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AAO 2017

EyeNet News

SUBSPECIALTY DAY EDITION
NEW ORLEANS

Subspecialty Day Meetings

An Insider's Guide

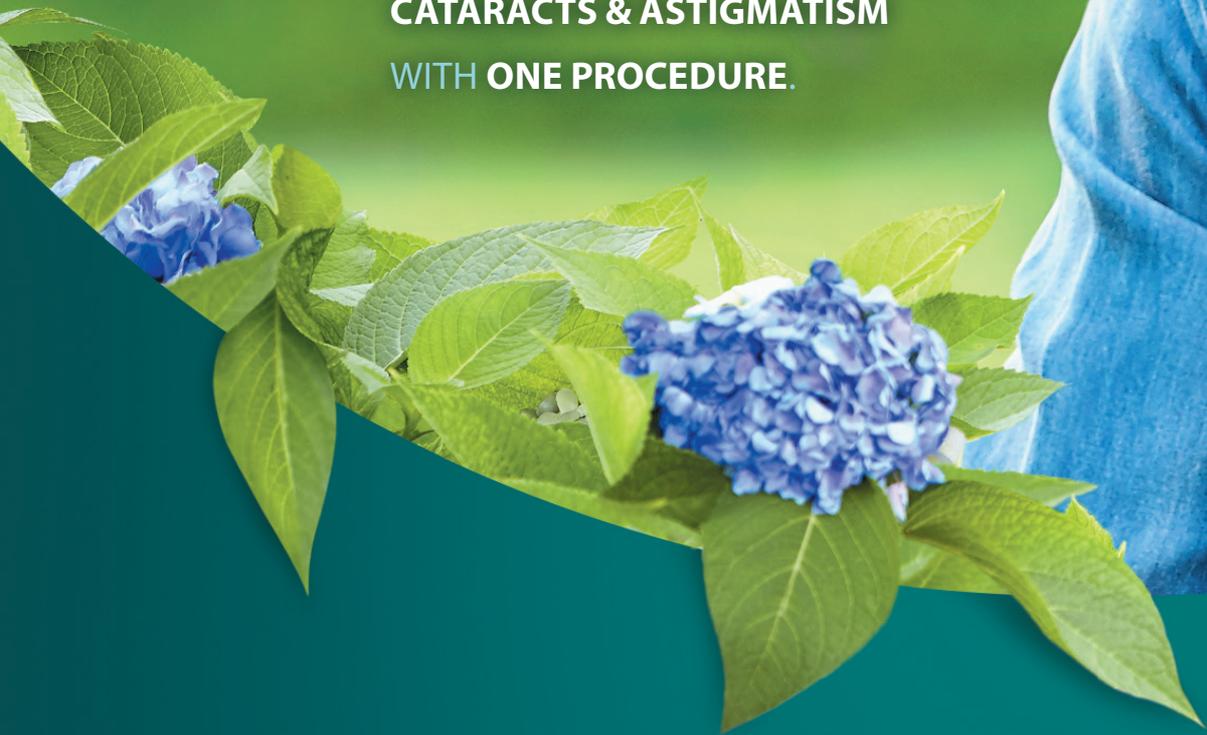
AAO 2017
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EyeNet Corporate Events

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

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

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

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

aao.org/eyenet/corporate-events

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

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4-8 What's Hot at Subspecialty Day

The program directors preview some of the highlights.

10 Dr. Hoskins on Data

The Orbital Gala honoree discusses the importance of mining for big-data gold.

12-14 Meet Drs. McLeod and Schachat

The editors-in-chief of the Academy's journals are quizzed by Drs. Blomquist, Corrêa, Miller, and Rapuano.

16 New Glaucoma Education Center

Surgical simulations, interactive data, clinical tools, and more.

18-19 Award-Winning Photos

First Place winners from the 2016 OPS exhibit.

20-22 Why Hire a Low Vision Employee?

A win-win for the ophthalmologist and the new staff person.

27-28 Honorary Lectures, Part 1

Preview 9 of this year's named lectures.

30 Hidden New Orleans Gems

Discover spots that are off the beaten path.

From the Editor

Welcome to Subspecialty Day 2017!

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



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



On the Cover Traumatic Cataract

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

Program Directors Share Insights on Subspecialty Day From Cornea to Uveitis

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

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

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

Of Interest Across Subspecialties

CORNEA

La Nouvelle Orleans Ballroom AB
Point-of-Care Testing for Dry Eyes: Tears of Joy, or Tears From the Expense? presented by Anat Galor, MD (Saturday, 4:03-4:12 p.m.)

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

During Cornea Subspecialty Day, Anat Galor, MD, will address the issue of dry eye management and the use of new testing modalities for patients with dry eyes during the presentation entitled “Point-of-Care Testing for Dry Eyes: Tears of Joy, or Tears From the Expense?” Several point-of-care tests are now available for evaluating dry eye, from blood tests to measurements of tear composition and meibography. This presentation will weigh the costs and benefits of these new technologies for both patients and providers, and it will help providers determine if they should be implementing these tests in their office.

—Jennifer Li, MD,
Cornea program director

GLAUCOMA

New Orleans Theatre AB
Inflammation Nation—Uveitic and Steroid Glaucoma Diagnosis and Management, moderated by Meenakshi Chaku, MD, and Kelly Walton Muir, MD (Saturday, 10:28-11:28 a.m.)

Glaucoma secondary to uveitis and/or steroid use for uveitic inflammation is one of the most challenging forms of the disease to manage. The comprehensive ophthalmologist, uveitis specialist, retina specialist, anterior segment specialist, and pediatric ophthalmologist will appreciate and learn from presentations and discussion of real-life cases (both adult and pediatric). Experts in glaucoma therapeutics, pediatric glaucoma, and uveitis will be on hand to present diagnostic protocols and therapeutic options.

Advice will be provided about when to obtain a consult (rheumatology/uveitis), how to manage iris bombe, and how to achieve adequate reduction of intraocular pressure. Peter Netland, MD, PhD, will discuss “The Good, The Bad, and The Ugly of Treatment Options: What Works? The Evidence.”

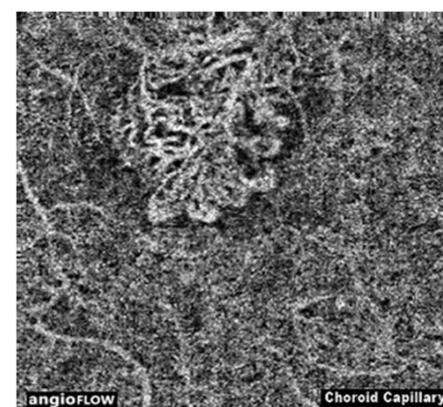
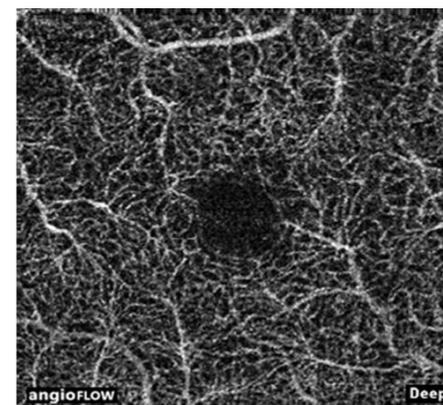
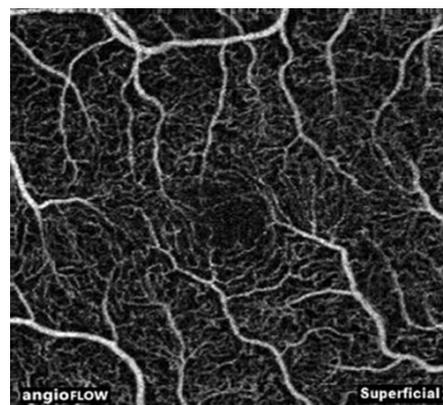
For the pediatric case, the advantages and downsides of using steroids will be discussed, and surgical treatments will be covered. Alan Beck, MD, will be on hand to speak on “Goniotomy in Uveitic Glaucoma: What is the Evidence?”

—Shan Lin, MD,
Glaucoma program director

NEURO-OPHTHALMOLOGY

La Nouvelle Orleans Ballroom C
Don't Tell Me You're Seeing Double! moderated by Collin M. McClelland, MD, and Mitchell B. Strominger, MD (Saturday, 1:23-3:12 p.m.)

At some point, all ophthalmologists may be faced with a patient who has double vision, and the differential diagnosis for this symptom includes not only common conditions such as dry eye and monocular diplopia from cataracts but also potentially life-threatening disorders like aneurysmal cranial nerve palsy. Patients describe their visual symptoms in a variety of ways, and the concept and perception of “double vision” varies across ages and even regions of the country and world. The session will engage the audience with several cases in which the initial symptoms alone can lead the clinician down several diagnostic and therapeutic pathways. New this year is a discussion of diplopia in the setting of concussion, which can be confusing when patients



RETINA. OCT angiography of choroidal neovascularization. Normal superficial and deep retinal vascular networks (top left and top right, respectively). Normal avascular outer retina (lower left). At the level of the choriocapillaris, the bottom right image shows the abnormal subfoveal choroidal neovascular complex.

have additional neurological symptoms. Our speakers and expert panelists will help the ophthalmologist identify these problems and direct diagnosis and management in the most efficient and effective way. Come to this session and learn more!

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

OCULOFACIAL PLASTIC SURGERY

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

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

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

PEDIATRIC OPHTHALMOLOGY

New Orleans Theatre C
When the Complaints Go Marching In—Glasses Problems and How to Fix Them, moderated by R. Michael Siatkowski, MD (Saturday, 3:32-4:32 p.m.)

Comprehensive ophthalmologists, pediatric ophthalmologists, strabismologists, and other subspecialists all encounter patients who are unhappy with their glasses. Experienced experts in optics, refraction, and strabismus will share cases that illustrate helpful nuances of how to prescribe spectacles for the most difficult patient. After hearing talks on topics such as “I Want My Money Back” (3:33-3:44 p.m.) and “These Glasses Make Me Sick,” (3:44-3:55 p.m.), every attendee will take home new perspectives and insights that will be helpful in their everyday clinical practice. Panelists will share how they anticipate problems and how they deal with the dissatisfied patient who has just picked up a pair of spectacles that they simply cannot tolerate. —Jonathan M. Holmes, MD, and Yasmin Bradfield, MD, Pediatric Ophthalmology program directors

REFRACTIVE SURGERY

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

Personalized medicine is coming to all subspecialties within ophthalmology, and it's already affecting refractive surgery. The Refractive Surgery keynote lecture, delivered by John Marshall, PhD, covers how the knowledge of the human genome coupled with rapid advances

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in the molecular biology of diagnostic techniques promise a new era of surgery underwritten by personal molecular screening. In fact, the 5 corneal granular dystrophies can now be identified with 100% accuracy using a simple buccal swab. This is just the first group of diseases to be explored by this technology, which is very useful in Asia, where these dystrophies are especially prevalent.

