

TECHNOLOGY

How UWF retinal imaging can elevate eye exams

OCULAR SURFACE DISEASE

Why your ears are the best dry eye instruments

OptometryTimes®

PRACTICAL CHAIRSIDE ADVICE

DECEMBER 2021 VOLUME 13, NUMBER 12

PER®
gotoper.com

REFRACTIVE

EFFECTS OF PREGNANCY ON KERATOCONUS

By Annie Nguyen, MD; and
Gloria B. Chiu, OD, FAAO, FSLs

Although the exact cause of keratoconus remains unknown, it is believed to be caused by a combination of genetic, environmental and hormonal factors.

CONTINUED ON PAGE 24

RETINA

Evolving technologies offer better outcomes

GLAUCOMA

Decrease medical burden, increase quality of life

CONTACT LENSES

The benefits of expanded contact lens offerings

TOBRADEX® ST (tobramycin/dexamethasone ophthalmic suspension) 0.3%/0.05%

Brief Summary

This Brief Summary does not include all the information needed to use TOBRADEX ST safely and effectively. Please see Full Prescribing Information for TOBRADEX ST at MyTobraDexST.com.

INDICATIONS AND USAGE

TOBRADEX ST is a topical antibiotic and corticosteroid combination for steroid-responsive inflammatory ocular conditions for which a corticosteroid is indicated and where superficial bacterial ocular infection or a risk of bacterial ocular infection exists.

Ocular steroids are indicated in inflammatory conditions of the palpebral and bulbar conjunctiva, cornea and anterior segment of the globe where the inherent risk of steroid use in certain infective conjunctivitis is accepted to obtain a diminution in edema and inflammation. They are also indicated in chronic anterior uveitis and corneal injury from chemical, radiation or thermal burns, or penetration of foreign bodies.

The use of a combination drug with an anti-infective component is indicated where the risk of superficial ocular infection is high or where there is an expectation that potentially dangerous numbers of bacteria will be present in the eye.

DOSAGE AND ADMINISTRATION

Recommended Dosing: Instill one drop into the conjunctival sac(s) every four to six hours. During the initial 24 to 48 hours, dosage may be increased to one drop every 2 hours. Frequency should be decreased gradually as warranted by improvement in clinical signs. Care should be taken not to discontinue therapy prematurely.

CONTRAINDICATIONS

Nonbacterial Etiology: TOBRADEX ST is contraindicated in most viral diseases of the cornea and conjunctiva including epithelial herpes simplex keratitis (dendritic keratitis), vaccinia, and varicella, and also in mycobacterial infection of the eye and fungal diseases of ocular structures.

Hypersensitivity: Hypersensitivity to any component of the medication.

WARNINGS AND PRECAUTIONS

IOP increase: Prolonged use of corticosteroids may result in glaucoma with damage to the optic nerve, defects in visual acuity and fields of vision. IOP should be monitored.

Aminoglycoside sensitivity: Sensitivity to topically applied aminoglycosides may occur.

Cataracts: May result in posterior subcapsular cataract formation.

Delayed healing: May delay healing and increase the incidence of bleb formation after cataract surgery. In those diseases causing thinning of the cornea or sclera, perforations have been known to occur with the use of topical steroids.

Bacterial infections: May suppress the host response and thus increase the hazard of secondary ocular infections. In acute purulent conditions, steroids may mask infection or enhance existing infection. If signs and symptoms fail to improve after 2 days, the patient should be re-evaluated.

Viral infections: Treatment in patients with a history of herpes simplex requires great caution. Use of ocular steroids may prolong the course and may exacerbate the severity of many viral infections of the eye (including herpes simplex).

Fungal infections: Fungal infections of the cornea are particularly prone to develop with long-term use. Fungal invasion must be considered in any persistent corneal ulceration.

Use with systemic aminoglycosides: Use with systemic aminoglycoside antibiotics requires monitoring for total serum concentration of tobramycin.

ADVERSE REACTIONS

The most frequent adverse reactions to topical ocular tobramycin (TOBEX®) are hypersensitivity and localized ocular toxicity, including eye pain, eyelid pruritus, eyelid edema, and conjunctival hyperemia. These reactions occur in less than 4% of patients. Similar reactions may occur with the topical use of other aminoglycoside antibiotics.

Non-ocular adverse events occurring at an incidence of 0.5% to 1% included headache and increased blood pressure.

The reactions due to the steroid component are: increased intraocular pressure (IOP) with possible development of glaucoma, and infrequent optic nerve disorder; subcapsular cataract; and impaired healing.

Secondary Infection.

The development of secondary infection has occurred. Fungal infections of the cornea are particularly prone to develop with long-term use. Fungal invasion must be considered in any persistent corneal ulceration. Secondary bacterial ocular infection following suppression of host responses also occurs.

USE IN SPECIFIC POPULATIONS

Pregnancy and Nursing Mothers

There are no adequate and well controlled studies in pregnant women. TOBRADEX ST ophthalmic suspension should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Caution should be exercised when TOBRADEX ST is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in pediatric patients below the age of 2 years have not been established.

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

Rx Only

Distributed by: Eyevance Pharmaceuticals LLC.
Fort Worth, TX 76102



© 2021 Eyevance Pharmaceuticals LLC. All rights reserved.
TOBRADEX® ST is a registered trademark of Eyevance Pharmaceuticals LLC. All other trademarks are the property of their respective owners.
TST-01-20-MS-06 09/21

Viewpoints: Remote monitoring centers for dry age-related macular degeneration

Roundtable of experts discuss impact, management of retinal disease

By John Raney

Editor's note: The following discussion was produced in partnership with Notal Vision.

