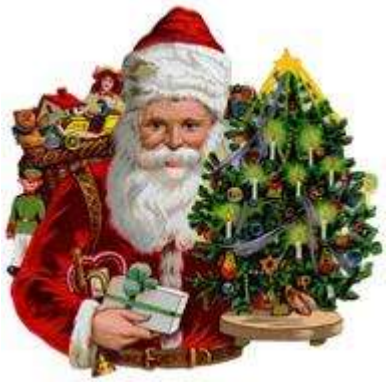
Bulletin

December, 2013

P.O. Box 6136 Chesterfield, MO 63006



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636 272-1444
Executive Director
Barbara Nahlik
Phone: 314 725-2020
FAX 314 961-1041
e-mail: bnahlik8544@charter.net

COMING UP!!

Tuesday, December 10

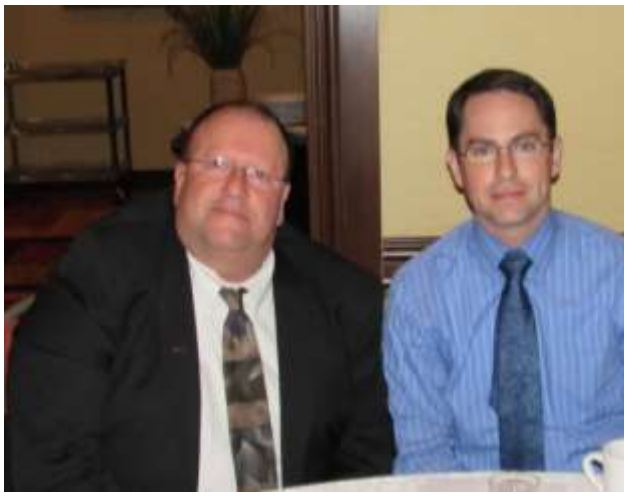
Midland Optical hosts
Annual SLOS Holiday Party

Cardwell's Restaurant
Brentwood & Maryland in Clayton

6:00 p.m. Cocktails
7:00 p.m. Dinner

Fun to follow!

RSVP by Thursday, December 5
Bnahlik8544@charter.net
314 725-2020



MOA President, Dr. James Hunt, visited with SLOS member, Dr. Jeremy Beatty

MOA REPORT

Dr. Robert Goerss. Trustee

MOA President, Dr. Jim Hunt, from Doniphan, MO and Executive Director, Dr. Lee Ann Barrett, discussed the plans for the MOA over the next year. The primary focus will be on building membership and working toward passage of No-Cap Fees language. Mark your calendars for the

MOA Legislative Conference, January 12-13, 2014 at the Capitol Plaza Hotel. Please visit www.moeyecare.org for the most updated information and registration.

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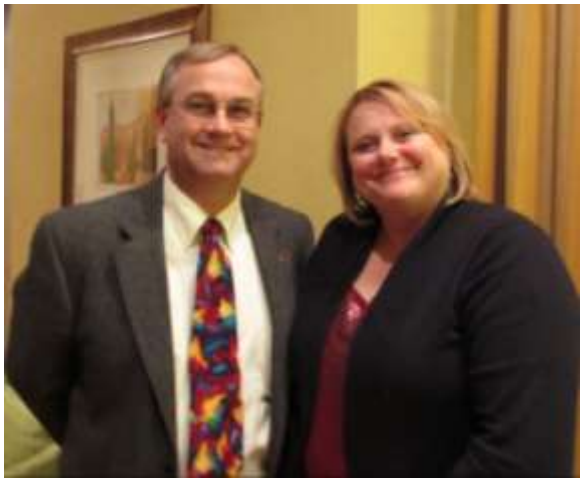

College of Optometry Dean, Dr. Larry Davis and MOA Executive Director, Dr. Leeann Barrett

FROM THE NOVEMBER MEETING…

Grand Rounds

Robert Ensley, OD, Sarah Gore, OD, Amanda Nicklas, OD, Nick Olberding, OD

Optometry residents from the University of Missouri-Saint Louis College of Optometry and Saint Louis VA Medical Center presented cases for the continuing education at the November SLOS meeting.

Nick Olberding, OD, a resident at the Saint Louis VA Medical Center, presented "A Conjunctival Finding." A 64 year old white male presented to the Saint Louis VA for a routine eye examination, except for a unique finding on anterior segment examination. There was a lesion that looked somewhat like pinguecula located on the nasal aspect of the interpalpebral conjunctiva. There are a number of potential diagnoses for this conjunctival lesion which were discussed.