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

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

RETINA

Great Hall

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

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

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

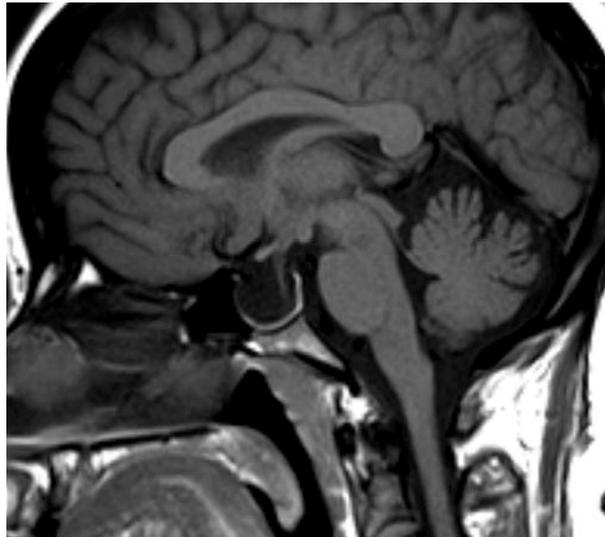
Clinical Practices to Reconsider

CORNEA

La Nouvelle Orleans Ballroom AB

Should We Still Be Doing DSAEK? presented by Winston D. Chamberlain, MD, PhD (Saturday, 9:15-9:24 a.m.)

Endothelial keratoplasty (EK) has evolved in recent years, and traditional Descemet stripping automated EK (DSAEK) may not provide the best outcomes for our patients, now that ultra-thin (UT)-DSAEK and Descemet membrane EK (DMEK) are available. Winston D. Chamberlain, MD, PhD, will present data on both visual outcomes and graft rejection rates of the various types of EK. He will also discuss other advantages and disadvantages of



NEURO. Sagittal T1 MRI without contrast in a patient with bilateral papilledema shows a large, empty sella turcica. Does this patient, a 28-year-old woman with headache, pulsatile tinnitus, and a body mass index of 37, need any additional workup?

each procedure and outline the clinical indications for employing UT-DSAEK versus DMEK. In addition, surgical challenges of transitioning from traditional DSAEK to UT-DSAEK and DMEK will be discussed. Understanding the best surgical procedure for each patient will allow the cornea surgeons to provide the very best patient care possible using current data.

—Bennie H. Jeng, MD,
Cornea program director

GLAUCOMA

New Orleans Theatre AB

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

Cataract surgery in patients with glaucoma has numerous controversial aspects. Should you use a toric or multifocal intraocular lens (IOL) in the patient who has had a previous filtering surgery or who has a good chance of such a surgery in the future? Is clear lens extraction a reasonable option in eyes with angle-closure glaucoma? What precautionary steps can you take before and during cataract surgery in exfoliation eyes? How do you choose the correct IOL in the patient with post-trabeculectomy hypotony? You will hear from surgeons who deal with such cases frequently. They'll discuss their hits and misses in dealing with these cases, their mistakes and what they learned, and the evidence available in the literature.

—Shan Lin, MD,
Glaucoma program director

NEURO-OPHTHALMOLOGY

La Nouvelle Orleans Ballroom C

Abnormal Test Result—Panic, or Repeat It? moderated by Dean M. Cestari, MD, and Mays A. El-Dairi, MD (Saturday, 3:45-5:20 p.m.)

Neuro-ophthalmologists rely on ancillary tests to establish a diagnosis in patients

who present with exam findings such as optic disc swelling. However, abnormal test results may be found in asymptomatic patients as well. What is the predictive value of ancillary and laboratory testing, and how do we deal with test results that are at odds with the clinical exam and history? In the case of suspected intracranial hypertension, accepted testing includes magnetic resonance imaging (MRI) of the brain, MRI of the cerebral venous system, and diagnostic lumbar puncture to assess opening pressure and cerebrospinal fluid contents. Are these tests

truly necessary in a patient with typical signs and symptoms of idiopathic intracranial hypertension? How reliable are MRI and lumbar puncture, and should you trust the results? Should we reserve testing only for when clinical uncertainty exists? Join us for the “Abnormal Test Result—Panic, or Repeat It?” session at Neuro-Ophthalmology Subspecialty Day, where you will participate in case discussions centered around these dilemmas.

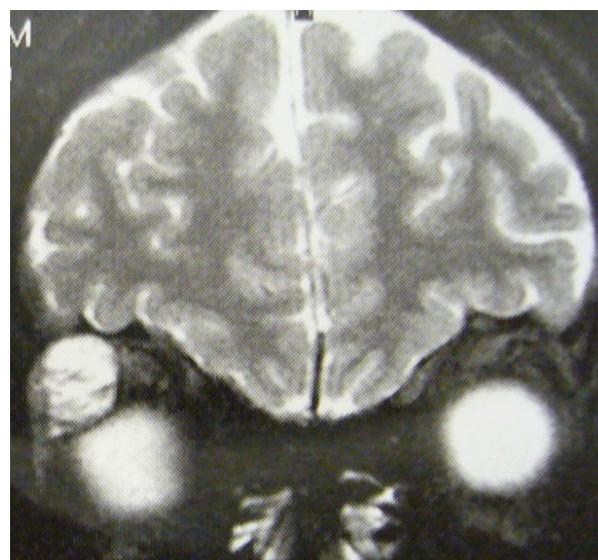
—Prem S. Subramanian, MD, PhD,
Neuro-Ophthalmology program director

OCULOFACIAL PLASTIC SURGERY

Room 243

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

Diagnosis and management of thyroid eye disease can be challenging. Decisions about how and when to proceed can be controversial. Raymond S. Douglas, MD, PhD, will lead a session on thyroid eye disease that will include case presentations and discussion of medical and surgical management. His research and his



PLASTICS. MRI of lacrimal gland tumor 1.

experience with management of patients in this field is vast. The knowledge that he will share should prove valuable to all.

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

PEDIATRIC OPHTHALMOLOGY

New Orleans Theatre C

The Heart and Soul—Bourbon Street and Strabismus, moderated by Jonathan M. Holmes, MD (Saturday, 8:01-9:22 a.m.)

Strabismus surgeons will enjoy an exciting back-and-forth discussion of 4 challenging cases. Two experienced strabismus surgeons will present their preferred surgical approach for each case, with clinical pearls and tips. This will be followed by a panel discussion. The audience members will vote on their preferred approach for each case, both before and after the presentations. Attendees will take home ideas for improving their own previously preferred technique—and, perhaps, practical recommendations for an alternative technique that they are not using.

One clinical scenario to be discussed will be a hypotropia that is worse in adduction. This scenario indicates that the superior oblique needs to be weakened in a controlled manner. Several surgical approaches will be presented and debated. Panelists will share their experience and the reasons why they prefer one technique over another, with practical step-by-step illustrations of how to perform each specific type of procedure.

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

REFRACTIVE SURGERY

La Nouvelle Ballroom AB

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

The Refractive Surgery program ends with a *Journal of Refractive Surgery* session, moderated by J. Bradley Randleman, MD, in which the Troutman

award goes to Riccardo Vinciguerra, MD, with a presentation on his paper “Detection of Keratoconus With a New Biomechanical Index.” In this study, a novel combined biomechanical index called the Corvis Biomechanical Index (CBI) is described. The CBI is based on corneal thickness profile and deformation parameters obtained by Corvis ST (Oculus) and was calculated to optimized accuracy to detect keratoconic corneas. In this multicenter retrospective study, 98.2% of the cases included in

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the training set were correctly classified with 100% specificity and 94.1% sensitivity. In the validation dataset, the same cutoff point correctly classified 98.8% of the cases with 98.4% specificity and 100% sensitivity. These novel data are integrated with tomography to further augment accuracy on cases with subclinical ectatic disease.

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

RETINA

Great Hall

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

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

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

Exciting Developments

CORNEA

La Nouvelle Orleans Ballroom AB

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

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



PEDIATRICS. A Boston Keratoprosthesis in a child.

tool to diagnose and manage surgical complications. In his presentation, Dr. Shousha will show the cornea specialist and the general ophthalmologist how to use OCT to manage commonly encountered problems. —Carol L. Karp, MD, Cornea program director

GLAUCOMA

New Orleans Theatre AB

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

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

NEURO-OPHTHALMOLOGY

La Nouvelle Orleans Ballroom C

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

Patients with transient vision loss can frustrate the ophthalmologist because the eye examination is likely to be normal when the patient is not in the midst of an event. The major concern is that this symptom could herald permanent vision loss and/or stroke. In many cases, the patient may have cardiovascular risk factors that would seem to explain the

episodes, but the need to act on related findings (such as carotid artery stenosis seen on vascular imaging) has not been clear based on the older literature. In this session, speakers and panelists will discuss cases of transient vision loss and consider new research that points to the predictive value of acute neuroimaging in the prediction of stroke risk. Come and learn when the workup of transient vision loss may be urgent and when it likely is not, and put those older studies and data behind you!

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

OCULOFACIAL PLASTIC SURGERY

Room 243

Orbit, moderated by Brett W. Davies, MD, and Eric M. Hink, MD (Saturday, 1:10-3:35 p.m.)

The lacrimal gland and lacrimal system will be areas of focus during the Orbit section at this year's Oculofacial Plastic Surgery Subspecialty Day. David Tse, MD, will give a talk on tumors of the lacrimal gland and will include a case presentation and expert discussion (1:50-2:20 p.m.). Regarding lacrimal surgery, traditional procedures are often followed, but new developments have recently arisen. Andrew R. Harrison, MD, will speak about minimally invasive conjunctivodacryocystorhinostomy (2:40-2:55 p.m.), and Stephen J. Laquis, MD, will speak about nonendoscopic transnasal dacryocystorhinostomy (2:55-3:10 p.m.).

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

PEDIATRIC OPHTHALMOLOGY

New Orleans Theatre C

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

Pediatric and comprehensive ophthalmologists will be excited to hear the latest developments in pediatric cornea. There will be a lively exchange between 2 cornea specialists on the pros and cons of using the KPro (Boston Keratoprosthesis) in the most challenging pediatric cases. Are the benefits worth the risk? Are the results long-lasting enough to warrant putting a baby through this? Kathryn A. Colby, MD, PhD, will discuss the alternatives to the KPro and present

her view of their risks and benefits (11:06-11:16 a.m.). In a counterpoint, Sarah M. Nehls, MD, will share the latest developments in this technology, and she will present her opinions on the current indications (11:16-11:26 a.m.). Additional presentations in this section

will include discussions of conjunctival stem cell transplantation and corneal cross-linking in the pediatric population. This will be an exciting session of "what's new" for kids with corneal problems!

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

REFRACTIVE SURGERY

La Nouvelle Ballroom AB

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

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

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

RETINA

Great Hall

Late Breaking Development—Part II, moderated by Joan W. Miller, MD (Saturday, 8:53-9:23 a.m.)