On September 15, 2021, *Optometry Times*® hosted a *Viewpoints* discussion of remote monitoring centers and their impact on the treatment of dry age-related macular degeneration (AMD).

The discussion was moderated by John Rumpakis, OD, MBA, president and CEO of Practice Resource Management in Lake Oswego, Oregon. The participants were Steven Ferrucci, OD, chief of the optometry section at Sepulveda VA Medical Center in North Hills, California, and a professor at Marshall B. Ketchum University Southern California College of Optometry; and Jaya Pathapati, OD, of Eye Care Plus in Amarillo, Texas.

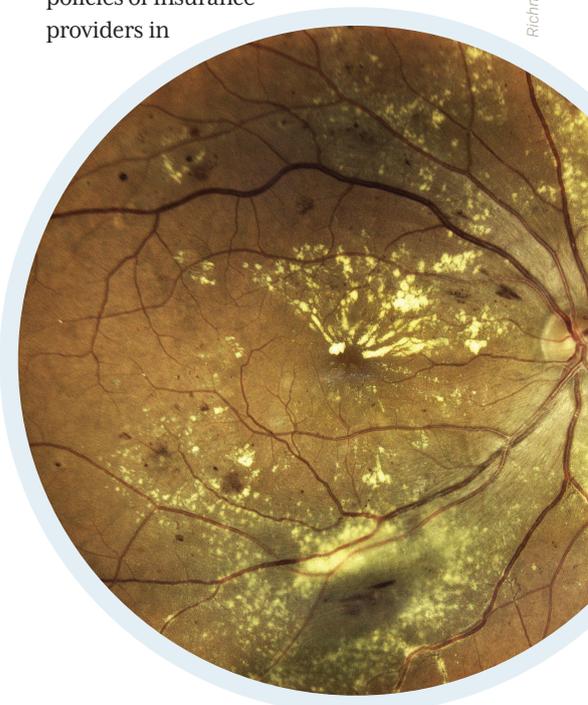
AMD treatment

The panel opened with Ferrucci and Pathapati agreeing that early diagnosis and intervention for AMD is crucial. To that end, Rumpakis asked them how often they see patients with a genetic predisposition for AMD in nonremote settings.

Both concurred that they use

a mix of the patient's current macular degeneration and their genetic and personal history to determine how often they need to be seen. This ranges from once every 3 months to once a year.

Ferrucci and Pathapati emphasized that patient education is a vital part of treatment. Actions such as showing patients fundus photos helps patients visualize what is happening to them and what the goals of treatment are. It is also important to talk through the costs of procedures and the policies of insurance providers in



Richman Photo @Adobe Stock

order to form a game plan.

They then discussed the benefits of early patient diagnosis.

“The earlier a diagnosis, the better,” Pathapati said.

She reiterated that education helps lead patients to cooperate and aid in the detection process.

Ferucci stated that optometrists should talk to patients with mild dry AMD about things they can do to prevent their condition from getting worse and should seek to detect patients who have converted to wet AMD as soon as possible.

“The sooner we can detect that conversion, the sooner we get them treatment, the better off the patient will be,” Pathapati said.

Remote monitoring

Pathapati noted that remote monitoring is important because the Amsler grid is an outdated tool with low patient adherence. Ferucci added that patients’ conditions can convert between appointments, making monitoring even more crucial.

Ferucci noted that the remote monitoring center will alert the practitioner when there is a significant change in the patient, and the practitioner will in turn call the patient in to determine if they have converted.

Pathapati also feels more comfortable letting patients who have to travel to see her wait longer between appointments when she can maintain their quality of care with remote monitoring.

TAKEHOME MESSAGE

ODs who incorporate remote monitoring into their day-to-day clinical activities enjoy many benefits including detecting and diagnosing AMD early, reduced out-of-pocket costs for patients during routing follow-ups and a higher quality of care.

Rumpakis noted that the remote monitoring centers are independent entities, which the physician refers the patient to. The physician is then the beneficiary of the monitoring. Ferucci stated that this process is seamless.

The center sends patients the remote



John Rumpakis, OD, MBA, Steven Ferrucci, OD, FAAO, and Jaya Pathapati, OD, discuss the role of remote monitoring in the management of dry age-related macular degeneration

monitoring unit and trains them on how to use it. If there’s a significant change, the center will send an alert to the patient and to the doctor’s office instantaneously. Pathapati said she receives a monthly report from the monitoring center that lists the patients, has plentiful data to review, and is easy to access.

She stated that patients have peace of mind and “feel so much more comfortable that I’m going to be monitoring them.” Ferucci added that there is also more adherence than with an Amsler grid, because the center can see if the patient is doing the test and remind them.

Economics of remote monitoring

Rumpakis then discussed the economics of remote monitoring. The center is a separate entity, but the time spent reviewing the data can be the basis for billing. He also discussed the codes that have come out and their impact on remote monitoring.

“I think this is really going to impact the future of how we start to manage retinal disease. As much as I hate to say it, ...there are some out there that unfortunately only approach technology if there is a reimbursement in it.”

Pathapati responded that it is good to be

reimbursed properly, “but, at the end of it, we do have to make sure that the patient is cared for at the highest level.” She also pointed out that the technology attracts new patients and new revenue helps profits.

Ferucci added that, throughout the years, various companies have approached him to give his feedback on their technology. While there have been some technologies that he thinks would be great for patient care, there’s no way these would be economically feasible, he said.

“There are other ones that I’ve seen that I don’t think are good for patient care but a doctor can bill and make money on,” he explained. “But when there’s something like this that can help the physician take better care of the patient and it can economically help a practice, to me that’s the win-win. That’s the best situation.”●

.....

Jack Raney
jackraney98@gmail.com



For full access to our Viewpoints sessions, scan this QR code with your smartphone