A limbal dermoid is benign congenital conjunctival tumor. It is a smooth, well delineated yellow-white mass typically located inferior temporally, near the limbus. It is a choristoma, which is histologically normal tissue in an abnormal location. Another choristoma is a dermal lipoma. This conjunctival tumor looks so similar to prolapsed orbital fat that it can be difficult to differentiate the two. Dermal lipomas can have small hairs that grow on the surface and when digital pressure is applied to the globe it will not retract like prolapsed orbital fat.

Conjunctival intraepithelial neoplasm (CIN) is the most common conjunctival malignancy in the United States. It appears as an elevated gelatinous mass typically vascularized with feeding vessels. Nearly all are found in the interpalpebral limbal area. It is dangerous because it is a precursor to squamous cell carcinoma. Squamous cell carcinoma is generally larger than a CIN and it becomes a squamous cell carcinoma when a CIN extends through the epithelial basement membrane into the stroma. In the stroma, it can gain access to the blood vessels and lymph channels where it can possibly metastasize.

Continued on next page…

Grand Rounds cont.

Ocular melanosis is a very common and benign pigmented conjunctival lesion and typically presents as pigmentation around the peripheral cornea or limbal area. Another pigmented conjunctival lesion is a nevus, although it should be mentioned that conjunctival nevi can sometimes be non-pigmented. They typically occur on the interpalpebral conjunctiva near the limbus. Primary Acquired Melanosis (PAM) is a lesion that has relatively higher capability to convert to a malignant melanoma. Malignant melanoma is more likely to metastasize to another location and 20% of these cases can result in death. Most malignant melanomas develop from a PAM and much less often from a conjunctival nevus.

Conjunctival lymphomas are most commonly found at the conjunctival fornix rather than the limbus. These are smooth fleshy lesions with a salmon colored patch appearance. They can be benign or malignant and biopsy is the only way to differentiate.

The patient discussed in this case was diagnosed with a Bitot spot. It is keratinization and abnormal differentiation of epithelial cells that is highly suggestive of Vitamin A deficiency. It typically presents as a dry, scaly patch with a foamy appearance and usually resolves in weeks to months with proper treatment. Vitamin A deficiency is the second or third most common nutritional deficiency, behind caloric deficiencies, worldwide. It can affect the conjunctiva with Bitot spots and the cornea with pathologic dry eye. It can also cause night blindness as vitamin A is required by the rod photoreceptors to produce rhodopsin.

It is often difficult to differentiate between the problematic and benign conjunctival lesions due to variable presentations. Sometimes a biopsy is the only truly differentiating method. It is important to know that melanoma, squamous cell carcinoma, and lymphomas are the most common malignant conjunctival lesions.

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Grand Rounds cont.

Robert Ensley, OD, the Cornea and Contact Lens resident at UMSL, presented "A Mini-Scleral Fit on an Aphakic Microcornea Patient." The Scleral Lens Education Society recently published guidelines on terminology for lens sizes. Any lens that rests partly on the cornea and partly on the sclera is a corneo-scleral lens and any lens that rests entirely on the scleral is a scleral lens. Scleral lenses can further be divided into two categories based on size.

The first patient Dr. Ensley discussed was a 21 year old female who was aphakic, amblyopic and had microcornea. Her corneal diameters based on topography were 9.55mm on right and 9.73mm on the left. This patient required a contact lens refit because she presented wearing a Custom O2 Optix contact lens which had been discontinued. Dr. Ensley decided to fit this patient with a scleral lens. He started with a larger 14.6mm diameter and ended with a 13.8mm Blanchard Onefit lens. They were able to achieve this patient's best corrected vision of 20/40 in the right eye and 20/30 in the left eye. While her vision did not improve objectively with the new lenses, she felt there was a subjective improvement.

The second patient Dr. Ensley discussed was a keratoconic patient. Her best corrected vision with spectacles was 20/70 in the right eye and 20/30 in the left eye. Topography showed the steepest part of her right cornea was about 75 diopters located inferiorly. He was able to achieve a good fit on the right eye with the Europa scleral lens, however the patient noted ghosting. The left eye achieved 20/20 vision with a Biofinity toric contact lens. After trying these lenses, the patient returned and still reported unacceptable ghosting. No lens flexure was observed. There was a two diopter over refraction on the right eye however this did not eliminate the ghosting reported by the patient. He then fit this patient's right eye with the TruKone keratoconic gas permeable contact lens which centered relatively well. The patient continued to note ghosting although it was

Continued on next page "Grand Rounds"

Grand Rounds…

much more acceptable with this lens as compared to the previous lens. The most likely cause of the reported ghosting was higher order aberrations. Because this patient was in karate, Dr. Ensley decided to put a soft lens on top of the TruKone, resulting in a reverse piggyback. The best fit was achieved with a custom soft lens, the Intelliwave, with a 7.8mm base curve and a 14.5mm diameter. This arrangement prevented the smaller diameter TruKone lens from dislodging and improved the patient's comfort. Her visual acuity was 20/40 in her right eye and 20/20 in her left eye.