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

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

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

H. Dunbar Hoskins Jr., MD, is the guest of honor at the Orbital Gala on Sunday night. An internationally recognized glaucoma specialist, Dr. Hoskins inspires many as a champion for ophthalmic education, physician and patient advocacy, and technological innovation. He also spent 16 years (1993-2009) leading the Academy as its Executive Vice President.

Below, Dr. Hoskins discusses his legacy of physician data collection and his hopes for the future of the information collected by the IRIS Registry (Intelligent Research in Sight).

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

The IRIS Registry is a centralized data mine and reporting tool (covering all aspects of ophthalmology) that can analyze patient information to produce national and interpractice benchmark reports. Ophthalmologists can compare their patient outcomes, professional

performance, and care processes against other ophthalmologists across the country. It now contains more than 100 terabytes of data, making it the largest specialty-based clinical data registry in the world. In only 3 years, the IRIS Registry has collected data from 37 million individual patients and 148 million patient visits.

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

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

About the Orbital Gala

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

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

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



PAVING THE WAY FOR TECHNOLOGY. Dr. Hoskins with his mentor, Robert N. Shaffer, MD. "Dr. Hoskins was a true visionary in a lot of ways, but particularly in how technology would change everything we do—at the Academy and in medical practices," said Debra Rosencrance, the Academy's Vice President for Meetings.

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



DONATE TO IMPROVE QUALITY CARE. Dr. Hoskins and his wife, Ann Hoskins, are making an initial donation to the Hoskins Center IRIS Research Fund. "Ann was incredibly supportive of my activities during my tenure as Executive Vice President of the Academy," said Dr. Hoskins.

current moment but also for the future.

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

—H. Dunbar Hoskins Jr., MD

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Ask Me Anything: Meet The Editors-in-Chief

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

As of Jan. 1, the Academy's peer-reviewed journal, *Ophthalmology*, has a new editor-in-chief: Stephen D. McLeod, MD. Dr. McLeod is the Theresa M. and Wayne M. Caygill, MD Distinguished Professor and Chair of the Department of Ophthalmology at the University of California, San Francisco. He specializes in refractive surgery, cataract, and corneal disease, and he recently served as the Academy's secretary for Quality of Care.

In addition, Jan. 1 saw the inaugural issue of *Ophthalmology Retina*, the first new journal from the Academy in over 100 years, headed by Andrew P. Schachat, MD. Dr. Schachat is a retina clinician and vice chair at the Cleveland Clinic's Cole Eye Institute. He was editor-in-chief of *Ophthalmology* from 2003 to 2012 and remains one of its 4 Distinguished Senior Editors.

Get to know the new editors-in-chief.

EyeNet editorial board members Preston H. Blomquist, MD, Comprehensive Ophthalmology section editor, Zélia M. Corrêa, MD, PhD, Ophthalmic Oncology section editor, Kevin M. Miller, MD, Cataract section editor, and Christopher J. Rapuano, MD, Cornea and External Disease section editor, quizzed Drs. McLeod and Schachat. See below for their plans for the journals, thoughts on the future of peer-reviewed publishing, and vineyard forecasts.

Stephen D. McLeod, MD Editor-in-Chief *Ophthalmology*

From Preston H. Blomquist, MD

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

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

practicing comprehensive ophthalmologist. In truth, it is the highly technical, very specialized reports that we are most reluctant to publish, especially since there are now a number of superb subspecialty journals that are a more appropriate venue than *Ophthalmology*.

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

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

From Zélia M. Corrêa, MD, PhD

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

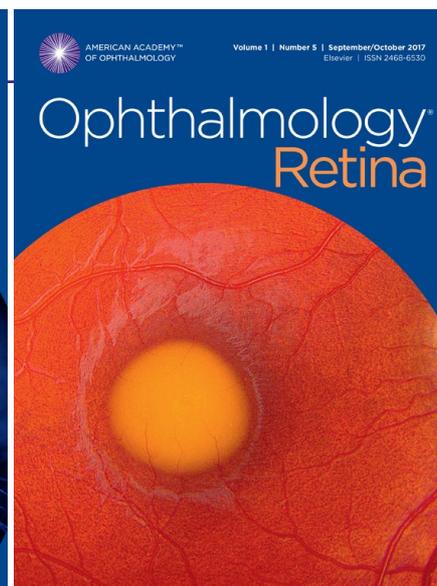
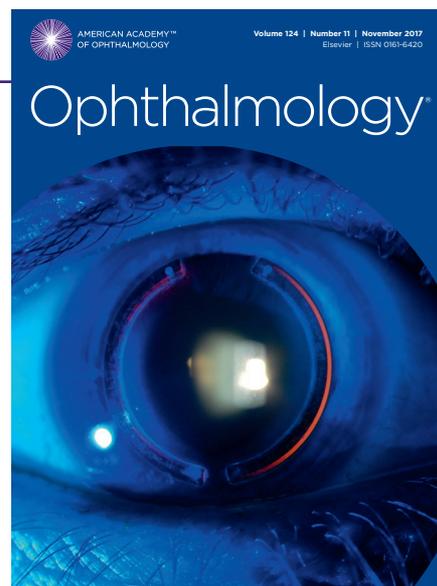
A. There is a lot that can and should be done to improve the user-friendliness of the journal's platform, both for authors and for our reviewers. We have begun intense discussions with the journal's publisher, Elsevier, and are confident that over the next few months we will see substantial improvements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

Q. Do you have pearls to share with Academy members to increase their chances of publishing their research in *Ophthalmology*?

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

From Kevin M. Miller, MD

Q. With the proliferation of trade journals, including the Academy's *EyeNet* and informational websites, how do you see *Ophthalmology* maintaining inter-



AT THE RESOURCE CENTER

Join Drs. McLeod and Schachat

Ophthalmology and *Ophthalmology Retina* article authors and peer-reviewers are invited to chat with the editors-in-chief and members of the editorial boards at a meet and greet. **When:** Sunday, 1:00-3:00 p.m. **Where:** Resource Center (Booth 3140).

ested readers going forward?

A. I think that it is really important to recognize that these different publications all serve different purposes, and no one publication can—or should—be all things to all people. Some publications are meant to stimulate the readership by presenting the latest ideas and trends in the field but don't intend to critically evaluate them. Others are meant to provide an up-to-date summary of current thought to help clinicians care for patients, even where hard evidence might be lacking. Others—like *Ophthalmology*—are meant to be the venue where the best scientific evidence is put out to the public so that clinicians and other researchers may critically evaluate and respond to it. The question then becomes,



Dr. McLeod taking time out to relax with his daughter, Elise.

does that publication serve its readers well, and does it draw them back with each issue? *Ophthalmology* is first and foremost a scientific journal, but it is intended to be clinically relevant and to be read by a general audience that includes trainees, comprehensive ophthalmologists, and subspecialists.

Ophthalmology has been incredibly successful and continues to have the highest impact factor of all the major clinical ophthalmology journals. However, *Ophthalmology* is not created for researchers to write papers to each other (which is how impact factor is ultimately calculated). It is intended to be the place where the most important work is first published and where readers should have confidence that if a paper is published, it represents the most rigorous standards. If that is the case, then when an *Ophthalmology* paper offers clinical guidance, the evidence to justify that guidance must be of the highest quality possible. And if that study is suggesting a fundamental change in the way we think about a clinical problem, this change in direction must serve our patients well and likely hold up going forward.

Q. How do you balance home and work demands when your work demands are over the top?

A. I'm very fortunate to have a forgiving wife, Marion, and a truly good-natured daughter, Elise. The department chair and editor-in-chief roles are probably 2 full-time jobs, but there are 2 key elements to managing this. The first is working with superb people—we have

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Reference: 1. OMIDRIA [package insert]. Seattle, WA: Omeros Corporation; 2016.

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

From Christopher J. Rapuano, MD

Q. Given that the vast majority of Academy members are clinicians, and I suspect most of the readers of *Ophthalmology* are too, how do you balance the number of clinical versus basic science articles you accept for publication?

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

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

A. Yes, we have a small vineyard in Sonoma, where we grow Rhône varieties. Much of the growing season in that area tends to be extremely dry and so just about everyone relies on drip irrigation. Unfortunately, irrigation can only go so far; we think of stressed vines as creating more complex fruit, but without the normal seasonal cycle and winter rain, you end up with an unhealthy stressed vine. Because the irrigation source is ground water, you accumulate a lot of salts in the soil, which throws off the chemistry and impedes nutrient uptake. It's been a struggle recently, and the yields have been low for the last couple of seasons, but the winter rain returned this year, and the vines are much happier now.

Andrew P. Schachat, MD
Editor-in-Chief
Ophthalmology Retina

From Dr. Blomquist

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

A. The driving force was the explo-

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

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

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

From Dr. Corrêa

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

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

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

A. For one, while authors are welcome to submit to *Ophthalmology Retina* directly, we offer "one-stop shopping" and encourage submission to *Ophthalmology* if the authors think the paper will be



Dr. Schachat and his wife, Robin, at a holiday party.

competitive and of interest to the broad spectrum of readers. Sometimes, the editors may suggest transfer of an article to *Ophthalmology Retina* if we think the topic is too esoteric, but often we will send the paper for review and learn as we digest the reviewer comments. While we do not want to print things that are incorrect, I believe that "the perfect is the enemy of the good enough," and I have written that when it comes to journals, peer review, and medical publishing, faster is better. We focus on that.

From Dr. Miller

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

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

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

A. Maybe the most highly cited? A 1992 Beaver Dam Eye Study diabetic retinopathy prevalence paper has been cited 1,331 times. A 1991 Early Treatment Diabetic Retinopathy Study main result

paper has 962 cites. But to get close to your 10-year parameter, in 2006, a paper by Bob Avery and colleagues on bevacizumab for wet AMD has been cited 895 times. As a retina specialist, it has been thrilling to see the improved outcomes for some of the most common eye diseases with the introduction of anti-VEGF therapy. While large clinical trial papers and meta-analyses are the most important, Bob's wins in most cites over the last 10 years or so.

