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Redbird Club – Busch Stadium

Bulletin

June, 2014

Installation and Awards Banquet
Tuesday, June 10, 2014

6:30 p.m. ***Cocktail Reception***
Hosted by Midland Optical &
Galanis Cataract & Laser Eye Center

7:30 p.m. ***Dinner***
William DeWitt II, Speaker

Presentation of Awards
Installation of New Officers

Special Thanks to our Sponsors

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NEW BANQUET SPONSORS THIS YEAR
SLOS members welcome Envision Eye Specialists, Drs. Brent Davidson & Shana Rose, along with Quantum Vision Centers, also, Synergeyes. VSP also made a contribution to the event. Thanks to all.

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THANKS TO UMSL STUDENT LIAISONS
Third year optometry students from UMSL College of Optometry, Brad Collins and Alex Permann, have assisted at regular meetings during the past year. Many thanks for all your help.

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MOA REPORT – *Dr. Robert Goerss*
SB692 Failed to make it out of the House Insurance Policy Committee therefore it was not able to go to the floor for a vote before the end of session. Thanks to all who contacted their Senators and Representatives. There was much effort made by the MOA Board and Trustees in an attempt to pass this No Cap Fees legislation this year. Unfortunately Luxottica fought a strong battle against us at the capital including producing false information in regards to our profit margins for materials and our general philosophy on how we care for our patients. They are not our friend and continue to work against our profession as they grow stronger and stronger. For those who are not involved in the legislative process, please consider getting more involved next year as we move forward with future legislative endeavors. St. Louis Optometric Society is a direct branch of the Missouri Optometric Association and is the largest society with the greatest number of legislators to contact. We as an organization need to work harder to build stronger grass roots with our legislators if we want to continue to thrive as a profession.

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Thanks to Dr. Eric Polk for his COPE approved C.E.

FROM THE MAY MEETING…

"Corneal Refractive Surgery Enhancements"
Eric Polk, O.D.

Dr. Eric Polk presented the continuing education for the May SLOS meeting. Dr. Polk is a member and past president of SLOS, and is the clinical director at TLC Laser Eye Center in St. Louis.

Over 28 million LASIK surgeries have been performed worldwide and most patients are very happy and have stable vision. TLC has found that approximately 2% of their patients seek out enhancement surgery. The average patient who seeks out enhancement surgery has 20/30 to 20/40 uncorrected vision.

New technology, such as the use of the femtosecond laser to create LASIK flaps, has likely resulted in fewer patients requiring enhancements. Additionally, the newer generation lasers such as Alcon's Allegretto and Abbott Medical Optics' Visx lasers have produced better outcomes than their predecessors. Most doctors performing refractive surgery today also have more experience.

Several preoperative factors affect the likelihood of a patient requiring enhancement surgery. First, the magnitude of refractive error plays a role. Patients that are highly nearsighted or farsighted or have high astigmatism are more likely to seek out enhancement surgery. Patients over the age of 40 tend to be more likely to return for enhancement due to the onset of presbyopia.

Continued on next page – Dr. Polk

Dr. Polk Continued

Also, patients that have their LASIK flap created with a microkeratome tend to seek enhancement surgery more often than patients who had their flap created by the laser.

Hyperopic patients are about twice as likely to return for an enhancement as myopes. The reason is likely due to the type of ablation required to correct hyperopic patients. Rather than flattening the cornea as done in a myopic ablation, the cornea has to be steepened by a circular ablation pattern on the peripheral cornea. The ablation essentially tightens the corneal fibers and they may loosen with time causing the steepened cornea to flatten, making these patients hyperopic again. Some doctors have started corneal collagen cross-linking with hyperopic LASIK surgeries. After LASIK surgery has been performed, riboflavin is put in the eye followed by exposure to UVA light. They have found less regression when cross-linking was done with hyperopic surgeries. Unfortunately, corneal cross-linking is not yet FDA-approved and the cost of this procedure in addition to the cost of LASIK can lead to a very expensive surgery.

Monovision patients have a higher risk of requiring enhancement surgery partly because there are two distances being corrected rather than one. Additionally, presbyopia advances with age and patients return because their vision isn't as good as it was in the years immediately following their procedure. Dr. Polk tries to educate these patients at their preoperative visits that they should expect a change in their vision at some point after surgery.

