

Letters

Reflection on Physician Payment

I very much enjoyed reading Dr. Parke's editorial "How Much Is Not Enough? Part One" (Current Perspective, July).

As the word "value" has permeated the health policy debates on health care reform, I feel that this is exactly where we should focus. We should promote awareness of the value of our treatments in terms of patient quality of life.

How much value does an ophthalmologist provide when he or she evaluates a patient, discusses their blinding eye disease, and structures a treatment plan? When you consider that many auto mechanics charge \$100 to evaluate your auto, the cost of an office visit for a new patient who is legally blind due to a retinal detachment does not seem out of bounds.

How much value does an ophthalmologist provide to a patient and to our society when he or she treats a working age adult who is legally blind due to diabetic retinopathy and brings them back to driving vision, reading vision, working vision? One could make a similar argument about a healthy 70-year-old who is 20/50 and struggling to read and drive. She regains the ability to read her medication bottles, drive herself to appointments, and stay out of a nursing home when a cataract surgery brings her to 20/25 vision.

Those who propose that doctors are paid too much may not be considering the value that modern medicine brings to our society. With better outcomes, and with treatments with less morbidity, patients are receiving more value with less discomfort, fewer days of hospitalization, and more rapid return to function than 20 years ago. We should make sure that our society and our legislators are aware of this.

—Jerry Brown Jr., MS, MD
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Reply

Thank you for your letter. I agree with you that the notion of value is at the heart of the issue. The question then becomes, "What are relative values, and how do you quantify them?" It's a massive subject. To put it crassly, "What is the relative value of the ophthalmologist doing cataract surgery or a thoracic surgeon removing a lung or a new drug that cures glaucoma or a great middle school teacher or an outstanding airline pilot—and what's the economic variance?" (I pondered this question recently at 32,000 feet on a regional jet, recognizing that the pilot likely made about \$75,000 a year.) To a certain extent these are market questions—and they are societal ones. And addressing them will require evidence to bolster rational policy and budgetary priorities.

—David W. Parke II, MD
Academy CEO
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Dextenza: Optimal Timing for Insertion

The April *EyeNet* cover story included discussion of Dextenza, which is FDA approved to treat pain and inflammation after ophthalmic surgery.¹ Dextenza, a cylinder that is inserted into the punctum/canaliculus, slowly elutes dexamethasone as the device dissolves over 30 days. During the clinical trials, investigators deployed Dextenza after cataract surgery. However, this may not be the optimal timing in terms of bacterial prophylaxis.

Colonies of bacteria can frequently be isolated from the ocular surface and the adnexa.^{2,3} Cataract surgeons employ various prep strategies, including use of topical povidone-iodine, to prevent these bacteria from precipitating active infections. Moreover, if an active infection is present, elective cataract surgery is cancelled until it is resolved.

Infections of the ocular surface are typically symptomatic and thus detectable. However, chronic low-grade infections of the lacrimal system are not uncommon⁴ and are more difficult to detect. There are often no signs at the slit lamp, unless the nasolacrimal sac is compressed, the punctum/canaliculus is probed, or punctal plugs are inserted. Potentially infectious material can then be displaced onto the ocular surface.

The prep regimen effectively targets the ocular and adnexal surfaces. Although some of the prep solution may enter the punctum, there is no effective way to get it into the lumen of the nasolacrimal system. If the surgeon does not apply pressure to the nasolacrimal sac during surgery, this is not an issue. However, insertion of the Dextenza device and the required instrumentation of the proximal nasolacrimal passageway will occasionally displace potentially infectious bacteria onto the ocular surface.

Considering these things, it might be prudent to insert the Dextenza device before the prep. Then, if unintended bacterial spillage occurs during Dextenza deployment, the prep has access to these bacteria. Although Ocular Therapeutix did report a case of dacryocanalculitis with the placebo canalicular insert, they did not report any cases of endophthalmitis in their Dextenza clinical trials;⁵ however, the sample size for approval was small relative to the rate of endophthalmitis after cataract surgery.

—Michael S. Korenfeld, MD, ACOS
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1 Baker-Schena L. *EyeNet Magazine*. 2019;23(4):48-49.

2 Ratnumnoi R et al. *Clin Ophthalmol*. 2017;11:237-241.

3 Walker CB, Claoué CM. *J R Soc Med*. 1986;79(9):520-521.

4 Kumar DA. *TNOA J Ophthalmic Sci Res*. 2017;55(4):293-297.

5 Walters T et al. *J Clin Exp Ophthalmol*. 2016;7:572.