From Dr. Rapuano

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

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

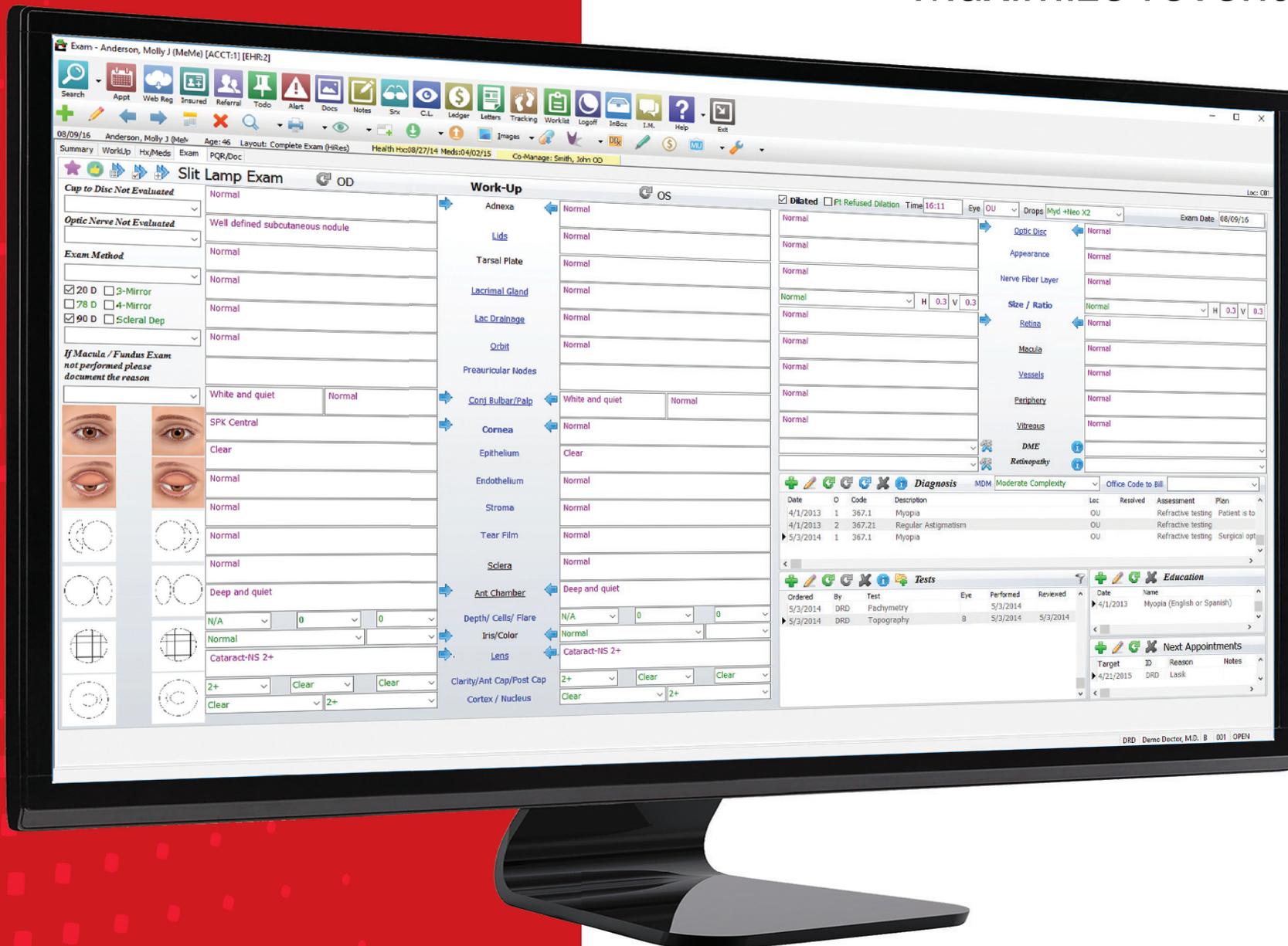
Q. I chuckle when I read case reports and small case series that have 4 or 5 times (and occasionally more) as many authors as subjects. Does the number of authors affect how you judge a paper?

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

Meet Dr. Schachat. Early subscribers to *Ophthalmology Retina* are invited to a launch reception to meet Dr. Schachat and members of the *Ophthalmology Retina* editorial board. **When:** Monday, 10:00-11:00 a.m. **Where:** Museum of Vision, Booth 3047. **Access:** Invitation only.

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

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

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

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

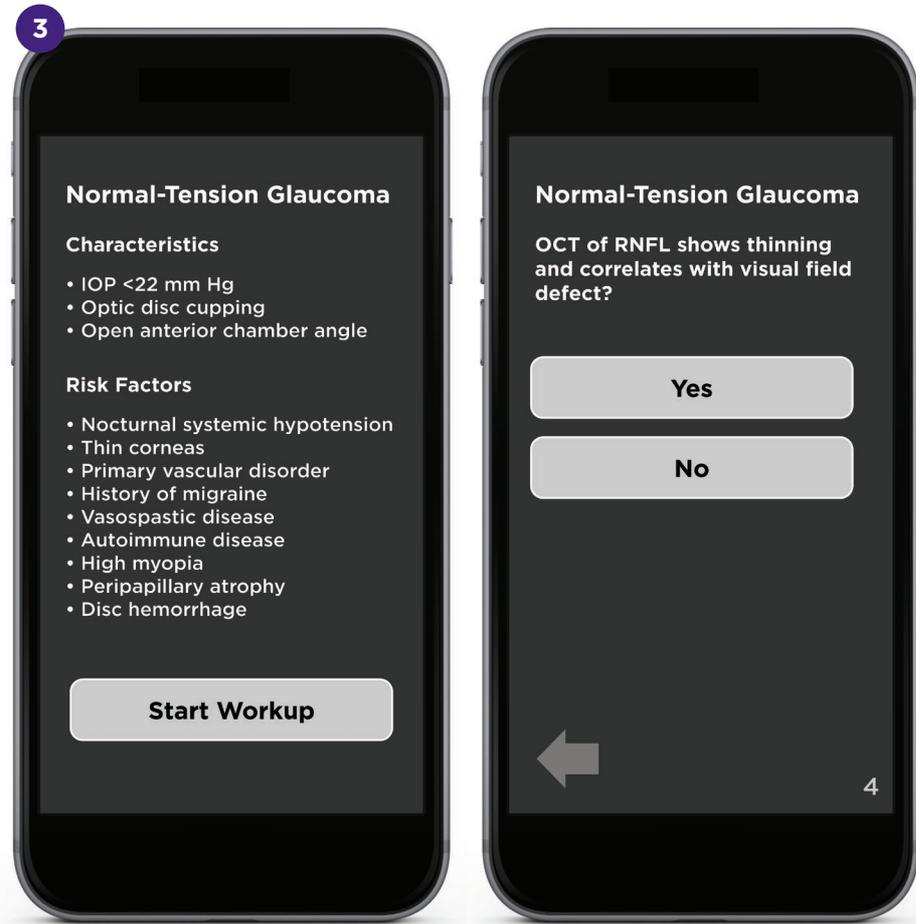
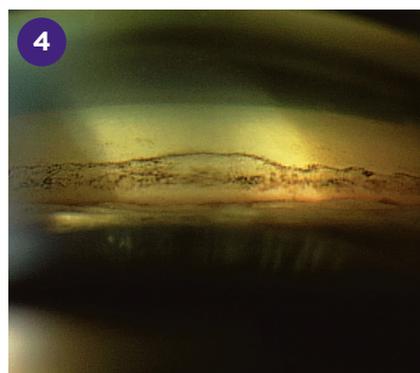
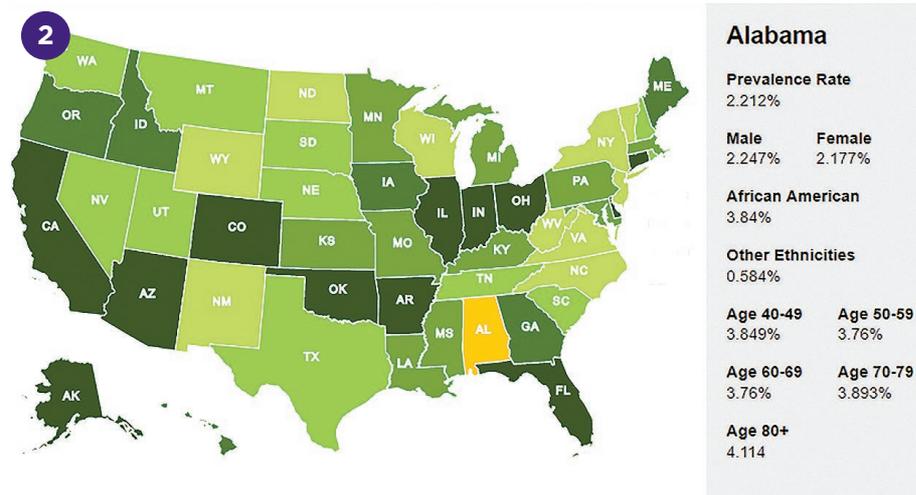
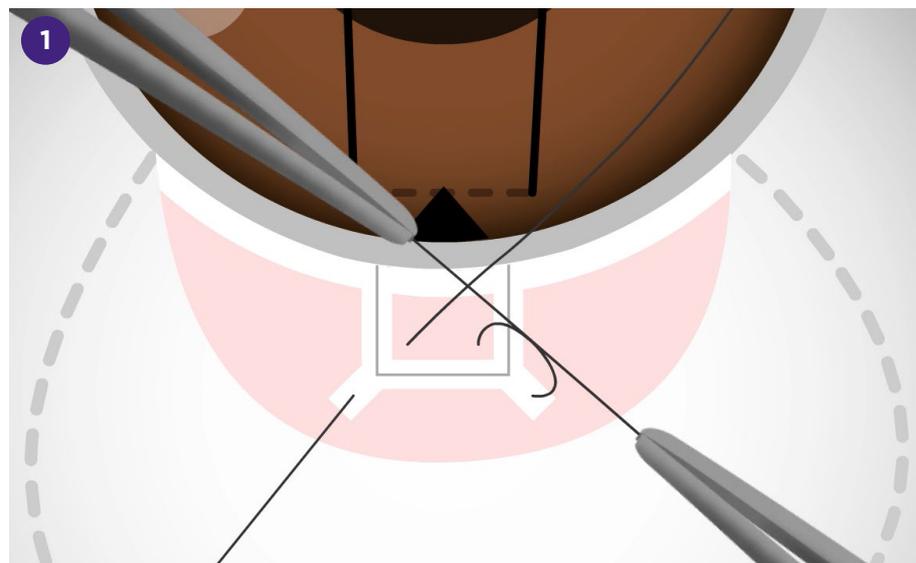
Interactive maps and data. Epidemiologic and incidence data come alive through an interactive map that quickly conveys basic information for each U.S. state (Fig. 2).

Diagnosis and treatment algorithms.

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

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

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



AT THE RESOURCE CENTER

ONE Network: Celebrating Innovation in Education



Mr. Pyott

Join the visionaries of the Academy’s ONE Network for a special look at the evolution and impact of the world’s largest collection of ophthalmic education, inclusive of the launch of the new David E.I. Pyott Glaucoma Education Center. **When:** Saturday, 2:00-3:00 p.m. **Where:** Resource Center (Hall G, Booth 3140). **Access:** Open to all attendees.

Pre refractive



**OPD-Scan III
Wavefront and
ARK Systems**



**TRS-5100/3100
Total Refraction
Systems**



**TS-310 Tabletop
Refractive System**



**LM-7 Series
Auto Lensmeters**



**ULTRA M5
Slit Lamp with
iON Imaging**

SOLUTIONS



**EPIC Refraction
Workstation**

Automated technology includes the OPD-Scan III Integrated Wavefront Aberrometer, the TRS5100/3100 Digital Refractors, Autorefractors/Keratometers and EPIC Refraction Workstation. **NEW PRODUCTS INCLUDE:** TS-310 Tabletop Refractive Workstation, LM-7 Series Lensmeters—all with EMR integration. Also introducing the NEW Ultra M Series Slit Lamps with the integrated anterior segment iON IMAGING_{SM} System.

