanian, MD, PhD

Councilors Representing State Societies

Alabama Academy of Ophthalmology: E.M. Brendan Wyatt, MD

Alaska Society of Eye Physicians and Surgeons: David S. Zumbro, MD

Arizona Ophthalmological Society: Matthew J. Welch, MD

Arkansas Ophthalmological Society:

Scott C. Claycomb, MD

California Academy of Eye Physicians & Surgeons: Amin Ashrafzadeh, MD, Vineet N. Batra, MD, Mark J. Mannis, MD, and Diana R. Shiba, MD

Colorado Society of Eye Physicians and Surgeons: Rebecca Sands Braverman, MD

Connecticut Society of Eye Physicians:

Edward S. Lim, MD

Delaware Academy of Ophthalmology: Dorothy M. Moore, MD

Florida Society of Ophthalmology:

Jaime H. Membreno, MD, Mark Michels, MD, FACS, and Joseph T. Nezgoda, MD, MBA

Georgia Society of Ophthalmology: Amy J. Estes, MD

Hawaii Ophthalmological Society: William K. Wong Jr., MD

Idaho Society of Ophthalmology: Daniel Gealy, MD

Illinois Society of Eye Physicians &

Surgeons: Evan P. Lagouros, MD, and James Ford McDonnell, MD

Indiana Academy of Ophthalmology: Stephen R. Klapper, MD

Iowa Academy of Ophthalmology: Erin M. Shriver, MD

Kansas Society of Eye Physicians and Surgeons: Paul D. Weishaar, MD

Kentucky Academy of Eye Physicians and Surgeons: Woodford S. Van Meter, MD, FACS

Louisiana Academy of Eye Physicians and Surgeons: Donald C. Falgoust, MD

Maine Society of Eye Physicians and

Surgeons: Sara Bozorg, MD
Maryland Society of Eye Physicians and Surgeons: Renee C. Bovelie, MD, and Lee A. Snyder, MD
Massachusetts Society of Eye Physicians and Surgeons: Jason M. Gilbert, MD, and John Mandeville, MD, PhD
Michigan Society of Eye Physicians and Surgeons: Thomas M. Aaberg Jr., MD, and Thomas J. Byrd, MD
Minnesota Academy of Ophthalmology: Sasha Strul, MD
Mississippi Academy of Eye Physicians and Surgeons: Kimberly A. Crowder, MD
Missouri Society of Eye Physicians and Surgeons: Linda M. Tsai, MD
Montana Academy of Ophthalmology: Scott M. Guess, MD
Nebraska Academy of Eye Physicians and Surgeons: Matthew F. Appenzeller, MD
Nevada Academy of Ophthalmology: TBD
New Hampshire Society of Eye Physicians and Surgeons: Nancy D. Effer-son-Bonachea, MD
New Jersey Academy of Ophthalmology: Isaac C. Ezon, MD, and Michele A. Miano, MD
New Mexico Academy of Ophthalmology: David T. Truong, MD
New York State Ophthalmological Society: Amjad M. Hammad, MD, Brad E. Kligman, MD, Michael A. Pisacano, MD, and Grace Sun, MD
North Carolina Society of Eye Physicians and Surgeons: Susan K. Burden, MD
North Dakota Society of Eye Physicians and Surgeons: Michael D. Greenwood, MD
Ohio Ophthalmological Society: Joseph M. Coney, MD, and W. Walker Motley, MD
Oklahoma Academy of Ophthalmology: Ben J. Harvey, MD
Oregon Academy of Ophthalmology: Chad M. Bingham, MD
Pennsylvania Academy of Ophthalmology: Robert L. Bergren, MD, David I. Silbert, MD, and Sharon L. Taylor, MD
Puerto Rico Society of Ophthalmology: Cristina Ferrari, MD
Rhode Island Society of Eye Physicians and Surgeons: Richard G. Bryan, MD, PhD
South Carolina Society of Ophthalmology: Edward G. Mintz, MD, PhD
South Dakota Academy of Ophthalmology: Daniel Christian Terveen, MD
Tennessee Academy of Ophthalmology: Mark D. Ewald, MD
Texas Ophthalmological Association: Sidney K. Gicheru, MD, Robert D. Gross, MD, and Sanjiv R. Kumar, MD
Utah Ophthalmology Society: Brian C. Stagg, MD
Vermont Ophthalmological Society: Jeffery D. Young, MD
Virginia Society of Eye Physicians and Surgeons: Alan L. Wagner, MD, FACS
Washington Academy of Eye Physicians and Surgeons: Michael Brush, MD
Washington DC Metropolitan Ophthalmological Society: Leslie S. Jones, MD
West Virginia Academy of Eye Physicians and Surgeons: Charles D. Francis, MD