Amanda Nicklas, OD, the Pediatric and Binocular Vision resident at UMSL, presented her case, "Can You Define Weird?" Her patient was a five year old male referred by his school nurse for an exam. He had previously been seen at Cardinal Glennon and was told that he had weird looking nerves. His uncorrected vision was 20/50 in the right eye and 20/20 in the left eye. Extraocular muscle testing showed an overaction of the medial rectus in both eyes and he was unable to abduct the right eye. Cover test orthophoric. This patient refracted to 20/20 in each eye and had a normal anterior segment exam. When dilated, a right esotropia was evident and he appeared to have leukocoria. His dilated retinal exam revealed massive optic nerve cupping with no apparent rim tissue such that the posterior pole view consisted mainly of large, cupped optic nerves in both eyes. This patient was diagnosed with refractive error, Type 1 Duane Syndrome and optic nerve coloboma in both eyes. *Continued*

Grand Rounds cont.

There are three types of Duane syndrome. Type one is the most common and is defined by limited abduction, normal adduction, and a possible esotropia in primary gaze. These patients could have an associated face turn toward affected side. Type two is the least common form of Duane syndrome with limited adduction and a possible exotropia. Patients with type three have problems with abduction and adduction. There can be retraction of globe with narrowing of the palpebral fissure in all types of Duane syndrome.

The leukocoria noted in this patient was most likely due to reflection of coloboma, however, the most ominous potential cause of leukocoria is retinoblastoma. This is the most common childhood intraocular malignancy. It can be bilateral or unilateral and is usually diagnosed between 12 and 24 months. Leukocoria is the most common presentation of retinoblastoma and strabismus is the second most common presentation.

Optic nerve coloboma is a congenital anomaly that affects the inferior aspect of the optic nerve due to the way the eye is formed in utero. It will typically result in a superior visual field defect because the inferior rim is either very thin or absent. Potential complications include serous retinal detachment of the macula and progressive excavation of nerve rim tissue. Other diagnoses to consider in a differential are Morning Glory Syndrome and Megalopapilla.

Sarah Gore, OD, a resident at the Saint Louis VA Medical Center, presented her case, "There is a Spot in my Vision." A 60 year old white male presented complaining of a black spot in his vision with the left eye for the previous week and a half. He also noted that the lower portion of his visual field was missing. His previous ocular history was significant for ocular hypertension for which he had discontinued treatment, mild NPDR with CSME in both eyes. He had previous focal laser in both eyes. He also had been diagnosed with a Hollenhorst plaque in the right eye**.** **Cont.**

Grand Rounds…

His medical history was significant for hypertension, hyperlipidemia, diabetes, coronary artery disease with a history of a myocardial infarction.

His vision was 20/40 in the right eye and 20/400 with the left eye, although he could achieve 20/40 with eccentric fixation. There was a slight APD in the left eye and an inferior restriction to his visual field in his left eye. His dilated retinal exam showed mild diabetic retinopathy as well as the Hollenhorst plaque previously noted in his right eye. In his left eye there was embolus evident, slight nerve pallor and a sclerotic vessel. His Humphrey visual field showed a shallow central scotoma in his right eye which was likely due to his cataract. The field for his left eye was severely restricted with only a small island of central vision. OCT showed atrophy of all retinal layers sparing the area between the optic nerve and the macula. This patient was diagnosed with a central retinal artery occlusion (CRAO). He was able to obtain 20/40 vision with eccentric fixation because he had a cilioretinal artery.

Classic CRAO presentation will have severely reduced vision, a marked APD, and arteriolar narrowing. There will be retinal opacification with a cherry red spot if there is no cilioretinal artery, although this opacification typically disappears within days to weeks. Cilioretinal arteries are present in about 20% of the population. This artery usually hooks out of temporal portion of the nerve and courses toward the macula. It arises from the posterior ciliary circulation and supplies the inner retinal layers of the papillomacular bundle.

