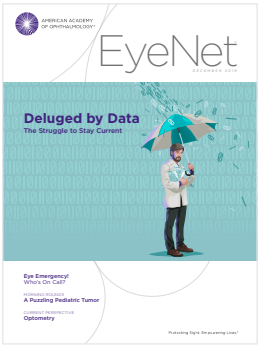
Letters



Testing Recommended

I read with great interest "A Puzzling Pediatric Tumor" (Morning Rounds, December). The presentation of an 8-year-old with retinoblastoma was nicely described as was the differential diagnosis to be considered in this setting. As an ocular oncologist who treats this cancer, I believe that one comment should be corrected. The authors state: "Although it was not confirmed whether Emily's tumor was caused by a germline or somatic mutation, based on presentation it can be assumed that it was likely somatic."

This is a common fallacy that my colleagues and I (and others) have addressed. While it is correct that somatic mutations in the *RB1* tumor suppressor gene will only produce unilateral disease, the inverse is not always true and cannot be assumed. In fact, approximately 15% of children without a family history of retinoblastoma who present with unilateral, unifocal retinoblastoma *will* have a germline (or mosaic) *RB1* mutation. The second misperception is that age at presentation can be used to stratify the risk of a germline mutation. In this case, the assumption is that because Emily is 8 years old and has unilateral disease, she could not have the germline form. In our study,[1] we evaluated 182 patients with unilateral retinoblastoma who presented to Children's Hospital Los Angeles over a 27-year period and identified 32 patients with a germline or mosaic mutation in the *RB1* gene. Of these patients, 44% were diagnosed between 25 and 130 months of age, and the oldest patient to have a confirmed germline mutation was 120 months (10 years!) old.

There are significant consequences for a germline (or mosaic) *RB1* mutation including a risk of secondary nonocular tumors as an adult and risk of passing the mutation to future offspring. Unfortunately, our service has treated multiple children with retinoblastoma whose parents had unilateral disease, were not genetically tested, and were incorrectly advised that they could not pass the mutation on. Our recommendation is for *RB1* mutation testing of the leukocytes (peripheral blood) on every child with retinoblastoma, but it is most critical for children with unilateral disease and we would recommend testing for Emily.

Jesse L. Berry, MD
Associate Director of Ocular Oncology
Children's Hospital Los Angeles, USC Roski Eye Institute
Keck School of Medicine

1 Berry JL et al. *Ophthalmic Genet.* 2018;39(3):407-409.

Reply

I would like to thank Dr. Berry for pointing out the importance of testing all children for the *RB1* germline mutation regardless of age or unilateral presentation of retinoblastoma. The patient described in the case report was tested soon after presentation and had the somatic mutation.

Steve Gerber, MD
South Bend, Ind.

Another Alternative to PE

I was disappointed to read "Alternatives to Private Equity for Ophthalmology Practices" (Practice Perfect, December). After 20 column inches on the specifics behind merging with or being acquired by other practices or larger entities, there was a single sentence stating that remaining independent was also an option: "If the practice is doing well financially, satisfying the needs of patients and physicians, and there isn't any imminent threat to the practice in the marketplace, the owners may decide to remain independent."

I think it is irresponsible for *EyeNet* to put forth the position that practices that wish to avoid being bought out by private equity have only two realistic options: merging or being acquired. And I do not believe that only practices that are "doing well financially" and without "imminent threat to the practice in the marketplace" can remain independent and under the control of their physician owners.

To address exactly this fear, my colleagues and I have created a management services organization (MSO) called Associated Eye Care Partners (AECP) to provide expertise and support for any eye care group whose strategy is to remain independent from merger with, or acquisition by, any other entity. Comprehensive EyeCare Partners in Las Vegas is another MSO with a similar mission, and there are probably more. The hope of these MSOs is that by providing practices with help or expertise in strategic planning, human resources, compliance, finance, information technology, health information management, or any of the myriad issues that continually come up in practice administration, we can allow the physician owners to keep control and ownership of the businesses that they have built.

Gary S. Schwartz, MD, MHA
Cochair and Executive Medical Director,
Associated Eye Care Partners
Stillwater, Minn.

Reply

"Alternatives to Private Equity for Ophthalmology Practices" was aimed at practices that want to consolidate but don't want to do a deal with private equity. As Dr. Schwartz pointed out,

and as discussed in this month's Opinion (page 15), with the right strategies and resources in place, many practices can continue to maintain their independence.