The Difference is Marco.



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Winning Photography Is on Display

The photos shown here were selected from among the First Place winners—in both the print and stereo categories—at the 2016 Ophthalmic Photographers' Society (OPS) Scientific Exhibit during AAO 2016 in Chicago. To see this year's winners, stop by the 2017 OPS Scientific Exhibit (Hall H, Booth 3940), and enter the raffle. Prizes include: one mounted print, two 1-year OPS memberships, which includes 2 certification-oriented webinars

(the CRA and OCT-C*), and three 2018 OPS calendars.

Calendars will also be for sale for \$15 at the booth. Proceeds help fund the OPS scholarship program to assist photographers in getting started in the field by funding part of their travel to and registration for the OPS annual meeting, which takes place simultaneously with the Academy's annual meeting.

Learn more about the OPS at opsweb.org.



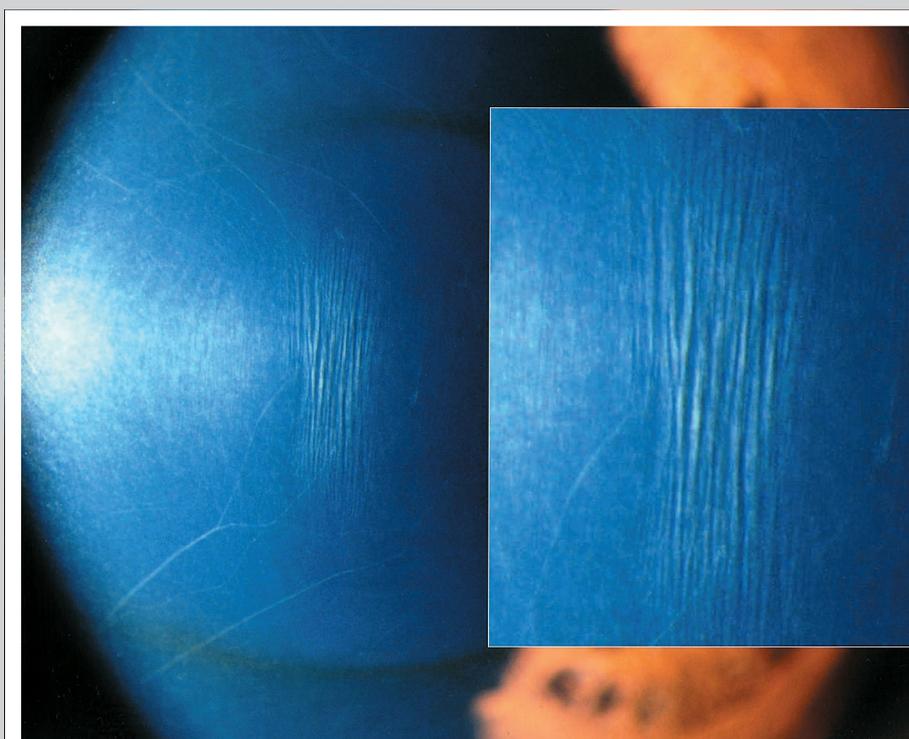
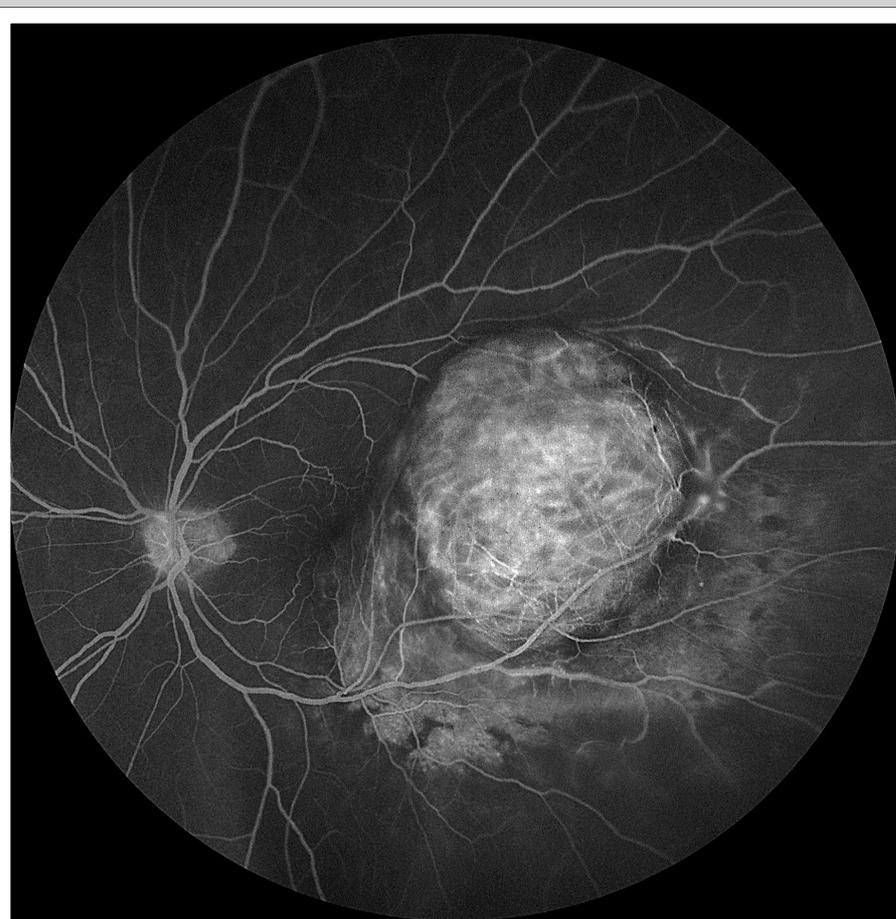
2016 OPS Exhibit Winners.

From left to right, and top to bottom.

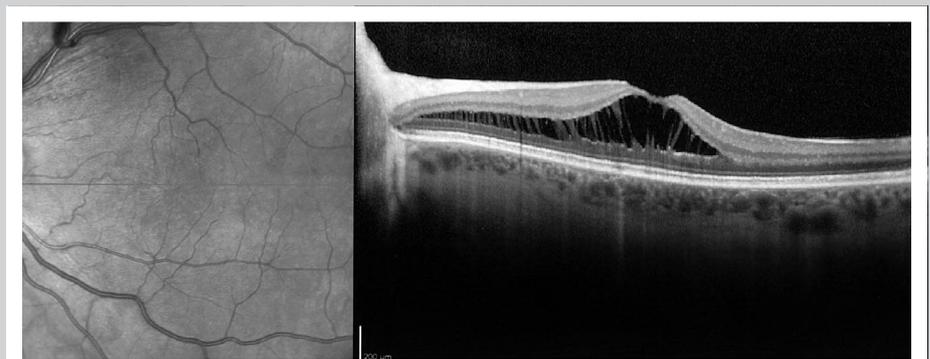
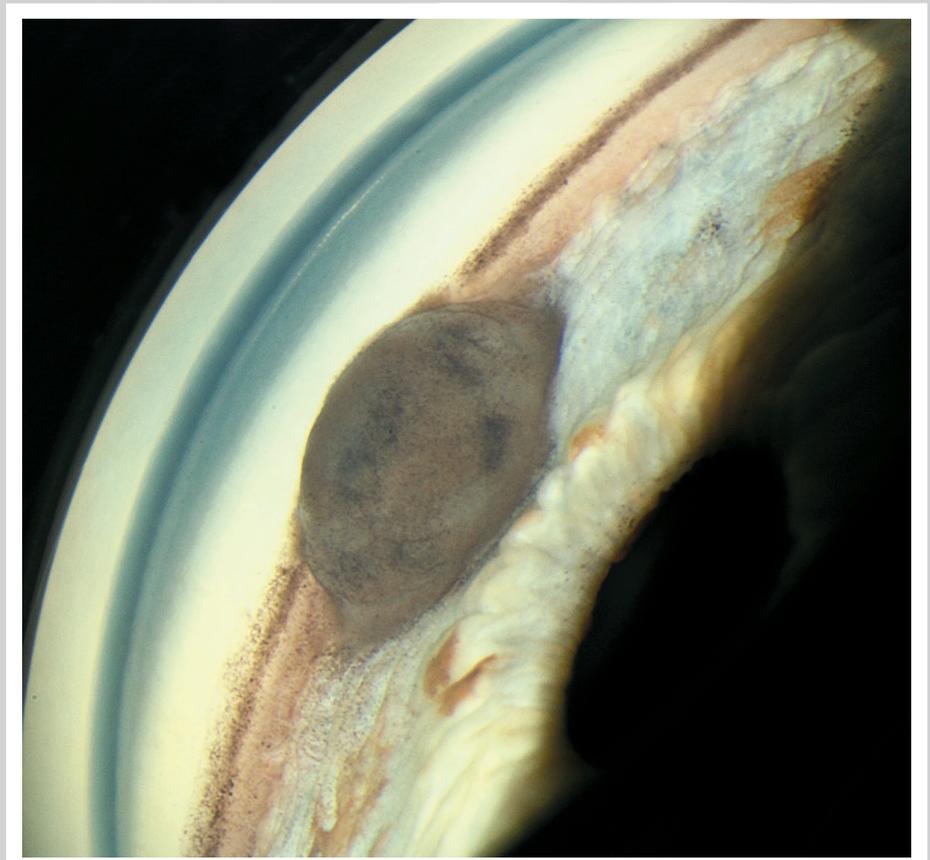
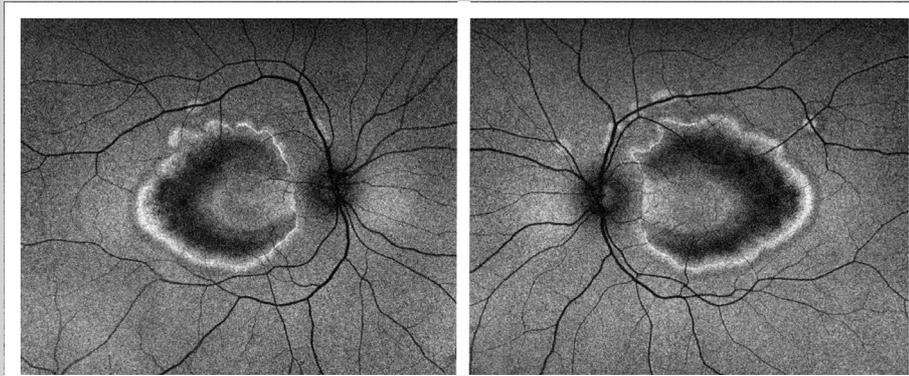
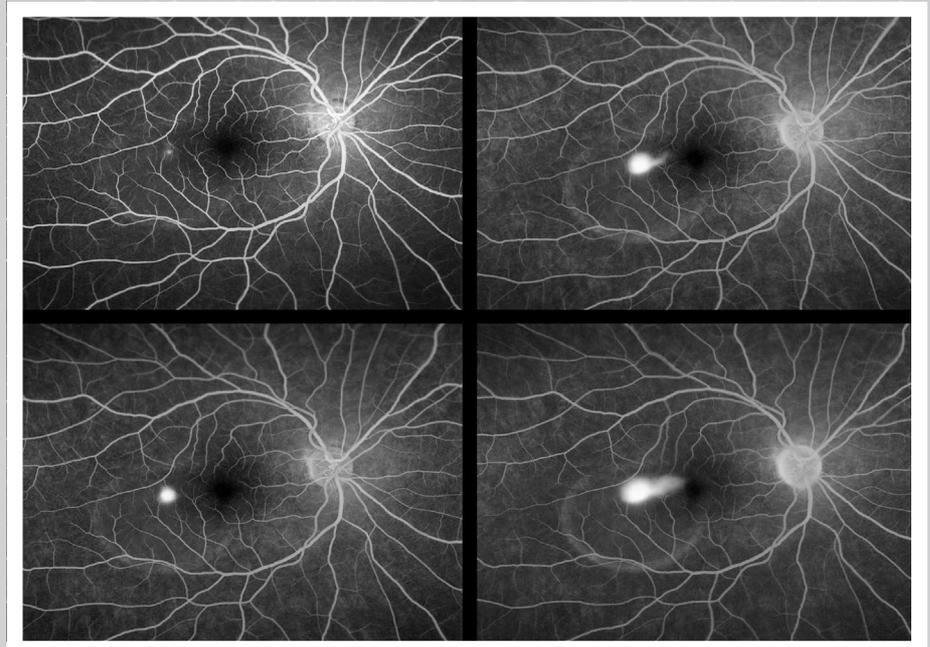
Gonio Photography, Print. *Trauma Exposing Ciliary Body.* David T. Miller, CRA. Wake Forest University Eye Center.