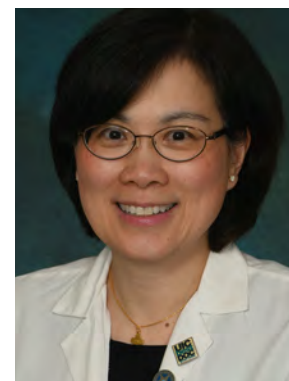
Wisconsin Academy of Ophthalmology: Suzanne M. Falkenberry, MD
Wyoming Ophthalmological Society: David J. Smits, MD
Councilors Representing Subspecialty and Specialized Interest Societies:
American Academy of Pediatrics, Section on Ophthalmology: Daniel J. Karr, MD
American Association for Pediatric Ophthalmology and Strabismus: Stacey J. Kruger, MD, and Scott A. Larson, MD
American Association of Ophthalmic Oncologists and Pathologists: Alison H. Skalet, MD, PhD
American Board of Ophthalmology: K. David Epley, MD
American College of Surgeons, Advisory Council for Ophthalmic Surgery: Kimberly D. Davis, MD, FACS, MBA, and Edward L. Raab, MD
American Glaucoma Society: Samuel Solish, MD
American Ophthalmological Society: Sophie J. Bakri, MD
American Osteopathic College of Ophthalmology: Donald A. Morris, DO
American Society of Cataract & Refractive Surgery: Susanne M. Hewitt, MD, and Majid R. Moarefi, MD
American Society of Ophthalmic Plastic & Reconstructive Surgery: Kathleen M. Duerksen, MD
American Society of Ophthalmic Trauma: Fasika A. Woreta, MD
American Society of Retina Specialists: Justis P. Ehlers, MD, and G. Baker Hubbard, MD
American Uveitis Society: Jennifer E. Thorne, MD, PhD
Association for Research in Vision and Ophthalmology: Louis R. Pasquale, MD
Association of University Professors of Ophthalmology: Donald L. Budenz, MD, MPH
Association of Veterans Affairs Ophthalmologists: Eric B. Suhler, MD, MPH
Canadian Ophthalmological Society: Michael E. Ashenhurst, MD
Cornea Society: Maria A. Woodward, MD, MS
Eye and Contact Lens Association: Ira J. Udell, MD
Eye Bank Association of America: William Barry Lee, MD
International Joint Commission on Allied Health Personnel in Ophthalmology: Richard C. Allen, MD, PhD
Macula Society: Sharon D. Solomon, MD
National Medical Association, Ophthalmology Section: Daniel Laroche, MD
North American Neuro-Ophthalmology Society: Peter A. Quiros, MD
Ocular Microbiology and Immunology Group: Cecilia S. Lee, MD
Outpatient Ophthalmic Surgery Society: David S. George, MD
Pan American Association of Ophthalmology: Maria Soledad-Cortina, MD
Retina Society: Audina M. Berrocal, MD
Society of Military Ophthalmologists: Rachel A. Lieberman, MD
Women in Ophthalmology: Femida Kherani, MD

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My guilty pleasure at the annual meeting—I'm a sucker for swag! When I'm not swiping free swag, you might catch me ribbon counting—look at all those ribbons!

Dr. Lim—Have a Schedule, But Savor Moments of Serendipity
Jennifer I. Lim, MD, is Marion H. Schenk Esq. Chair and Professor of Ophthalmology, Director of the Retina Service, and Vice Chair for Diversity and Inclusion at the University of Illinois at Chicago.

My first annual meeting—1989. At my first meeting, in New Orleans, I was amazed to see so many of ophthalmology's luminaries in person. In fact, I would introduce myself to them whenever the opportunity arose. It was also a great opportunity to network with my fellow residents who were applying to retina fellowships. A group of us, who had met during interviews, gathered together for dinner at the Court of Two Sisters. Some of us ended up as co-fellows in the same program, and these friendships continue to this day!



DR. LIM: "Serendipity is a key element of the AAO meeting, and it has resulted in the launch of many projects and the forging of many friendships."

Best tip—maximize your time. Look through the symposia, papers, posters, and other programming and make a list of what you don't want to miss. I also make plans ahead of time to meet with colleagues from around the country.

Best clinical lesson you've learned at an annual meeting—trial results. I always look to see if any phase 3 clinical trial results are unveiled. I also enjoy learning about innovative surgical procedures.