Risk factors for CRAO include hypertension, diabetes, carotid occlusive disease, cardiac valve disease, and smoking. The most common etiology are emboli which can be visualized. Cholesterol emboli usually arise from the carotid artery. Emboli can also be calcific which usually arise from heart valves. Fibrin platelet emboli typically arise from atheromas in carotid arteries. Less common causes of CRAO include giant cell arteritis, collagen vascular disease, oral contraceptives, high homocysteine levels, hypercoagulation disorders, and antiphospholipid syndrome.

No treatment has been proven effective for patients that acutely present with CRAO, however measures can be taken in attempt to preserve some vision if initiated within two hours of symptom onset. Ocular massage can be done digitally or with a three mirror lens in effort to dislodge the embolus and move it distally. Intraocular pressure can be lowered with hypotensive agents or paracentesis to stimulate retinal reperfusion. Patients can also hyperventilate into a paper bag. When this is done the brain interprets an increase in blood carbon dioxide and a decrease in oxygen which stimulates vasodilation. Even with these treatments, visual improvement is rare.

The recommended work up for patients diagnosed with a CRAO includes blood pressure evaluation, serology, carotid doppler, and an echocardiogram if a calcific emboli is suspected.

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Dr. Charles Bruce and Mike Fiordelisi of EMS

THANKS TO ENHANCED MEDICAL SERVICES

Mike Fiordelisi of Enhanced Medical Services arranged for their sponsorship of the November meeting. EMS hosted the cocktail hour and buffet. Mike brought several pieces of equipment for members to view and demonstrate.

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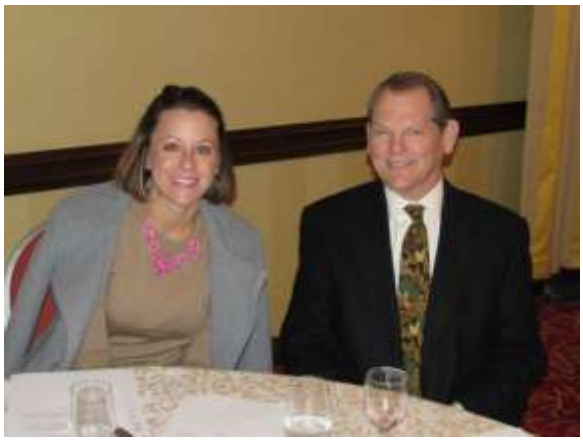
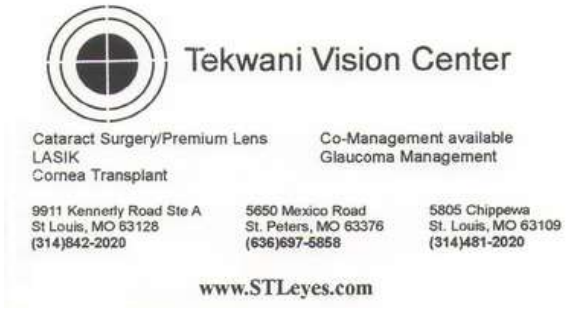


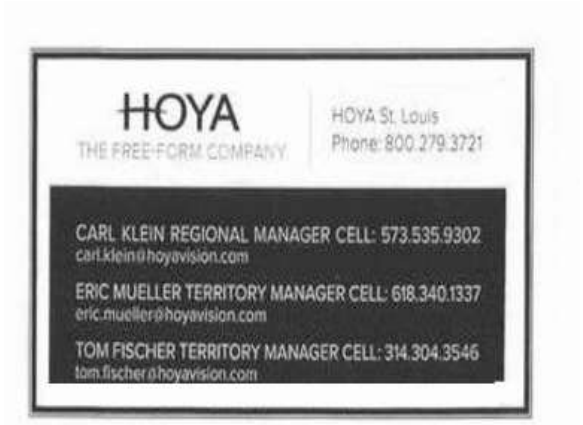
OPPORTUNITIES

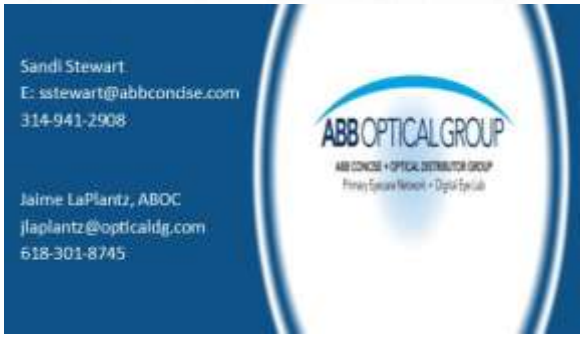
Arnold EyeCare is looking for a positive, knowledgeable Optometrist to join our busy, well-established private practice. Please email Diane Wilson at dianewilson1661@gmail.com for more information.