Fluorescein Angiography, Stereo. *Choroidal Melanoma.* Robert Prusak, CRA. University of Michigan Kellogg Eye Center.

Slit Lamp Photography, Print. *Keratoconus.* Kasi Sandhanam. Singapore National Eye Centre.



*Certified Retinal Angiographer and Optical Coherence Tomographer-Certified.



Fundus Photography—Wide Angle, Print. *Stargardt Disease*. Matt Atkinson, CRA. The National Eye Institute.

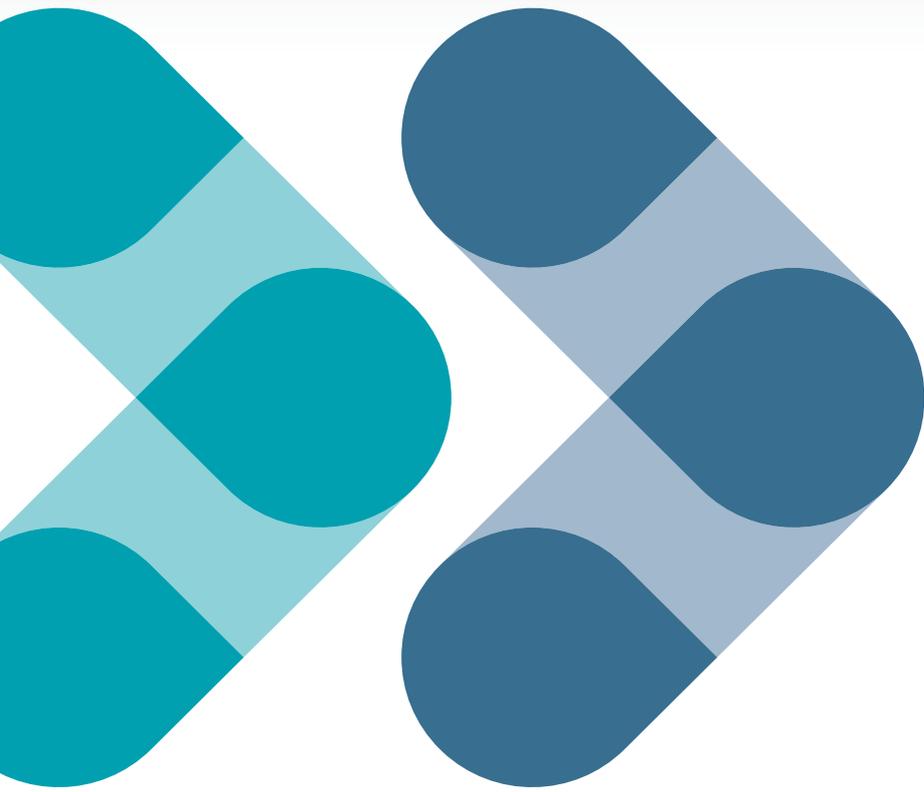
Fundus Autofluorescence, Print. *Bull's Eye Maculopathy*. Sarah M. Armstrong, CRA, OCT-C, FOPS. University of North Carolina Kittner Eye Center.

Fundus Photography—Wide Angle, Stereo. *Retinal Detachment*. Robert Prusak, CRA. University of Michigan Kellogg Eye Center.

Fluorescein Angiography, Print. *Central Serous Chorioretinopathy*. Robert Mays, OCT-C. The National Eye Institute.

Gonioscopic Photography, Stereo. *Iris Melanoma*. Tim Steffens, CRA, OCT-C, FOPS. University of Michigan Kellogg Eye Center.

Optical Coherence Tomography, Print. *Macular Pucker With Retinoschisis*. Bradley A. Stern, CRA, OCT-C. Henry Ford Health System.



UltraSert™ Pre-loaded Delivery System

Exceptional control for
your AcrySof® IQ IOL
implantations.¹⁻³



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

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



Please see adjacent page for important product information.

Alcon A Novartis
Division

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UltraSert™
PRE-LOADED DELIVERY SYSTEM



Advancing
CATARACT SURGERY

*Results of prototype testing of Pre-loaded IOL Delivery System (UltraSert) in artificial setting by 42 Ophthalmologists and 20 nurse/technicians (US). (Alcon Market Research, Feb. 2015) 1. UltraSert™ Delivery System Prototype Human Factor Testing, February, 2015. 2. AcrySof® IQ Aspheric IOL with the UltraSert™ Pre-loaded Delivery System Directions for Use. 3. Comparative Assessment of IOL Delivery Systems. Alcon internal technical report: TDOC-0018957. Effective Date 19 May 2015.

Consider Hiring a Visually Impaired Employee

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

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

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

LDP project. As the LDP participant representing the North American Neuro-Ophthalmology Society (NANOS), Dr. Acierno selected a project that would allow her to pursue her passion to 1) cre-

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

Dr. O'Sullivan's experience. Prior to her LDP involvement, in her role as a Lighthouse Louisiana board member,

Learn More

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

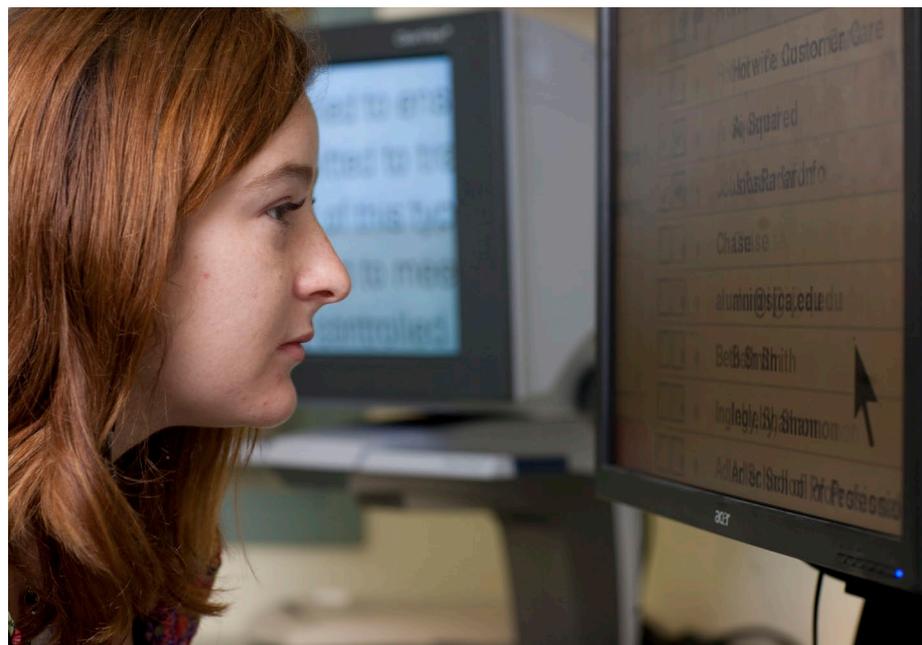
Louisiana Lighthouse welcomes AAO 2017 attendees to see its facilities. Call in advance to arrange a tour. The number is 504-899-4501. Facility hours are from 8:00 a.m.-4:30 p.m.

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

Learn more at aao.org/about/leadership-development/overview.



Dr. Acierno presents her project to LDP classmates and the incoming LDP class.



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

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

The Decision to Hire a Low Vision Employee

EyeNet: Dr. O'Sullivan, how did you decide to hire a low vision employee?

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

After taking a tour of Lighthouse of Louisiana's paper manufacturing plant, where people with impaired vision are employed, I was inspired and felt moved to provide someone with low vision an opportunity to work.

Lighthouse has a job placement agency, and I knew that they helped people with low vision get jobs, make their own money, and get out there and show people that they can be independent.

This, along with Dr. Acierno's encouragement, inspired me to try and find somebody through Lighthouse for our clinic.

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

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

Set Up and Accommodation

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

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

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

Dr. O'Sullivan: Lighthouse came in and worked for 3 or 4 days to set him up on a computer station with a monitor and a special program that enlarged everything for better visibility of the screen and graphics. They also came in and made minor tweaks and adjustments as we went along to help him with his job, but that was all. We had no other adjustments to the office. And Lighthouse did this at no cost to me.

EyeNet: Did that 3 or 4 days of setup work upset the office?

Dr. O'Sullivan: No, not at all. There was no interruption of clinic flow. Actually, he worked in my office. I cleaned out another desk for him; I was eager for him

to come on board. Setup was a very positive experience and easy to implement.

Advice: Fit and Honesty Are Important

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

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

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

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

Dr. O'Sullivan: The toughest thing is

finding a job that they can do. As ophthalmologists and retina surgeons, we—of all people—should be able to accommodate them a little bit more than an average place of employment.

EyeNet: What did you learn from your experience?

Dr. O'Sullivan: I learned that, in a lot of ways, it is good to have a low vision employee because there can be a sense that they want to work even harder to make the point that they can do this.

But I also learned that it pays to go the extra mile to figure out their strengths and limitations. Even though I have a lot of patients who are legally blind, I was reminded of how much sighted people take their vision for granted because I was surprised by what he could and couldn't do.