How has the annual meeting changed over the years—more condensed and personalized. It has become shorter and

more focused on clinical relevance. It also has become more personalized for the attendee, who can, for example, choose to view Scientific Posters via the Mobile Meeting Guide, via the Virtual Meeting, or in the Poster Theater and Lounge.

My guilty pleasure at the annual meeting—dessert! Whatever city we're at, I'll enjoy some decadent dining with rich desserts. In Chicago, I might warm up for dessert with an authentic Peking Duck banquet dinner at Evergreen Restaurant or with a cornbread crust deep dish pizza stuffed with sausage, mushrooms, green pepper, and onion at Gino's East.



IMPORTANT PRODUCT INFORMATION

CAUTION: Federal law restricts this device to sale by or on the order of a physician.

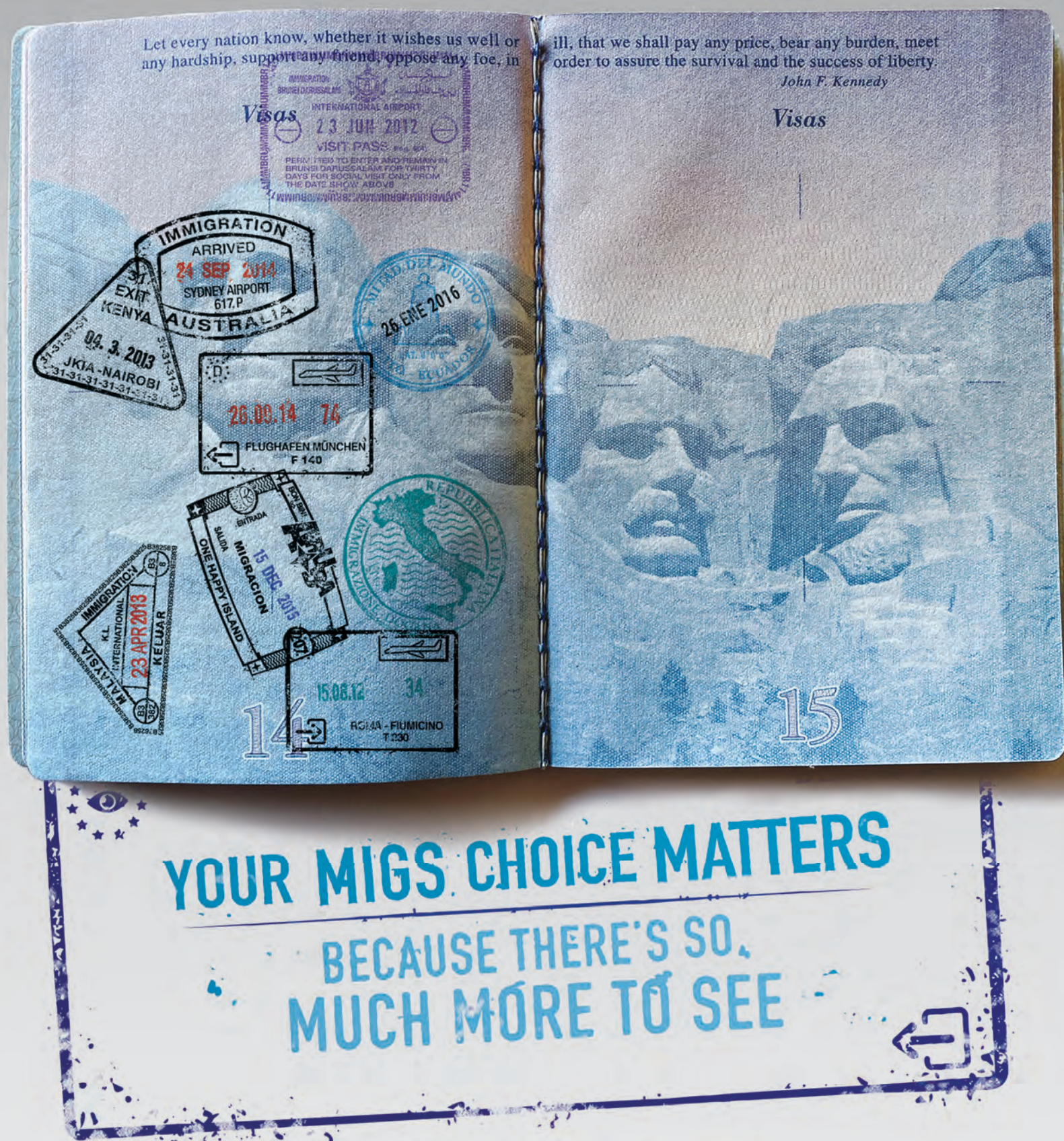
INDICATIONS FOR USE: The Hydrus Microstent is indicated for use in conjunction with cataract surgery for the reduction of intraocular pressure (IOP) in adult patients with mild to moderate primary open-angle glaucoma (POAG). **CONTRAINDICATIONS:** The Hydrus Microstent is contraindicated under the following circumstances or conditions: (1) In eyes with angle closure glaucoma; and (2) In eyes with traumatic, malignant, uveitic, or neovascular glaucoma or discernible congenital anomalies of the anterior chamber (AC) angle. **WARNINGS:** Clear media for adequate visualization is required. Conditions such as corneal haze, corneal opacity or other conditions may inhibit gonioscopic view of the intended implant location. Gonioscopy should be performed prior to surgery to exclude congenital anomalies of the angle, peripheral anterior synechiae (PAS), angle closure, rubeosis and any other angle abnormalities that could lead to improper placement of the stent and pose a hazard. The surgeon should monitor the patient postoperatively for proper maintenance of intraocular pressure. The surgeon should periodically monitor the status of the microstent with gonioscopy to assess for the development of PAS, obstruction of the inlet, migration, or device-iris or device-cornea touch. The Hydrus Microstent is intended for implantation in conjunction with cataract surgery, which may impact corneal health. Therefore, caution is indicated in eyes with evidence of corneal compromise or with risk factors for corneal compromise following cataract surgery. Prior to implantation, patients with history of allergic reactions to nitinol, nickel or titanium should be counseled on the materials contained in the device, as well as potential for allergy/hypersensitivity to these materials. **PRECAUTIONS:** If excessive resistance