Private Practice For sale: Two location practice with gross revenues of nearly $900,000. State-of-the-art equipment with well-furnished optical. Owner is selling to pursue other business opportunities. Contact Dirk Massie, O.D., Practice Broker: drmassie@gmail.com, 618-567-0744

Practice for Sale (including building) in South St. Louis. Call Dr. Greg Boschert @ 314 352-7766 or 314 610-4612







UMSL students, Liindsay Schad & Aimee Miller

AOA-PAC CONGRESSIONAL ADVOCACY CONFERENCE

10 students and myself were able to attend the annual AOA-PAC Congressional Advocacy Conference in Washington, D.C. from September 9-11 thanks in part to SLOS' generous contributions. A total over 600 students and doctors had the opportunity to learn more about the current legislature affecting optometry from leaders in the field as well as gain advice from top political advisers, commentators and legislators.

The primary topics of focus were the Equity in Medicaid Act and National Health Services Corps Improvement Act. The National Health Services Corps bill is one of particular interest to students in that it aims to allow optometry students to compete for scholarships and the loan repayment program that other health professionals such as primary care physicians, dentists, physicians assistants, nurse practitioners and the like are already able to receive. Not only would this help to ease the debt burden that professional school entails, but it also helps bring us, as primary care eye specialists, to areas that are medically underserved with no additional cost to the system. The goal of Equity in Medicaid Act is to allow optometrists to continue to provide the estimated 81% of eye health and vision care through Medicaid. This bill would simply allow us the security of equal recognition as physician providers under Medicaid - as we have been under Medicare for the last 27 years.

Armed with this new knowledge, we were equipped to go to Capitol Hill and lobby our position to congressional members in private meetings. Our message was so well received that since our visit, Missouri Representative Cleaver is now co-sponsoring the Equity in Medicaid Act and Representatives Wagner and Smith have joined as co-sponsors of our Health Services Corps Act. With all that has been happening in Washington as of late, this progress is a true testament that our efforts on Capitol Hill are both well respected and effective. As a student, being able to witness and partake in the actual process of making progress as a profession is one that I hope so many others will be able to experience.

The 2014 AOA Congressional Advocacy Conference will be held April 28-30th, again in Washington, D.C.

Aaryn McComb . AOA PAC Liaison
UMSL College of Optometry, c/o 2015

Students, Jerika Kirwan & Katherine Gettinger

SLOS Contact Lens Report
Dan Friederich, O.D.

B+L Receives U.S. FDA Clearance for Novel Monthly Disposable Contact Lens
Valeant Pharmaceuticals International, Inc. and Bausch + Lomb (B+L) announced that the U.S. Food and Drug Administration (FDA) has issued marketing clearance for B+L's newest frequent replacement silicone hydrogel contact lenses made with MoistureSeal™ Technology. According to the company, this novel technology combines a breakthrough material with new manufacturing processes to produce a contact lens that offers superior comfort and vision.

SynergEyes to Streamline Its Policies and Procedures
SynergEyes, Inc. has announced that it will modernize its policies and procedures for ordering and returning lenses to make it easier for customers to do business with the company. Effective November 1st, prescribers will no longer need to return lenses in order to receive credit for discontinued fits, whether they are working with Duette, UltraHealth or SynergEyes lenses. In addition, the warranty period for all lenses will be 90 days and receiving credit will be easy and hassle-free. SynergEyes will also be automating a number of procedures, from account setup to billing. Accounts will have the option to receive printed versions of their statements or go paperless by using an online account management system.

CooperVision Extends Biofinity Parameters with Biofinity XR
The Biofinity (CooperVision) line of lenses has a new addition: Biofinity XR. Biofinity XR is now available up to -20.00 D and +15.00 D, giving us a simple high Dk (128) option for our high myopes and hyperopes. Biofinity is still only available in one base curve and diameter.

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CALENDER

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Dec. 10 — Midland Optical hosts SLOS Hol,iday Party
Cardwell's in Clayton
RSVP by Dec. 5
Bnahlik8544@charter.net
314 725-2020

2014

Jan. 12-13 — MOA Legislative Conference
Capitol Plaza Hotel
Jefferson City, MO
www.moeyecare.org

Jan. 11 — SLOS Meeting
St. Louis Marriott West
Program TBA

# # #

Looking for an opportunity to serve your community! Join the Eye Care Charity of Mid-America's volunteer doctors and serve on the Ronald McDonald Care Mobile. Call Dr. Christy Hayes at 636-778-1022 or email her at drhayes@eccoma.org.