Rethinking Call Duty

"Who's on Call? Emergency Care Crisis Looms" (Clinical Update, December) was timely. For most ophthalmologists, responding to the emergency department (ED) and in-patient hospital consultation requests is not effective. It diverts attention away from medical and surgical ophthalmology. It is not a way to generate new patients for the office. Moreover, most ophthalmologists already see emergencies out of their offices, instead of directing them to hospital EDs. Care rendered in the office is more cost-effective than ED care.

Hospital bylaws outline a call obligation in general language. However, the application varies among attending physicians. Some are paid for call; others are not. Due to this unequal treatment, there may be uncertainty as to whether the call schedule is binding. ED service contracts are now being written to clarify responsibilities and remuneration.

The amount of call is factored into employment offers. Light call or no call is often sought: In one contract that I heard of recently, the new hire only had two call days per year!

In many institutions, senior ophthalmologists and retina specialists may be excused from call. It can be argued that retina physicians should not be saddled with ED call since they make themselves available to general ophthalmologists for emergencies.

While the tradition of the unpaid ED obligation is being questioned, we need to remember that our medical colleagues and patients need our help. With privilege comes responsibility. "Who's on Call? Emergency Care Crisis Looms" points out many ways that we can try to meet this challenge.

Lawrence Stone, MD
Louis A. Weiss Memorial Hospital
Chicago

Statewide On-Call Scheduling Platform

With regard to "Who's on Call? Emergency Care Crisis Looms" (Clinical Update, December), emergency call is not easy or fun, yet it is the fuel that makes the American medical system work. Americans expect to be taken care of when a medical emergency occurs, no matter the time of day or night. The Emergency Medical Treatment and Active Labor Act (EMTALA) was passed by Congress in 1986; it states that any patient who presents to an emergency department (ED) must be triaged regardless of ability to pay.

As Alaska's only oculoplastic surgeon, I have been taking voluntary call without compensation for more than 25 years. Out of the need to protect my sanity, I gathered a team to design, build, and launch CallDR, an EMTALA physician on-call scheduling platform. CallDR is now deployed in the largest hospital in Alaska and networked throughout the state in 22 out of 24 EDs (including all three hospital sectors—military, native/public health, and private). Providence Hospital in Anchorage has become the hub, as it houses, operates, and maintains all the equipment and is home base for the medical specialists who cannot be found elsewhere in the state for referrals and patient transfers. There simply will never be a full-time ophthalmologist, neurosurgeon, or cardiothoracic surgeon in Nome, Sitka, or Adak. These communities need help reducing delay in finding the appropriate physician when an emergency occurs.

By sharing the call schedule, which historically has been siloed and kept secret, CallDR has improved internal and external hospital communications. Now nurses on the floors, ED physicians, consultants in their offices, technicians, and outside facilities know who is available and can communicate with them through either an internal or external secure, encrypted messaging system. CallDR can be accessed from a desktop on the floor, in the ED, or in a clinician's office as well as via smartphone. Patient information can be sent by multiple avenues, including video, audio, and text.

When CallDR was installed over a year ago, some physicians balked, thinking that it would increase liability costs, malpractice risk, or the already burdensome work that comes with call. The program threatened a way of life, and we initially encountered a great deal of resistance and hostility. But as time has gone by, those same physicians have now embraced the program. It makes call life easier and more efficient. It even helps them avoid coming into the ED or hospital, as many clinical questions can be answered through text or dialogue.

Analysis of the data supports our contention that CallDR is reducing delay of patient care, improving patient experiences, and helping doctors do their jobs more efficiently. Currently we have over 7,200 logins per month, and we have seen a 90% reduction in phone calls to the ED asking who is on call—from over 800 phone calls per day to fewer than 80 per day. We have over 235 logins per day, with the greatest number coming from ICUs. Patient transfers occur with less friction from outside hospitals since patient data is communicated more effectively.

We now are implementing an alert cascade for disaster management and mass casualties, as during the November 2019 earthquake (7.1 magnitude), hospital leadership realized that it doesn't take much to overwhelm hospitals. Volunteer response teams work better if the teams have information telling them where and what kind of medical resources are needed most.

If you would like more information, please leave a message in the Comments area of this article at aao.org/eyenet.

Carl E. Rosen, MD
CEO of CallDR and
President of Ophthalmic Associates
Anchorage, Alaska

WRITE TO US. Send letters to *EyeNet Magazine,* AAO, 655 Beach Street, San Francisco, CA 94109; e-mail eyenet@aao.org.

For more about ED call, see "OMIC Tip: Emergencies and After-Hours Calls," page 48.