Gas permeable contact lenses can be a risk factor because it is difficult to match the quality of the vision achieved with gas permeable contact lenses. Previous gas permeable contact lens wearers tend to return for enhancements more often even though they had been out of lenses for at least six weeks prior to surgery.

Lastly, depression has been shown to increase the likelihood of a patient returning for an enhancement procedure. Studies have shown that patients with depressive symptoms prior to their procedure were more likely to be unhappy with their results based on their perception.

Sometimes patients have blurred vision postoperatively regardless of all efforts to reduce this possibility. This can be due to the fact that eyes can over respond or under respond to the laser due to differing biomechanical properties of the cornea. ***Continued on page 5 – Dr. Polk***

Dr Polk Continued

Eyes become more dense and less hydrated with age which can alter the response to a laser ablation. A cornea with high hydration and low density tends to under correct while a cornea with low hydration and high density tends to over correct.

Patients may also experience blurred vision due to regression associated with age. The Beaver Dam Study showed that patients in their 40s and 50s tend to experience a hyperopic shift (+0.48D) in addition to the onset of presbyopia. Patients over the age of 70 can have myopic shifts often due to nuclear sclerosis. Altering surgical goals can compensate for this age based regression. Doctors at TLC set a goal of +0.25D for patients under the age of 30 and plano for patients between the ages of 30 and 44. A slightly myopic goal of -0.25D to -0.50D in the non-dominant eye is discussed with patients over the age of 45, however some of these patients chose to be fully corrected for distance.

Enhancements should be done when patients have blurred vision and are symptomatic. Good candidates are patients with uncorrected vision of 20/30 to 20/40 or less. Correction should be -0.50 DS or higher, +0.75 DS or higher, or -0.75D cylinder or higher. While lasers can be set for corrections as low as 0.25D, it is difficult to get a laser ablation to correct this because such a small amount of tissue is being ablated. Patients that complain of irregular vision such as ghost imaging can sometimes be corrected with a custom wavefront ablation.

There are cases in which enhancement surgeries should not be done. First, patients with corneal thickness of 400 microns or less should not have another procedure because the risk is too high for corneal ectasia. Secondly, postoperative keratometry should not be too flat or too steep because loss of best corrected vision or night vision issues can result. Myopic ablations should not flatten a cornea beyond 34D and hyperopic ablations should not steepen a cornea greater than 50D. Additionally, patients that show early signs of keratectasia should not go forward with an enhancement. This includes topographies that show irregular astigmatism, inferior steepening or posterior corneal float. Lastly, it is better to avoid enchancing patients that are experiencing a myopic shift due to nuclear sclerosis. After the enhancement procedure these patients will likely become nearsighted again as the cataract develops.

Continued on page 6 - Dr. Polk

Dr. Polk Continued

There are different methods for enhancement surgery. LASIK flaps can be lifted years after surgery. Flaps with fibrotic edges tend to be particularly adherent and can be difficult to lift. This increases this risk for torn flaps as well as irregular edges often found on lifted flaps. This increases the risk of epithelial ingrowth which is a proliferation of epithelial cells at the interface that can cause flap necrosis and, ultimately, a flap melt.

Enhancements can also be done utilizing a femtosecond laser to assist in the flap lift. Side cuts are created at the edge of the existing flap to create straight edges to a smaller diameter flap from the original LASIK flap. This method can sometimes result in slivers of corneal tissue and can increase the cost of enhancement surgery.

TLC's primary enhancement method is PRK. The epithelium is removed and the anterior portion of the existing flap is ablated. This method has very little risk for epithelial ingrowth and less risk for keratectasia.

Patients who have had PRK enhancement procedures often have unusual refractions around the five day post operative day. As the epithelium grows back, it is thinner and heals in a sideways direction. This can result in about 1D of with-the-rule astigmatism and as the epithelium heals the refraction will improve. It can sometimes take four to eight weeks for patients to reach their end result.

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Optometrist wanted: Part time with medical optometry/ophthalmology experience, comfortable with mild to moderate pathology. Contact Dr. Mason Bias, mbias@visionarysight.com

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Fill in OD needed at small practice in Saint Peters, Missouri. One to four Saturdays and/or Sundays per month. Hours Saturdays 9:30 - 4:30, Sundays 11-4. Competitive salary, professional liability insurance included. Great part time opportunity. Call 314-276-2217 for more information.

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NEXT REGULAR SLOS MEETING: July 8
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