EyeNet: How did you deal with this surprise?

Dr. O'Sullivan: I had to learn not to treat him with kid gloves. After awhile I learned that, in many ways, he is like everybody else. He might not complete a project on time or he might want to leave early, for example, and I just had to say, "hey, no, this is your job."

Low vision employees are special and unique, just like every employee, and they should perform up to expectations.

Benefits to Practice

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

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

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

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

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

Benefits to Employee

EyeNet: Do you think there's anything about your practice—you said it's a

retina practice—that made it especially suitable?

Dr. O'Sullivan: I think it's less about being a retina or ophthalmology practice and more that it is small. I'm the only doctor, and we have 9 nurses and office staff. There is a family feel about our practice—everybody gets along really well. He loved the whole aspect of being in the clinic with the patients, staff, and nurses.

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

Future Hires

EyeNet: Will you hire another low vision employee?

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

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

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

UltraSert®

PRE-LOADED DELIVERY SYSTEM

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

INDICATIONS: The AcrySof® IQ aspheric intraocular lens ("AcrySof IQ") is intended for the replacement of the human lens to achieve visual correction of aphakia in adult patients following cataract surgery. This lens is intended for placement in the capsular bag.

WARNING/PRECAUTION: Use the UltraSert™ Pre-loaded Delivery System ("UltraSert") at temperatures between 18° C (64° F) and 23°C (73° F). Use only Alcon viscoelastic qualified for this device. Do not use the UltraSert if the nozzle appears damaged or deformed. Follow the Directions for Use for correct order and sequence of steps to avoid damage to the IOL or the UltraSert.

Careful preoperative evaluation and sound clinical judgment should be used by the surgeon to decide the risk/benefit ratio before implanting a lens in a patient with any of the conditions described in the Directions for Use. Caution should be used prior to lens encapsulation to avoid lens decentrations or dislocations.

Studies have shown that color vision discrimination is not adversely affected in individuals with the AcrySof® Natural IOL and normal color vision. The effect on vision of the AcrySof® Natural IOL in subjects with hereditary color vision defects and acquired color vision defects secondary to ocular disease (e.g., glaucoma, diabetic retinopathy, chronic uveitis, and other retinal or optic nerve diseases) has not been studied. Do not resterilize; do not store over 45° C.

ATTENTION: Reference the Directions for Use for Model AU00T0 for a complete listing of indications, warnings and precautions.

Alcon A Novartis Division

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LOW VISION AT THE MEETING

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

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

SATURDAY SYMPOSIA

(Room 242, Free of charge)

Let There Be Light (Sym01)

When: 10:00-11:00 a.m.

The Psychological Impact of

Irreversible Vision Loss (Sym02)

When: 11:15 a.m.-12:15 p.m.

Current Research on Measuring

Vision Rehabilitation Outcomes (Sym04)

When: 1:00-2:00 p.m.

Technological Advancements in

Vision Rehabilitation (Sym07)

When: 2:15-3:15 p.m.

SUNDAY AND BEYOND

Advanced Techniques for Challenging Cases in Vision Rehabilitation (249)

When: Sunday, 2:00-3:00 p.m.

Where: Room 282

Access: Academy Plus course pass

Identifying and Assisting the Patient with Low Vision (LL31)

When: Monday, 2:00-3:00 p.m.

Where: Learning Lounge 1 (Hall G, Booth 3847)

Access: Free

Advances in Vision Restoration Techniques and Devices (539)

When: Monday, 4:30-5:30 p.m.

Where: Room 388

Access: Academy Plus course pass

Smart Phones and Tablets for Low Vision (B175)

When: Tuesday, 7:30-8:30 a.m.

Where: Hall C

Access: Ticket required.

AAO 2017
New Orleans



xiidra[®]
(lifitegrast
ophthalmic solution)5%

Diisc

**Proven to treat the signs of inferior corneal staining in 12 weeks
and symptoms of eye dryness in 12, 6, and as little as 2.**

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

Take it all in at Xiidra-ECP.com

Four randomized, double-masked, 12-week trials evaluated the efficacy and safety of Xiidra versus vehicle as assessed by improvement in the signs (measured by Inferior Corneal Staining Score) and symptoms (measured by Eye Dryness Score) of Dry Eye Disease (N=2133).

OVER

what Dry Eye patients have been waiting for

Indication

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

Important Safety Information

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

To avoid the potential for eye injury or contamination of the solution, patients should not touch the tip of the single-use

container to their eye or to any surface.

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

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

For additional safety information, see accompanying Brief Summary of Safety Information and Full Prescribing Information on Xiidra-ECP.com.



BRIEF SUMMARY:

Consult the Full Prescribing Information for complete product information.

INDICATIONS AND USAGE

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

DOSAGE AND ADMINISTRATION

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

ADVERSE REACTIONS

Clinical Trials Experience

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

USE IN SPECIFIC POPULATIONS

Pregnancy

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

Animal Data

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

Lactation

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

Pediatric Use

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

Geriatric Use

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

NONCLINICAL TOXICOLOGY

Carcinogenesis, Mutagenesis, Impairment of Fertility

Carcinogenesis: Animal studies have not been conducted to determine the carcinogenic potential of lifitegrast.

Mutagenesis: Lifitegrast was not mutagenic in the *in vitro* Ames assay. Lifitegrast was not clastogenic in the *in vivo* mouse micronucleus assay. In an *in vitro* chromosomal aberration assay using mammalian cells (Chinese hamster ovary cells), lifitegrast was positive at the highest concentration tested, without metabolic activation.

Impairment of fertility: Lifitegrast administered at intravenous (IV) doses of up to 30 mg/kg/day (5400-fold the human plasma exposure at the recommended human ophthalmic dose (RHOD) of lifitegrast ophthalmic solution, 5%) had no effect on fertility and reproductive performance in male and female treated rats.



Manufactured for: Shire US Inc., 300 Shire Way, Lexington, MA 02421.

For more information, go to www.Xiidra.com or call 1-800-828-2088.

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US Patents: 8367701; 9353088; 7314938; 7745460; 7790743; 7928122; 9216174; 8168655; 8084047; 8592450; 9085553; 8927574; 9447077; 9353088 and pending patent applications.

Last Modified: 12/2016 S26218

New Thinking in Ophthalmology

9 Honorary Lecturers Preview Their Presentations

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

FRIDAY, Nov. 10

RETINA

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

When: Friday, 9:29-9:55 a.m., during Retina Subspecialty Day 2017.

Where: Great Hall.

“The first published clinical trial was a recounting in the Bible’s Book of Daniel. The first randomized clinical trial was of streptomycin for tuberculosis



in 1948, and the first major randomized clinical trial in ophthalmology was the Diabetic Retinopathy Study, which started in 1972. I will discuss how this landmark study was

started, with the confluence of new ideas for treating diabetic retinopathy and the birth of the National Eye Institute in 1968. By focusing on diabetic retinopathy, I will review how clinical trials have evolved in the last 4 decades and where they are likely to go in the future.”

Retina Subspecialty Day 2017: Retinal Mardi Gras (Friday, 8:00 a.m.-5:33 p.m., and Saturday, 8:00 a.m.-5:23 p.m.) is organized in conjunction with American Society of Retina Specialists, the Macula Society, the Retina Society, and Club Jules Gonin.

REFRACTIVE SURGERY

Troutman Award: Detection of Keratoconus With a New Biomechanical Index, presented by Riccardo Vinciguerra, MD.

When: Friday, 4:03-4:23 p.m., during Refractive Surgery Subspecialty Day 2017.

Where: La Nouvelle Ballroom AB.

“How can we diagnose ectasia earlier? It is well known that topography and tomography analysis can help detect alteration in the shape of the cornea such as thinning and increased curvature.



However, these instruments cannot measure the mechanical stability that is

thought to be the initiating event of the disease, even before notable changes in corneal morphology take place. A direct consequence of this theory is that it might be possible to diagnose an ectasia based on observed deterioration in mechanical properties before the resulting changes in thickness and curvature profiles become evident.

This lecture will present the new Corvis Biomechanical Index (CBI), a combined biomechanical parameter aimed to separate normal from keratoconus, which was showed to be highly specific and sensible.”

Refractive Surgery Subspecialty Day 2017: Linking to the Expanded World of Refractive Surgery (Friday, 8:00 a.m.-5:28 p.m.) is the Annual Meeting of the International Society of Refractive Surgery.

SATURDAY, Nov. 11

GLAUCOMA

The American Glaucoma Society Subspecialty Day Lecture: The Glaucoma Renaissance, presented by Kuldev Singh, MD, MPH.

When: Saturday, 11:28 a.m.-noon, during Glaucoma Subspecialty Day 2017.

Where: New Orleans Theatre AB.

“Over the past 2 decades, we have seen an acceleration of advances in glaucoma diagnostics and therapeutics, which



impact patient care. We are in the midst of a Glaucoma Renaissance. The best and brightest are being drawn to our subspecialty in this exciting era, with many more discoveries to come. This lecture

will review recent glaucoma therapeutic advances and highlight the partnerships between practitioners, innovators, regulators, and others who have created a unique environment that will undoubtedly lead to better glaucoma care and continue to make ours the most exciting of all subspecialties for clinicians, researchers, and educators.”

Glaucoma Subspecialty Day 2017: Inspirations and Innovations: New Insights in Glaucoma Care (Saturday, 8:00 a.m.-5:26 p.m.) is organized in conjunction with the American Glaucoma Society.

SUNDAY, Nov. 12

RETINA

Jackson Memorial Lecture: Intravitreal Therapy for Retinal Diseases: From CMV to CNV, presented by Daniel F. Martin, MD.

When: Sunday, 9:31-9:58 a.m., during

Sym62, the Opening Session.

Where: Great Hall.

“Intravitreal therapy for retinal diseases has grown from a few hundred intravitreal injections a year in the



early 1990s to over 5 million injections in 2015 in the United States. This dramatic change in how we treat retinal disease began with cytomegalovirus (CMV) retinitis and

moved rapidly into posterior uveitis, diabetic macular edema, choroidal neovascularization (CNV) associated with AMD, and other retinal disorders. I have had the privilege of serving in a leadership role or participating in many of the clinical trials that spurred these changes and will cover this 20-year evolution from CMV retinitis to CNV. This lecture will cover the rationale and results from many of the most important clinical trials and, in particular, will cover the political challenges and important clinical findings from the Comparison of Treatment Trials (CATT).”

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

OPHTHALMOLOGY AND THE ARTS

Michael F. Marmor, MD, Lecture: One Man’s Vision, presented by Henry Butler.

When: Sunday, 9:06-9:31 a.m., during Sym62, the Opening Session.

Where: Great Hall.

“The Michael F. Marmor Lecture in Ophthalmology and the Arts will take us on a musical flight that mixes soul, blues, jazz, traditional jazz, bebop, and boogie



woogie. I see the audience and myself as instruments. We both play each other. It is an ebb and flow. What the audience gives me is a certain kind of energy where I can bring it to another level.