is encountered during the insertion of the microstent at any time during the procedure, discontinue use of the device. The safety and effectiveness of use of more than a single Hydrus Microstent has not been established. The safety and effectiveness of the Hydrus Microstent has not been established as an alternative to the primary treatment of glaucoma with medications, in patients 21 years or younger, eyes with significant prior trauma, eyes with abnormal anterior segment, eyes with chronic inflammation, eyes with glaucoma associated with vascular disorders, eyes with preexisting pseudophakia, eyes with pseudoexfoliative or pigmentary glaucoma, and when implantation is without concomitant cataract surgery with IOL implantation. Please see a complete list of Precautions in the Instructions for use. **ADVERSE EVENTS:** The most frequently reported finding in the randomized pivotal trial was peripheral anterior synechiae (PAS), with the cumulative rate at 5 years (14.6% vs 3.7% for cataract surgery alone). Other Hydrus postoperative adverse events reported at 5 years included partial or complete device obstruction (8.4%) and device malposition (1.4%). Additionally, there were no new reports of persistent anterior uveitis (2/369, 0.5% at 2 years) from 2 to 5 years postoperative. There were no reports of explanted Hydrus implants over the 5-year follow-up. For additional adverse event information, please refer to the Instructions for Use. **MRI INFORMATION:** The Hydrus Microstent is MR-Conditional meaning that the device is safe for use in a specified MR environment under specified conditions. **Please see the Instructions for Use for complete product information.**

References: 1. Ahmed I, et al; HORIZON Investigators. Long-term Outcomes from the HORIZON Randomized Trial for a Schlemm's Canal Microstent in Combination Cataract and Glaucoma Surgery. [https://www.aaojournal.org/article/S0161-6420\(22\)00160-9/fulltext](https://www.aaojournal.org/article/S0161-6420(22)00160-9/fulltext) 2. Hydrus Microstent Instructions for Use)

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Your patients have seen tremendous things, and plan to see a whole lot more. That's why the Hydrus® Microstent was purposefully designed for outcomes that stand the test of time. Choose the MIGS device built to enable life's biggest experiences.

HYDRUS
MICROSTENT

The only MIGS option proven in a pivotal trial at 5 years to deliver:

- 66% of patients medication-free¹
- 👁 >50% relative reduction in incisional SSIs* compared to cataract surgery alone (2.4% in Hydrus vs. 5.3% in CS only)^{2†}
- Established long-term safety at 60-months with comparable SAE rates reported vs cataract surgery alone^{2‡}

*SSI = Secondary Surgical Intervention

† includes trabeculectomy, tube shunt, gel stent, ECP/TSCP, non-penetrating; (9/369 Hydrus and 10/187 CS)

‡ 13/369 (3.5%) in Hydrus eyes vs. 8/187 (4.3%) in the control eyes