“The lecture will also take us on a life journey. I was blinded by glaucoma as an infant—with both eyes enucleated as a toddler. I grew up in the Calliope housing project in New Orleans, playing touch football before sports balls could be fitted with sound transmitters, and attending the Louisiana State School for the Blind, at a time when the blind were not welcomed in the public school system. I owe a lot to my mother, who allowed me independence and provided mentors who gave me opportunities to succeed, or fail, just like a sighted person. At age 12, I was given a band to arrange

and write for—a dance band with 5 or 6 horns, a drummer, and no bass player. That is how I got started. I had to be heard.”

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

NEURO-OPHTHALMOLOGY

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

When: Sunday, 11:35-11:59 a.m., during Sym09, From Ground Zero to the Moon: How Intracranial and Intraocular Pressure Disparities Relate to Vision.

Where: La Nouvelle Orleans C.

“Migraine is an extremely common disease: It affects almost 20% of all women and 10% of all men and is



estimated to affect more than 36 million people in the United States alone. So, patients with migraine will show up in every ophthalmologist’s office every day!

Migraine is more than a headache, too, as it also affects the eye and vision. Patients regularly visit the ophthalmologist with eye complaints, thinking the problem is related solely to their eyes. Ophthalmologists need to recognize when these visual complaints are related to migraine. Common symptoms include eye pain, photophobia, aura, and visual phenomena like visual snow. While the ophthalmologist may not want to treat migraine, all of us need to be able to recognize migraine, explain the ocular symptoms, address comorbidities (such as dry eyes), and direct the patient to find help for their migraine.

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

From Ground Zero to the Moon: How Intracranial and Intraocular Pressure Disparities Relate to Vision (10:30 a.m.-noon) is cosponsored by the North American Neuro-Ophthalmology Society.

PATHOLOGY/ONCOLOGY

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

Laboratory, presented by Seymour Brownstein, MD.

When: Sunday, 11:35-11:57 a.m. during Sym10, *Molecular Pathology of Ocular Diseases: Implications for Targeted Therapy*.

Where: New Orleans Theater C.



“My presentation will review my 55-year ‘voyage’ with electron microscopy [EM] beginning with my fellowship at the Armed Forces Institute of Pathology in 1971, where my first 3 papers were dependent on my learning

EM from world-class mentors, including Drs. Ben Fine, Ray Font, Merlyn Rodrigues, Mark Tso, and Lorenz Zimmerman. The primary benefit of EM is the ability to obtain high-grade informative images, which complement and frequently supersede those obtained by other modalities. These are valuable for diagnosis, teaching, and science, and they have led to improved therapeutic management. The latter includes targeted therapy and genetic counseling, especially concerning childhood inherited lethal conditions, infiltrations, infection, and neoplasia.”

Molecular Pathology of Ocular Diseases: Implications for Targeted Therapy (10:30 a.m.-noon) is cosponsored by the American Association of Ophthalmic Oncologists and Pathologists.

CORNEA

Whitney G. Sampson Lecture: Corneal Crescents and Patches, presented by Sheraz M. Daya, MD.

When: Sunday, 3:00-3:25 p.m., during Sym17, *Infections, Corneas, and Contact Lenses*.

Where: Room 243.

“This lecture pushes the boundaries of corneal surgery and essentially tells a story of how alternative techniques can be used to deal with corneal problems. Traditionally, standard circular corneal transplants have been used to correct corneal abnormalities, sometimes unnecessarily replacing normal host tissue to attain a goal that perhaps could be achieved by more conservative, albeit more challenging, surgery. The lecture will discuss the influence of corneal pathology on corneal shape. It will also address how this influence can be remedied via lamellar techniques that do not require transplantation—and can be made technically easier by use of the femtosecond laser. Taking the story further, complex corneal conditions resulting from inflammatory disorders can be challenging.



These can be managed through a variety of measures, including patch grafts and crescentic grafts. When all else fails, drastic measures like procuring tissue from sites like the tibia may save the eye. To encompass this ‘potpourri’ of problems and solutions, the title ‘Corneal Crescents and Patches’ seems appropriate.”

Infections, Corneas, and Contact Lenses (2:00-3:30 p.m.) is cosponsored by the Contact Lens Association of Ophthalmologists.

OCULOPLASTICS/PROSTHETICS

Ruedemann Lecture: Enucleation in the Management of Primary Choroidal Melanoma, presented by James J. Augsburger, MD.

When: Sunday, 4:59-5:14 p.m., during Sym22, *Volume Augmentation: Fillers, Grafts, and Implants*.

Where: New Orleans Theater C.

“Enucleation of an eye containing a primary choroidal melanoma was once the only treatment that provided any chance for cure. Currently, the role of enucleation in management of choroidal melanoma is limited mainly to primary treatment of patients with an extremely large intraocular tumor, a tumor encircling or invading the optic disc, or a tumor causing the eye to be blind and painful, and secondary treatment of patients whose eye became blind and painful following initial methods intended to be eye-preserving (plaque radiotherapy, proton beam irradiation) or who experienced local tumor relapse after that initial treatment. My presentation will focus on currently recognized potential benefits versus potential risks and limitations of enucleation for choroidal melanoma.”



Volume Augmentation: Fillers, Grafts, and Implants (3:45-5:15 p.m.) is cosponsored by the American Society of Ocularists.

EYECARE AMERICA: A Reception for Volunteers

EyeCare America volunteers seldom get to meet each other. Enjoy snacks and beverages with your fellow volunteers as Academy staff honor your dedication to this vital public service. Ophthalmologists who enroll as new ECA volunteers receive a reception invitation from the Resource Center Foundation desk before the reception. Since 1985 the program has helped nearly 2 million people. Network with colleagues, bring a friend interested in volunteering, and leave with a special recognition gift.

When: Sunday, 3:00-5:00 p.m.

Where: Museum of Vision, Booth 3047.

NETWORK WITH OTHER VOLUNTEERS. The reception is open to all ECA volunteers—you can also bring a friend who is interested in joining the program.



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BE SURE TO CLAIM CME

The Academy is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education (CME) for physicians. The Academy designates this live activity for a maximum of 31 AMA PRA Category 1 Credits™.

Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Those whose attendance has been verified at AAO 2017 can claim their CME credit onsite at Ernest N. Morial Convention Center or online after the meeting. Registrants will receive an email on Monday, Nov. 13, with the link and instructions on how to claim credit.

Visit aao.org/annual-meeting/cme.

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New Orleans Gems Discover New Favorites

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

Neighborhood Strolls

French Quarter without the commotion.

Avoid the crowds of the French Quarter but still enjoy its architecture by walking Royal, Dauphine, and Burgundy streets from end to end (Canal to Esplanade Ave.). The quiet walk through this enchanting neighborhood keeps you (almost) clear of rowdy tourists. Unique spots on this stroll include Bourbon French Parfums, a boutique perfume shop, and Papier Plume, a purveyor of luxury paper and writing implements.

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

Culture

Arts District (Warehouse District). Walking distance from the convention center, the National WWII Museum is a can't-miss. A popular exhibit is "Final Mission: The U.S.S. Tang Experience," which re-

creates the submarine's last battle. Allow 3 to 4 hours to see this museum, and a bit longer if you plan to watch the 4-D movie across the street, "Beyond All Boundaries." Other museums in the area include the Ogden Museum of Southern Art and the Contemporary Arts Center.

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

For more information, visit www.chickiewahwah.com.

Bars

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

For more information, visit www.oaknola.com.

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

Where: 700 N Rampart St. (at St. Peter St.), French Quarter.



TAKE AN ACADEMY TOUR. The Academy offers a wide range of tours, open to AAO 2017 registrants and their spouses and guests. Buy tickets at the Ticket Sales counter (Lobby E).

For more information, visit www.accentregister.com/register/aa017.

For more information, visit www.yelp.com/biz/black-penny-new-orleans.

Dive bar with the locals. Get yourself to Fahy's Irish Pub if you want a locals-mostly dive with a crowd that will go into the wee hours. There are 2 pool tables, darts, and plenty of conversations that you can step right into with people asking your opinion on whatever topic they're discussing. Want to get out of city central? This is a good place to catch a cab because it's just 1 block away from the exit that is nearest to the I-10 entrance ramp. **Where:** 540 Burgundy St. (at Toulouse St.), French Quarter.

For more information, visit www.yelp.com/biz/fahys-irish-pub-new-orleans.

Food

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

For more information, visit www.atchafalayarestaurant.com.

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

For more information, visit www.patoisnola.com.

More upscale eating. For upscale dining at its best without having to wear a coat and tie, Herbsaint is a fantastic

option. The dining room is perfectly lit and has an expert staff. The chef, Rebecca Wilcomb, won the 2017 James Beard Award for best chef in the South. The menu features items like beef short rib with potato rösti, salsa verde, and horse-radish cream; baked asiago with oregano and lemon; and coconut custard pie with buttermilk chantilly and orange caramel. The street cars passing by add to the atmosphere. **Where:** 701 St. Charles Ave. (at Girod St.), Warehouse District.

For more information, visit www.herbsaint.com.

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

For more information, visit www.bearspoboys.com.

Bonus

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

For more information, visit www.jackdempseys.net.

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

Little Gem

Little Gem Saloon, located just a mile and a half from the convention center, is a jazz bar owned by local Academy member **Nicolas G. Bazan, MD, PhD**, and his family (pictured from left to right: Cheryl Nix Bazan, private events director; Nick Bazan III, general manager/partner; **Haydee E.P. Bazan, PhD**; Dr. Bazan; Maria E. Bazan, manager/partner.) Stop by for refined soul food and music by local artists on the art deco stage upstairs, or a specialty cocktail in the downstairs bar (which has outdoor gallery seating).

For more information, visit www.littlegemsaloon.com.



INSIGHTS COME TO LIGHT

AT ALLERGAN BOOTH 1324

Saturday, November 11, 2017

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

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

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

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

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

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

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

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

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

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

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

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

3:30 PM
Complicated Case Management
Bonnie Henderson, MD

Sunday, November 12, 2017

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

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

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

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

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

12:00 PM
**The Science Behind Neurostimulation
and Ophthalmology**
John Sheppard, MD, MMSc

12:30 PM
**Multifactorial Approaches
to DME and RVO**
David Callanan, MD

1:00 PM
Lowering IOP in the Real World
Ronald Gross, MD

1:30 PM
**Surgical Techniques for the
Complex Cataract Patient**
Terry Kim, MD

2:00 PM
**Multifactorial Approaches
to DME and RVO**
Jeremy Wolfe, MD

2:30 PM
**A Minimally Invasive Approach
to IOP Control**
Robert Noecker, MD

3:00 PM
**Breaking Bad—A Cataract Surgeon's
Guide to Unconventional Techniques**
Gary Wortz, MD

3:30 PM
**Multifactorial Approaches
to DME and RVO**
Robert Kwun, MD

4:00 PM
Resident Writer Award Ceremony

Monday, November 13, 2017

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

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

Booth 1324



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